WOMEN'S RIGHT TO ACCESS FAMILY PLANNING AND MATERNAL HEALTH CARE SERVICES IN HWANGE RURAL DISTRICT, ZIMBABWE: CHALLENGES AND OPPORTUNITIES

BY

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DECLARATION

I, LINET SITHOLE, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university. I authorise the University to reproduce for research either the whole or any portion of the contents in any manner whatsoever.

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DEDICATION

To my husband, Walter Tawanda Muswera, for believing in me always. To my children Chiedza Gabriella Muswera and Theodore Zvikomborero Muswera, who had to endure the inconvenience of mum's divided attention and absence during this journey – I love you.

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ABSTRACT

The significance of reproductive health and rights cannot be overemphasised. Investment in the rights of rural women, specifically their reproductive health rights, is a fundamental determinant of their empowerment and social development. Access to reproductive health services enables rural women to make informed choices in their reproductive lives. This is of paramount significance because the exercise of choice in one domain opens possibilities for choices in others. International and regional human rights treaties recognise the significance of reproductive health rights for women's wellbeing and survival and require that State Parties provide access to reproductive health services. Zimbabwe has ratified the relevant human rights treaties and has domesticated many of their provisions through the Constitution and other laws. Zimbabwe has obligations to respect, protect, promote and fulfil the right to reproductive health. Despite these obligations, rural women face a plethora of challenges in accessing reproductive health services, and their right to reproductive health continues to be infringed. The infringement is in violation of Zimbabwe's international and domestic human rights obligations. The purpose of this study was to examine and establish the challenges confronting rural women when accessing reproductive health care services in Hwange Rural District Zimbabwe. Using a phenomenology qualitative research design, data were gathered through structured face-to-face interviews with 20 women of reproductive age and five health care providers. Data from the field were bolstered with reviews of extant literature. Collected field data were thematically analysed and presented.

The research findings revealed that although most of Zimbabwe's legislative, policy and institutional frameworks have provisions that comply with international obligations, the frameworks also contain restrictive provisions which perpetuate the challenges women face in accessing reproductive health care services. Furthermore, the human-rights compliant legislative and policy frameworks are often not properly implemented, thus leading to a violation of the right to reproductive health in practice.

The study's empirical research revealed that in Hwange Rural District, women's capabilities to exercise their reproductive rights are limited by factors such as physical barriers like distance to the nearest health facility, availability of services and quality of care given at health facilities, poverty, religion and patriarchal tradition. A major challenge unearthed by the study was that rural women in Hwange District are not aware of their reproductive health rights. This lack of

knowledge is disempowering because women who do not know their rights are not knowledgeable enough to demand their rights or defend them when violated.

To redress the challenges faced by rural women, the study found that women can use judicial and non-judicial mechanisms ─ including the courts, human rights institutions, non-governmental organisations, and civil society organisations ─ for litigation, exertion of political pressure, awareness raising and grassroots mobilisation. Such strategies are essential for ensuring that women hold the State accountable for violations of their reproductive rights.

The study concludes that there is need to raise awareness on the right to reproductive health and the enacted laws and policies so as to equip women with the necessary information that will allow them to exercise their rights. It recommends that intensive human rights education programmes for both the formal and informal sector should be prioritised. It recommends the provision of adequate resourcing of various state institutions responsible for women's rights issues. Further, there should be a situational analysis of challenges faced by rural women in Zimbabwe based on the intricate factors of location within rural areas, religion, gender, human rights knowledge, culture and tradition. After such situational analysis, there is need to enact laws and policies that respond directly to the unique challenges faced by rural women, without using a 'one size fits all' approach.

Key words: *Reproductive health services; rural women; right to reproductive health; Hwange Rural District, Zimbabwe*

TABLE OF CONTENTS

Contents

ABBREVIATIONS AND ACRONYMS

ACRWC	African Charter on the Rights and Welfare of the Child
AU	African Union
BDPA	Beijing Declaration and Programme for Action
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHI	Complaints Handling and Investigations
CHW	Community Health Workers
COMMPAC	Community Mobilization for Post abortion Care in Kenya
CRC	Convention on the Rights of the Child
CWGH	Community Working Group on Health
DVA	Domestic Violence Act
EPR	Education, Promotion and Research
ICESCR	International Covenant on Social, Economic and Cultural Rights
ICPD	United Nations International Conference on Population and Development
IEC	Information, Education and Communication
LAD	Legal Aid Directorate
MDG	Millennium Development Goals
MoHCC	Ministry of Health and Child Care
MRCZ	Medical Research Council of Zimbabwe

MWH	Maternity Waiting Home
OAU	Organization of African Unity
PHC	Primary Health Care
TWG	Thematic Working Groups
UPR	Universal Periodic Review
WHO	World Health Organisation
MWH	Maternity Waiting Home
SDG	Sustainable Development Goals
UDHR	Universal Declaration of Human Rights
UNESCO	United Nations Educational, Scientific, Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VDPA	Vienna Declaration and Programme of Action
ZIMSTAT	Zimbabwe National Statistics Agency
ZDHS	Zimbabwe Demographic Health Survey
ZGC	Zimbabwe Gender Commission
ZHRC	Zimbabwe Human Rights Commission
ZNFPC	Zimbabwe National Family Planning Council
ZWLA	Zimbabwe Women Lawyers Association

CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

'....it is time to invest more in rural women, protect their rights and improve their status. On this international day, I call on all partners to support rural women, listen to their voices and ideas, and ensure that policies respond to their needs and demands. Let us do everything we can to enable them to reach their potential for the benefit of all.'

United Nations Secretary General, Ban Ki-moon. International Day of the Rural Women. New York, 15 October 2012.

1.1 INTRODUCTION AND BACKGROUND

The import of reproductive health and rights cannot be emphasised enough. Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions. This 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.[1] Reproductive health and rights remain vital to people's wellbeing and survival, and ultimately the realisation of wider socio-economic development goals.[2] Realisation of rural women's rights, precisely their reproductive health rights is a fundamental determinant to their empowerment and social development. Further, access to reproductive health services for rural women allows them to make informed choices in their reproductive lives.[3] This is of paramount significance because the exercise of choice in one domain opens up possibilities of choices in others, such as education and employment.

The importance of reproductive health services is anchored in various international treaties and policies to which Zimbabwe is a state party. The treaties include but are not limited to the following: Covenant on Economic, Social and Cultural Rights;[4] Convention on the Elimination of all forms of Discrimination against Women;[5] the African Charter on Human

[1] United Nations *Report of the International Conference on Population and Development* (1994). *Cairo, 5-13 September 1994*, A/CONF.171/13/Rev.1. A detailed discussion of reproductive health is given in section 1.2.1 below.
[2] Starrs AM, Ezeh AC & Barker G *et al* 'Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission.' 2018 *The Lancet*.
[3] Similo Ngwenya 'Communication of reproductive health information to the rural girl child in Filabusi, Zimbabwe' (2016) *African Health Sciences Volume 16 (2)*.
[4] International Covenant on Economic, Social and Cultural Rights, Adopted United Nations General Assembly Resolution 2200A (XXI) of 16 December 1966 and entered into force on 3 January 1976.
[5] Convention on the Elimination of All Forms of Discrimination Against Women, Adopted by United Nations General Assembly Resolution 34/180 of 18 December 1979 and entered into force on 3 September 1981.

and Peoples' Rights;[6] African Charter on the Rights and Welfare of the Child;[7] the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.[8] Likewise, development policies including the Millennium Development Goals (MDGs) were put in place to direct nations in major challenges affecting humanity. At their expiry in 2015, the MDGs were replaced with the 2030 Agenda for Sustainable Development that includes 17 Sustainable Development Goals (SDGs) designed as a 'blueprint to achieve a better and more sustainable future for all'. In light of the SDGs and the mentioned treaties, it is imperative to assess the strides made by the Government in complying with its international obligations and therefore project opportunities available in promoting and protecting women's reproductive rights in the 21st century.

Besides being a State Party to international law and policy framework, the Zimbabwean government has made some efforts in addressing reproductive health services. Notably, the Zimbabwe promulgated a progressive Constitution Amendment (No.20) Act of 2013 (hereinafter referred to as the Constitution). The Constitution is hailed for its potential to regard the reproductive rights of women as inalienable, interdependent, universal and indivisible. This is unlike Zimbabwe's former flawed and inadequate Constitution which did not provide for the right to health, let alone the right to access reproductive health services. The inadequacies and flaws of the Lancaster House Constitution are cured by Section 76(1) of the current Constitution of Zimbabwe which provides that:–

> Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services.

The right to health is also echoed in Chapter 2 of the Constitution which lays down the National Objectives. Section 29 clearly stipulates the State's obligations with regards to the right to health and provides as follows:

1. The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.
2. The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution.
3. The State must take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease.

[6] African Charter on Human and Peoples' Rights adopted by the then Organization of African Unity (OAU) on 27 June 1981 and came into force on 21 October 1986.
[7] African Charter on the Rights and Welfare of the Child, 11 July 1990, CAB/LEG/24.9/49. Entered into force on 29 November 1999.
[8] Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 11 July 2003.

The Constitution of 2013 and other laws enacted before it such as the Termination of Pregnancy Act[9] and the Domestic Violence Act[10] work to protect reproductive health rights.

The Government has attempted to improve women's reproductive health through various programmes and projects during the past decade. One significant project is the Maternity Waiting Homes (MWHs) Project. The concept of MWHs was introduced after independence in 1980 and all rural district hospitals in Zimbabwe have a MWH.[11] However, since 2007 most MWHs were dilapidated resulting in underutilization or disuse. To revitalise the dilapidated MWHs, the Government, through the Ministry of Health and Child Welfare[12] established the Maternity Waiting Homes Operational Guidelines in 2010. The objective of the guidelines was to renew MWHs[13] as a practical strategy and intervention designed to improve access to health institutions, increasing institutional deliveries, improving access to skilled attendance at birth and thus reducing maternal mortality.[14]

In 2010, Zimbabwe launched the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)[15] under the theme 'Zimbabwe Cares: No Woman Should Die While Giving Life!' The main objective of the campaign was to 'activate improved national and stakeholder efforts to accelerate the availability, accessibility and utilisation of quality health services, including those related to sexual and reproductive health, which are critical for

[9] [Chapter 15:10].
[10] [Chapter 5:16].
[11] United Nations Population Fund 'Maternity Waiting Homes: Promoting Institutional Delivery and Pregnant Women's Access to Skilled Care' Available *at https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/MATERNITYWAITINGHOMES.SUMMARY.pdf*, accessed 21 March 2020.
[12] The Ministry of Health and Child Care is the government ministry responsible for health in Zimbabwe whose purpose is to promote the health and quality of life of the people of Zimbabwe.
[13] Maternity waiting homes are homes that provide a setting where high risk women can be accommodated during the final weeks of their pregnancy near a hospital with essential obstetric facilities.
[14] UNFPA 'Maternity Waiting Homes'. See also Holmes W & Kennedy E *Reaching emergency obstetric care: overcoming the 'second delay* (2010). Holmes and Kennedy argue that strategies typically designed for inaccessible areas, like maternity waiting homes, aim to facilitate the timely movement of women from home to health facility by diminishing barriers that inhibit access to care such as distance, geography, seasonal barriers or the time of day. The interventions relate to improving infrastructure or transport, addressing the cost of transport or enabling communication between referral points; Loveday Penn-Kekana *et al* 'Understanding the implementation of maternity waiting homes in low- and middle-income countries: a qualitative thematic synthesis' (2017) *BMC Pregnancy and Childbirth* 17:269.
[15] The African Union (AU) launched a Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009 to bring attention to the maternal mortality challenge and to foster champions to advocate for policies to improve maternal health. CARMMA was born out of the Maputo Plan of Action (Maputo PoA), adopted by the AU in 2006, whose aim was to achieve universal access to comprehensive sexual and reproductive health and rights in Africa by 2015.

the reduction of maternal and neonatal mortality.'[16] However, it is apparent that efforts to reduce maternal mortality need to intensify as statistics show a worsening trend.[17]

Another effort made by the Government of Zimbabwe through the then Ministry of Health and Child Welfare in partnership with the United Nations and international development partners, was the establishment, in 2012, of a four year national Integrated Support Programme (ISP) which was aimed at improving women and girls' sexual and reproductive health.[18] The ISP, which ran from 2012 to 2015, had the objective of addressing four priority areas in an integrated approach, namely: family planning, cervical cancer, gender based violence and HIV prevention. Another noteworthy strategy is Zimbabwe's 2016-2020 National Health Strategy, which builds on the 2009-2013 strategy[19] and its extension in 2014-15. As explained by the Ministry of Health and Child Care, the 2016-2020 Strategy:

> by addressing existing gaps and, more importantly, seeks to sustain the gains achieved thus far through a comprehensive response to the burden of disease and strengthening of the health system to deliver quality health services to all Zimbabweans.[20]

However, despite the positive developments outlined above (the progressive Constitution, the policy measures and the ratification of international human rights treaties), reproductive health, which includes maternal health and family planning, remains a major public health problem.[21] This is evidenced by the high incidence of maternal mortality,

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[16] SAFAIDS 'Zimbabwe to Launch CARMMA No Woman Should Die While Giving Life!' 2010 available at *http://www.safaids.net/content/zimbabwe-launch-carmma-no-woman-should-die-while-giving-life*, accessed on 12 April 2016.

[17] Government of Zimbabwe & United Nations Zimbabwe 'Zimbabwe Millennium Development Goals Progress Report 2012' available at *http://www.undp.org/content/dam/undp/library/MDG/english/MDGper cent20Countryper cent20Reports/Zimbabwe/MDGRper cent202012finalper cent20draftper cent208.pdf?download*, accessed on 15 March 2016.

[18] United Nations Zimbabwe 'Zimbabwe Launches a Four Year Sexual and Reproductive Health and HIV Prevention Programme' available at: *http://www.zw.one.un.org/newsroom/news/zimbabwe-launches-four-year-sexual-and-reproductive-health-and-hiv-prevention*, accessed on 18 March 2016.

[19] Ministry of Health and Child Care *The National Health Strategy for Zimbabwe (2009–2013), Equity and Quality in Health: A People's Right* (2010); whose aim is to provide a framework for immediate resuscitation of the health sector (Health System Strengthening), and secondly, to put Zimbabwe back on track towards achieving the Millennium Development Goals.

[20] Ministry of Health and Child Care *The National Health Strategy for Zimbabwe (2016–2020), Equity and Quality in Health: Leaving No one Behind* (2016).

[21] See Cicely Dudley, Jenna Kerns & Karen Steadman *More than 'women's issues': Women's reproductive and gynaecological health at work*. 2017. Available at *https://static1.squarespace.com/static/5b2ca1c955b02cb43fbf85fe/t/5c7ea67df9619ad5a8accbd0/1551804029472/419_MoreThanWomensIssues.pdf*, accessed on 29 April 2020. The Report argues that reproductive health is a public health issue with far reaching impacts, especially for women, throughout the whole of life, with intergenerational effects on children and families, and economic impacts through lost hours of work and school absenteeism as a result of unwanted reproductive symptoms

unplanned teenage pregnancy[22] and unsafe abortions.[23] Women's limited access to reproductive health services is especially evident in developing nations as compared to developed nations. For instance, the WHO states that:

> The high number of maternal deaths in some areas of the world *reflects inequities in access to health services, and highlights the gap between rich and poor.* Almost all maternal deaths (94%) occurred in low-income and lower-middle-income countries, and almost two thirds (65%) occurred in the World Health Organization (WHO) African Region.[24]

According to the UN Secretary General, there are 'serious urban/rural discrepancies as a result of poor service delivery in rural areas and rural underdevelopment,' which include higher rates of poverty.[25] Each year in developing regions,

> …more than 30 million women do not give birth in a health facility, more than 45 million have inadequate or no antenatal care, and more than 200 million women want to avoid pregnancy but are not using modern contraception.[26]

The rural-urban discrepancy is worsened by societal discrimination. Although rural women constitute a quarter of the world population,[27] they remain discriminated against[28] and are unjustly affected by a lack of realisation of human rights.[29] Additionally, the Inter-Agency Taskforce on Rural Women reports that,

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[22] Zimbabwe National Statistics Agency and ICF International *Zimbabwe Demographic and Health Survey 2015*.
[23] Mahomed K, Healy J, & Tandon S 'A comparison of manual vacuum aspiration (MVA) and sharp curettage in the management of incomplete abortion' (1994) *International Journal of Gynaecology and Obstetrics 46(1):*27-32.
[24] WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division *Maternal mortality: Levels and trends 2000 to 2017*. (2019). Available at *https://www.who.int/reproductivehealth/publications/maternalmortality-2000-2017/en/,* accessed 18 July 2020.
[25] United Nations Secretary General *The empowerment of rural women and their role in poverty and hunger eradication, development and current challenge*, United Nations General Assembly Document E/CN.6/2012/3 (2011).
[26] Stars AM, Ezeh AC & Barker G *et al* 'Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission.' 2018 *The Lancet*.at 2644.
[27] See, UN Women 'In Focus: International Day of Rural Women' available at *https://www.unwomen.org/en/news/in-focus/rural-women-day*, accessed 15 August 2 019; Alette van Leur. 'Rural women need equality now' (2018). Paper presented at the UN 62nd session of the Commission on the Status of Women.
[28] See generally, United Nations GA/SHC/3887 'Prioritizing Rural Development Fundamental to Advancement of Women' discussed at the Sixty-second General Assembly Third Committee (Social, Humanitarian and Cultural) Meeting held in October 2007 where the discussions centred around the fact that rural women still face manifold disadvantages and discrimination; Bobo, T 'Challenges Facing Rural Women' available at *http://www.masimanyane.org.za/sites/default/files/Challengesper cent20facingper cent20ruralper cent20women.doc,* accessed on 17 March 2016; General Statement of the Committee on the Elimination of Discrimination against Women on Rural Women adopted on 19 October 2011, available at *http://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/StatementRuralWomen.pdf*, accessed on 16 March 2016.
[29] United Nations Secretary General *Improvement of the situation of women in rural areas*, United Nations General Assembly Document A/62/202 (2007).

> Rural women report more physical abuse than urban women, with more difficulty accessing the police or other service providers because of their geographic location. Rural girls in particular face more significant pressure to submit to harmful traditional practices, such as child betrothal, early and forced marriage and early pregnancy, which put their rights at risk.'[30]

Patriarchy, as deeply rooted in culture and custom, remains one major hindrance to the enjoyment of rural women's rights in general, and their reproductive rights in particular.[31] By their nature, patriarchal structures and systems favour men and despise women in different ways. This makes women more vulnerable to human rights violations in rural areas.

The impact of patriarchy on women in general, and on women's autonomy is succinctly described by Kambarami as follows:

> The family, as a social institution, is a brewery for patriarchal practices by socializing the young to accept sexually differentiated roles. In the Shona culture, from a tender age, the socialization process differentiates the girl child from the boy child. Shona males are socialized to view themselves as breadwinners and heads of households whilst females are taught to be obedient and submissive housekeepers… In the family, the male child is preferred to the female child. In fact, males rule females by right of birth and even if the male child is not the first born in a family, he is automatically considered the head of the household who should protect and look after his sisters.[32]

Although visible in urban areas, the effects of patriarchy are most common in rural areas. For instance, decision-making is always left to the men - women are not consulted and, as a result, their voices are silent whilst their role is limited to listening and implementing of men's decisions.[33] In the Shona culture, the proverb *'chakafukidza dzimba matenga'* (loosely translated to 'the secrets of the home need to remain untold') is used to perpetuate control of women by men as it silences women from disclosing how their husbands treat them. Manyonganise argues that,

> In such cases, abusive partners would continue with their abusive behaviour realising that the public would never know about it. Even after discovering that their husbands are engaging in extra-marital relationships and have contracted HIV, most women continue to sleep with their husbands, making themselves vulnerable to infection in the process. Shona women are taught

[30] Inter-Agency Task Force on Rural Women 'Rural women and Millennium Development Goals Report 5' (2010) available at *http://www.un.org/womenwatch/feature/ruralwomen/documents/En-Rural-Women-MDGs-print.pdf*, accessed on 12 March 2016.
[31] Helen Chukwuma 'Women's Quest for Rights: African Feminist Theory in Fiction' (2006) *Forum on Public Policy*, available at *http//www.forumonpublicpolicy.com/archivespring07/chukwuma.pdf*, accessed on 23 March 2016.
[32] Kambarami M 'Femininity, Sexuality and Culture: Patriarchy and Female Subordination in Zimbabwe' (2006) *Understanding Human Sexuality Seminar Series* at 3.
[33] Manyonganise M 'Oppressive and liberative: A Zimbabwean woman's reflections on *ubuntu*', (2005) Verbum et Ecclesia 36(2) at 3.

> that at no point should they deny their husbands sex *(murume haanyimwe bonde').* Moreover, their subordinate position does not enable them to demand that thy use protection during sexual intercourse.[34]

Rural women's capacities and capabilities to be autonomous and thus make reproductive health decisions are limited by their sex and gender. This is compounded where their sex and gender intersects with class, literacy levels and poverty. While access to reproductive health care services largely depends on class, status, and economic independence, women in rural areas continue to suffer in poverty. For example, the right to health for rural women remains inaccessible due to a number of factors that hinder access. These factors include distance to health facility, lack of transport and shortage of both human and medical resources at the facilities. In Zimbabwe, a substantial number of the populace lives in rural areas where availability, accessibility, and affordability of health services remain a challenge.[35]

This dissertation analyses the impact of the Government of Zimbabwe's intervention strategies with regard to rural women's right to access reproductive health care services. Furthermore, the study invokes the words of rural women to explain their experiences in accessing reproductive health services in Hwange District. This focus helps to fill a gap in the existing literature regarding rural women's enjoyment of sexual and reproductive rights in Zimbabwe.

1.2 CONCEPTUALISING THE RIGHT TO REPRODUCTIVE HEALTH

Promotion and protection of women's rights in rural areas, precisely their sexual and reproductive health rights, is a fundamental determinant of women's empowerment and social development. Upholding the right to reproductive health 'is key to ensuring that all people can be equal and free to make decisions in all spheres of their lives, without discrimination, without violence or coercion, and with the assurance of their dignity upheld.'[36] Violence against women is a form of discrimination, directed towards a woman because she is a woman.[37] This violence,

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[34] Manyonganise M 'Oppressive and liberative' 2005 at 4.

[35] Zimbabwe National Statistics Agency. *Zimbabwe Demographic and Health Survey 2015.* The report indicated that the population of Zimbabwe was 13 061 239. The proportion of male and female population was 48 and 52 percent respectively. The report further highlighted that 67 per cent of the country's population live in the rural areas, and approximately 52 per cent of this rural population are women.

[36] Kate Gilmore, UNFPA Deputy Executive Director (Programme) at the High Level Side Event "Sexual and Reproductive Health and Rights: The key to gender equality and the empowerment of women and girls" at the 59th Commission on the Status of Women.

[37] CEDAW general recommendation No 19: Violence against Women Committee on the Elimination of Discrimination against Women 11th session UN Doc A/47/38 (1992).

which is expressly linked to the right to health, limits women's ability to enjoy rights and freedoms on a basis of equality with men.

It is against this background that stakeholders the world over have tried to eliminate violations of reproductive rights including unsafe abortion, violence against women, maternal deaths and child marriages. In some parts of the world, these practices are tolerated and accepted as either natural and inevitable or customary and necessary despite the fact that they impede development in many ways.

This study argues that the efforts to avert reproductive health violations have, in the past, had minimal success due to the fact that focus was on reproductive health as a population issue and not as a human rights issue. However, if progress is to be made in ensuring that women in general, and rural women in particular, have access to reproductive health services, it is time that human rights were invoked. Specifically, states should be held accountable for their obligations to respect, protect and promote the right to reproductive health. These obligations are discussed in detail in Chapter Two.

This thesis examines whether the reproductive health rights of Zimbabwe's rural woman are currently respected, protected, promoted and fulfilled. The dissertation includes an empirical investigation into the provision of reproductive health services in rural Hwange District in Zimbabwe, and examines the relevant legal framework in terms of national, regional and international human rights law. The dissertation concludes that the reproductive health rights of rural Zimbabwean women are inadequately protected at present, and makes some recommendations as to how the reproductive rights of rural woman could be better respected, protected and promoted through compliance with international and domestic law.

1.2.1 Conceptual clarification of the right to reproductive health

Having highlighted the significance of using the human rights framework, this section briefly clarifies the conceptual framework of the right to reproductive health adopted in this dissertation. The clarification is brief because a detailed discussion of the concept of, and the right to reproductive health is presented in Chapter Two.

Even though reproductive health rights are grounded upon other existing human rights, there is no conventional definition of the term.[38] The United Nations International Conference on Population and Development (ICPD) 1994 defines reproductive health as follows:

> Reproductive health is 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 to 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 right 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 are 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.[39]

The ICPD further defines reproductive healthcare as a constellation of methods, techniques and services that contribute to reproductive health which includes;[40]

a) Family planning services;
b) Access to contraception, counselling and information;
c) Antenatal, postnatal and delivery care, health care for infants;
d) Treatment for reproductive tract infections and sexually transmitted diseases (including HIV/AIDS);
e) Safe abortion services where legal[41] and management of abortion-related complications;
f) Prevention and appropriate treatment for infertility,
g) Information, education and counselling on human sexuality, reproductive health and responsible parenting and discouragement of harmful practices.

[38] UNFPA *Integrating Reproductive Rights into the work of National Human Rights Institutions of the Asia Pacific Region: A Preliminary study of current views and practices, challenges opportunities* (2011).
[39] United Nations *Report of the International Conference on Population and Development* (1994). *Cairo, 5-13 September 1994,* A/CONF.171/13/Rev.1.
[40] Paragraph 7.2 and 7.6 of the United Nations Report of the International Conference on Population and Development.
[41] Under the Zimbabwe Termination of Pregnancy Act, section 5, abortion is legally permitted only in the following circumstances: to save the life of the pregnant woman, if the continuation of the pregnancy endangers her life; if the pregnancy is a serious threat to the pregnant woman's physical health and could cause permanent damage; if there is a serious risk that, if the child is born, it will suffer from a physical or mental defect that will cause the child to be severely handicapped; where the pregnancy is as a result of unlawful intercourse.

Given the above definitions, it is imperative to note that this study cannot focus on reproductive health care in its entirety. Instead the study focuses specifically on:

a. Access to ante-natal care, safe motherhood services, assisted childbirth from a trained attendant (maternal health),
b. Access to family planning services; and
c. Information and education on human sexuality and reproductive health.

The following sub-sections present an introduction to the specific elements of the rights that this study focuses on. In both cases, the study looks particularly at 'access'[42] to the services concerned. This thesis adopts the following elements when considering access to reproductive health care: geographic availability, accessibility, affordability, acceptability and quality.

1.2.2 Right to have access to family planning information and services

The first right to be discussed is the right to have access to family planning services. What do we mean by family planning? The World Health Organization does not define the term. Instead, it describes what family planning does and its benefits as follows:

> Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy. [43]

[42] For the sake of clarity, I explain the meaning of the term 'access' that my study adopted. Access is itself a multi-faceted concept. Etymologically, access is defined as the means or opportunity to approach or enter a place or permission, liberty, or ability to enter, approach, or pass to and from a place or to approach or communicate with a person or thing. Within health care, Daniels N.' Equity of Access to health care: some conceptual and ethical issues' Milbank Memorial Fund Quarterly Volume 60 (1982) defines access as access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs. Owen O'Donnell 'Access to health care in developing countries: breaking down demand side barriers' (2007) *Cad Saúde Pública, Rio de Janeiro Volume 23 No. 12* postulates that access to health care, in its narrowest sense, refers 'to geographic availability.' A comprehensive definition of the term, according to Penchansky R & Thomas J W 'The concept of access: definition and relationship to consumer satisfaction' cited in Owen O'Donnell 'Access to health care in developing countries: breaking down demand side barriers' (2007) Cad Saúde Pública, Rio de Janeiro Volume 23 No. 12, 'identifies four dimensions of access: availability, accessibility, affordability, and acceptability.' Another definition proffered by Rogers A, Flowers J & Pencheon D 'Improving access needs a whole systems approach' (2009) is that access to health care means the 'provision of the right service, at the right time, in the right place.' Guided by these definitions, this thesis adopted the following elements when considering access to reproductive health care: geographic availability, accessibility, affordability, acceptability and time.

[43] WHO *Handbook on Family Planning* 2007

The WHO in its Standards for Maternal and Neo-Natal Report of 2017 further states that family planning is a way of thinking and living that is adopted voluntarily upon the bases of knowledge, attitude, and responsible decisions by couples and individuals.[44] Mathur[45] defines family planning as a deliberate attempt to space the births of the children and to plan the size of the family in accordance with their social, economic and health conditions, to ensure that the family is happy both physically and mentally. Family planning has also been defined as:

> a preventive service that allows married couples achieving their desired number of children and deciding the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health.[46]

Therefore, from the aforementioned definitions, it is clear that family planning deals with a number of factors that contribute to the overall good reproductive health of every human being: precisely, individuals and couples having the power to decide the number and spacing of their children, avoiding undesired pregnancies and abortions, and preventing sexually transmitted diseases.

Article 16 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[47] guarantees women equal rights in deciding 'freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.' The Committee on the Elimination of Discrimination Against Women has explained that 'in order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention.'[48] Contraception is also a key dimension of the right to the highest attainable standard of physical and mental health as set out in the International Covenant on Social, Economic and Cultural Rights

[44] World Health Organization *Standards for Maternal and Neonatal Care* 2007.
[45] Mathur JS *Preventive and Social Medicine*: *A Comprehensive Textbook with Special Focus on Nepal* (2007).
[46] Nazli Sensoy, Yasemin Korkut, Selcuk Akturan et al 'Factors Affecting the Attitudes of Women toward Family Planning' in Zouhair Amarin (ed) 2018 *Family Planning*.
[47] Convention on the Elimination of All Forms of Discrimination Against Women, Adopted by United Nations General Assembly Resolution 34/180 of 18 December 1979 and entered into force on 3 September 1981.
[48] General Recommendation 21 (1994) on equality in marriage and family relations, para. 22

(ICESCR).[49] Women's childbearing role also has an impact on their enjoyment of other rights protected by the ICESCR, such as the rights to education and to work.[50] Therefore, women should be able to control how child bearing affects their education and employment.

Ensuring women's reproductive health rights means that women's autonomy to make decisions regarding their bodies must be respected. However, in many sub-Saharan Africa countries, women lack access to family planning services because issues concerning sexual intercourse and condom use are shrouded in secrecy.[51] It has also been noted that:

> Deficient or incorrect family planning methods, wrong attitudes and behaviours toward the methods and consequent unplanned pregnancies, increased maternal and infant mortality rates are the main health problems in most countries.[52]

For instance, in 2008, the global estimations of unsafe abortions, which could be prevented by contraception, were between 21 million and 22 million – nearly 2 million more than the number projected for 2003.[53] The review of abortion policies done by the United Nations revealed that they were roughly 210 million pregnancies in 2008[54] implying that around one in 10 pregnancies ends in an unsafe abortion worldwide. The burdens of unsafe abortion and of maternal deaths due to unsafe abortion are disproportionately higher for women in Africa than in any other developing region.[55]

The WHO's global estimates on abortion indicate that:

> while Africa accounts for 27 per cent of global births annually and for only 14 per cent of the women aged 15–49 years in the world, its share of global unsafe abortions was 29 per cent and, more seriously, 62 per cent of all deaths related to unsafe abortion occurred in Africa in 2008.[56]

The significance of family planning cannot be overemphasized. Family planning is a key pillar of safe motherhood services and its benefits include: reduction of child and maternal

[49] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/66/254 (2011), paras. 44, 48. See also International Covenant on Economic, Social and Cultural Rights, Article 12.
[50] International Covenant on Economic, Social and Cultural Rights, Articles 13 and 6.
[51] Eugene Kofuor, Maafo Darteh & David Teye Doku *et al* 'Reproductive health decision making among Ghanaian women' (2014) *Reproductive Health Volume 11 Issue 23*.
[52] Nazli Sensoy et al 'Factors Affecting the Attitudes of Women toward Family Planning'.
[53] Stars AM, Ezeh AC & Barker G *et al* 'Accelerate progress' 2018 at 2650.
[54] United Nations *Abortion policies: A global review Volume 3* (2002).
[55] Shah I & Ahman E 'Unsafe abortion: global and regional incidence, trends, consequences and challenges' (2009) *Journal of Obstetrics and Gynaecology Canada* Volume 31 No. 2.
[56] Stars AM, Ezeh AC & Barker G *et al* 'Accelerate progress' 2018.

morbidity and mortality by preventing unintended pregnancies and unsafe abortions;[57] it also enables birth spacing, ultimately reducing child mortality while enhancing the nutritional status of both mother and child.[58] Despite the existence of legal instruments that provide for women's access to reproductive health care, rural women still face challenges. The purpose of the study is to unearth the challenges from the rural women's lived experiences, thus adding knowledge on rural women's access to reproductive health care.

1.2.3 The right to access maternal health services

The second right to be discussed is the right to have access to safe maternal health services. The World Health Organisation defines maternal health as 'the health of women during pregnancy, childbirth and the postpartum period.'[59] Maternal health care services therefore include access to prenatal, delivery and postnatal care in order to ensure a healthy and fulfilling experience on one hand and reduce maternal morbidity and mortality on the other.[60]

In an attempt to define 'safe motherhood', which is a result of access to maternal health services, Maine gives a sequence of three events which explain unsafe maternal health:

- a woman becomes pregnant, voluntarily or involuntarily;
- she suffers one or more complications caused or aggravated by pregnancy and/or childbirth; and
- the complications are not treated or are not treated properly.[61]

Safe motherhood, from the aforementioned sequence therefore translates to availability of services that can prevent women from dying because of pregnancy-related complications. According to the Human Rights and Reproductive Health Matrix;

> Safe motherhood encompasses a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynaecological, family planning, prenatal, delivery and postpartum care, in order to achieve optimal health for the mother, foetus and infant during pregnancy, childbirth and postpartum.[62]

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[57] Moreland S & Talbird S *Achieving the millennium development goals: the contribution of fulfilling the unmet need for family planning* (2006).
[58] World Health Organisation *Family planning* (2010).
[59]WHO. Maternal health (2016). Available from: *http://www.who.int/maternal_child_adolescent/topics/maternal/en/.* Accessed on 19 March 2020.
[60] See Mark A Belsey 'Maternal and Child Health: A Basic Part of Public Health' (2009) *Medical Sciences Volume 1*.
[61] Maine D *Studying Maternal Mortality in Developing Countries: A Guidebook on Rates and Causes* 1987.
[62] Human Rights and Reproductive Health Matrix 'Safe Motherhood' available at *http://www.policyproject.com/matrix/safemotherhood.cfm*, accessed on 12 March 2016.

Rebecca Cook *et al*[63] correctly state the following in relation to women's right to safe motherhood:

> The failure to address preventable maternal disability and death represents one of the greatest social injustices of our times…. [W]omen's reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy but, rather, injustices that societies are able and obligated to remedy….[64]

Thus, women's reproductive risks are avoidable misfortunes that states, Zimbabwe included, are obligated to prevent. States should therefore take all steps necessary for the advancement of women's reproductive health rights. Providing access to affordable, high quality, respectful maternity care is not a matter of preferential treatment for women; it is recognition that the failure to do so is an infringement of their right to access maternal health services. There is no comparable threat to the health of men.'[65] This obligation can only be complied with if Zimbabwe has adequate information on challenges rural women face in as far as the advancement of their reproductive health rights is concerned.

According to Campbell, antenatal care, which is a major component of maternal health care services, has been shown to improve maternal health and reduce maternal mortality when started early and is adequate and appropriate.[66] The WHO recommends at least four antenatal care (ANC) visits for each pregnancy with the first occurring within the first 16 weeks of pregnancy. Skilled providers also play a very critical role in safe motherhood services as they, through ANC, monitor the pregnancy. The risks for both mother and child during pregnancy and at delivery can be reduced by monitoring pregnancy through antenatal care. According to the Zimbabwe Demographic Health Survey 2010-2011 (ZDHS), antenatal care enables:

1. early detection of complications and prompt treatment;
2. prevention of diseases through immunisation and micronutrient supplementation;
3. birth preparedness and complication readiness; and
4. health promotion and disease prevention through health messages and counselling of pregnant women.[67]

[63] Rebecca J Cook, Bernard M Dickens & Andrew FO Wilson *et al Advancing Safe Motherhood through Human Rights* (2001).
[64] Rebecca J Cook *et al Advancing Safe Motherhood through Human Rights* at 69.
[65] Alicia Ely Yamin & Deborah P Maine 'Maternal mortality as a human rights issue: measuring compliance with international treaty obligations' (1999) *Human Rights Quarterly Volume 21 No. 3.*
[66] Oona M.R Campbell & Wendy J Graham 'Strategies for reducing maternal mortality: getting on with what works' (2006) *The Lancet Maternal Survival Series Volume 368, No. 954*.
[67] Zimbabwe National Statistics Agency *Zimbabwe Demographic and Health Survey 2010-11* (2012).

Globally, a total of between 11 and 17 per cent of maternal deaths occur during childbirth itself while 50 to 71 per cent occur in the post-partum period.[68] The periods spent in the critical moments of labour and giving birth require more attention, as does the often-neglected post-partum period.[69] According to the World Health Organisation,[70] Zimbabwe has made commendable progress in reducing maternal mortality as the maternal mortality rate for Zimbabwe declined from 614 deaths per 100,000 live births in 2014 to 462 deaths per 100,000 live births in 2019.[71] This is worrisome as there is a limited number of research projects that have been done to establish the role that safe antenatal care can play in the reduction of the maternal mortality rate in Zimbabwe. This study will fill in this gap by exploring women's lived experiences vis-à-vis their right to safe motherhood services.

Zimbabwe has shown some commitment to improving maternal health as maternal health has been advocated for at the national level.[72] However, effective implementation of the programmes, especially in the rural areas, remains uncertain. In this regard, this thesis will argue that improvements to the service delivery of maternal healthcare should always stem from grassroots demand, if it is to be effective and positively impact women's reproductive lives. Accordingly, this research will fill in this gap by exploring how national commitments permeate down to primary health care facilities and rural women themselves.

In relation to the right to access antenatal care and safe motherhood services, this research seeks to document women's lived experiences in the Maternity Waiting Homes that exist in Hwange Rural District, the region selected for this research. Such information, which has not been adequately documented previously, will assist in assessing the effectiveness or otherwise of Maternity Waiting Homes in advancing rural women's reproductive rights.

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[68] Monir Islam 'The Safe Motherhood Initiative and beyond' (2007) *Bulletin of the World Health Organization Volume 85 Number 10*.

[69] Ibid.

[70] WHO *Perspectives on Maternal Mortality in Zimbabwe: A Reflection of the Year 2014* available at *http://www.afro.who.int/en/zimbabwe/press-materials/item/7271-who-perspectives-on-maternal-mortality-in-zimbabwe-a-reflection-of-the-year-2014.html*, accessed 26 October 2016.

[71] Zimbabwe National Statistics Agency *Multiple Indicator Cluster Survey 2019* (2020).

[72] See for example, the National Maternal and Neonatal Health Road Map 2007-2015, a strategic framework for addressing maternal and neonatal health challenges currently facing Zimbabwe. The Road Map was an over-arching strategy for scaling up the national response to reduce the current levels of maternal and neonatal mortality and morbidity in line with the MDG health related targets; Zimbabwe Maternal and Perinatal Mortality Study which was a study conducted by the then Ministry of Health and Child Welfare to establish precisely the national estimates for indicators relating to mothers and new-borns.

1.3 THESIS STATEMENT AND JUSTIFICATION OF THE STUDY

The overall thesis of this study is that reproductive health rights of rural women in Hwange Rural District, Zimbabwe, are being infringed in several ways. This is in violation of Zimbabwe's human rights commitments in terms of international human rights treaties. It is also in violation of Zimbabwe's Constitution and other domestic laws. This situation can be remedied through compliance with international and domestic human rights obligations.

Despite such observation on the continued infringement of rural women's rights, there is a gap in academic literature on research that documents women's lived experiences in accessing reproductive health care services. Existing studies are suggestive but do not provide directly relevant comprehensive reproductive health data for women in rural Zimbabwe. For instance, Choguya's[73] study focused mainly on traditional health attendants and maternal mortality, which is just one element in the broader sexual and reproductive health right to safe motherhood services. Esser's[74] study focused only on the right to health in general without focusing on women's reproductive health rights, let alone the rights of women in rural Zimbabwe to have access to reproductive health care services. Ferguson's[75] thesis analysed the policies of the Zimbabwe National Family Planning Council, the practices of local level health workers and their impact on the reproductive self-determination of women living in Mabika village. Ferguson's study did not, however, focus on the rural women's lived experiences in as far as access to reproductive health care services is concerned. A recent study by Muchabaiwa and Mbonigaba evaluated the impact of the adolescent sexual and reproductive health (ASRH) strategy implemented by government of Zimbabwe between 2010 and 2015 to improve ASRH.[76] Thus, research on reproductive health rights of rural women in Zimbabwe is fragmented. This is evidenced by the lack of literature about the views, experiences and ideas of the rural women in relation to their reproductive rights.

Furthermore, the women's voices on their experiences in accessing reproductive health care services have not been adequately captured. The available literature has only

[73] Naume Zorodzai Choguya 'Traditional and Skilled Birth Attendants in Zimbabwe: A Situational Analysis and Some Policy Considerations' (2015) *Journal of Anthropology Volume 2015*.
[74] Charlotte Esser 'Neither bad luck nor chance: the health crisis in Zimbabwe in the context of human rights' (2011) *Menschenrechte und Gesundheit / Amnesty-Aktionsnetz Heilberufe, Jg. 1*.
[75] Ferguson Claire *Reproductive rights and citizenship: Family planning in Zimbabwe*. (Published PhD thesis, University of London, 1999).
[76] Muchabaiwa L and Mbonigaba J 'Impact of the adolescent and youth sexual and reproductive health strategy on service utilisation and health outcomes in Zimbabwe' (2019) *PLoS ONE* 14(6)

focused on a broad range of disciplines incorporating general discussions on the right to health and reproductive health. For instance, Nilses discussed the health in women of reproductive age in general,[77] the Research and Advocacy Unit of Zimbabwe considered adolescent reproductive health and the impact of early marriages on reproductive health rights.[78] Complementing this literature is Hindin's discussion of harmful traditional practices on women's reproductive rights, women's attitudes on wife beating[79] and Chikovore's exploration of gender power dynamics in sexual and reproductive health rights.[80] A study conducted by Mugweni, Omar and Pearson[81] on safer sexual practises in Zimbabwe revealed that women face a number of obstacles in negotiating for safer sex. In this study, one female interview respondent aged 31 indicated as follows:

> I ask my friends, 'If you caught your husband with a girlfriend would you ask him to use a condom'. They say it's difficult for us women…… (*Tinofira mukati* – we suffer silently).

The Mugweni, Omar and Pearson study, while raising some facets of the right to make decisions freely, did not investigate all the elements of the right. The study was limited to aspects of sexual intercourse and condom use. However, the right to make decisions freely includes the power to decide the number and spacing of children, when to get married and what contraception to use, among others.

In response to this gap in knowledge and the potential benefits of new information to guide programming, the qualitative research undertaken for this dissertation captures a wide range of rural women's experiences in accessing reproductive health care services, particularly access to maternal health care services and family planning services. An empirical inquiry of this nature helps in gathering insights from the rural women who are directly affected by the different challenges. The results will assist the government in ensuring its compliance with international and national obligations towards women's right to reproductive health. A study that focuses directly on women's experiences, specifically one that is able to capture a range

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[77] Carin Nilses *Health in women of reproductive age. A survey in rural Zimbabwe* (PhD thesis, Uppsala University, 2000).
[78] The Research and Advocacy Unit 'Let them grow first: Early Marriage in Goromonzi, Zimbabwe' (2011) The Research and Advocacy Unit available at:
http://archive.kubatana.net/docs/chiyou/rau_child_marriage_111030.pdf, accessed on 17 February 2016.
[79] Michele J Hindin 'Understanding Women's attitudes towards wife beating in Zimbabwe' (2003) *Bulletin of the World Health Organization* 501-508.
[80] Jeremiah Chikovore 'Gender Power Dynamics in Sexual and Reproductive Health: A Qualitative Study in Chiredzi District, Zimbabwe' (2004) *Umea University Medical Dissertations New Series No 876*.
[81] Esther Mugweni, Mayeh Omar & Stephen Pearson 'Understanding barriers to safer sex practice in Zimbabwean marriages: implications for future HIV prevention interventions' (2014) *Health Education Research*.

of experiences, has the opportunity to add significant value to our understanding of the facilitators and barriers to access to reproductive health care. The study also deepens our understanding of Zimbabwe‘s ability to create interventions that improve access. Thus, this study is of significance to Zimbabwe as it provides useful information for the legislature, policy makers and relevant stakeholders such as civil society organisations on the justification for advancing women’s reproductive rights, the challenges faced as well as the opportunities for advancing such rights. New feasible strategies that are in line with women’s lived experiences and ideas for the effective promotion and protection of women’s reproductive rights were proffered by the study.

1.4 RESEARCH OBJECTIVES

The study objectives, which help in proving the various aspects of the thesis statement are as follows.

1. Explaining what is meant by ‘reproductive health rights’ and how these rights have evolved jurisprudentially.
2. Explaining Zimbabwe’s legal obligation to respect, protect and promote women’s reproductive rights in terms of international treaty obligations; the Zimbabwean Constitution; and various domestic laws which activate Zimbabwe’s international and constitutional obligations;
3. Presenting empirical data showing that the reproductive rights of women in Hwange Rural District, Zimbabwe are being infringed;
4. Exploring the opportunities available for the fulfilment of Zimbabwe’s obligations with respect to reproductive rights; and
5. Making recommendations on how the reproductive rights of rural woman could be better respected, protected and promoted through compliance with international and local law.

1.5 RESEARCH QUESTIONS

The overall research question of this study is: what challenges do women of reproductive age in Hwange Rural District, Zimbabwe, face in seeking reproductive health care, with specific attention to access to family planning and safe motherhood services? The study will also address the following specific questions:

1. What is meant by 'reproductive health rights' and, why is the recognition and protection of reproductive health rights, an important element in enhancing women's ability to achieve their full potential as members of society?
2. What are Zimbabwe's legal obligations towards women's reproductive rights in terms of international treaties; the Zimbabwean Constitution; and various domestic laws which activate Zimbabwe's international and constitutional obligations?
3. What are the experiences and challenges that women in Hwange Rural District, Zimbabwe face in accessing reproductive health services?
4. What opportunities are available for the fulfilment of Zimbabwe's obligations with respect to reproductive rights? and
5. What recommendations can be made on how the reproductive rights of rural woman could be better respected, protected and promoted through compliance with international and local law?

1.6 ZIMBABWE: COUNTRY BACKGROUND

This section briefly discusses Zimbabwe's general county profile with particular attention to its health care system and economy. It also discusses some of the challenges that rural women in Zimbabwe face in accessing maternal health care and family planning services.

1.6.1 Country profile

Zimbabwe is a landlocked country situated in Southern Africa with a total land area of 390,757 square kilometres. It is bordered by Mozambique to the east, South Africa to the south, Botswana to the west, and Zambia to the north and northwest. It has a population of 16 million, with 67 per cent being rural and 33 per cent being urban.[82] The country is divided into 10 administrative provinces and 62 districts. Two thirds of the population is below the age of 25. The major ethnic groups are Shona and Ndebele.[83]

Zimbabwe is characterized by abundant land and natural resources, a relatively educated and skilled human capital base, and existing but inadequate physical infrastructure.[84] The agricultural sector focuses on tobacco (for export) and food crops (for domestic

[82] World Bank 'Zimbabwe country profile' Available at: *http://databank.worldbank.org/data/Views/Reports/ReportWidgetCustom.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=ZWE* accessed 18 January 2020.
[83] World Bank 'Zimbabwe country profile.'
[84] African Development Bank. *Zimbabwe Economic Report: Building a new Zimbabwe*. 2018

consumption). Dependence on natural capital for development is high. Mining is the main driver of the economy: the country has the world's third largest platinum reserves and is the fifth largest producer of lithium, which is essential for rechargeable batteries.[85]

1.6.2 Healthcare system

Prior to Zimbabwe's independence in 1980, the health care system was skewed towards the urban and in favour of the ruling white population. The independent Zimbabwean government therefore inherited a racially divided health sector.[86] As a way of trying to redress colonial racial inequalities and improve social services provision, the government adopted the Primary Health Care (PHC) approach, 'directing resources towards disadvantaged areas and active participation of communities in transforming their health'.[87] Zimbabwe was hailed for having one of the best health care system in Sub-Saharan Africa as it 'boasted a thriving teaching hospital network, a strong primary healthcare system installed in the 1980s by the Mugabe regime.'[88]

Zimbabwe witnessed one of the worst economic crises in its history in 2018 and 2019 that saw deterioration in major sectors of the economy including health, manufacturing, and farming. The World Bank states that 'extreme poverty is estimated to have risen from 29 per cent in 2018 to 34 per cent in 2019, (an increase from 4.7 to 5.7 million people), owing to economic contraction and the sharp rise in price of food and basic commodities.'[89] The severe social and economic decline has resulted in an unparalleled deterioration of health care infrastructure, loss of skilled health personnel and a decline in the quality of health services available for the population. For instance, doctors went on a prolonged strike in 2019 due to poor salaries[90] and lack of hospital equipment – hospitals were shut down, with no patients

[85] African Development Bank. 'Zimbabwe Economic Report'
[86] Ivo Mhike & Eric K Mkaombe 'Mission and State Health Institutions: "Invisible" Public Private Partnerships in Zimbabwe, 1980–1999' (2018) *Studia Historiae Ecclesiasticae Volume 44 Number 1*.
[87] Loewenson R & Sanders D 'The political economy of health and nutrition' in Stoneman C (ed) *Zimbabwe's prospects* (1988) 133–152.
[88] Woelk GB 'Primary health care in Zimbabwe: can it survive? An exploration of the political and historical developments affecting the implementation of PHC' 1994 *Social Science and Medicine Journal* 39.
[89] World Bank Zimbabwe 'Zimbabwe Overview' Available at *https://www.worldbank.org/en/country/zimbabwe/overview*, accessed 18 January 2020.
[90] Gibbs Dube & Blessing Zulu 'Zimbabwe Doctors' Strike Continues as Government Cries Foul' *VOA Zimbabwe* October 23, 2019; 'Zimbabwe doctors end strike after billionaire's offer' *BBC News* 22 January 2020.

being admitted. This led to a number of deaths and women resorting to backyard motherhood services.[91] This is in violation of their right to safe motherhood services.

Additionally, economic decline and political instability have led to a reduction in health-care budgets, affecting provision at all levels. For instance, in 2018, the Ministry of Health and Child Care was allocated a total of US$473.9 million, which was 68.1 per cent higher than US$281.98 million allocated in 2017. The total budget allocation to health for 2018 represents 8.3 per cent of total expenditure, some 1.4 percentage points up from 6.9 per cent in 2017.[92] Although the 2018 budget allocation was higher, it remained below the Abuja Target.[93] At 8.3 per cent of the total budget, the 2018 health care budget allocation is 6.7 percentage points lower than the 15 per cent budget share recommended under the Abuja Target, and also falls short of the Southern Africa Development Committee (SADC) average budget share of around 11.3 per cent.[94]

For the year 2019, the Ministry of Health and Child Care was allocated a total of US$694.467 million,[95] which was 33 per cent higher than US$473.9 million allocated in 2018.[96] The 2019 health budget allocation translated to 10 per cent of the national budget. Although commendable, the 2019 budget was still 5 per cent lower than the Abuja Declaration stipulating 15 per cent of national budget. The constrained budget allocated to the Ministry of Health and Child Care remains inadequate to fund the critical needs in the health sector such as the rehabilitation of hospitals and the procurement of medical equipment since a larger percentage of the budget allocation goes to employment costs.[97] Further, the small percentage

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[91] Paidamoyo Chipunza 'Woman delivers 100 babies in 8 days' *The Herald* 15 November 2019; Chris Muronzi 'As Zimbabwe's doctors strike, pregnant women search for care' *Aljazeera* 17 December 2019.

[92] UNICEF *Health and Child Care 2018 Budget Brief* Available at *https://www.unicef.org/esaro/UNICEF-Zimbabwe-2018-Health-Budget-Brief.pdf*, accessed on 22 March 2020.

[93] The Abuja Declarations and Frameworks for Action on Roll Back Malaria was a pledge made in 2001 by members of the African Union during a conference in Abuja, Nigeria. In it, the member nations pledged to increase their health budget to at least 15 per cent of the state's annual budget. See World Health Organisation, The Abuja Declaration: Ten Years on, available at *https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1* accessed 20 March 2020. Tracking progress that had been made, the World Health Organisation in 2010 indicated that only one African country, Tanzania had reached this target. Twenty-six countries had increased the proportion of government expenditures allocated to health and 11 had reduced it. In the remaining nine countries there was no obvious trend up or down.

[94] UNICEF Health and Child Care *2018 Budget Brief*.

[95] Ministry of Finance and Economic Development '2019 National Budget Highlights' 5.

[96] Kudakwashe Pembere 'Treasury on Thursday allocated US$694.5 million to the Ministry of Health and Child Care in the 2019 National Budget' *The Health Times* 22 November 2018.

[97] Shepherd Shamu, James January & Simbarashe Rusakaniko 'Who benefits from public health financing in Zimbabwe? Towards universal health coverage' (2017) *Global Public Health*, 12:9, 1169-1182.

of capital expenditure is used at national and provincial hospitals, while district hospitals, where most vulnerable citizens access their healthcare, receive less funding – implying that:

> Richer households disproportionately benefit from public health subsidies overall, particularly at secondary and tertiary levels, which receive more funding and provide a higher level of care.[98]

This leads to the exclusion of the majority of citizens, meaning that universal coverage of health will be a pipedream for most Zimbabweans. Such exclusion is a violation of socio-economic rights in general and the right to reproductive health in particular.

1.6.3 Challenges for reproductive health care

These overall problems with the healthcare system have implications for the right to reproductive health in particular. For instance, the Zimbabwe 2012 MDG Progress Report indicated that (with reference to Millennium Development Goal number 5 that deals with improved maternal mortality rates and improved maternal health) there had been an upsurge in the number of mothers dying while giving birth.[99] This increase was attributed to lower rates of attended births; unaffordable maternity fees resulting in reduced visits by the expectant mothers to the antenatal clinics; location of clinics and healthcare facilities far away from villages; and to social or cultural pressures which rendered some women unable to make any choices regarding their reproductive health.[100]

Maternal mortality is one of the major challenges in relation to women's reproductive rights. The 2012 MDGs Progress Report highlighted that the maternal mortality rate of 960 deaths per 100,000 live births was significantly higher than the rate of 612 deaths per 100,000 live births recorded for 2005–2006.'[101] Another factor highlighted in the report was that in Zimbabwe, and in the rural areas particularly, there had been a decline in the proportion of births attended by skilled health personnel. All these factors had a negative impact on rural women's access to reproductive health care services. Further, they put rural women at a disadvantage compared to their urban counterparts.

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[98] Ibid.
[99] Government of Zimbabwe. *Zimbabwe 2012 Millennium Development Goals Status Report* United Nations (2012) 9.
[100] Ibid.
[101] Ibid.

1.6.4 Challenges faced by women in rural Zimbabwe

The thesis for this study is that rural women's reproductive rights are violated despite the fact that Zimbabwe has a progressive Constitution and has ratified a number of regional and international instruments that protect the right to reproductive health.

There is no universally accepted definition of the term 'rural'. The Supreme Court of West Virginia demonstrated the concept's flexibility as follows:

> [A] rural community is, by definition, completely unrelated to an urban or metropolitan area. . . . Thus, a "rural community" may be distinguished by its dominant character as a social and economic unit founded in rural, land-based interests. It is inhabited, in the main, by country people, who live a country life, and who engage in country pursuits. Its residents are removed from the immediacy of urban and suburban environs, and are not immediately tied to any city or urban area; they work, socialize and politick as an independent, integral community.[102]

In this study, rural Zimbabwe therefore refers to geographical areas that are located outside cities and the centers of major towns in Zimbabwe. Such rural areas are often referred to as the periphery, characterized by all forms of marginalization and doctrinaire traditional beliefs, which disadvantage marginalized groups such as the women. Hwange Rural District is one such area in Matabeleland North Province, a very poor and drought-stricken province in Zimbabwe.

Globally, and with only a few exceptions, rural women fare worse than rural men and urban women and men – they are often perceived and treated as second-class citizens.[103] Zimbabwe, with 62 per cent of women living in rural areas,[104] is no exception. Rural women still face a myriad of challenges in accessing reproductive healthcare services. Poverty, lack of health insurance, isolation from resources commonly available in urban areas, (such as public transportation to services and the availability of a wide range of health resources) are some of the challenges that inhibit their access to reproductive health services. Without access to reproductive health services, rural women remain disempowered and underdeveloped.

Generally, women in rural Zimbabwe face a number of challenges in accessing healthcare facilities where 'availability, accessibility, and affordability of services are key

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[102] *Stephens v Raleigh County Bd. Of Educ., 257 S.E.2d 175, 179 (W. Va. 1979).*
[103] International Labour Organisation *Gender equality in the rural sector: The ever-present challenge* (2012) available at *https://www.ilo.org/global/about-the-ilo/newsroom/features/WCMS_174876/lang--en/index.htm*, accessed on 22 July 2019.
[104] Zimbabwe National Statistics Agency (2016) *Women and Men Report* at 11.

issues impinging on health access.'[105] A study on the Access to Health Care Services carried out in 2007 found that while 'most communities in rural Zimbabwe live within a 5 km radius of their nearest health facilities, whilst 23 per cent live between 5 and 10 km and 17 per cent are over 10 km from their nearest health centre.'[106] The public sector dominates Zimbabwe's health system as it accounts for an estimated 65 per cent of health care service facilities across the country.[107] The global challenges affecting rural women's reproductive health are also relevant for Zimbabwe. For instance, 61 per cent of the population live in areas with a nearby health clinic but access is more common in cities (75 per cent) than in rural areas (52 per cent).[108]

Lack of nearby health facilities, unaffordability of services and the unfair impact of legal restrictions on accessing reproductive health services, are some of the obstacles that further hinder rural women from accessing to reproductive health services.[109] Adding a voice to the plight for rural women, the Zimbabwe Doctors for Human Rights (ZADHR) stated that:

> …the health nightmare for rural women that contributes to high maternal mortality was due to inadequacy of infrastructure and poor access to the facilities. Besides, most of the peripheral health centres in Zimbabwe are not staffed by experienced health personnel as the experienced staff concentrated in urban areas and central hospitals.'[110]

The 2010 Zimbabwe Millennium Development Goals Status Report describes Zimbabwe's society as one that is strongly patriarchal and accustomed to the subordination of women by men.[111] As a result, reproductive health issues like abortion are condemned by both the church and the state. One of the Christian leaders posed the following question on abortion: 'Why do we even debate on this issue when it's obvious that it is wrong and perpetuates moral decadence in our society?'[112] Morally, this claim may be in good faith. However, legally, this

[105] Ministry of Health and Child Welfare *The National Health Strategy for Zimbabwe* (2009–2013),
[106] Makuto D and James V *Study on Access to Health Care Services in Zimbabwe* 2007.
[107] Naume Zorodzai Choguya 'Traditional Birth Attendants and Policy Ambivalence in Zimbabwe' (2014) *Journal of Anthropology Volume 2014*
[108] Thomas Isbell and Matthias Krönke 'Ill-prepared? Health-care service delivery in Zimbabwe' (2018) *Afrobarometer Dispatch No. 240* at 4.
[109] Centre for Reproductive Rights 'Submission for the CEDAW Committee's Half Day of General Discussion on Rural Women' available at *http://www.ohchr.org/Documents/HRBodies/CEDAW/RuralWomen/CRR.pdf*, accessed on 19 February 2016.
[110] Jonga Kandemiiri 'Poverty wears the face of rural women' *Nehanda Radio* 16 October 2013.
[111] Government of Zimbabwe *2010 Millennium Development Goals Status Report Zimbabwe* United Nations (2010).
[112] Phyllis Mbanje 'To legalise abortion or improve access to contraceptives?' News Day April 13, 2016.

has serious implications on women's sexual and reproductive health rights because policies and statutes protecting their rights are affected by such attitudes and mind-sets.

The Christian belief and perception of moral decadence does not only affect policy and legislative considerations, it also affects the women themselves − women's bodies have become a yardstick of morality in both traditional and religious perspectives as Hwange, just like the rest of the country, is largely a Christian District.[113] Sexual purity, a principle which, according to religious and cultural beliefs, leads to real womanhood, encourages heavy controlling of women's sexual body by parents, husbands, society and religious institutions through strict norms.[114] Any conduct which deviates from these norms attracts punishment from the family, normally in the form of being disowned, as such conduct is believed to bring disgrace on the family.[115] This again is a huge burden on rural women. This study argues that the use of words such as 'disgrace' in line with women's sexual and reproductive health rights takes away their freedom to freely control their bodies without fear or some sort of reprisal from their families, their churches and the community as a whole.

Further, women are bound to be silent and not voice their concerns for fear of being blamed for perpetuating moral decay. This was succinctly stated by one lawyer who advocates for women's rights as follows:

> Traditionally, in Zimbabwe, women have not been called on to voice their opinions, so the concept of saying what they want is foreign to them. Human rights organisations will advocate for women's issues, such as the legalisation of abortion, and the government will say, let's ask the women what they want. And, of course, no-one will say a word…This presents a three-pronged dilemma: moral, human right and societal. Few women are going to be brave enough to stand up and be the isolated voice that went against the moral and societal foundations on which the country had been established.[116]

Additionally, the Centre for Reproductive Rights argues that 'the barriers that all women face in exercising their reproductive rights are compounded for rural women who may experience multiple layers of discrimination that result in additional obstacles and

[113] Zimbabwe Statistics Agency's 2015 Demographic and Health Survey for Zimbabwe states that 86 per cent of Zimbabwe's population is Christian.
[114] Kezia Batisai 'The Politics of Control and Ownership over Women's Bodies' (2015). Available at *http://thisisafrica.me/politics-control-ownership-womens-bodies/*, accessed on 23 October 2016.
[115] Ibid.
[116] Pambazuka News 'Our ugly secret: abortion in Zimbabwe, illegal but thriving.' May 16, 2012 Available at http://www.pambazuka.org/governance/our-ugly-secret-abortion-zimbabwe-illegal-thriving, accessed on 23 October 2016.

marginalization.'[117] This discrepancy is intensified by a number of barriers which include discrimination within traditional families and communities.

As if the aforementioned challenges are not enough, the Office of the United Nations High Commissioner for Human Rights, in its Convention on the Rights of the Child Concluding Observations on Zimbabwe highlighted the following:

> Although the Committee notes the provisions guaranteeing the primacy of the Constitution over inconsistent laws and practices, the Committee is concerned that the State party has not taken sustained measures to modify or eliminate stereotypes and harmful practices. In particular, it is deeply concerned about: (a) Harmful norms, practices and traditions that perpetuate discrimination against girls, including, in particular, forced and early marriages, polygamy, bride-price (lobola) and, in certain regions, virginity testing and witch hunting; (b) Allegations of involvement of members of religious sects, such as apostolic churches, in harmful cultural practices, particularly early marriage, including of girls as young as 10 with older men for "spiritual guidance'.

Child and early marriages are a major challenge in Zimbabwe that requires urgent attention if women's reproductive rights are to be advanced. Indeed, unacceptable traditional beliefs and customs have contributed considerably to sexual abuse and violence against girls and women. The Constitution of Zimbabwe clearly provides that no person may be compelled to enter into marriage against their will.[118] The Marriage Act,[119] Criminal Law Codification and Reform Act,[120] the Children's Act[121] and the Customary Marriages Act[122] have a similar provision. All the local Acts on the rights of children in Zimbabwe were promulgated well before the Constitution of 2013. Despite the Constitution, marriage laws in Zimbabwe are a stumbling block to ending child marriages. The Marriage Act calls for 16 years as the marriageable age for girls,[123] as opposed to the 18 years old for both sexes under Section 78 of the Constitution of Zimbabwe, regional and international human rights instruments. It is the purpose of this study to review some of these local laws to determine the extent to which they impact on the advancement of reproductive rights in Zimbabwe.

[117] Centre for Reproductive Rights 'Submission for the CEDAW Committee's Half Day of General Discussion on Rural Women'.
[118] Section 78 (2) of the Constitution of Zimbabwe Amendment (No.20) of 2013 which provides that 'No person may be compelled to enter into marriage against their will.'
[119] [Chapter 5:11].
[120] [Chapter 9:23].
[121] [Chapter 5:06].
[122] [Chapter 5:07].
[123] Section 22 of the Marriage Act.

1.6.5 Study area Profile: Hwange Rural District

This study was carried out in Matabeleland North Province of Zimbabwe, which is one of the most poverty-stricken provinces in Zimbabwe. According to the 2012 Provincial Census Report, Matabeleland North Province had a total of 749 017 people out of the total Zimbabwean population of 13 061 239. Of the 749 017, 360 776 (48 per cent) constituted the male population while the female population was 388 241 (52 per cent).[124] The greater number of people in Matabeleland North Province are based in rural areas accounting for 91 per cent of the total population of the province. They have deep-rooted religious and cultural beliefs that perceive women as subordinates – their rights are excised subject to men's approval.[125]

Matabeleland North Province has (as shown in *Figure 1* below) 9 Districts which are Victoria Falls, Bubi, Hwange Rural, Hwange Urban, Umguza, Tsholotsho, Nkayi, Binga and Lupane. It is important to note that there is a difference between Hwange District and Hwange Rural District, the latter being the focus of this study. Hwange District (also known as the Hwange Town Council), is a local authority for the town of Hwange urban created by statute under the Urban Councils Act.[126] Hwange Rural District on the other hand, is a local authority for rural Hwange, established in terms of the Rural Districts Council Act.[127]

Hwange Rural District (HRD)[128] is located in the north-western part of Matabeleland North Province. HRD has twenty administrative wards of which 18 are rural and only 2 are peri-urban. It has 123 schools of which 90 are primary schools, 33 secondary schools and two tertiary colleges. Among these educational institutions, Hwange Rural District Council administers 56 primary schools and 18 secondary schools. There are 45 health facilities of which 10 are administrated by the local authority.

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[124] Zimbabwe National Statistics Agency 'Provincial Census Report: Matabeleland North Province' 2012.

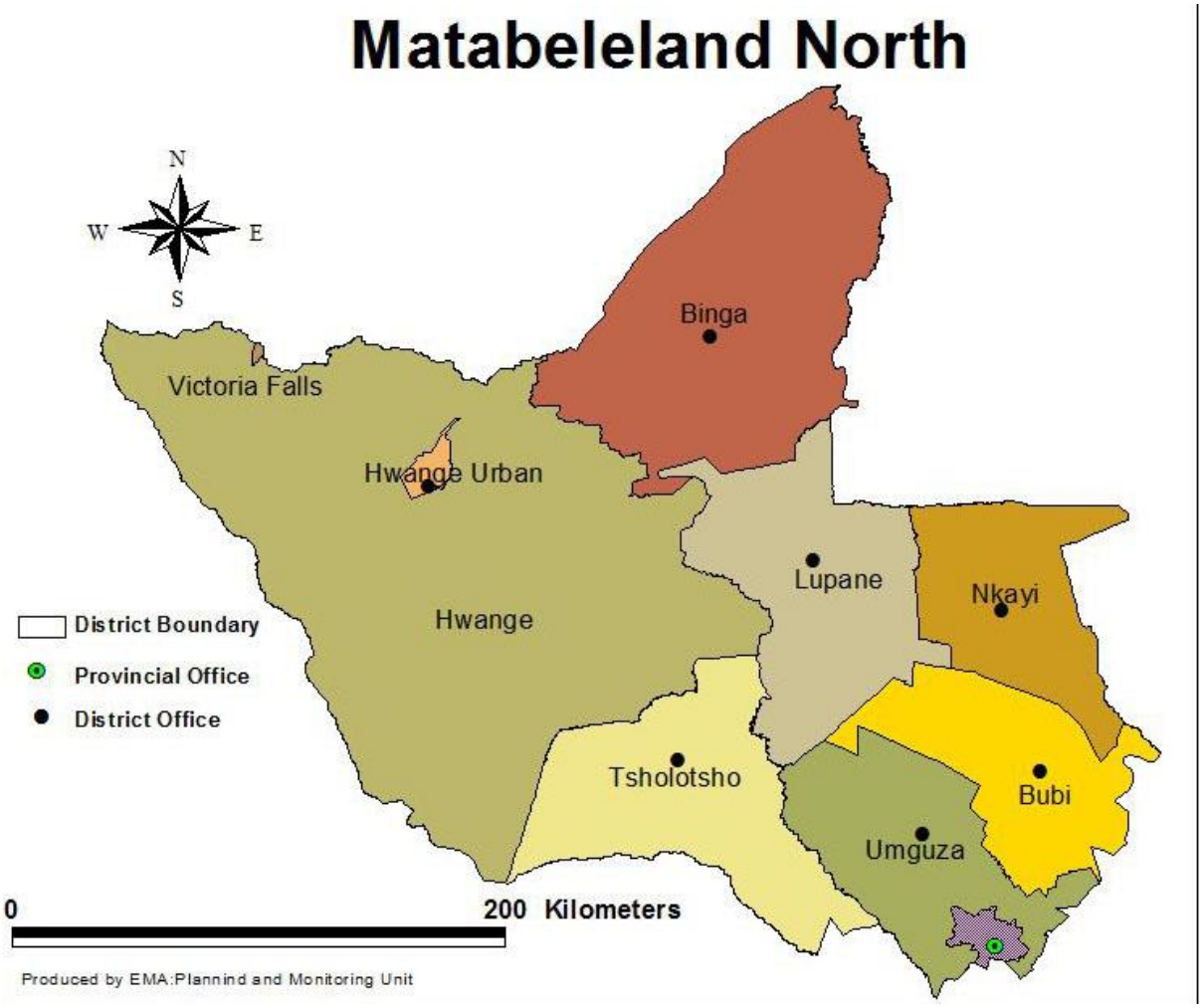
[125] Food and Agriculture Organisation of the United Nations 'Zimbabwe: Customary norms, religious beliefs and social practices that influence gender-differentiated land rights' available at *http://www.fao.org/gender-landrights-database/country-profiles/countries-list/customary-law/customary-norms-religious-beliefs-and-social-practices-that-influence-gender-differentiated-land-rights/en/?country_iso3=ZWE,* accessed on 17 August 2018.

[126] [Chapter 29:15].

[127] [Chapter 29:13].

[128] Hwange Rural District Council Available at *https://hwangerdc.co.zw/,* accessed on 14 May 2019.

Figure 1: Matabeleland North Province Map



Source: Zimbabwe Statistics Agency 2012 Zimbabwe Census Report

1.7 RESEARCH METHODOLOGY

Qualitative research method was used in the study targeting women in the reproductive age range. According to Morrow and Smith, 'the purpose of qualitative research is to understand and explain participant meaning.'[129] More specifically, Creswell defines qualitative research:

> As an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting.[130]

[129] Susan L Morrow & Smith ML 'Qualitative research for counselling psychology' in S D Brown & R W Lent (eds) *Handbook of counselling psychology* 3 ed (2000).
[130] John W Creswell Qualitative enquiry and research design: choosing among five traditions (1998) 15.

Thus, using a qualitative methodology allowed the researcher to study the phenomenon of women's reproductive rights in its natural setting.

The research relied mainly on primary data from the field through qualitative means, gathered from women within the reproductive age (18-45), and different state and non-state actors working in the field of women's reproductive rights through interviews and participant observations in rural homes, households and communities. The purpose of the primary data was to provide insights relating to the challenges faced by women and different stakeholders in protecting women's reproductive rights, as well as insights into the rationale and opportunities available for the effective promotion of women's reproductive rights. Primary data from the field was coupled with detailed review of available literature on reproductive health rights in Zimbabwe.

1.7.1 Inclusion and exclusion criteria

The primary target for this study was women[131] of reproductive age with children aged below five years at the time of the study. In order to be eligible for this research, the women had to be residents of Hwange Rural District, or had to have lived in the area for at least six months, had full pregnancy with a child below five years of age, and most importantly, they had to voluntarily accept participation in the research after being taken through the terms and conditions of the research. The research participants were asked questions on their knowledge of human rights in general, knowledge of reproductive health services and challenges faced in trying to access these services. A copy of the Interview Guide is **Appendix 7.**

1.7.2 Data generating instruments

The researcher used semi-structured interviews and unstructured interviews. In semi structured interviews, the key questions are decided and prepared by the researcher prior to the interview.[132] Be that as it may, semi structured interviews have no rigid adherence – their implementation is dependent on how the interviewee responds to the question asked by the researcher. This therefore gives the interviewer flexibility to probe some of the answers the

[131] This thesis embraced and adopted the definition of 'women' which includes girls as defined under the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ((hereafter referred to as the African Women's Protocol). The African Women's Protocol provides, in Article 1(k) that "Women" means persons of female gender, including girls. This definition is of paramount significance to this study as women and girls face similar challenges on reproductive rights issues.

[132] Stuckey, HL 'Three types of interviews: Qualitative research methods in social health' (2013) *Journal of Social Health and Diabetes, 1(2*).

respondents give to gain more information.[133] Unstructured interviews on the other hand, allow the interviewer to gain an in-depth view/understanding about a topic from the point of view of the interviewee using probing questioning.[134] They are very useful in studying topics about which there is little existing literature,[135] as is the case in this study. Consequently, the use of interviews, especially unstructured and semi-structured interviews was found to be most appropriate means for data collection in this kind of a study, where the lived experiences of rural women in accessing reproductive health care services, have not been previously documented.

1.7.3 Sampling

The study used purposive and snowball sampling to deliberately select stakeholders and individuals to enhance the understanding of the phenomenon under investigation.[136] Maxwell[137] defines purposive sampling as 'a type of sampling in which particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices.'[138] With this kind of sampling, at least 20 women and girls who were sexually active, and living in the chosen research site were recruited. Five key informants were also recruited.

For the recruitment of the 20 women and key informant participants, the researcher first approached the Ministry of Health and Child Care (MoHCC), which is the parent Ministry responsible for health matters and all health personnel in Zimbabwe. At the MoHCC, the researcher sought permission to recruit or engage nurses and health workers to assist the researcher in recruiting participants. After permission was granted, the researcher then made a courtesy call to the District Medical Officer responsible for both Hwange Rural and Urban Districts, informing him that the researcher would be conducting research in his District. The letter obtained at national level from the MoHCC was furnished as proof that the research was authorised.

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[133] DiCicco-Bloom, B & Crabtree, B.F 'The qualitative research interview' (2006) *Medical Education, 40(4)*, 314-321.
[134] Brinkmann S & Kvale S *Interviews: Learning the Craft of Qualitative Research Interviewing* (3rd ed). (2014) Sage, London.
[135] Creswell, J W. 2013. *Qualitative inquiry and research design: choosing among five approaches*. London: Sage.
[136] John W Creswell *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* 3 ed (2008).
[137] Joseph A Maxwell 'Designing a qualitative study' in Leonard Bickman & Debra J Rog (eds) *Handbook of applied social research methods* (1998).
[138] Maxwell A 'Designing a qualitative study' at 87.

The researcher then approached nurses and health workers at different clinics in the research area to discuss the aim and objectives of the research. The purpose of the discussion with the nurses was to help them understand the purpose of the research and thus assist them in how to recruit potential participants. This was because the nurses have profiles of their patients and would thus know the different ages of the potential research participants. The visits were strategically made on days when antenatal and postnatal classes were conducted. After the introductory processes with the health workers, they (nurses and health workers) then explained the objectives of the research to potential participants and invited them to participate in the research. After the nurses and health workers had explained the research objectives to the potential research participants, those interested in the research then met with the researcher privately. At this stage, the researcher repeated, in brief, the research objectives and distributed information sheets, all written in the local languages of Tonga/Dombe and Ndebele, were distributed to the potential participants to allow them time to read and understand the purpose of the research. After this introduction and reading of the information sheet, those interested in participating were asked to provide a time and date when they could freely talk to the researcher. It is at this second meeting that the research was explained in detail, consent forms signed and interviews conducted.

Girls (children below the age of 18) were considered a very valuable group who would provide rich information in this study. However, it is important to note that this research focused only on children below the age of 18 who were married as common law provides that marriage legally terminates minority status. Because married children under the age of 18 have their own homesteads, are sexually active and are already receiving reproductive health services and thus, do not require parental consent to participate in research. Such acknowledgment of the 'married children status' circumvented the need to seek additional parental consent for their participation in this study. This circumvention thus protected the participants from the risk of questioning or even intimidation by their parents when parental consent is sought. In light of the above, the researcher was of the view that there was no need for a separate consent form for minors.

1.7.4 Study Design

This study employed the phenomenology qualitative research design. According to Welman and Kruger[139] 'the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved'. Differently stated, a researcher applying phenomenology is 'concerned with the lived experiences of the people involved, or who were involved, with the issue that is being researched.'[140] A comprehensive understanding of the experiences of rural women, obstacles and prospects for advancing reproductive health rights requires scholars and policy makers to broaden the scope of the discussion and solicit information from the women themselves, state actors and non-state actors alike. In-depth interviewing with a phenomenological orientation provides the opportunity for the narrator, namely the individual who has lived that experience, to create meaning of the lived experience through language and storytelling.[141]

1.8 DATA COLLECTION METHODS AND TOOLS

This section presents the data collection tools and methods used in this study.

1.8.1 In-depth individual interviews

In-depth interviews were conducted with 20 women, who are in the reproductive age range (15-49 years) in order to gain a better and deeper understanding of their enjoyment of reproductive rights. In-depth interviews were used because they 'give voice to common people, allowing them to freely present their life situations in their own words, and open for a close personal interaction between the researchers and their subjects.'[142] The study used an interview guide which comprised of more open-ended questions so as to create a more friendly conversation with respondents.[143] The guide had several key questions to help define the areas to be explored, but also allowing the interviewer or interviewee to diverge in order to pursue

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[139] Johannes Christiaan Welman & Fanie SJ Kruger *Research methodology for the business and administrative sciences* (1999).

[140] See generally Greene M 'The lived world, literature and education' in Donald Vandenberg (ed) *Phenomenology & education discourse* (1997); Immy Holloway *Basic concepts for qualitative research* (1997); Dreyer Kruger *An introduction to phenomenological psychology* 2 ed (1988); Steinar Kvale *Interviews: An introduction to qualitative research interviewing* (1996); David Robinson & Val Reed (Editors) *The A – Z of social research jargon* (1998).

[141] Irving Seidman *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences* 3 ed (2006).

[142] Steinar Kvale 'Dominance through Interviews and Dialogues' *Qualitative Inquiry Volume 12 Number 3* (2006)

[143] Irving Seidman *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (1991).

an idea or response in more detail.[144] Polkinghorne argues that due to the fact that much of an individual's life world is invisible to others and because experience has vertical depth:

> Interviewing distinguishes itself from other research approaches by engaging participants directly in a conversation with the researcher in order to generate deeply contextual, nuanced and authentic accounts of participants' outer and inner worlds, that is, their experiences and how they interpret them.[145]

The 20 women were visited at their homes so as to provide for a conducive environment for them to freely talk about their experiences. The interviews were conducted in local languages of Tonga, Ndebele and Nambya[146] as most women in the area of study did not understand English.[147]

1.8.2 Key informant interviews

To understand the provision of reproductive health care services in Hwange Rural District, the study also interviewed five key informants, namely personnel from the Ministry of Health and Child Care, precisely the District Medical Officer, nurses from clinics and hospitals in the research site and representatives of civil society organizations dealing with women's reproductive health rights and services. The key informant interviews took the form of semi-structured interviews. An interview guide with a set of similar open-ended questions was used to guide the researcher. Key informants were interviewed at their work places. The interviews were mainly conducted in English, as all these respondents were learned and conversant in the chosen language.

1.8.3 Observations

Marshall and Rossman[148] define observation as 'the systematic description of events, behaviours, and artefacts in the social setting chosen for study'. Observations enable the researcher to describe existing situations using the five senses, providing a 'written photograph'

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[144] Nicky Britten 'Qualitative Interviews in Healthcare' in Pope C & Mays N (eds) *Qualitative Research in Health Care* 2 ed (1999).
[145] Polkinghorne Donald E 'Language and meaning: Data collection in qualitative research' (2005) *Journal of Counselling Psychology*.
[146] The researcher understands and can communicate in all the languages mentioned.
[147] The researcher was assisted by 2 research assistants to conduct interviews with the women and girls as well as key informants who participated in the research. The research assistants were selected because they were conversant with the local languages used by the participants in the rural areas.
[148] Marshall Catherine & Rossman Gretchen B *Designing qualitative research* (1989) cited in Kawulich Barbara B 'Participant Observation as a Data Collection Method' (2005) *Forum: Qualitative Social Research Volume 6 No.* 2.

of the situation under study.[149] According to DeWalt and DeWalt, the 'goal for design of research using participant observation as a method is to develop a holistic understanding of the phenomena under study that is as objective and accurate as possible given the limitations of the method.[150] The researcher therefore used participant observation 'as a way to increase the validity of the study, as observations may help the researcher have a better understanding of the context and phenomenon under study.'[151] In order to obtain rich data using this method, the researcher visited rural health centres situated in the research as a patient. This assisted the researcher to assess how nurses and other health staff members treat reproductive rights issues as well as to evaluate accessibility, affordability, availability and quality of reproductive health care services.

1.9 DATA MANAGEMENT AND ANALYSIS

Patton states that:

> Qualitative analysis transforms data into findings. No formula exists for that transformation. Guidance, yes. But no recipe. Direction can and will be offered, but the final destination remains unique for each inquirer, known only when and if arrived at.[152]

Marshall and Rossman define qualitative analysis in terms of organizing and attributing meaning to the data.[153] To accomplish these tasks, the researcher followed the three-phase procedure described by Miles and Huberman which includes: (a) data reduction, (b) data display, and (c) conclusion drawing and verification.[154]

1.10 ETHICAL CONSIDERATIONS

When conducting research with human subjects, particularly vulnerable groups like women and girls, there are a number of ethical considerations to be dealt with. Amar Jesani and Tejal Barai[155] point that social scientists have duties when conducting research and should understand such ethical duties and thus conduct themselves within parameters of this expected behavior. The researcher obtained the necessary ethical clearance from the University of Cape

[149] Erlandson David A, Harris Edward L & Skipper Barbara L *et al Doing naturalistic inquiry: a guide to methods* (1993) cited in Kawulich Barbara B 'Participant Observation as a Data Collection Method' (2005) *Forum: Qualitative Social Research Volume 6 No. 2*.
[150] DeWalt Kathleen M & DeWalt Billie R *Participant observation: a guide for fieldworker*s (2002).
[151] Kawulich Barbara B 'Participant Observation as a Data Collection Method' (2005) *Forum: Qualitative Social Research Volume 6 No. 2*.
[152] Michael Quinn Patton *Qualitative Research and Evaluation Methods* 3 ed (2002) 432.
[153] Marshall Catherine & Rossman Gretchen B *Designing Qualitative Research* 4 ed (2006) 154.
[154] Mathew B Miles & Michael A Huberman *Qualitative Data Analysis* 2 ed (1994) 10-12.
[155] Amar Jesani and Tejal Barai *Ethical Guidelines for Social Science Research* in Health (2000).

Town's Faculty of Law Ethics Board to conduct research involving human subjects. The researcher also obtained ethical clearance to conduct research from the Medical Research Council of Zimbabwe, a specialized Council of the Research Council of Zimbabwe,[156] established in 1974 under the Research Act of 1959. The MRCZ also acts as the National Research Ethics Committee. On the issues of children, it is important to note that there are no specific laws that are dedicated to research involving children in Zimbabwe. The researcher spoke to the Director of the Medical Research Council of Zimbabwe (MRCZ) who advised that they were currently working on a draft legislation that would clearly provide for different research issues, including the issue of children and their participation in research. In the absence of legislation, researchers rely on the age of majority, which is 18 years and the best interests of the child principle as provided for in the Constitution of Zimbabwe (Amendment No.20) 2013. It is important to reiterate that this research focused only on married children as defined above.

1.10.1 Informed consent

One of the major issues to be considered when conducting research is the issue of informed consent. According to Armiger,[157] informed consent means 'that a person knowingly, voluntarily and intelligently, and in a clear and manifest way, gives his consent'. It is important to highlight that this research focuses on mature or emancipated minors only – no minors under the age of 18 were interviewed. Mature minors are minors who are married, have their own homesteads, are sexually active and are already receiving reproductive health services and thus, do not require parental consent to participate in research. In light of the above, the researcher was of the view that there was no need for a separate consent form for minors.

Thus, the researcher sought informed consent from the respondents and responsible authorities in the Province and District of research before embarking on the process of data gathering. The researcher stressed the following points to the participants; the aims and objectives of the study; that participation was voluntary; that they were free to decline participation in the study, that they were free to refrain from answering any particular questions and that they could cease their participation whenever they felt it was in their best interest to

[156] The Medical Research Council of Zimbabwe (MRCZ), is a specialized Council of the Research Council of Zimbabwe, established in 1974 under the Research Act of 1959. The MRCZ also acts as the National Research Ethics Committee.

[157] Armiger Sister Bernadette 'Ethics in Nursing Research: Profile, Principles, Perspective' (1997) *Nursing Research Volume 26 Issue 5* 26.

do so. As a way of trying to adhere to the informed consent principle, participants were obliged to read and sign the informed consent form before participating in the study. This is important as the research can infringe on people's freedom and self-determination.

Accordingly, the researcher ensured that the respondents of this research understood the use and type of information that the researcher sought to obtain. The researcher therefore explained to the respondents that the study had no direct benefits except that it sought to contribute towards the scientific body of knowledge on the lived experiences of rural women in Zimbabwe. The research was explained to be purely academic and respondents were expected to make an informed decision to voluntarily participate in the research or not. Another important issue that was expressly explained to the respondents was that after the research, respondents would not be receiving any gifts for their participation.

1.10.2 Do no harm principle

The research dealt with a sensitive subject as reproductive rights are intertwined with tradition, religion and women's roles in society. Culture and tradition regard women as minors and thus demand that women be subordinate to men.[158] Because the common religion in Hwange is Christianity, the general belief is that abortion (and sometimes contraception), which are reproductive health rights, are immoral.[159] The researcher anticipated that women would be hesitant to share their experiences as participation would be viewed to be against tradition, leading to social isolation. In light of the above, this study, by definition, only recruited participants who were willing to talk about the subject as it was very clear from the recruitment meetings and study title what the interview content would explore. In the event that participants became distressed during the course of the interviews, the interviewer acknowledged this and asked if the participant/s would like to take a break, prefer to reschedule for another time, or withdraw from the study altogether. Distressed participants were also advised of, and given details (phone numbers, emails and addresses) of organisations offering free counselling services as well as those that deal with women's rights in general. These details are in the public domain and were also available to the researcher through partnerships that had been made

[158] Cerna CM and Wallace JC 'Women and Culture' in Askin KD & Koenig DM (eds) *Women and International Human Rights Law, Human Rights Issues* Vol 1 (1999) 623-682.

[159] Some religions believe that the use of contraception is synonymous to committing abortion, which is considered sinful. The use of family planning is generally perceived to be against faith teaching and commands. The common text refereed by different Christian critics of family planning is Genesis 1:28, which describes God's words to Adam and Eve upon their expulsion from the Garden of Eden: "God blessed them, and God said to them, 'Be fruitful and multiply, and fill the earth, and subdue it…'

between the researcher's previous employer (the Zimbabwe Human Rights Commission) and civil society organizations/non-governmental organizations.

1.10.3 Confidentiality and anonymity

Confidentiality and anonymity could, because the author was conducting face to face interviews, be difficult to ensure during interviews. However, anonymity was guaranteed during reporting by changing the names of places and individuals to prevent identification and, any resemblance to other individuals outside the research would be entirely accidental. Further, the researcher excluded visual material from the research report and excluded visual material in which research participants featured. Where research participants featured, the visual materials were taken from an angle that did more to conceal than to reveal their identities.

Further, confidentiality was also guaranteed during reporting as participants were allocated pseudonyms in all discussions of interview data. After the completion of the fieldwork, all other personal identifiers were removed. The details of each interview were fully anonymised so that anyone analysing that data would not be able to trace the participants. The researcher stored the data gathered (that is, recordings and transcripts) in a safe, completely secure place, so that only the researcher would have access to the data. The computer that was used for the processing of the data was in the sole custody of the researcher and was password protected at the login and individual file level.

1.11 THEORETICAL FRAMEWORK

The study was informed by Sen and Nussbaum's capabilities approach[160] as well as Robert Chambers' urban bias theory.[161] This section therefore justifies the choice of these guiding theories by explaining their relevance to my study.

1.11.1 The Capabilities Approach

The human capabilities approach as conceived by Sen and later expanded by Nussbaum was developed out of concern with persistent inequalities in quality of life in general. The capabilities approach emphasises on the importance of the well-being of the individual in terms

[160] Amartya Sen, 'Equality of what?' in SM McMurring (ed) *Tanner Lectures on Human Values* Volume 1 (1980); Amartya Sen 'Capability and Well-being' in Sen and Nussbaum *The Quality of Life* (1993)
[161] Chambers, R *Rural Development: Putting the last first* 1983.

of what he or she is able to do and become and the kind of life he or she is able to lead.[162] According to Sen, the capabilities approach focuses on the reasons why people have unequal abilities to utilise the resources available to them. Human development is seen as a 'process of expansion of the real freedoms that people enjoy'; that is, expansion of the capabilities that enable people 'to live the life they have reason to value.'[163] Thus, by investing in people, Sen argues that people are empowered to pursue many different life choices, thus developing their capabilities.[164] This is important for women's reproductive health rights as empowerment of women ensures that they can exercise control over bodies, access reproductive health care services and defend these rights when violations occur.

The capabilities approach does not prioritise ownership of goods and commodities but instead stresses people's opportunities to access and make use of goods and services to achieve well-being. Consequently, for any meaningful development to occur in any nation, 'policies should be evaluated not on the basis of their ability to satisfy utility or increase income, but to the extent that they enhance the capabilities of individuals and their ability to perform socially accepted functionings.'[165] By definition, functionings are the 'beings and doings' of a person whereas capabilities are 'the various combinations of [valued] functionings that a person can achieve. The most basic capabilities a person can have therefore include: to lead a long and healthy life; to be knowledgeable; to have access to the resources and social services required for a decent standard of living.[166] In relation to women's reproductive health rights, this talks to the different policies and laws that a State puts in place for the realisation of the rights. The laws enacted and policies made should enhance women's capabilities by empowering them to exercise their rights.

The capabilities approach, according to Nussbaum, 'makes clear, however, that the pertinent goal is to make people able to function in a variety of areas of central importance.'[167] She states as follows:

> Instead of asking "How satisfied is person *A,"* or "How much in the way of resources does *A* command," we ask the question: "What is *A* actually able to do and to be?" In other words, about a variety of functions that would seem to be of central importance to a human life, we

[162] Sen A *Development as Freedom* (2000).
[163] Ibid.
[164] Ibid.
[165] Sen A *Inequality re-examined* (1995).
[166] Ibid.
[167] Martha Nussbaum, 'Human Rights and Human Capabilities' (2007) *Harvard Human Rights Journal* 20: 21-24

> ask: Is the person capable of this, or not? This focus on capabilities, unlike the focus on aggregate utility, looks at people one by one, insisting on locating empowerment in *this* life and in *that* life, rather than in the nation as a whole.[168]

In advancing the capabilities approach, Nussbaum lists a number of what she terms 'central capabilities'.[169] These, she argues, are 'not just instrumental to further pursuits: They are held to have value in themselves, in making a life fully human.'[170] Of the ten central capabilities established by Nussbaum, four are most relevant to my research, namely; life, health, bodily integrity and practical reason. The central capability of life implies that one should be able to live a normal life to the end, and not dying prematurely. This is particularly significant for women's right to access maternal health care services which, when denied, can lead to maternal death. Maternal deaths that can be avoided through accessibility of necessary maternal healthcare services therefore hamper women's capability to life.

Another capability significant to this study is bodily integrity. Nussbaum defines this capability as being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.[171] The significance of such a capability to women's reproductive health cannot be overemphasised. This is aptly described by Pyles as follows:

> The reason for setting forth this capability is to recognize the community's responsibility to provide the social conditions (laws, interventions, etc.) that enable this capability in the case of women who experience lack of bodily integrity as a capability deprivation. This is crucial, as bodily integrity is an important freedom in its own right as well as a means to further freedoms and economic opportunities.[172]

Nussbaum defines practical reason as 'Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. This entails protection for the liberty of conscience and religious observance.'[173] Practical reason is linked to women's autonomy which has three dimensions: physical, economic and decision-making. The most relevant dimension to this study is physical autonomy which is tied to human rights, namely; (i) reproductive and sexual rights, and (ii) the right to a life free of violence. These rights are

[168] Martha C Nussbaum 'Women and Equality: The Capabilities Approach' (1999) *International Labour Review Volume 138 No 3*.
[169] See Nussbaum, M *Women and Human Development: The Capabilities Approach* (2000).
[170] Martha C Nussbaum *Capabilities and Human Rights* (1997) 286.
[171] Nussbaum M *Women and Human Development: The Capabilities Approach* 2000 at 78.
[172] Pyles L 'The capabilities approach and violence against women: Implications for social development' (2008) *International Social Work, 51,* 31–38.
[173] Nussbaum *Women and Human Development*.

directly linked to women's freedom and autonomy over their bodies, as personal and private territory over which every woman should have legal power and the capability to take independent decisions. This is enshrined in several articles of the Convention on the Elimination of All Forms of Discrimination against Women,[174] which will be discussed in more detail in Chapter 2. Women's autonomy in reproductive health decision-making is therefore fundamental to the advancement of their reproductive rights, which in turn play a major role in ensuring gender equity and women empowerment. For instance, a woman's right to freely decide the number and spacing of her children is particularly significant in her exercise of control and autonomy over her body.

The capabilities approach and human rights have one common feature: their focus on a person's liberty and freedom.[175] Nussbaum's human capabilities jurisprudence, speaks of 'legal guarantees of freedom of expression ... and of freedom of religious exercise'[176] as aspects of the general capability to use one's mind and one's senses in a way directed by one's own practical reason. She also speaks of 'guarantees of non-interference with certain choices that are especially personal and definitive of selfhood,' and of 'the freedoms of assembly and political speech.'[177] The link between human rights has been articulated well by Garret as follows:

> The idea of human rights may be interpreted as implying the following moral principle: the capabilities of human beings should not be permitted to fall below a certain floor, so far as nation-states and the international community are able to produce that minimum threshold for everyone. What we are actually capable of doing is primarily a matter of combined capabilities, which depend in turn upon internal capabilities and basic capabilities, but internal capabilities and combined capabilities depend in different ways upon external conditions, and it is these that political and public action can modify or improve. (It is, alas, also true that badly chosen government action can degrade these conditions and thus degrade combined capabilities.) To the extent that "private" citizens affect the actions of their governments and public agencies, they are responsible for these units' implementation or failure to implement

[174] Convention on the Elimination of All Forms of Discrimination against Women. GA res. 34/180. UN Doc. A/34/46. 18 December 1979. See the following articles that talk to women's autonomy: Articles 5 on gender-based stereotyping and prejudice, Article 6 on suppressing all forms of traffic in women and exploitation of prostitution of women, Article 12 on ensuring access to reproductive health care and Article 16 deciding freely and responsibly on the number and spacing of their children and having access to the information, education and means to enable them to exercise these rights.

[175] Polly Vizard, Sakiko Fukuda-Parr & Diane Elson 'Introduction: The Capability Approach and Human Rights' (2011) *Journal of Human Development and Capabilities, 12:1,* 1-22

[176] Martha C Nussbaum 'Human Capabilities, Female Human Beings,' in M Nussbaum & J Glover (eds) *Women, Culture, and Development* (1995) 84.

[177] Martha C Nussbaum 'Human Capabilities' 84-85.

> the conditions that promote a fair level of capabilities for everyone. In principle, human rights are everyone's business.[178]

The capabilities approach as developed by Sen and Nussbaum emphasises that the capabilities of individuals can be inhibited or enhanced by internal and external factors. Sexual and reproductive behaviour for instance, is one issue that is heavily influenced by both internal and external factors. As correctly put by Price and Hawkins, sexual and reproductive behaviour is not just an individual decision making process as social networks, religious background and affiliation[179] as well as political environment shape an individual's behaviour.[180] Schaalma *et al* also weigh in on the argument that reproductive behaviour is not an individual decision. They argue that it is socially negotiated and subject to moral and sociocultural standards that vary across religion, age and gender.[181]

Thus, in the context of women's reproductive health right to maternal health and family planning services, the capabilities approach means women's ability to make decisions on whether or not to have children and women's ability to avoid adverse consequences (including death) due to pregnancy-related illnesses or complications. This can be achieved through women's access to basic requirements such as access to health care services, family planning information and services. Early marriage or pregnancy for instance, or repeated pregnancies spaced too closely together (often the result of efforts to produce male offspring because of the preference for sons) have a devastating impact on women's health with sometimes fatal consequences.'[182]

Further, poverty also plays a role in the capabilities theory as it is understood as deprivation of basic capabilities. Poverty deprives women of their capabilities in several ways; for instance, lack of financial resources means they cannot afford to travel to health centres or

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[178] Jan Garret 'Martha Nussbaum on Capabilities and Human Rights' Available at *https://people.wku.edu/jan.garrett/ethics/nussbaum.htm*, accessed on 1 April 2020.

[179] Akpenpuun Joyce Rumun 'Influence of religious beliefs on healthcare practice' (2014) *International Journal of Education and Research Vol. 2 No. 4*. See also: Agnes Cyril Msokaa, Eunice Siaity Pallangyoa, Sharon Brownie and Eleanor Holroydd 'My husband will love me more if I give birth to more children: Rural women's perceptions and beliefs on family planning services utilization in a low resource setting' (2019) *International Journal of Africa Nursing Sciences Volume 10*, 152-158 whose study findings revealed that religion was one of the biggest barriers to acceptance of family planning services; O'Brien S and Broom A 'HIV in (and out of) the clinic: Biomedicine, traditional medicine and spiritual healing in Harare' (2014) *Journal of Social Aspects of HIV/AIDS, 11(1):96.*

[180] Price, NL & Hawkins, K 'A Conceptual Framework for the Social Analysis of Reproductive Health' (2007) *Journal of Health Population and Nutrition 25*, 24-36.

[181] Schaalma HP, Abraham C & Gillmore MR *et al* 'Sex Education as Health Promotion: What does it take?' (2004) *Archives of Sexual Behavior, 33*: 259-269

[182] United Nations Office of the High Commissioner for Human Rights. Sexual and reproductive health rights. Available at: *https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.aspx*, accessed 15 January 2020.

pay for the required fees to access reproductive health care services. Women's inability to control their reproductive health has the negative effect of worsening their impoverishment. The thesis argues that because women are denied their right to reproductive health, they cannot finish their education and thus cannot fully participate in the workplace. This incapacitation of women therefore fuels the vicious cycle of poverty.

The significance of empowering women, and thus promoting their reproductive health and rights cannot be overemphasised. The right to reproductive health remains vital to women's wellbeing and survival, and ultimately the realisation of wider socio-economic development goals.[183] For rural women, investing in their rights, particularly their reproductive health rights, is a fundamental determinant to their empowerment and social development. According to Madre[184] (an international women's human rights organization whose organization name means 'mother') 'the positive impact of women's autonomy over their reproductive health choices is transparent: it increases her decision-making power, placing her in a stronger position overall to demand other rights…..for herself, her family and her community.'[185] The International Planned Parenthood Federation (IPPF) argues that women who can control their bodies, their fertility, and their lives in general, can take advantage of opportunities for education, employment, and political empowerment, and have a greater ability to achieve and maintain overall health and well-being as well as to maintain their productivity and contributions to society.[186]

Patriarchy is an example of an external factor inhibiting women from exercising their capabilities. Violations of rural women's right to have access to reproductive health care services are often too deeply embedded in patriarchal concepts of women being minors and thus unable to control or make decisions that concern their bodies and their lives in general. Traditional practices such as the subordination of women to men continue to hinder efforts to empower women and thus enable them to have control over their reproductive health mainly because:

[183] Stars AM, Ezeh AC & Barker G *et al* 'Accelerate progress' 2018.
[184] An NGO that strengthens grassroots women's organizations in war, disaster and their aftermath. It supports its partners to meet urgent needs and to build communities that are safer and healthier for women and families.
[185] MADRE. 'Reproductive Health: Important for Women, Families and Communities.' Available at https://www.madre.org/press-publications/article/reproductive-health-important-women-families-and-communities, accessed 19 November 2016.
[186] The International Planned Parenthood Federation (IPPF). 'Sexual and reproductive health and rights – the key to gender equality and women's empowerment.' Available at *http://www.ippf.org/sites/default/files/2020_gender_equality_report_web.pdf*, accessed 19 November 2016.

> Custom in Africa is stronger than domination, stronger than the law, stronger even than religion. Over the years, customary practices have been incorporated into religion, and ultimately have come to be believed by their practitioners to be demanded by their adopted gods, whoever they may be.[187]

As a result of the power of African custom as clearly shown in the aforementioned quotation, the most serious violations of African women's human rights are 'rooted deeply within the family system, bolstered by community norms of male privilege and frequently justified by religious doctrines or appeals to custom or tradition.'[188] Accordingly, the reproductive decisions of the African woman are typically made under 'enormous pressures from family, community, and society to comply with the prevailing gender and reproductive norms, as well as internalized commitments to act responsibly towards others.'[189]

Male dominance, a direct consequence of custom and tradition is also a major inhibiting factor to individuals', particularly women's capabilities. Darteh *et al*[190] argue that 'women's decision making in general and in sexual and reproductive health in particular have largely been genderised within power relations with men playing influential roles in women's decision making.'[191] A study conducted by Grieser *et al* on decision-making and the HIV epidemic in Zimbabwe found that decision-making in whatever context is a complex issue and gender is largely considered as the major power source in reproductive decision making.[192] Another study conducted by Ndlovu found that in Zimbabwe, it is common practice that 'women have no control or power over the means of reproduction.'[193] Thus, male dominance, which exists in both the public and private domain, 'incapacitates women from doing anything freely.'[194]

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[187] Lightfoot-Klein 1989:47 in Maureen Kambarami 'Femininity, Sexuality and Culture: Patriarchy and Female Subordination in Zimbabwe' 2006 *Understanding Human Sexuality Seminar Series.*

[188] Correa S & Petchesky R 'Reproductive and Sexual Rights: A Feminist Perspective' in Gita Sen, Adrienne Germain & Lincoln C Chen (eds) P*opulation policies reconsidered: Health, Empowerment, and right* (1994) 110.

[189] Ibid at 110.

[190] Nawal M Nour 'Child Marriage: A Silent Health and Human Rights Issue' (2009) *Reviews in Obstetrics and Gynaecology Journal Volume 2* 51-56.

[191] Ibid at 54.

[192] Mira Grieser, Joel Gittelsohn & Anita V Shankar et al 'Reproductive decision making and the HIV/AIDS epidemic in Zimbabwe' (2001) *Journal of Southern African Studies, Volume. 27 No. 2* 225–243.

[193] Ndlovu V 'Communication and the Decision Making Process among Couples with HIV/AIDS in Bulawayo, Zimbabwe' (2014) *International Scholarly Research Notices Infectious Diseases Volume 2014* at 1.

[194] Ilene S Speizer, Lisa Whittle & Marion Carter 'Gender relations and reproductive decision making in Honduras' (2005) *International Perspectives on sexual and reproductive health Volume 31 No. 3* 131–139; Margaret E. Greene and Ann E. Biddlecom 'Absent and problematic men: demographic accounts of male reproductive roles' (2000) *Population and Development Review Volume 26 No. 1* 81–115.

1.11.2 The Urban Bias Theory

The urban bias theory emphasises the point that most development takes place in or near towns because officials prefer the tarmac roads and do not like to travel to remote rural districts. It states that rural development is limited due to the hazards associated with visiting rural areas such as dirt roads, the comfort of the visitor, the location of places to visit, no cell phone network services and poor accommodation facilities. The result of such choice is overlapping urban biases where research investigations in rural areas are not often undertaken. Such bias greatly disadvantages the women in rural areas as no one is willing to visit such places in order to understand rural women's human rights concerns better.

According to the Food Agricultural Organisation of the UN, the population of the developing world is more rural than urban with 51 per cent of the total population living in rural areas.[195] For Zimbabwe, her rural population was, according to the World Bank's 2018 collection of development indicators, 67.79 per cent in 2018.[196] Notwithstanding the aforementioned position that urban residents make up only a minority of the total population, both globally and nationally in Zimbabwe, public resources are often skewed in favour of urban areas.[197]

Lipton's urban bias theory has two major elements, namely (a) allocation of resources are deeply biased towards urban areas and (b) such bias is embedded in the political structure of the state, which is dominated by the urban group. He further states that:

> The rural sector contains most of the poverty, and most of the low cost sources of potential advance; but the urban sector contains most of the articulateness, organization and power. So the urban classes have been able to 'win' most of the rounds of the struggle with the countryside; but in doing so they have made the development process slow and unfair. Such urban rural biases and disadvantages rooted in inequalities often disproportionately hold back certain groups of the society, particularly rural women and indigenous peoples.[198]

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[195] Food and Agriculture Organisation of the UN Rural areas, too long seen as poverty traps, key to economic growth in developing countries Available at *http://www.fao.org/news/story/en/item/1042091/icode/*, accessed on 24 July 2020.

[196] World Bank. Rural population (per cent of total population) – Zimbabwe. Available at *https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?contextual=default&locations=ZW*, accessed 30 March 2020.

[197] Michael Lipton *Why Poor People Stay Poor: Urban Bias in World Development* (1977) cited in Sumon Majumdar, Anandi Mani & Sharun Mukand 'Politics, Information and Urban Bias' *Journal of Development Economics vol. 75(1).*

[198] International Fund for Agricultural Development (IFAD) at 17.

The urban bias theory assisted the researcher to understand whether rural tarmac biases have an impact on rural women's access to reproductive health care services.

1.12 CHAPTER SYNOPSIS

Chapter 1: This chapter is the introduction. It presents the background of the study, statement of the research problem, research objectives, methodology and significance of the study. It also presents the theoretical framework guiding this study.

Chapter 2: Presents the historical development of the right to reproductive health. In discussing the historical overview, the Chapter discusses the obligations of States, including Zimbabwe, as outlined in the international treaties. It also discusses the violations approach which explains how the right to reproductive health can be violated and the grounds on which such violations can be challenged.

Chapter 3: Discusses Zimbabwe's domestic legal and policy frameworks on women's reproductive rights. The aim is to establish whether Zimbabwe is in compliance with its international human rights obligations as discussed in Chapter 2.

Chapter 4: Presents findings from the interviews conducted. This provides a detailed description of the lived challenges that women in Hwange Rural District face in accessing reproductive health services.

Chapter 5: This Chapter discusses opportunities available to assist Zimbabwe comply with its international and domestic obligations, thus ensuring that rural communities have access to reproductive health care services.

Chapter 6: Conclusions and recommendations are proffered in this chapter.

Bibliography: Presents the references used in the thesis

Appendix: Several pertinent materials that could not be included in the main body of the dissertation constitute the appendix section.

CHAPTER 2: THE RIGHT TO REPRODUCTIVE HEALTH IN INTERNATIONAL HUMAN RIGHTS LAW

2.1 INTRODUCTION

The previous chapter provided an introduction to the dissertation, providing some background information, and introducing some core concepts, including the concept 'right to reproductive health'. This chapter examines the right to reproductive health in more detail and focuses specifically on the right to reproductive health in international human rights law.

The chapter begins with a historical introduction, looking at the precursors of the modern human right to reproductive health. The precursors emerged in the population and women's rights movements of the nineteenth and early twentieth centuries. This early history is set out in section 2.2.1, which also discusses and analyses historical writings on women's reproductive rights.

The right to reproductive autonomy and reproductive health started to transform during the second half of the twentieth century, primarily through a sequence of international conferences which began to refer to a 'right' to reproductive health in the language of human rights rather than social policy. The contributions made through these conferences are set out in section 2.2.2

To some extent, the development of the legally binding international and regional human rights regimes was a parallel process. As explained and analysed in section 2.2.3, international human rights law matured into a legally binding system of norms from the 1960s onwards. The development of binding rules of human rights law is extremely important for our understanding (and use) of a right to reproductive health, but as explained in section 2.2.3, recognition of the right to reproductive health as a legally binding human right was fairly slow and modest in international and regional human rights treaties. Section 2.2.3 examines the right to health as a binding right of international human rights law and discusses some of the elements of the right to reproductive health, particularly the right to maternal health and family planning services. This section introduces the concepts of 'minimum core obligations' and the 'violations approach' which are useful tools when assessing compliance with rights that are subject to progressive realisation. Section 2.2.3 also discusses theoretical foundations that are

relevant to women's reproductive health rights. Section 2.2.4 looks at the regional human rights treaties through a similar lens.

Section 2.3 looks at state obligations in relation to women's reproductive rights. This discussion is based on the tripartite typology of obligations and adopts the violations approach. Section 2.4 concludes the chapter.

2.2 DEVELOPMENT OF THE INTERNATIONAL RIGHT TO REPRODUCTIVE HEALTH

This section presents the historical development of the right to reproductive health, and examines its evolution within the modern international human rights law regime. This section lays a foundation for Chapter Three, which examines the extent to which Zimbabwean law complies with Zimbabwe's human rights commitments under international and regional human rights law.

2.2.1 Development of the right to health through the population and women's rights movements

An examination of historical origins is helpful for understanding the modern concept of the right to reproductive health. This dissertation focuses on the origins of the right to reproductive health from when they began to emerge in the late 18th century. According to Laura Davis Mattar, 'the construction of reproductive rights as human rights was achieved historically by two distinct movements: the population movement and the women's movement.'[199] It is for this reason that Freedman and Isaacs call it a 'schizophrenic history', since it is split between two distinct historical movements.[200]

The population movement was based on Malthusian theory as propounded by Thomas Malthus.[201] Thomas argued that populations are continually overburdening their food supply and 'natural causes, misery, and vice' serve to check that growth. In later editions, Malthus

[199] Laura Davis Mattar 'Legal recognition of sexual rights – a comparative analysis with reproductive rights' (2008) *International Journal of Human Rights Year 5 Number 8 São Paulo*.
[200] Freedman LP & Isaacs SL 'Human Rights and Reproductive Choice' (1993) *Studies in Family Planning, Volume 24, Number 1* 18-30.
[201] Thomas R Malthus (1766-1834), a 19th century British economist, defended in his treatise 'An Essay on the Principle of Population his theory that while populations grow at geometric rates, food supplies to sustain these populations tend to increase at an arithmetic rate. Therefore, Malthus predicted the collapse of the human population if birth rates were not voluntarily reduced.

introduced the corrective of 'moral restraint' in the form of abstinence and late marriage to prevent the misery and vice necessarily resulting from overpopulation. Although Malthus's idea of moral restraint could be viewed as a form of birth control, he was opposed to contraception, which is interesting considering the birth control movements that later emerged and benefited from his work. For instance, Malthus' work informed the birth control and eugenics movement in the United States of America. The Malthusian League, founded by Charles Bradlaugh and Annie Besant in London, England, in 1877, was based on the principles of Thomas Malthus and promoted the use of contraception to limit family size. The League advocated for limiting family size voluntarily through contraception to avoid the overpopulation and poverty cautioned against in Malthus' work. The 'eugenics' movement on the other hand,[202] promoted the ideal of improving the human race by reducing the birth rate of 'undesirables' and multiplying the 'desirables.'[203] The movement sought to genetically improve the human race by regulating reproduction. Denford and Snow explained the eugenics movement as follows:

> Like the early birth control movement, the eugenicists diagnosed a social problem— the 'wrong' kind of people out-producing the 'right' kind of people— and proposed a solution, a program of sterilization. In this way, sterilization was the eugenics movement's form of prognostic framing, both a solution and a plan of attack that gained support for the movement.[204]

The population and eugenics movements encouraged studies 'on ways of reducing fertility, which led to the introduction of contraception, such as the pill and IUDs…'[205] However, it is important to note that the introduction of contraceptive methods were actually viewed as devices for controlling women and their fertility and not tools of female liberation.[206]

The other historical source of the modern right to reproductive health was the women's movement. Reproduction was one of the major concerns of the women's movement. However, this was in the context of an entirely different objective and focus from the

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[202] Francis Galton first coined the term 'eugenics' in 1883. Put simply, eugenics means 'well-born.' Galton's eugenics was a program to artificially produce a better human race through regulating marriage and thus procreation. Galton put particular emphasis on "positive eugenics", aimed at encouraging the physically and mentally superior members of the population to choose partners with similar traits, with the idea of building an "improved" human race.

[203] Daniel J Kevles 'Eugenics and human rights' 1999 *BMJ* 435–438.

[204] Robert D Benford & David A Snow 'Framing Processes and Social Movements: An Overview and Assessment' (2000) *Annual Review of Sociology Volume 26*: 615-616.

[205] Laura Davis Mattar 'Legal recognition of sexual rights' at 67.

[206] Avilla MB 'Reproductive Rights: chaos and government action' in Corrêa S & Ávilla MB *Reproductive Rights and the female condition* (1989) 18.

population movements. The women's movement was primarily concerned with women's equality[207] and women's autonomy,[208] precisely, their ability to control their own bodies, their sexuality and their reproductive lives. The women's movement was therefore characterised by the 'our bodies, our choice' mantra.[209] Thus, the women's movement, unlike the population movement (whose focus was to use birth control so as to control population growth), was focused on women as independent individuals who ought to have autonomy and enjoy equality. Reproductive rights advocates in the women's rights movement pursued the development of legal recognition of reproductive rights through litigation of cases against state laws that impeded women's right to make reproductive health decisions or to access reproductive health services. For instance, in *Griswold v Connecticut,*[210] the United States Supreme Court held that married couples had a constitutional right to use contraception within a 'zone of privacy,' which encompasses the 'marital relationship.' However, the limitation on the right to use contraception to married couples or even adults was reversed in *Eisenstadt v Baird,*[211] where the US Supreme Court extended the right to use contraceptives to unmarried individuals. In the landmark decision *Roe v Wade*[212] the Court recognized that this right to privacy extended to a woman's decision to terminate her pregnancy by stating that:

> … the right is broad enough to encompass a woman's decision whether or not to terminate her pregnancy… the Court respects a woman's urgent claim . . . to retain the ultimate control over her destiny and her body… the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear…[213]

The women's rights movement therefore focused on the woman and ensuring that the she has control over her body. Like the capabilities approach, the women's rights movement underscored on the importance of the well-being of the individual women themselves, precisely

[207] See Rosalind Pollack Petchesky 'Reproductive Freedom: Beyond 'A Woman's Right to Choose' (1980) *Signs; Journal of Women in Culture and Society Volume 5 No 4:* 661-685, who argues that equality is derived from the biological connection between women's bodies, sexuality, and reproduction. It is an extension of the general principle of 'bodily integrity,' or "bodily self-determination," to the notion that women must be able to control their own bodies and procreative capacities-that is, the reproductive and sexual uses to which their bodies

[208] Autonomy 'historical and moral argument' based on the social position of women and the socially determined needs which that position generates. It states that, insofar as women, under the existing division of labour between the sexes, are the ones most affected by pregnancy, since they are still the ones responsible for the care and rearing of children, it is women who must decide about contraception, abortion, and childbearing.

[209] Wells Susan 'Our Bodies, Ourselves: Reading the Written Body' (2008) S*igns: Journal of Women in Culture and Society Volume 33 No 3*:697–723.

[210] 381 US 479 (1965).

[211] 405 US 438 (1972).

[212] 410 US 113 (1973).

[213] At 153–54; 859-862.

in terms of what the women were able to do with their bodies. This thesis argues that this was a significant movement as it sought to enhance women's capabilities.

2.2.2 Development of the right to reproductive health through international conferences, programmes and policies

From the mid-twentieth century, a specific 'right' to 'reproductive health' has emerged from a number of international conferences and programmes. To some extent, these developments have been distinct from and parallel to the development of the international human rights treaty regime. This section examines the right to reproductive health that emerged from the conferences and programmes.

It is useful to begin with the International Conference on Human Rights, held in Tehran in 1968. The Conference adopted the Proclamation of Teheran which affirmed, for the first time in a global agreement, the basic right of parents as follows: 'parents have a basic human right to determine freely and responsibly the number and the spacing of their children and a right to adequate education and information in this respect'.[214]

At the World Population Conference held in Bucharest in 1974, the World Population Plan of Action was adopted. Fundamental principles articulated in the World Plan of Action, were:

- The formulation and implementation of population policies are the sovereign right of each nation;
- All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; and
- Population and development are interrelated.

[214] Proclamation of Teheran Resolution XVIII: Human Rights Aspects of Family Planning, Final Act of the International Conference on Human Rights. U.N. Doc. A/CONF. 32/41, p.15); Freedman & Isaacs 'Human Rights and Reproductive Choice'.

The Conference reaffirmed the right to reproductive choice, although it broadened its definition to include couples and individuals.[215] It further established that people should have the information, education and means to exercise their reproductive rights.

The autonomy mantra which was the basis of the women's rights movement was then included in the Declaration of the 1st World Conference on Women held in Mexico in 1975, and organised by the United Nations Decade for Women.[216] The Conference participants, predominantly women, 'successfully managed to include in the Declaration of the Conference the right to reproductive autonomy.'[217] The UN women's conference in Mexico City therefore produced two major documents: the 'Declaration of Mexico on the Equality of Women and Their Contribution to Development and Peace'[218] and the 'World Plan of Action for the Implementation of the Objectives of the International Women's Year.'[219]

In 1984 came the International Conference on Population held in Mexico, whose mandate was 'to review progress made over the 10 years following the World Population Conference in Bucharest in 1974, which adopted the World Population Plan of Action.'[220] The Conference adopted the Recommendations for the Further Implementation of the World Population Plan of Action.[221] One of the main recommendations included was the obligation of governments to make family planning programs universally available.

Nine years after the Mexico conference, the World Conference on Human Rights in Vienna in 1993 became 'the tipping point in the recognition of women's rights as human rights' because 'Before Vienna, feminists who sought this recognition were often dismissed as

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[215] See Paragraph 14(f) of the Principles and Objectives which states that: 'All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities toward the community'

[216] The United Nations Decade for Women was a period from 1975 to 1985 focused on the policies and issues that impact women, such as pay equity, gendered violence, land holding, and other human rights. It was adopted December 15, 1975 by the United Nations General Assembly by Resolution 31/136.

[217] Laura Davis Mattar 'Legal recognition of sexual rights' at 68.

[218] United Nations General Assembly, *World Conference of the International Women's Year*, 15 December 1975, A/RES/3520.

[219] United Nations General Assembly, *Implementation of the World Plan of Action adopted by the world Conference of the International Women's Year*, 12 December 1975, A/RES/3490.

[220] Heisel OF 'The road to Mexico City: Preparation for the 1984 International Conference on Population' (1984) *Management International Development* 1 (5):23-44.

[221] UN Second Conference on Population 1984. Recommendations for the Further Implementation of the World Population Plan of Action. Adopted at the World Population Conference. Mexico. 6 to 14 August 1984. Available online: *https://www.unfpa.org/sites/default/files/event-pdf/Recommendations per cent20for per cent20implementation per cent20of per cent20World per cent20Population per cent20Plan per cent20of per cent20Action_1.pdf*, accessed on 12 April 2019.

annoying or ridiculed when they sought human rights support for abuses like domestic violence, gang rape, or forced pregnancy.'[222] The Conference resulted in the adoption of the Vienna Declaration and Programme of Action, (VDPA) which affirmed that women's rights are human rights by providing that:

> The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community.[223]

Another significant milestone achieved by the Conference was the action it took to promote and protect the rights of women, precisely by calling for and supporting the creation of a new mechanism such as a Special Rapporteur on Violence against Women, who was subsequently appointed in 1994.[224] Such achievement cannot be overemphasized as violence against women is a major contributing factor in depriving them their capabilities to lead healthy reproductive lives.

A fundamental shift in the population and reproductive health agenda came through the International Conference on Population and Development (ICPD) held in Cairo in 1994, when the public health aspects of contraception were emphasized and the concepts of 'reproductive health' and 'sexual health' were introduced. According to Laura Matar, this was the occasion when 'women, the main victims of the population control programs, were elevated from the object to the subject of the population and development programs.'[225] It is at this Conference in 1994 that a precise definition of reproductive health,[226] that was twofold in nature, was adopted as follows:

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[222] Charlotte Bunch - Founding Director and Senior Scholar of the Centre for Women's Global Leadership, Rutgers University

[223] Part 1, Para 18 of the Vienna Declaration and Programme of Action of 1993.

[224] United Nations Human Rights Office of the High Commissioner. *The United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences*. Available at *https://www.ohchr.org/Documents/Issues/Women/15YearReviewofVAWMandate.pdf*, accessed on 2 April 2020.

[225] Laura Davis Mattar 'Legal recognition of sexual rights' at 71.

[226] There is no conventional definition for reproductive rights. See Cook Rebecca J & Mahmoud F Fathalla 'Advancing Reproductive Rights Beyond Cairo and Beijing' (1996) *International Family Planning Perspectives Volume 22 No 3*: 115–121 who define reproductive rights as legal rights and freedoms relating to reproduction and reproductive health. The World Health Organization defines reproductive rights as follows: Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence."

> Reproductive health is 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 to 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 right 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 are 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.[227]

On the one hand, the Conference conceptualized reproductive rights as 'the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health'. On the other hand, the 1994 Conference stated that these rights 'embrace certain human rights that *are already recognized in national laws, international laws and international human rights documents* and other consensus documents'. This effectively means that reproductive rights, although not expressly mentioned in the regional and international treaties, are nevertheless incorporated within the rights that are expressly provided in these treaties.

In addition, the ICPD confirmed a human-rights approach to population and reproductive issues by recognizing, inter alia, that human rights provisions recognised in national laws and international human rights documents must also apply to reproductive rights.[228] The ICPD Programme of Action made it clear that population issues should be addressed by emphasizing the need of individual men and women rather than on demographic targets.[229] Key to this new approach was the idea of empowering women, providing them with more choices and ultimately, protecting their human rights.

In 1995, the Fourth World Conference on Women adopted the Beijing Declaration and Programme for Action (BDPA) which reaffirmed the principles set up in the ICPD Programme of Action regarding women's reproductive rights. The BDPA stated, on a more general level:

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[227] United Nations *Report of the International Conference on Population and Development* (1994).
[228] Guichon A 'Background Report on Women's Reproductive Rights' Available at *http//www.newr.bham.ac.uk/pdfs/Reproductive/Background per cent20report per cent20on per cent20reproductive per cent20rights.pdf*, accessed on 20 April 2016.
[229] United Nations Population Fund 'International Conference on Population and Development (ICPD).' Available at *https://www.unfpa.org/events/international-conference-population-and-development-icpd*, accessed on 2 April 2020.

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual 5 respect, consent and shared responsibility for sexual behaviour and its consequences.[230]

In September 2000, the United Nations signed the Millennium Declaration – a Declaration which, through a framework of Eight MDGs, 18 targets and 48 indicators, committed world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015. The emergence of the Goals further supported the realisation of the reproductive health rights had already been recognised in the ICPD in 1994. The Goals provide a common framework agreed to by all United Nations governments, complete with measurable targets and indicators of progress, around which governments, UN agencies, international finance institutions and civil society alike could rally.[231] However, it should be noted that when the MDGs were initially drafted and adopted, no explicit goal on reproductive health and rights was included in the MDGs.[232] It was only after seven years of negotiations that 'a global agreement to add a target to the MDGs that called for universal access to reproductive health'[233] was reached. This led to the addition of MDG 5, on Improving Maternal Health which specifically mentioned reproductive health in two of its targets. Target A's aim was to reduce the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015; while Target B was aimed at achieving universal access to reproductive health by 2015.

The duration of the MDGs lapsed in 2015 with progress toward achieving the set targets on reproductive health being uneven. For instance, a 2015 UN Millennium Development Goals Report, detailing the progress made by the MDGs from 2000 to 2015, acknowledges that 'globally, the proportion of deliveries attended by skilled health personnel

[230] Paragraph 96 of the Beijing Platform for Action.
[231] Peggy Antrobus 'Critiquing the MDGs from a Caribbean Perspective' in Caroline Sweetman (ed) *Gender and the Millennium Development Goals* (2005).
[232] See, Crossette B 'Reproductive health and the Millennium Development Goals: the missing link' (2005) *Studies in Family Plann*ing 36: 71–79; UNFPA *State of world population 2005: The Promise of Equality Gender Equity, Reproductive Health and the Millennium Development Goals* (2005) at 25; Marianne Haslegrave & Stan Bernstein 'ICPD Goals: Essential to the Millennium Development Goals' (2005) *Reproductive Health Matters, 13:25*, 106-108. Crossette states that 'In 2000, crafters of the Millennium Development Goals (MDGs), the UN plan to reduce poverty worldwide by 2015, omitted sexual and reproductive health altogether out of concern that including it might put adoption of the Millennium Declaration at risk.'
[233] Galati A 'Sexual and reproductive health and rights in the context of the Sustainable Development Goals' (2015) *Guttmacher Policy Review* 18: 77–84.

increased from 59 per cent around 1990 to 71 per cent around 2014.'[234]This translates to 12 per cent progress made towards achieving the set target of maternal health in 15 years. Although there was progress recorded, more than one in four babies and their mothers were, and are still, left without access to crucial medical care during childbirth, thus violating the right to maternal health care services.

In September 2015, the General Assembly adopted the 2030 Agenda for Sustainable Development that includes 17 SDGs designed to be a 'blueprint to achieve a better and more sustainable future for all'. The SDGs framework expressly mentions reproductive health under SDG 3, which seeks to ensure healthy lives and promote wellbeing for all at all ages. Two targets under Goal 3 specifically mention reproductive health and rights. Target 3.7 states, 'By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes,' while Target 5.6 aims to, 'Ensure universal access to sexual and reproductive health and reproductive rights.' Although these targets are commendable as they 'offer a solid basis for moving forward, they do not offer a comprehensive agenda for sexual and reproductive health and rights (SRHR).'[235] This may be the same challenge that was faced by the MDGs which provided, under Goal 5, 'universal access to sexual and reproductive health by 2015.' Four years after the close of the MDG set deadline and women still do not have adequate access to reproductive healthcare services.

The platforms discussed in this section have promoted the development of reproductive rights, particularly women's reproductive rights. Although the various documents are not treaties and do not create specific obligations for the states, they reflect the international community's common goals and policies regarding reproductive rights contemporaneous with the binding treaties[236] that are discussed in the following section (below). The various platforms discussed in this section were important in the conceptualisation of reproductive rights but they did not create a binding legal obligation with regard to the right.

[234] United Nations *The Millennium Development Goals Report 2015*.
[235] Stars AM, Ezeh AC & Barker G *et al* 'Accelerate progress' at 2643.
[236] Saona H 'The Protection of Reproductive Rights Under International Law: The Bush Administration's Policy Shift and China's Family Planning Practices' (2004) *Pacific Rim Law and Policy Journal* 245.

2.2.3 Development of the right to reproductive health through the Human Rights Movement

The previous sections discussed the emergence and evolution of the right to reproductive health. Section 2.2.2 (above) examined how a right to reproductive health has developed into a self-standing right that has been incorporated into very important international documents including the MDGs and the SDGs adopted by the UN General Assembly.

Recognition of a right to reproductive health by international organisations and international conferences is of course extremely significant for understanding our contemporary right to reproductive health. It is important to note, however, that the international conferences and documents discussed in section 2.2.2 did not take the form of binding treaties and did not create a *legally binding right* to reproductive health.

For the genesis of the legally binding right to reproductive health, we must examine its emergence through the international human rights regime. This can almost be seen as a parallel process historically: at the same time that a right to reproductive health was being developed through international conferences and programmes, the international human rights treaty regime was taking shape. This section discusses the recognition of a legally enforceable right to reproductive health as protected by international human rights treaties.

Before discussing the relevant human rights treaties, it would be useful to provide a brief discussion on the significance of general comments as they provide the normative content of what State's obligations entail. The discussion of the various treaties relies on the general comments as prepared by the relevant treaty bodies.

2.2.3.1 The legal significance of general comments and general recommendations

What are general comments? Philip Alston defines general comments as,

> A means by which a UN human rights expert committee distils its considered views on an issue which arises out of the provisions of the treaty whose implementation it supervises and presents those views in the context of a formal statement of its understanding to which it attaches major importance.[237]

[237] Philip Alston 'The Historical Origins of the Concept of "General comments" in Human Rights Law' in Laurence Boisson de Chazournes & Vera Gowlland-Debbas (eds) *The International Legal System in Quest of Equity and Universality* (2001) 763.

To further clarify what general comments are, and their significance, Ngwena *et al* state that,

> Primarily, general comments are authoritative interpretive guidance issued by the UN or regional treaty bodies to aid states in their implementation of human rights treaties. General comments are quasi-judicial guidance to help states to achieve treaty objectives. Through general comments, treaty bodies clarify the nature and extent of the normative content of ratifying states' treaty obligations…Although they do not constitute binding law, general comments can be invaluable in promoting the objectives of a treaty, especially when they seek to clarify treaty obligations in areas that are novel and for which there are no precedents, or that are historically morally contested or stigmatized. General comments are particularly important for providing interpretive guidance in areas where human rights remain unprotected as is the case with women's reproductive health, especially safe abortion care.[238]

The Human Rights Committee expressed the purpose of its general comments as follows:

> The purpose of these general comments is to make this experience available for the benefit of all States parties in order to promote their further implementation of the Covenant; to draw their attention to insufficiencies disclosed by a large number of reports; to suggest improvements in the reporting procedure and to stimulate the activities of these states and international organizations in the promotion and protection of human rights.[239]

On the question of whether the general comments are legally binding or not, Gerber *et al* argue that 'while they have acquired a more normative and prescriptive status than in the past, the precise contours of that status are difficult to define.'[240] Craven states that although general comments are not binding, they have 'considerable legal weight'.[241] Further, Shelton submits that general comments are 'secondary soft law' instruments, interpreting and adding detail to the express rights in treaties.[242] Consequently, although not legally binding like the treaties they seek to clarify, general comments do carry some authoritative value that has been accepted by state parties.

The discussion on the various treaties in the following sections will often refer to the general comments issued by the relevant treaty bodies in order to enhance understanding of

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[238] Charles G Ngwena, Eunice Brookman-Amissah & Patty Skuster 'Human rights advances in women's reproductive health in Africa' (2015) *International Journal of Gynaecology and Obstetrics* 1.
[239] Report of the Human Rights Committee, UN GAOR, 36th sess, Supp No 40, UN Doc A/36/40 (29 September 1981).
[240] Paula Gerber, Joanna Kyriakakis & Katie O'byrne 'General comment 16 on state obligations regarding the impact of the business sector on children's rights: what is its standing, meaning and effect?' (2013) *Melbourne Journal of International Law Volume 14:7*.
[241] Matthew CR Craven *The International Covenant on Economic, Social, and Cultural Rights: A Perspective on Its Development* (1998) 91.
[242] Dinah Shelton 'Commentary and Conclusions' in Dinah Shelton (ed) *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System* (2003) 449, 451.

what the treaties require. Some treaty bodies (such as the CEDAW) issue 'general recommendations' rather than general comments, but these have the same jurisprudential weight.

2.2.3.2 United Nations Human Rights Council

Perhaps the first important United Nations body to discuss before discussing the different human rights treaties is the Human Rights Council (HRC). The HRC was created by the United Nations General Assembly on 15 March 2006 by resolution 60/251.[243] It is an inter-governmental body within the United Nations system responsible for strengthening the promotion and protection of human rights around the globe and for addressing situations of human rights violations and make recommendations on them.

Of particular significance to this study is the HRC's fundamental role in forging linkages between the human rights and health fields on this topic, and in highlighting the importance of issues relating to voice, gender equality, and accountability.[244] This was achieved through its Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes for the reduction of preventable maternal mortality and morbidity.[245] The purpose of the Technical Guidance document is to assist States and other stakeholders in moving from theory to practice in operationalizing human rights in the area of maternal health, including sexual and reproductive health.[246] The significance of a human rights-based approach to maternal health cannot be overemphasised. It creates environments that enable rights holders to claim their entitlements and duty bearers to meet their legally binding human rights obligations – thus representing a shift away from passive delivery of services to a culture of accountability for internationally guaranteed human rights.[247] Yamin argues that the significance and promise of the Technical Guidance is that

> it provides an opportunity to integrate an HRBA into national initiatives, and to educate duty bearers about their obligations and how to meet them. In so doing, it can bring human rights

[243] OHCHR 'Welcome to the Human Rights Council' Available at *https://www.ohchr.org/En/HRBodies/HRc/Pages/aboutcouncil.aspx#:~:text=The%20Human%20Rights%20Council%20is,and%20make%20recommendations%20on%20them*., accessed on 6 February 2021.
[244] Alicia Ely Yamin 'Applying human rights to maternal health: UN Technical Guidance on rights-based approaches' *International Journal of Gynecology and Obstetrics* 2013.
[245] A/HRC/21/22.
[246] Paragraph 3 of the Report of the Office of the United Nations High Commissioner for Human Rights on the Application of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity A/HRC/27/20 2014.
[247] Paragraph 4 of the Report of the Office of the United Nations High Commissioner for Human Rights.

> much closer to home, much closer to the realities of policy makers and practitioners, and ultimately women, in countries around the world.[248]

Two key principles of an HRBA, which are set out in the Technical Guidance, relate to women's active participation and accountability.[249] In an HRBA, women are not passive targets of public health programming – rather, 'they are active agents who are entitled to participate meaningfully in decisions that affect their sexual and reproductive health and in turn their lives.'[250] This is significant particularly for rural women. If their right to have access to maternal health and family planning information and services is to be successfully realised, rural women have to actively participate in any decisions affecting their reproductive health lives. This in turn allows women to hold the government accountable for any reproductive health right violations and abuses.

Another key aspect of the Technical Guidance is its specific mention of rural women as a vulnerable group requiring special measures for the realisation of their reproductive rights. Paragraph 15 specifically provides that:

> Human rights require "particular attention to vulnerable or marginalized groups". Among other groups …ethnic and racial minorities, indigenous women…women living in underserved areas and other stigmatized and excluded populations should be paid special attention.

To ensure that rural women's sexual and reproductive health rights are realised, Zimbabwe should therefore meet standards with regard to health facilities, goods and services – particularly availing hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.

2.2.3.3 Universal Declaration of Human Rights

The international human rights regime that we know today began in 1948 with the Universal Declaration of Human Rights (UDHR) – which is not a binding treaty, but laid the groundwork for subsequent binding treaties such as the ICESCR, relied on in this thesis. Established by the United Nations General Assembly Resolution 217A in 1948, the UDHR was proclaimed as 'a common standard of achievements for all peoples and all nations. It is a milestone document

[248] Yamin 'Applying human rights to maternal health'.
[249] Paragraph 17 and 18 of the HRC Technical Guidance Report.
[250] Yamin 'Applying human rights to maternal health'.

in the history of human rights as it sets out, for the first time, fundamental human rights to be universally protected.'[251]

While the UDHR does not specifically provide for the right to reproductive health, the right to reproductive health is premised primarily on the right to health which was first provided for in the UDHR. In addition, the commitments by states and the United Nations system overall to reproductive health and reproductive rights followed from the general principles of equality and human dignity set out in the UDHR. They also related to specific UDHR provisions, for example rights to marry, protection of mothers and children, and free speech and access to information.

The UDHR, although non-binding, has widely been accepted as an authoritative human rights instrument worldwide and Humphrey argues that the Declaration has attained the status of customary international law due to its influence in the drafting of many national constitutions.[252] As a foundation of human rights, the closest provisions in the UDHR has that can be linked to women's reproductive rights are Article 16[253] and Article 25. Article16 provides for the right to marry and found a family as well as the right to consent to marriage. This provision protects reproductive rights as it clearly provides that marriage should be entered into with the free and full consent of the parties involved. This protects women's right to make decisions free from violence, discrimination and coercion. However, it is important to note that the first section of Article 16 refers to 'full age' but does not explain what 'full age' means leaving the term open to interpretation. Furthermore, while the section provides a right to people of full age, it does not explicitly prohibit marriage of people who are not of full age.

Article 25 provides for the right to a standard of living adequate for health and well-being, including the right to special protection for a woman in her role as a mother.[254] The right to health requires governments to provide health care and to work toward creating conditions conducive to the enjoyment of good health. Although reference is made to motherhood, the

[251] United Nations 'Universal Declaration of Human Rights' Available at *https://www.un.org/en/universal-declaration-human-rights/*, accessed on 23 July 2019.
[252] JP Humphrey 'The Universal Declaration of Human Rights: Its history, impact and juridical character' in BG Ramcharam (ed) *Human rights: Thirty years after the Universal Declaration* (1979) 21.
[253] Article 16 provides that: '(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. (2) Marriage shall be entered into only with the free and full consent of the intending spouses. (3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.'
[254] Article 25 of the UDHR.

Article does not sufficiently deal with issues related to motherhood. This can be attributed to the fact that the UDHR is a broad framework of human rights in general, without particular emphasis on a group of rights or a group of people. It is my argument that for a foundational human rights instrument, whose purpose was to be used globally, these provisions on women's reproductive rights cannot be faulted or labelled as inadequate.

Scholars have also identified several gaps in the UDHR regarding the broader protection of women's rights. The name Universal Declaration of Human Rights itself shows that this instrument was 'stated in universal terms without any consideration to cultural diversities and peculiarities of individual people and communities.'[255] The Preamble provides for the 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.'[256] This in itself shows the gap that the UDHR has in so far as the advancement of women's rights is concerned. It was not drafted to focus on women's reproductive rights at all but rather establishes the foundation for the international protection of human rights.

2.2.3.4 International Covenant on Civil and Political Rights

The International Covenant on Civil and Political Rights (ICCPR),[257] although originally adopted to protect and promote 'civil and political rights' such as the right to life, the right to be free from arbitrary detention and torture, the right to free expression,[258] has provisions that have been elaborated by general comments to include protection of women's reproductive rights. The right to life for instance, as provided for in Article 6 of the ICCPR has been described in the UDHR Preamble as the 'most precious for its own sake as a right that inheres in every human being, but it also constitutes a fundamental right.' The HRC General Comment 36[259] on the right to life further states that the effective protection of the right to life 'is the prerequisite for the enjoyment of all other human rights and the content of which can be informed by other human rights.'[260] The HRC argues that the consequences of unsafe abortions

[255] Okon Etim E *Religion and Human Rights Education* (2011).
[256] First preamble paragraph, UDHR, 1948.
[257] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999 (entered into force 23 March 1976) [*ICCPR*].
[258] Sarah Joseph, Jenny Schultz & Melissa Castan *The International Covenant on Civil and Political Right: Cases, Materials and Commentary* (2ed) (Oxford University Press, 2004) at 4.
[259] UN Human Rights Committee (HRC), *General comment no. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35. This general comment replaces general comments No. 6, adopted by the Committee at its sixteenth session (1982), and No. 14, adopted by the Committee at its twenty-third session (1984).
[260] Paragraph 2.

and pandemic preventable maternal deaths interfere with the right to life of the mother. In this regard, the HRC General Comment 36 calls upon State Parties to,

> …provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable.[261]

Zimbabwe, as a State Party to the ICCPR therefore has an obligation to ensure that rural women have access to safe, legal and effective abortion services.

Article 3 of the ICCPR provides for equality of rights between men and women. The Human Rights Committee (HRC) was one of the earliest treaty bodies to address some of the challenges women encounter regarding their sexual and reproductive health and rights. In its General comment 28,[262] the HRC calls for the equal enjoyment of human rights between men and women by taking cognisance of the impact of culture and tradition on women by stating that:

> Inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes. The subordinate role of women in some countries is illustrated by the high incidence of prenatal sex selection and abortion of female foetuses.[263]

To protect women's reproductive right to maternal health, the HRC General Comment 28 therefore enjoins State Parties to:

> When reporting on the right to life protected by article 6, States parties should provide data on birth rates and on pregnancy- and childbirth-related deaths of women. Gender-disaggregated data should be provided on infant mortality rates. States parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions.[264]

In General Comment 28, the HRC enumerates 3 types of acts that may constitute torture or inhumane or degrading treatment with respect to women's reproductive health and choice, namely: (i) denial of abortion service, including terminating pregnancy as a result of rape or incest; (ii) forced abortion and sterilization; (iii) FGM. In *KL v Peru*,[265] UN Human Rights Committee held that in its failure to ensure access to legal abortion services for a pregnant

[261] Paragraph 8.
[262] UN Human Rights Committee (HRC), *CCPR General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, 29 March 2000, CCPR/C/21/Rev.1/Add.10.
[263] Paragraph 5
[264] Paragraph 10.
[265] KL v Peru CCPR/C/85/D/1153/2003, Communication No. 1153/2003.

adolescent, Peru had violated its domestic laws as well several articles under the International Covenant on Civil and Political Rights, including, among others, provisions pertaining to the right to be free from cruel, inhumane, and degrading treatment, privacy, and special measures of protection for minors.

The rights to life, to be free from inhuman and degrading treatment, to privacy and to equality between men and women, as provided for in the ICCPR, are therefore significant in the realisation of women's reproductive health rights. States, Zimbabwe included, are obliged to put in place measures that do not violate these rights.

2.2.3.5 International Covenant on Economic, Social and Cultural Rights

In 1966, the United Nations General Assembly, through GA. Resolution 2200A (XXI) adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR).[266] The Covenant came in force on 3 January 1976. The most influential recognition of the right to health is found in Article 12 of the ICESR which provides;

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.

Article 12 emphasises that every person has the right to the 'enjoyment of the highest attainable standard of physical and mental health.' This is of particular significance to this study as the right to reproductive health is an integral part of the right to health that has enjoyed longstanding recognition based on Article 12 of ICESCR as well as other existing international human rights instruments.[267] Although the ICESCR itself does not have sufficient provisions dealing with women's reproductive rights, this inadequacy is cured by the ICESCR's general comments.[268] The Committee on Economic, Social and Cultural Rights (CESCR), which

[266] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, General Assembly resolution 2200A (XXI) 16 December 1966.
[267] The following documents as examples: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979, Article 12; Convention on the Rights of the Child (CRC), 1989, Articles 17, 23–25 and 27; Convention on the Rights of Persons with Disabilities (CRPD), 2006, Articles 23 and 25.
[268] See Charles G Ngwena, Eunice Brookman-Amissah & Patty Skuster 'Human rights advances in women's reproductive health in Africa' (2015) *International Journal of Gynecology & Obstetrics, Volume 129, Issue 2* who clearly explain the significance of General comments as will be discussed in more detail under the obligations section.

monitors the ICESCR, through general comment 14,[269] fleshes out the meaning of the right to health to include important elements of reproductive rights such as 'the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference such as the right to be free from torture, non-consensual medical treatment and experimentation.'[270] General comment 14 further stated that

> [T]he provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, *including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information*.[271]

In addition, general comment 14 states that the realisation of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.[272] Therefore, Zimbabwe, as a State Party to this treaty, has an obligation to remove any barriers that may hinder women's access to family planning information and maternal healthcare services.

In March 2016, the CESCR published general comment No 22 (2016) on the Right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), with the aim of assisting State parties with the implementation of their international obligations.[273] General comment 22 is of particular importance to this study as it directly speaks to reproductive health. General comment 22 addresses states' legal duties to the right to sexual and reproductive health in 'its response to the continuing grave violations in practice and adopting a clear human rights based approach to matters of sexuality and reproduction.'[274] Among other issues, general comment No 22 recognizes abortion services as an integral part of the right to health[275] and notes that states have an obligation to repeal, eliminate laws, policies and practices that criminalize, obstruct or undermine an individual's

[269] Office of the High Commissioner for Human Rights. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000.
[270] General comment 14 Paragraph 8.
[271] General comment 14 Paragraph 14.
[272] Paragraph 21 of General Comment 14.
[273] CESCR general comment 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/GC/22, 2 May 2016.
[274] Lucía Berro Pizzarossa & Katrina S Perehudoff **'**Mapping Constitutional Commitments on Sexual and Reproductive Health and Rights: A Global Survey' in Sambine Klotz, Heinr Bielefedt, Martina Schmidhuber & Andreas Frewe (eds) *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation* (2017).
[275] See paragraphs 55-57.

or a particular group's access to health facilities, services, goods and information, including abortion.[276]

In explaining the normative content of the right to sexual and reproductive rights, general comment 22 follows the elaboration in the Committee's general comment14 on The Right to the Highest Attainable Standard of Health Article 12,[277] that a comprehensive sexual and reproductive health care contains the following four interrelated and essential elements namely, availability, accessibility, acceptability and quality. Paragraph 15 of general comment 22 states that accessibility means that 'health facilities, goods, information and services related to sexual and reproductive health care should be accessible to all individuals and groups without discrimination and free from barriers.' It further states that accessibility includes physical accessibility, affordability and information accessibility.

Physical accessibility – This implies that health facilities, goods, information and services related to sexual and reproductive health care must be available within safe physical and geographical reach for all, so that persons in need can receive timely services and information.[278] The World Health Organisation states that physical accessibility

> is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them.[279]

Affordability – States must ensure that health services and goods are affordable for everyone[280] and should provide free or low-cost reproductive health goods and services for women who cannot afford them.[281] World Health Organisation argues that economic accessibility or affordability 'is a measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect

[276] See paragraph 35.
[277] CESCR general comment 14: The Right to the highest attainable standard of health, (2000), para 12
[278] CESCR general comment 22
[279] WHO 'Universal Health Coverage and Universal Access' (2013) *Bulletin of the World Health Organization* 91:546–546A.
[280] See generally, CESCR general comment 22, paragraph 17, which states that publicly or privately provided sexual and reproductive health services must be affordable for all. People without sufficient means should be provided with the necessary support to cover the costs of health insurance and accessing health facilities providing sexual and reproductive health information, goods and services.
[281] ESCR Committee, Concluding Observations: Djibouti, para. 5, U.N. Doc. E C.12/DJI/CO/1-2 (2014); Poland, para. 27, U.N. Doc. E/C.12/POL/CO/5 (2009); Armenia, para. 22(b), U.N. Doc. E/C.12/ARM/CO/2-3 (2014)

and opportunity costs for instance, the costs of transportation to and from facilities and of taking time away from work).'[282]

Information accessibility - Information accessibility includes the right to seek, receive and disseminate information and ideas concerning sexual and reproductive health issues which include information on maternal health, contraceptives, family planning, safe abortion and post abortion care, and infertility and fertility options.[283]

Indeed the right to reproductive health is part of the right to health. Therefore, Zimbabwe as a State party to the ICESCR which provides for the right to health in Article 12, has an obligation to make maternal health care and family planning information and services accessible to rural women.

Minimum core obligations

The rights in the ICESCR are subject to 'progressive realization' – states are obliged to do what they are able to achieve within their available resources. In its general comments, the CESCR has developed some tools that help it to assess whether states are indeed fulfilling their treaty obligations. One of these tools is the concept of 'minimum core' obligations. The CESCR general comment 3 issued in 1990, established minimum core as follows:

> 10. On the basis of the extensive experience gained by the Committee, as well as by the body that preceded it, over a period of more than a decade of examining Statesparties' reports the Committee is of the view that minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education, is *prima facie*, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'etre.[284]

It is clear from this extract that the CESCR considers that every State party is bound to fulfil a minimum core obligation by ensuring the satisfaction of a minimum essential level of the socio-economic rights, including the right to access reproductive health services. Although not expressly stated in the content of the ICESCR, Muller argues that the minimum core doctrine was introduced by the Committee with the aim of ensuring 'the satisfaction of, at

[282] WHO 'Universal Health Coverage'.
[283] ESCR Committee, general comment 22, paragraph 18.
[284] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 14 December 1990, E/1991/23.

the very least, minimum essential levels of each of the rights is incumbent upon every State party.'[285] Yacoob J, in *Government of the Republic of South Africa and Others v Grootboom and Others*[286] explained the minimum core as follows

> The concept of minimum core obligation was developed by the committee to describe the minimum expected of a state in order to comply with its obligation under the Covenant. *It is the floor beneath which the conduct of the state must not drop if there is to be compliance with the obligation.*[287]

Similarly, Shue, although characterising basic rights in general and not economic, social and cultural rights in particular, states that: 'basic rights are the morality of the depths … [in that they] specify the line beneath which no one is to be allowed to sink.'[288] On the reason behind the development of the minimum core obligations, Forman *et al* argue that it was developed,

> to prevent progressive realisation within resources from undermining both domestic and international responsibilities towards health, international human rights law institutions developed the idea that these rights hold an inviolable 'core' equivalent to essential health needs.[289]

From the aforementioned arguments, it is clear that these minimum core obligations are non-derogable and, if they are not fulfilled, states will be regarded *prima facie* as having violated the rights concerned.[290] Although General Comment 14 goes further than General Comment 3, by providing that 'a State party cannot, under any circumstances whatsoever,

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[285] Amrei Müller 'An Analysis of Health-Related Issues in Non-International Armed Conflicts' in Michael O'Flaherty and David Harris (eds) *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law* (2013).
[286] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).
[287] *Grootboom* case para 31.
[288] Henry Shue *Basic Rights: Subsistence, Affluence and US Foreign Policy* 2 ed (1996) 18.
[289] Lisa Forman, Luljeta Caraoshi & Audrey R Chapman *et al* 'Conceptualising minimum core obligations under the right to health: How should we define and implement the 'morality of the depths' (2016) *The International Journal of Human Rights.*
[290] Audrey R Chapman & Sage Russell 'Introduction' in Audrey Chapman and Sage Russell (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (2002) 1–20; Audrey R Chapman 'Core Obligations Related to the Right to Health' in Audrey Chapman and Sage Russell (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (2002) 185–215. See also *Minister of Health and another v Treatment Action Campaign and others* (2002) 5 SALR 721 para. 35 where the South African Constitutional Court rejected the core concept on the basis that it was 'impossible to give everyone access even to a 'core' service immediately' and that '[a]ll that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the [constitution's socio-economic rights] on a progressive basis.

justify its non-compliance with the core obligations … which are non-derogable,'[291] it does not sufficiently address the question of the resources necessary to meet core obligations.[292]

General comment 3 acknowledges that the discharge of states' minimum core obligations is dependent on availability of resources. However, to ensure that states do not violate socio-economic rights based on unavailability of resources, general comment 3 requires states to 'demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.' Consequently, Zimbabwe has an obligation to, at least, at the very minimum, put in place measures to protect socio-economic rights, including the right to access maternal health care and family planning services, and reprioritize the national budget if adequate resources are not available.

Violations approach

Another tool adopted by the CESCR in the context of the 'progressive realization' yardstick in the ICESCR was the 'violations approach'. It has been argued that the 'progressive realization,'[293] standard that assesses governments' compliance with the covenant's provisions renders economic, social, and cultural rights very difficult to monitor.[294] Human rights scholars such as Audrey Chapman have identified and developed a categorization of violations for assessment of compliance with human rights obligations: 1) The first category includes state violations resulting from government actions, policies, and legislation; 2) The second contains violations related to patterns of discrimination; and 3) The third includes violations related to

[291] UN Committee on Economic, Social and Cultural Rights, *General Comment No 14, The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4 (2000), para. 47.
[292] Lisa Forman, Claudia Beiersmann & Claire E Brolan *et al* 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?' (2016) *Health and Human Rights Law Journal*.
[293] The standard of progressive realisation arises out of Article 2 (1) of the ICESCR, which commits States Parties —countries that have ratified the covenant—to take steps individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognized. Chapman argues that the requirement that progressive realisation be evaluated according to "available resources" assumes that the valid expectations and concomitant obligations of State Parties under each enumerated right are not uniform, but instead relative to levels of development and available resources. This necessitates the creation of a multiplicity of performance standards to fit the many social, developmental, and resource circumstances of specific countries.
[294] Audrey R Chapman 'Violations Approach' for Monitoring the International Covenant on Economic, Social and Cultural Rights' (1999) *Human Rights Quarterly 18* at 23. As put in the *Maastricht Guidelines*, the violations approach is intended to be 'of use to all who are concerned with understanding and determining violations of economic, social and cultural rights, and in providing remedies thereto, in particular monitoring and adjudicating bodies at the national, regional and international levels.'

the state's failure to fulfil minimum core obligations of enumerated rights.[295] This is line with general comment 22 which states that violations can occur through acts of commission or omission on the part of the State. Listed examples of such violations include:

a) the adoption of legislation, regulations, policies or programmes which create barriers to the realisation of the right to sexual and reproductive health;[296]
b) failure to take appropriate steps towards the full realisation of everyone's right to sexual and reproductive health and the failure to enact and enforce relevant laws. Failure to ensure formal and substantive equality in the enjoyment of the right to sexual and reproductive health constitutes a violation of this right;[297]

The human rights treaty bodies discussed have, to varying degrees, accepted responsibility for monitoring the implementation of reproductive rights, and have established legal procedures to ensure the compliance of states. This shows that reproductive rights are binding and create binding legal obligations which must be complied with. In the words of Tomris, 'reproductive rights are an essential prerequisite for the attainment of reproductive health, and they are of universal validity and applicability.'[298]

Despite the existence of the minimum core obligations and violations approach mechanisms to ensure State compliance, Petchesky argues that without a human rights framework, there is nothing to prevent governments, population experts or religious bodies from making sexual and reproductive decisions on behalf of individuals on the basis of 'political expediency, aggregate data, or fundamentalist interpretations of scripture.'[299] Consequently, embracing reproductive rights into already existing human rights is an essential but insufficient mechanism for improving women's sexual and reproductive wellbeing. In that regard, a clear reproductive rights system may be the best chance women have for the advancement of their reproductive rights over time. Put differently, for women's reproductive health rights to be fully realised, international instruments that specifically deal with health

[295] Chapman 'Violations approach' at 24. Chapman argues that a violations approach is both more feasible and more manageable than the pursuit of progressive realisation alone. While still requiring further definition and specification at this point, violations are more easily defined and identified, particularly for nongovernmental organizations and perhaps for governments and international bodies as well.
[296] CESCR general comment 22 paragraph 54.
[297] IESCR general comment 22 paragraph 55.
[298] Tomris Turmen 'Reproductive rights: How to move forward?' (2015) *Health and Human Rights Law Journal*.
[299] RP Petchesky & K Judd (eds) *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (1998) cited in Jenny Wigley 'Politics and Fertility: The Evolution of Sexual and Reproductive Rights' *Human Rights Research Journal* Volume 3.

issues of fundamental concern to women and integrate explicitly a fully gendered health perspective, should be adopted.

Violations of women's sexual and reproductive health rights are still frequent. These violations take many forms including poor quality and inaccessible reproductive health care services; discriminatory practices between the urban and the rural, the poor and the rich; subjecting women's access to services to third party authorization, particularly through subordinating them under men, and restrictive laws, for instance, abortion laws that do not allow women to freely terminate their pregnancies. Subjecting women to early or forced marriages also violates their right to reproductive health. The frequency of violations on women's reproductive rights which has stymied progress on their full realisation can be attributed to weak political commitment, inadequate resources, persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively.'[300]

2.2.3.6 Convention on the Elimination of all forms of Discrimination against Women

In 1979, the Convention on the Elimination of all forms of Discrimination against Women was adopted by the United Nations General Assembly on 18 December, through Resolution 34/80.[301] It entered into force as an international treaty on 3 September 1981. CEDAW. It is often described as an international bill of rights for women, or 'Women's Convention,' and is the most important human rights treaty for women. Cook has described CEDAW as the 'definitive international legal instrument requiring respect for and observance of the human rights of women.'[302] UN Women further stated that the Convention,

> …is the only human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations. It affirms women's rights to acquire, change or retain their nationality and the nationality of their children.[303]

[300] Stars AM *et al* 'Accelerate Progress' at 2642.
[301] Convention on the Elimination of All Forms of Discrimination against Women. GA res. 34/180. UN Doc. A/34/46. 18 December 1979. Available at *https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx*, accessed on 10 April 2019.
[302] Rebecca J Cook *Women's Health and Human Rights: The Promotion and Protection of Women's Health through International Human Rights law* (1994).
[303] UN Women 'CEDAW: Overview of the Convention' Available at *http://www.un.org/womenwatch/daw/cedaw/*, accessed on 21 November 2016.

While the ICESCR provides for the right to health, including the right to maternal health service, CEDAW does not specifically provide for the right to health. It does, however, provide for sexual and reproductive health rights by including provisions that address non-discrimination and reproductive health rights. To begin with, the Preamble sets the tone by stating that 'the role of women in procreation should not be a basis for discrimination'.[304] The Preamble emphasizes 'that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality of men and women'. This provision thus recognizes how detrimental cultural practices practised by the society may be to women's ability to access reproductive health services. Indeed, cultural practices such as *ukungena*[305] in South Africa, early child marriages and *lobola* in Zimbabwe, if not abolished or controlled, can cause harm to women's reproductive health through limiting women's access to reproductive health services. Upon this realization, Article 5 of CEDAW therefore obligates states to take,

> …all appropriate measures [to] modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

Apart from providing for the right of women not to be discriminated based on their procreation roles, CEDAW also provides for the right to access family planning and maternity care. Article 12 of CEDAW expressly calls upon State parties to:

> 1. …take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, *access to health care services, including those related to family planning.*
> 2. Notwithstanding the provisions of paragraph I of this article, *States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period,* granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

State parties therefore have obligations to ensure that women have access to maternal health care and family planning services. In this regard, CEDAW general recommendation

[304] The paragraph provides as follows: 'Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole…'

[305] Levirate unions occur when the deceased's surviving male relative inherits the widow of the deceased. The inherited widow becomes the wife to the surviving relative of the deceased. See, MJ Maluleke 'Culture, tradition, custom, law and gender equality' (2012) *Potchefstroom Electronic Law Journal (15)* 1.

24[306] states that high maternal mortality rates and women's lack of access to family planning or maternal health care services, provide an important indication for states of possible breaches of its duties to ensure women's access to health care.[307] It specifies that, under Article 12(2), states must report on maternal mortality rates affecting vulnerable groups of women, and the measures taken to enhance access to safe motherhood services aimed at tackling maternal mortality.[308] General recommendation 24 takes a step further by mentioning 'women's right to safe motherhood and emergency obstetric services' as follows:

> *Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services.* The Committee notes that it is the duty of States Parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.[309]

On 14 July 2017, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) published general recommendation No 35 on gender-based violence against women, updating general recommendation No 19.[310] General recommendation No 19 from 1992[311] was historic as it clearly stated that violence against women is a form and manifestation of gender-based discrimination, directed towards women because they are women. This violence inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.

Further, general recommendation 19 unequivocally brought violence outside of the private sphere and into the realm of human rights. It expressly links violence against women to the right to health.[312] It also provides that 'compulsory sterilisation or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children,'[313] a right protected by article 16(1)(e) of CEDAW.

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[306] CEDAW Committee 'General Recommendation 24' (1999) UN Document A/54/38/Rev.1.
[307] CEDAW general recommendation 24 paragraph 17.
[308] CEDAW general recommendation 24 paragraph 31.
[309] CEDAW general recommendation 24 paragraph 27.
[310] United Nations Human Rights Office of the High Commissioner. Launch of CEDAW General Recommendation No. 35 on gender-based violence against women, updating General Recommendation No 19 CEDAW/C/GC/35.
[311] CEDAW general recommendation No 19: Violence against Women Committee on the Elimination of Discrimination against Women 11th session UN Doc A/47/38 (1992).
[312] CEDAW Committee general recommendation 19 paragraph 19.
[313] CEDAW Committee general recommendation 19 paragraph 22.

General recommendation 35 elaborates on the gender-based nature of this form violence, building on the work of the Committee and other international human rights mechanisms, as well as developments at national, regional and international levels.[314] General recommendation No 35 is also a milestone, particularly for women's reproductive rights as it expands the understanding of violence to include violations of sexual and reproductive health rights.[315] Paragraph 18 of general comment No 35 states as follows:

> Violations of women's sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment

The CEDAW Committee has also pronounced judgments on women's reproductive rights. A classic example is the case of *Alyne vs Brazil*[316] where the CEDAW Committee found the Brazilian State accountable for a preventable maternal death and thus reinforced state obligation to provide maternal health care under Article 12 CEDAW.[317] The case 'accordingly constitutes a true landmark decision in acknowledging safe motherhood as a human right that, although it constitutes a part of the right to health, also has its own existence apart from it.'[318] In the words of Shaw and Cook:

> This decision establishes as a matter of international law that governments have human rights obligations to guarantee that all women in their countries, regardless of income level or racial background, have access to timely, non-discriminatory, and appropriate maternal health services in public and private health facilities.[319]

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[314] It stresses the need to change social norms and stereotypes that support violence, in the context of a resurgence of narratives threatening the concept of gender equality in the name of culture, tradition or religion; It clearly defines different levels of liability of the State for acts and omissions committed by its agents or those acting under its authority - in the territory of the State or abroad- and for failing to act with due diligence to prevent violence at the hands of private individuals and companies, protect women and girls from it, and ensure access to remedies for survivors; It unequivocally calls for the repeal of all laws and policies that directly and indirectly excuse, condone and facilitate violence; and It emphasizes the need for approaches that promote and respect women's autonomy and decision-making in all spheres of life.

[315] CEDAW general recommendation 35 on gender-based violence against women, updating general recommendation No.19, 2017 paragraph 18.

[316] *Alyne da Silva Pimentel Teixeira (deceased) v Brazil* CEDAW/ C/49/D/17/ 2008, August 10, 2011.

[317] In the *Alyne case*, the Brazilian State was found responsible for violations of article 2(c) (access to justice); article 2(e) (the state's obligation to regulate activities of private health providers), in conjunction with article 1 (discrimination against women), read together with General Recommendations 24 (on women and health) and 28 (related to article 2 of the Convention); and article 12 (access to health).

[318] Helene 'Is There a Human Right to Safe Motherhood.'

[319] Dorothy Shaw & Rebecca J Cook 'Applying human rights to improve access to reproductive health service' (2012) *International Journal of Gynaecology and Obstetrics* 119.

CEDAW also recognises rural women as a special group that may face challenges in exercising the right to access reproductive health services. Article 14 enjoins State parties to take into account the particular problems faced by rural women and take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure 'access to adequate health care facilities, including information, counselling and services in family planning'.[320] State Parties, Zimbabwe included, are consequently obligated to take measures that make certain that rural women have access to family planning and maternal health care services.

The right of women to access information and advice on family planning is also protected in CEDAW. It requires States Parties to ensure access to specific educational information for health and well-being of families, including information and advice on family planning.[321] Further, Article 16(1) of CEDAW requires State Parties to ensure, on a basis of equality, men and women have access to the information, education and means to enable them to exercise these rights…' Reinforcing the importance of the right as provided in Article 16 of CEDAW, Cook states that:

> …the ability to regulate the timing and number of births is one central means of freeing women to exercise the full range of human rights to which they are entitled. Women's right to control their fertility through invoking the prohibition-of all forms of discrimination against women may therefore be-considered a fundamental key that opens up women's capacity to enjoy other human rights.[322]

Consequently, maternal health is a human right that, albeit part of the right to health, also exists distinctively of it. The right to maternal health care is therefore a legally binding right that encompasses women's rights to the full range of services in connection with pregnancy, family planning and the postnatal period as well as the ability to access these services free from discrimination, coercion, and violence. Since Zimbabwe is a State Party to CEDAW, she has an obligation, in terms of the aforementioned provisions, to ensure that women, rural women included, have access to maternal health care and family planning services. Failure to comply with this obligation will be a breach of its obligations and a violation of women's rights to access maternal health care and family planning services.

[320] Article 14(2)(b).
[321] Article 10*(h)* and Article 16.
[322] Rebecca J Cook 'International Human Rights and Women's Reproductive Health' (1993) *Studies in Family Planning* Volume 24 No 2: 73-86.

2.2.3.7 Convention on the Rights of the Child

In 1989, the Convention on the Rights of the Child (CRC) was adopted by the UN General Assembly through Resolution 44/25 on November 20.[323] It entered into force on 2 September 1990. The CRC was 'celebrated as one of the most significant steps taken toward improving the lives of children throughout the world.'[324] It has also been described as unique because 'it protects the broadest scope of fundamental human rights ever brought together within one treaty; economic, social, cultural, civil and political.'[325] The CRC is the first binding international treaty to incorporate civil, political, economic, social and cultural rights into one treaty, placing equal emphasis on all these rights.[326]

The CRC provides for the right to health in Article 24. However, it has been argued that 'the terms 'recognise' and 'ensure' as provided in Article 24(1)[327] impose weak obligations.'[328] Article 24(2)(d) specifically states that,

> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (d) To ensure appropriate pre-natal and post-natal health care for mothers…

In interpreting the content of the abovementioned provision, the CRC, through its Committee on the Rights of the Child under general comment No 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Article 24), has stated the following:

> The care that women receive before, during and after their pregnancy has profound implications for the health and development of their children. Fulfilling the obligation to ensure universal access to a comprehensive package of sexual and reproductive health interventions should be based on the concept of a continuum of care from pre-pregnancy, through pregnancy, childbirth and throughout the post-partum period. Timely and good quality care throughout these periods provides important opportunities to prevent the

[323] United Nations *Convention on the Rights of the Child*, General Assembly resolution 44/25 of 20 November 1989 Available at *https://www.ohchr.org/en/professionalinterest/pages/crc.aspx*, accessed on 10 April 2019.
[324] Jonathan Todres 'Emerging Limitations on the Rights of the Child: the U.N. Convention on the Rights of the Child and Its Early Case Law' (1998) *30 Columbia Human Rights Law Review* 159.
[325] Osifunke Ekundayo 'Does the African Charter on the Rights and Welfare of the Child (ACRWC) only Underlines and Repeats the Convention on the Rights of the Child (CRC)'s Provisions?: Examining the Similarities and the Differences between the ACRWC and the CRC' (2015) *International Journal of Humanities and Social Science* Volume 5 No 7(1): 143-158 at 147.
[326] Cohen C 'The Developing Jurisprudence of the Rights of the Child' (1993) *St Thomas Law Review* 18.
[327] Article 24(1) 'States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.'
[328] Eide A & Eide WB 'Article 24, The Right to Health' in A Alen, J Van de Lanotte & E Verhellen *et al* (eds) *A Commentary on the United Nations Convention on the Rights of the Child* (2006) 1.

> intergenerational transmission of ill-health and has a high impact on the health of the child throughout the life course.[329]

The CRC general comment 4[330] which elaborates on the rights of adolescents, further enjoins States parties – in the context of the rights of adolescents to health and development – to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent.'[331] This places an obligation on Zimbabwe as a State party to ensure that universal access to a comprehensive package of sexual and reproductive health services is available to its citizens when they need it.

Article 24(2)(e) further provides for access to human rights education.[332] General comment 15 clearly states that access to education includes education on sexual and reproductive health information by stating that:

> Sexual and reproductive health education should include self-awareness and knowledge about the body, including anatomical, physiological and emotional aspects, and should be accessible to all children, girls and boys. It should include content related to sexual health and well-being, such as information about body changes and maturation processes, and designed in a manner through which children are able to gain knowledge regarding reproductive health and the prevention of gender-based violence, and adopt responsible sexual behaviour.[333]

In light of articles 3, 17 and 24 of the CRC, general comment 4 calls upon States Parties to provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy…States Parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent.[334] This is crucial for adolescents. Seeking parental consent for adolescents to get reproductive health information and services is therefore a violation of their right health and education as provided for in the CRC.

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[329] UN Committee on the Rights of the Child (CRC) *General comment No 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15. Paragraph 53.

[330] UN Committee on the Rights of the Child (CRC), General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4.

[331] Paragraph 5.

[332] 'To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of children's health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.'

[333] Paragraph 60.

[334] Paragraph 24.

Furthermore, the CRC has also condemned and called for the eradication of practices that are harmful to children's reproductive rights, such as child marriage.[335] The CRC recognizes that adolescents should have access to contraceptive methods, including condoms, hormonal contraceptives and emergency contraception;[336] 'safe abortion and post-abortion care services, irrespective of whether abortion itself is legal' and maternal health services.[337]

In line with the provisions of the CRC, international and regional human rights bodies have adjudicated several cases addressing children's right to sexual and reproductive health services. For instance, the European Court of Human Rights in *P&S v Poland*,[338] addressed human rights violations from hospital personnel and clergy members intentionally obstructing access to abortion services for a 14-year-old who became pregnant as a result of rape.[339] The Court highlighted that effective access to reliable information on the conditions for the availability of lawful abortion, and the relevant procedures to be followed, is directly relevant for the exercise of personal autonomy.[340] It concluded that the authorities failed to comply with their positive obligation under the CRC to secure to the applicants' effective respect for their private life.

The provision of Article 24 as fleshed out by general comment 15 although not sufficient to cover all the reproductive health issues, are adequate given the main purpose of the Convention. For a human rights treaty that was specifically drafted for children, it is

[335] Article 24(3).
[336] Paragraph 70.
[337] Paragraph 51-70.
[338] This case centers on P, a fourteen-year-old girl who in 2008 was raped by a classmate and became pregnant as a result. P obtained a certificate from the prosecutor confirming that her pregnancy resulted from unlawful sexual intercourse, and thereby she had a right to legal abortion under Polish law. However, her access to abortion was severely obstructed. Supported by her mother, S, P visited three different hospitals, receiving deliberately distorted information about the requirements for obtaining an abortion. One of the hospitals disclosed P's personal and medical data to the press and the general public. She and her mother were manipulated and harassed by doctors, anti-abortion groups, and representatives of the Catholic Church. Doctors invoked conscientious objection without referring P to another provider or hospital. Hospital staff, a priest and the police attempted to manipulate the relationship between P and her mother, asserting that the mother tried to coerce P into having an abortion—a process which resulted in state authorities removing P from her mother's custody and detaining her in a juvenile centre. Weeks after the rape occurred, the Ministry of Health intervened and P was able to get an abortion in a hospital 500 kilometres away from her home. Although the abortion was legal, the hospital refused to register P as a patient; she was given anaesthesia without warning; and was not given information about the procedure or any post-abortion care. P was also told to leave the hospital immediately after the procedure. Unable to gain recognition of wrongdoing and receive an effective remedy in the Polish legal system, P and S, with the support from the Reproductive Rights Legal Network of the Polish Federation for Women and Family Planning and in cooperation with the Center for Reproductive Rights, filed a complaint before the European Court of Human Rights in May 2009.
[339] *P and S v Poland* No 57375/08 Eur Ct HR (2008).
[340] Paragraph 70.

noteworthy to state that the provisions on reproductive health are remarkable and indeed commendable.

2.2.4 Development of the right to reproductive health through the Regional human rights system

The African countries also, having due regard to the efforts made at the international level, demonstrated their commitment to the realisation of reproductive health rights through adoption of a number of treaties. The African Union's (AU) objective, as contained in the Constitutive Act of the African Union, which is to:

> achieve greater unity and solidarity between the African countries and the peoples of Africa; defend the sovereignty, territorial integrity and independence of its Member States; promote and defend African common positions on issues of interest to the continent and its peoples; encourage international cooperation, taking due account of the Charter of the United Nations and the Universal Declaration of Human Rights; promote peace, security, and stability on the continent….[341]

The African human rights instruments therefore derive most of their clauses from the UN human rights frameworks with emphasis on African experiences unique to the African region. The African Charter on Human and Peoples' Rights is an African regional human rights instrument adopted by the Organization of African Unity (OAU), now the African Union (AU) on 7 June, 1981 and it entered into force on 21 October 1986.[342] The African Women's Protocol on the other hand was adopted by the 2nd Ordinary Session of the Assembly of the Union in Maputo, Mozambique on 11 July, 2003.[343] This section that follows briefly analyses the African human rights system's protection of women's reproductive rights.

2.2.4.1 African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples Rights,[344] which came into force on 21 October 1986, presents the first attempt to protect the right to health in the African region specifically.[345] Article 16 of the Charter provides as follows:

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[341] Article 3 of the Constitutive Act of the African Union adopted at Lome, Togo, on the 11th day of July, 2000

[342] World Health Organisation 'African Charter on Human and Peoples' Rights. Available at *https://www.who.int/hhr/Human_and_Peoples_rights.pdf*, accessed 10 April 2019.

[343] African Union, *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*. Adopted 11 July 2003.

[344] African Charter on Human and Peoples Rights CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

[345] Ebenezer Durojaye 'The approaches of the African Commission to the right to health under the African Charter' (2013) *Law, Democracy and Development* Volume 17 392-418: 397.

> 1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Despite this recognition of the right to health, the African Charter has been criticized for protecting economic, social and cultural rights in a very general and vague wording.[346] This ambiguity has also been applied to the right to health, where Ssenyonjo notes that Article 16 neither defines the content of this right nor indicates the specific measures states are required to adopt for its implementation.[347] Therefore, little guidance is provided as to the State's obligations and the individual's expectations.[348]

Durojaye criticises the lack of detail presented by Article 16 of the African Charter from a reproductive rights' view as follows:

> More importantly, Article 16 of the African Charter *fails to address issues, such as, maternal and infant mortality, access to contraception and HIV/AIDS*. In particular, these issues affect women more than men in Africa. Given that these are serious health issues that affect Africa more than other regions, *it is a serious omission on the part of the drafters of the Charter*, although one may argue that at the time the Charter was being finalised HIV/AIDS had not become a major challenge in the region. However, *it is inexplicable that issues, such as, infant and maternal mortality, which have always posed great challenges in the region, were not addressed in the Charter*.[349]

The African Commission on Human and People's Rights, taking cognisance of the inadequacies of Article 16 of the African Charter, has made attempts to broadly interpret the provisions of Article 16 to cover some of the issues not directly mentioned therein.[350] However,

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[346] M Ssenyonjo 'Analysing the Economic, Social and Cultural rights jurisprudence of the African Commission: 30 years since the adoption of the African Charter' (2011) *Netherlands Quarterly of Human Rights* 3 358-397.
[347] M Ssenyonjo 'Analysing the Economic, Social and Cultural rights' 363.
[348] Kufuor KO *The African Human Rights System: Origin and Evolution* (2010) 182.
[349] Ebenezer Durojaye *The approaches of the African Commission* 397.
[350] See *The Social and Economic Rights Action Center and the Center for Economic and Social Rights v Nigeria Communication* 155/96, (2001), 15th Activity Report, Annex V Done at the 30th Ordinary Session, held in Banjul, The Gambia from 13–27 October 2001. The Commission commented on the normative content of the right to a healthy environment under Articles 16 and 24 by stating as follows: 52. The right to a general satisfactory environment, as guaranteed under Article 24 of the African Charter or the right to a healthy environment, as it is widely known, therefore imposes clear obligations upon a government. It requires the State to take reasonable and other measures to prevent pollution and ecological degradation, to promote conservation, and to secure an ecologically sustainable development and use of natural resources. The right to enjoy the best attainable state of physical and mental health enunciated in Article 16(1) of the African Charter and the right to a general satisfactory environment favourable to development (Article 16(3)) already noted obligate governments to desist from directly threatening the health and environment of their citizens. The State is under an obligation to respect the just noted rights and this entails largely non-interventionist conduct from the State for example, not from carrying out, sponsoring or tolerating any practice, policy or legal measures violating the integrity of the individuals; *Centre on Housing Rights and Evictions v The Sudan Communication Nos 279/03 & 296/05 (2009*), 28th Activity Report. Adopted during the 45th Ordinary Session, held 13–27 May 2009, Banjul, The Gambia. In this case, the Commission further elaborated on the scope of the right to health under Article 16 by relying on the interpretation of the right to health in international law. The Commission stated that: 209. In its General Comment No. 14 on

such interpretations do not include reproductive rights. For a first regional human rights treaty, the omission of women's reproductive health rights is regrettable.

There are, however, some provisions of the African Charter that have been interpreted as protecting women's sexual and reproductive health rights. For instance, Article 4 of the African Charter provides for the right to life. The African Commission on Human and Peoples' Rights (the Commission) has described the right to life as the fulcrum of all other rights. It is non-derogable, and applies to all persons at all times. In its General Comment 3 on the African Charter on Human and Peoples' Rights: The Right to Life (Article 4),[351] the African Commission has broadly interpreted the right to life to include right to maternal health. It enjoins State Parties 'address more chronic yet pervasive threats to life, for example with respect to preventable maternal mortality, by establishing functioning health systems and eliminating discriminatory laws and practices which impact on individuals' and groups' ability to seek healthcare.' Zimbabwe therefore has a duty to put in place measures to ensure that preventable maternal deaths are addressed.

The African Commission has also adopted a Resolution on maternal mortality[352] which provides that preventable maternal mortality in Africa is a violation of women's right to life, dignity and equality enshrined in the African Charter on Human and Peoples' Rights and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.[353] Two issues relevant to this study as raised by this resolution are (1) its calls to State Parties to meet their obligations under the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases – particularly to allocate 15% of their national budgets to the health sector in accordance with the Declaration and to Ensure that health reforms, policies and programmes should make adequate considerations of the right of poor and rural women to access basic healthcare as enshrined in the Protocol to the African Charter on Human and

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the right to health adopted in 2000, the UN Committee on Economic, Social and Cultural Rights sets out that, 'the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as, access to safe and portable water, an adequate supply of safe food, nutrition, and housing […]'. In terms of the General Comment, the right to health contains four elements: availability, accessibility, acceptability and quality, and impose three types of obligations on States– to respect, fulfil and protect the right. In terms of the duty to protect, the State must ensure that third parties (non-state actors) do not infringe upon the enjoyment of the right to health.

[351] African Commission on Human and Peoples' Rights, *General Comment No. 3 on the African Charter on Human and Peoples' Rights: The Right to Life (Article 4)*, 18 November 2015

[352] Resolution on Maternal Mortality in Africa - ACHPR/Res.135(XXXXIV)08 adopted by the African Commission on Human and Peoples' Rights at its 44th Ordinary session held in Abuja, Federal Republic of Nigeria, from 10 - 24 November 2008.

[353] Paragraph 1.

Peoples' Rights on the Rights of Women in Africa; (2) Similar to the HRC Technical Guidance, the African Commission Resolution on maternal mortality requires State Parties to adopt human right based approaches in the formulation of country programs and strategies to reduce maternal mortality in Africa - in particular to, ensure participation of women and civil society in the formulation, implementation, monitoring and evaluation of policies and frameworks aimed at addressing maternal mortality. Zimbabwe, as a State Party to the ACHPR is obligated to put measures in place to protect the right to life by ensuring that preventable maternal deaths are addressed, and that rural women are empowered enough to claim their human rights.

Article 5 of the African Charter provides for the right against torture and other cruel, inhuman or degrading treatment. General Comment 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5)[354] provides that the failure by States to prevent and respond to acts of sexual and gender based violence – such as rape, domestic violence, forced marriage, isolation, dowry-related violence…denial of reproductive rights including forced or coerced pregnancy and abortion – may amount to torture and other ill-treatment in violation of Article 5 of the African Charter. Such acts of gender based violence inhibit women from accessing reproductive health care services freely. This therefore requires State Parties, Zimbabwe included, to put in place measures that protect women from the various acts of sexual and gender based violence.

2.2.4.2 Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa

In 2003, the African Union adopted the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa, also known as the African Women's Protocol[355] - Africa's first women's rights instrument. Zimbabwe is one of the 40 states that have ratified the Women's Protocol.[356] The African Women's Protocol has received significant praise for its protection of women's rights,[357] particularly, and relevant to the topic under discussion, that the Women's Protocol is 'the most emphatic and forthright instrument dealing with sexual and

[354] Adopted at the 21st Extra-Ordinary Session of the African Commission on Human and Peoples' Rights, held from 23 February to 4 March 2017 in Banjul, The Gambia.
[355] Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005
[356] Zimbabwe ratified the Protocol on 15 April 2008.
[357] Banda Fareda 'Blazing a Trail: The African Protocol on Women's Rights Comes into Force' (2006) *Journal of African Law* 50, No 1: 72-84.

reproductive health and rights in Africa, particularly the rights of women in this regard.'[358] Dorujaye and Muringi state that:

> For the first time in the history of any human rights instruments, the Protocol contains provisions relating to the sexual and reproductive health and rights of women, protects women's rights in the context of HIV, and allows for abortion on limited grounds.[359]

Gibbs *et al* further state that the Protocol provides a strong African framework for women's reproductive rights that goes beyond other binding international treaties in supporting and promoting reproductive rights.[360] The African Women's Protocol prohibits harmful practices against women. It defines harmful practices as 'all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity.'[361] Examples of harmful practices include wife inheritance, child marriages and son preference among others. Article 5 further provides that,

> States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:
>
> a) Creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;
>
> b) prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them…

The most relevant practice to this study is child marriage which has serious consequences for women's reproductive rights, aptly described by the 2018 State of African Women Report as follows:

> Child marriages are often deeply entrenched in cultural, religious and social norms of unequal gendered power relations. They are an expression of *societal control and regulation of women's sexuality and reproductive functions* and reinforce gender power hierarchies by placing girls in subordinate positions. *Girls and women married as children often lack control*

[358] E Durojaye & LN Murungi 'The African Women's Protocol and sexual rights' (2014) *International Journal of Human Rights* Volume 18 Issue 7-8:881-897 at 893.
[359] Durojaye & Murungi 'The African Women's Protocol and sexual rights.'
[360] Liesl Gerntholtz, Andrew Gibbs & Samantha Willan 'The African Women's Protocol: Bringing Attention to Reproductive Rights and the MDGs' (2011) *Plos Medicine Journal Volume 8 (4)*.
[361] Article 1.

> *over resources and information,* and risk being exposed to violence or physical and mental abuse of power.[362]

Another example of a traditional practice harmful to women's access to reproductive health care services is bride price or *lobola*. Chiweshe argues that,

> Through *lobola* women's bodies are commoditised and they become the site of complex interactions of patriarchy, power and politics. It is the body and specifically the vagina and womb which is the physical space for sex and reproduction which is intrinsically transferred from the father to the groom.[363]

Article 5 therefore places on Zimbabwe an obligation eliminate all forms of harmful practices which negatively affect the human rights of rural women.

Article 14 of the Protocol, which is the most relevant provision to this study, guarantees women's rights to fertility control, contraception, family planning education and abortion provides as follows:

> 1. Parties shall ensure that women's right to health, including sexual and reproductive health, is respected and promoted, including: (a) the right to control fertility; (b) the right to decide whether to have children, the number of children and the spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; (e) the right to be informed on one's health status and on the health status of one's partner—particularly if affected by sexually transmitted infections, including HIV/AIDS—in accordance with internationally recognized standards and practices; (f) the right to have family planning education. 2. *Parties shall take appropriate measures to: (a) provide adequate, affordable, and accessible health services, including information, education, and communication programs to women, especially those in rural areas;* (b) establish and strengthen existing prenatal, delivery, and postnatal health and nutritional services for women during pregnancy and while they are breastfeeding; (c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, or incest, and when the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

The African Women's Protocol is the first human rights treaty to explicitly call on states to ensure access to abortion in certain circumstances that include, sexual assault, rape, incest and when continued pregnancy poses a risk to the health of the mother.[364] According to Charles Ngwena,

> The Protocol has the potential to contribute toward transforming abortion law from a crime and punishment model…to a reproductive health model that complements the objects of

[362] European Union *State of the African Women Report* (2018). Available at: *https://rightbyher.org/resource/tthe-state-of-the-african-women/*, accessed 24 July 2020.
[363] Manase Kudzai Chiweshe 'Wives at the Market Place: Commercialisation of Lobola and Commodification of Women's bodies in Zimbabwe' (2016) *The Oriental Anthropologist, Volume 16, No. 2*: 229-243 at 229.
[364] Article 14(2)(c).

> CEDAW and the broader philosophy of the International Conference on Population and Development (ICPD).[365]

The African Commission on Human and Peoples' Rights,[366] in its general comment 2 on Article 14 (1) (a), (b), (c) and (f) and Article 14 (2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa,[367] elaborates provisions in Article 14 of the African Women's Protocol. It lays down states' obligations on women's reproductive health, particularly on the right to have access to abortion services. Ngwena *et al* argue that general comment 2 reaffirms international standards on the right to health interpreted in CESCR general comment 14 on the right to health and state that:

> In many respects, general comment 2 can be understood as a concrete application of the normative framework of the right to health that was developed in General Comment 14 to the specific contexts of the rights to fertility control, contraception, family planning education, and abortion that are guaranteed to women under the Protocol. In this way, the general comment consolidates international human rights best practices in an African regional context.[368]

General comment 2 explicitly obligates State Parties to ensure that relevant legislation guarantees that no woman is forced to undergo an abortion, emphasizing that 'use of family planning/contraception and safe abortion services by women should be done with their own informed and voluntary consent.'[369] This underscores the significance of ensuring that women have the ability control their fertility and bodies without any factors undermining their sexual and reproductive autonomy. Therefore, women's capabilities to make autonomous decisions whether or not to access reproductive health services, remains crucial to the realisation of their reproductive rights.

On accessibility of services as provided in Article 14(2) of the African Women's Protocol, general comment 2 states that it is crucial to ensure the availability, financial and geographical accessibility as well as the quality of women's sexual and reproductive health-care services, without any discrimination relating to age, health condition, disability, marital

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[365] Ngwena Charles G 'Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level' (2010) *International Journal of Gynaecology and Obstetrics*, 110: 163–166.
[366] Article 45(1)(b) of the African Charter on Human and Peoples' Rights gives the African Commission the competency to adopt General comments by authorising the African Commission to 'formulate and lay down principles and rules aimed at solving legal problems relating to human and peoples' rights'.
[367] Adopted at the African Commission's 55th Ordinary Session held from 28 April – 12 May 2014 in Luanda, Angola.
[368] Charles G Ngwena, Eunice Brookman-Amissah & Patty Skuster 'Human rights advances in women's reproductive health in Africa' (2015) *International Journal of Gynaecology and Obstetrics* 129 184-187: 186.
[369] The African Commission on Human and Peoples' Rights (African Commission), General Comment No. 2 on Article 14 (1) (a), (b), (c) and (f) and Article 14 (2) (a) and (c) of the African Women's Protocol at para 47.

status or place of residence.[370] This imposes an obligation on Zimbabwe, as a party to the African Women's Protocol, to provide reproductive health services which allow women to fully exercise their right of access. Failure to ensure access is a violation of Article 14(2) of the African Women's Protocol.

One of the issues that the African Women's Protocol addresses is the issue of violence against women. This is unequivocally mentioned in Article 4 which deals with the rights to life, and the integrity and security of the person. In terms of Article 4, States Parties are obliged to prohibit 'all forms of exploitation, [and] cruel, inhuman or degrading punishment and treatment'. States are further bound to take appropriate and effective measures to 'enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or in public.' Sheila Keetharuth argues that Article 4 is fairly comprehensive as it places obligations on States Parties 'ranging from the identification of causes and consequences of violence with a view towards their elimination, to the establishment of mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence.'[371] Thus, Article 4 of the Women's Protocol advances women's reproductive rights to make decisions free from violence and coercion. This shows that women's reproductive rights, depend on the realisation and interaction of other rights, rather than a function of the availability of contraceptives. This is aptly described by Krishnaraj Shanthi as follows:

> To the extent that women are economically disadvantaged, socially marginalised and politically voiceless in society, their reproductive rights will be constrained. Unless issues such as poverty, inequality, unemployment and environmental degradation are addressed first, women's rights and human rights will remain abstract concepts.[372]

The provision of the African Women's Protocol places an obligation on Zimbabwe to ensure it has taken all measures to prohibit all forms of violence against, thus empowering women to access reproductive health services. Non-compliance with the obligations imposed by the African Women's Protocol, and indeed all the treaties discussed, means that women's right to access reproductive health services will remain a pipedream.

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[370] General comment 2 paragraph 29.
[371] Sheila B Keetharuth 'Major African legal instruments and human rights' in Anton Bosl and Joseph Diescho (eds) *Human Rights in Africa* (2009) 184.
[372] K Shanthi 'Feminist Bioethics and Reproductive Rights of Women in India: Myth and Reality' in D Tong (ed) *Linking Visions: Feminist Bioethics, Human Rights and the Developing World* (2004).

2.2.4.3 African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child[373] (ACRWC) was adopted by the Organisation of African Unity (OAU), now the African Union (AU) on 11 July 1990 and entered into force on 29 November 1999. The African Children's Charter, as it is commonly known, 'is the only region focused child rights instrument in the world and can be seen as the legacy of the founders of the Organization of African Unity (OAU) to African children.'[374] The ACRWC also provides for the right to health under Article 14 as follows:

> Every child shall have the right to enjoy the best attainable state of physical mental and spiritual health. 2. State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: *(a) to reduce infant and child mortality rate;* (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care… (*e) to ensure appropriate health care for expectant and nursing mothers…* (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;…

This provision is laudable in that it has elements of reproductive health, precisely the right to safe maternal healthcare services and the obligation of states to ensure the reduction of infant and child mortality rate. Reduction of infant and child mortality rate cannot be achieved without ensuring that women have access to safe maternal healthcare services. For instance, provision of family planning to women of reproductive age can avoid high-risk births and thus reduce chances of having a baby who will die in infancy.

The ACRWC further prohibits child marriages and enjoins state parties to abolish traditional practices harmful to the health of children.[375] The ACRWC particularly prohibits, in Article 21(2) child marriages. The Joint General Comment of the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare

[373] African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990), entered into force Nov. 29, 1999.
[374] Ayalew Getachew Assefa & Kameni Ngankam 'Celebrating 25 Years of the African Charter on the Rights and Welfare of the Child: Lookin back to look ahead' (2016) *AU ECHO Newsletter 2016: African Year of Human Rights with Particular Focus on the Rights of Women* 22.
[375] See Article 21 which provides that 1. State Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex or other status. 2. Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

of the Child on ending child marriage states that in applying the best interests of the child principle, States Parties must adopt and enforce legislation that sets the minimum age of marriage at 18 for both boys and girls. The principle also requires the adoption of effective prevention and redress measures to address those at risk and those already affected by child marriage. This is important as it protects children's reproductive health right to choose when to get married and when to have children and their spacing. Consequently, although not entirely focused on women's reproductive health rights in particular, like other international treaties, the ACRWC does, in the two provisions discussed, provide for important elements of reproductive health. Zimbabwe, as a party to the ACRWC has an obligation to take all measures to end child marriages and to ensure that rural women have access to maternal health care services.

2.3 STATE OBLIGATIONS

This section discusses state obligations under international law, in terms of the right to reproductive healthcare services. The state obligations are considered in terms of the 'tripartite typology' which was developed to cure the problem of what some scholars believed to be un-enforceability and ambiguity of rights enshrined in treaties such as the ICESCR. The tripartite typology was initially suggested by Henry Shue[376] and was given broader exposure through the reports of Asbjørn Eide while a UN Special Rapporteur.[377] Following the tripartite typology, the Maastricht Principles stated in paragraph 6:

> Like civil and political rights, economic, social and cultural rights impose three different types of obligations on States: the obligations to respect, protect and fulfil. Failure to perform any one of these three obligations constitutes a violation of such rights. The obligation to respect requires states to refrain from interfering with the enjoyment of economic, social and cultural rights. Thus, the right to housing is violated if the State engages in arbitrary forced evictions. The obligation to protect requires states to prevent violations of such rights by third parties. Thus, the failure to ensure that private employers comply with basic labour standards may amount to a violation of the right to work or the right to just and favourable conditions of work. The obligation to fulfil requires states to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realisation of such rights. Thus, the

[376] Shue Henry *Basic Rights: Subsistence, Affluence, and US Foreign Policy* (1980).

[377] O De Schutter (ed) *Economic, Social and Cultural Rights as Human Rights* (2013). By the late 1970s, Eide had come to the conclusion that an effective guarantee of human rights required that the individual be protected from interference by the State in the exercise of certain freedoms; that the State protect the individual from interference by other actors, whose conduct the State is in a position to control; and that the State provide certain public goods that would be undersupplied if their provision were left to market mechanisms.

> failure of states to provide essential primary health care to those in need may amount to a violation.[378]

The tripartite typology is therefore significant because,

> focusing on the obligations of the State obligations rather than simply on the rights of the individual, makes it possible to move economic and social rights away from their initially "programmatic" nature to becoming enforceable rights, determinate enough for a "violations" approach to become plausible.[379]

CESCR general comment 14 and general comment 22 both make use of the tripartite typology to show that the right to health and the right reproductive health impose three kinds of obligations: obligations to respect, to protect and to fulfil the right concerned.[380] This section of the dissertation looks specifically at Zimbabwe and seeks to answer the following questions: What is expected from Zimbabwe as a State Party to the various international legal instruments which provide for the right to have health in general, and the right to access reproductive healthcare services in particular? Further, what would amount to a violation of the obligations imposed on State Parties?

2.3.1 Obligation to respect

The obligation to respect requires the state to refrain from directly or indirectly interfering with the enjoyment of rights occasioned by denying or limiting individuals' access to health care services. In relation to reproductive health, general comment 22 states that the obligation to respect implies that all efforts and measures that a state takes in fulfilment of its obligation to respect the right to access reproductive health services, should not directly or indirectly hinder access to the same. Examples include limiting or denying access to health services and information, such as laws or practices that criminalize abortion, limiting consensual sexual activities between adults, requiring third-party authorization for access to abortion or contraception, or excluding certain health services from publicly- or donor-funded programmes.[381]

According to Eide, the responsibility to respect requires the State:

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[378] The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 9–10, UN Doc. E/C.12/2000/13.
[379] O De Schutter *Economic, Social and Cultural Rights as Human Rights.*
380 CESCR general comment 14 paragraph 33.
[381] CESCR general comment 22 paragraph 40–41.

> to abstain from doing anything that violates the integrity of the individual or infringes on her or his freedom, including the freedom to use the material resources available to that individual in the way she or he finds best to satisfy the basic needs.[382]

Consequently, a state should not only abstain from an act that violates this obligation to respect the enjoyment of human rights by individuals, but a state should also abstain from taking measures that result in a denial of or hindrance to the access to such a right.[383] Zimbabwe therefore has an obligation to ensure that it does not directly or indirectly hinder rural women's access to reproductive health care services.

2.3.2 Obligation to protect

Under the obligation to protect, states must protect individuals' right to sexual and reproductive health from interference by third parties.[384] The obligation requires states to take steps to prohibit any third party conduct that undermines the full enjoyment of the right to sexual and reproductive health. This includes, for example, adopting legislation and other measures to prohibit or curb any form of violence and coercion committed by private individuals and entities, including domestic violence, rape including marital rape, and sexual assault, abuse and harassment.[385] Other examples of third party interference are religious teachings which bar women from accessing family planning services and husbands who use patriarchy to control women. As a result, where a State fails to take effective steps to prevent third parties from undermining the enjoyment of the right to sexual and reproductive health, it will be in violation of its obligation to protect. The African Commission in *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria Communication 55 of 1996 (SERAC),* highlighted that the state discharges the duty to protect through 'the creation and maintenance of an atmosphere or framework by an effective interplay of laws and regulations' to enable individuals to freely realise their rights and freedoms.'[386]

In Zimbabwe, this obligation is crucial because of the patriarchal and religious nature of the country. For instance, the common conduct by the Apostolic sect leaders that denies

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[382] A Eide 'Realisation of Social and Economic Rights and the Minimum Threshold Approach' (1989) *Human Rights Law Journal Volume* 1-2:35-51 at 42.
[383] Maite San Giorgi 'The Human Right to Equal Access to Health Care' (2012) *School of Human Rights Research Series Volume 53*.
[384] CESCR general comment 22 paragraph 42; CEDAW Committee general recommendation 24 paragraph 15; CRC Committee general comment 15 paragraph IV A.
[385] ESCR General Comment 22 paragraph 59.
[386] *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria Communication* 55 of 1996 (SERAC) at para 46.

women's access to reproductive health care services is evidence that shows how religious leaders, as third parties, interfere and undermine women's access to reproductive health services. The reports by the Zimbabwe Broadcasting Corporation[387] on one Apostolic sect leader's conduct of putting up tents on his shrine where pregnant and sick women stay waiting for their turn to be healed or assisted in giving birth, is testimony to third party interference. However, this thesis argues that the major drawback in exercising the duty to protect in this case is that the state cannot force the Apostolic sect to do anything contrary to their faith and beliefs. Furthermore, the women whose rights are infringed by the religious leaders voluntarily surrender to such treatment as they also believe and have faith in their religion. It is only when the women are being 'forced' into believing their faith will heal them that the state, as the duty bearer, is justified in limiting the freedom of religion in favour of the right to access reproductive health services. Such limitation is succinctly described by Campbell and Whatmore as follows:

> As a practical matter, it is impossible for the legal order to guarantee religious liberty absolutely and without qualification … Governments have a perfectly legitimate claim to restrict the exercise of religion, both to ensure that the exercise of one religion will not interfere unduly with the exercise of other religions, and to ensure that practice of religion does not inhibit unduly the exercise of other rights.[388]

2.3.3 Obligation to promote and to fulfil

The obligation to fulfil includes the obligations to facilitate, promote and provide.[389] It requires that the State facilitates and implements legislative and other measures in recognition of the right to health and adopts a national health policy with detailed plans on how to realise the right.[390] In terms of general comment 22, the obligation to fulfil requires states to take measures to eliminate obstacles to the full realisation of the right to reproductive health, such as disproportionate costs and lack of physical or geographical access to sexual and reproductive health care services.

Eide argues that this obligation requires

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[387] Zimbabwe Broadcasting Corporation 'Covid-19 team visits Madzibaba with 30 wives, 23 children' Available at *https://www.zbcnews.co.zw/covid-19-team-visits-madzibaba-with-30-wives-23-children/*, accessed on 24 July 2020.
[388] Enid Campbell & Harry Whitmore *Freedom in Australia* (1966) 204.
[389] See paragraph 25 of the UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant)*, 20 January 2003, E/C.12/2002/11
[390] CRC Committee general comment 15 paragraph IV A.

> …the State to take the measures necessary to ensure for each person within its jurisdiction opportunities to obtain satisfaction of those needs, recognized in the human rights instruments, which cannot be secured by personal efforts.[391]

The responsibility to fulfil mandates states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realisation of the right to sexual and reproductive health.[392] States must take steps to ensure universal access to sexual and reproductive healthcare, and to guarantee care for survivors of sexual and domestic violence, including emergency contraception and access to safe abortion services. States are required to provide comprehensive education about sexual and reproductive health for all and to take measures to eradicate social barriers that prevent individuals from autonomously exercising their right to sexual and reproductive health.[393]

This obligation requires that Zimbabwe, as a State party, should put in place and implement appropriate measures to ensure that rural women realise their right to access reproductive health care services. Lack of affordable and accessible reproductive health services is a breach of the duty to fulfil, and thus a violation of rural women's right to access reproductive health care services.

2.4 CHAPTER CONCLUSION

The chapter discussed the historical development of the concept of reproductive health rights. The history revealed that the concept was conceived mainly as a result of the population and women's rights movements. These shaped the population issue and the control women have over their bodies. However, it was the human rights movement that enshrined reproductive health as a human right. Most of the international and regional human rights instruments were drafted with the purpose of protecting specific rights and groups, they have legally binding provisions relating to reproductive issues. Consequently, there is a binding right to reproductive health that emerges from the binding international human rights treaties that Zimbabwe has ratified. Zimbabwe, as a party to the international treaties has obligations to respect, protect and fulfil reproductive rights.

The significance of realising the reproductive health rights set out in the human rights treaties cannot be overemphasised. Realisation of the rights will enhance the human capabilities

[391] A Eide 'Realisation of Social and Economic Rights' at 42.
[392] CESCR general comment 22 paragraph 45; CEDAW Committee general recommendation 24 paragraph 17.
[393] CESCR general comment 22 paragraph 47-48.

of rural women, thus empowering them to demand their right and to exercise control over their fertility and bodies. In the words of the UNFPA,

> What the future holds in terms of changes in population growth, contraceptive use and sexual and reproductive health and rights will both determine and be determined by the ability of women and girls to achieve their full potential as members of their societies.[394]

The next chapter assesses whether Zimbabwe is complying with her international obligations on reproductive rights. Chapter Three looks particularly at Zimbabwe's domestic legislative, policy and institutional framework on reproductive rights and assesses whether Zimbabwe has created a legal framework that is suitable for fulfilling the treaty obligations. Chapter Four will build on this by examining how the legal framework is operating in practice.

[394] UNFPA State of the World Population 2019.

CHAPTER 3: ZIMBABWE'S LEGISLATIVE, POLICY AND INSTITUTIONAL FRAMEWORK ON WOMEN'S REPRODUCTIVE HEALTH RIGHTS

3.1 INTRODUCTION

The previous chapter analysed the right to reproductive health and the nature of state obligations to respect, protect and promote the right in terms of international and regional treaties. This Chapter seeks to answer the following question: do the measures adopted by the government of Zimbabwe comply with its international obligations to give effect to the right to have access to reproductive healthcare services? In answering this question, the Chapter assesses the extent to which the Constitution and the various other mechanisms that Zimbabwe has put in place, comply with its international obligations towards the right to reproductive health, particularly with regard to maternal health and family planning.

The chapter comprises six sections starting with this introduction. The second section gives an analysis of the constitutional protection and promotion of women's reproductive rights. This section critically analyses the constitutional provisions relating to women's right to access reproductive healthcare services. The third section analyses the different pieces of legislation that speak to women's reproductive rights, particularly women's access to maternal healthcare services and family planning information. The fourth section discusses the policy framework on women's right to access reproductive health services in Zimbabwe while the fifth section considers the institutional framework that Zimbabwe has put in place to ensure that the right to access reproductive health services is realised. The sixth section is the conclusion.

3.2 CONSTITUTION AND REPRODUCTIVE RIGHTS

Domestic constitutions, as rightly argued by Pizzarossa and Perehudoff, are 'the most vital expressions of government responsibility and individual entitlements, and therefore one of the channels best suited to endorse states' commitments to human rights.'[395] Zimbabwe, like many other States, has also incorporated socio-economic rights in her 2013 Constitution, which replaced the previous Lancaster House Constitution.[396] In terms of its founding values and

[395] Lucía Berro Pizzarossa & Katrina Perehudoff 'Global Survey of National Constitutions: Mapping Constitutional Commitments to Sexual and Reproductive Health and Rights' (2017) *Health and Human Rights Journal Volume 19 Number 2*.

[396] Zimbabwe's first Constitution (agreed under the Lancaster House Agreement), came into force on 18 April 1980 when she gained her independence. The Lancaster House Agreement was signed on 21st December 1979

principles, the Constitution is commended for recognising the equal worth and inherent dignity of each human being in Zimbabwe. This acknowledgment of inherent dignity and equal worth of all human beings is pertinent especially for pregnant women who are often treated without dignity in government hospitals. The section in the Constitution providing for the recognition of the 'inherent dignity and equal worth of all human beings[397]' mirrors some of the general principles underlying the CEDAW in article 11[398] namely, the respect and special protection to women during pregnancy and the recognition of pregnancy as normal process of humanity and human diversity. The 2013 Constitution is an improvement on the Lancaster constitution with regard to the realisation of reproductive health rights.

The 2013 Constitution of Zimbabwe ushered in a new era by expressly providing for the right to have access to healthcare services and reproductive health services. Section 76 (1) provides that:

> Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, *including reproductive health-care services*.

The inclusion of the right to have to access reproductive health care services is commendable as it is a major shift from the old Constitution which did not provide for the right to have access to reproductive health care services. However, it is important to note that the current Constitution does not provide for the right to health, as it merely provides for the right to have access to health care services without prescribing the basic level of health care or defining what is termed 'basic health care'. Suffice it to say that by including the right to have access to reproductive health services in the Constitution, Zimbabwe is putting into domestic law, rules which enable it to abide by its treaty obligations under Article 12 of the ICESCR, Article 12 of CEDAW and Article 14 of the African Women's Protocol. Accordingly, this shows that Zimbabwe has domesticated provisions relevant to its obligation to protect and promote women's right to have access to reproductive health care services.

However, even with such domestication of international provisions, newspapers are awash with stories of mothers and babies being detained at the country's main hospitals over

after the conclusion of negotiations between the British Government, the Patriotic Front under the leadership of the late Robert Gabriel Mugabe and the Zimbabwe African Peoples Union (ZAPU) led by late Joshua Mqabuko Nyongolo Nkomo. The Lancaster House Constitution was amended nineteen times before it was finally replaced by the 2013 Constitution.

[397] Section 1(e).

[398] Article 11 of CEDAW.

the non-payment of maternity fees,[399] conduct which defeats the right to access reproductive health care services. Unaffordability of services is itself a barrier to women's right to access reproductive services.

Another provision of the Constitution relevant to women's reproductive health rights is Section 52. Section 52 safeguards the right to 'bodily and psychological integrity' which includes freedoms 'from all forms of violence from *public or private sources*' and the freedom to 'make decisions concerning reproduction'. Section 52(1)(a) which provides for the freedom 'from all forms of violence from public or private sources' denotes that women should be able to make reproductive decisions, such as, choice of a spouse or partner, without any interference by the state or other parties.

The freedom to make decisions concerning reproduction encompasses a variety of issues which include, among others, decisions on whether to use birth control, the type of contraception to use, whether to terminate a pregnancy, or the number and spacing of children. Inclusion of the right to bodily integrity is in compliance with Zimbabwe's obligation to protect women's right to access reproductive health services as provided for under Article 12 of the ICESCR, Article 14 of the African Women's Protocol and Article 24 of the CRC. These provisions, as explained under paragraph 42 of CESCR general comment 22 and paragraph IV A of CRC Committee general comment 15, enjoin State Parties to ensure that women have access to reproductive health care services free from any third party interference. It is therefore submitted that the Constitution does incorporate international standards on sexual and reproductive health rights.

Prior to the 2013 Constitution, non-discrimination did not include pregnancy as one of the prohibited grounds. As a result of widespread campaigns by women organisations, who advocated for a reproductive and gender sensitive Constitution, section 56 (3) of the Constitution included pregnancy as a prohibited ground for discrimination. Therefore, the Constitution now expressly prohibits discrimination on the grounds of pregnancy, sex, gender, marital status and age among others. The inclusion of these grounds as prohibited grounds of

[399] Newsday 'MPs concerned over 'hospital detentions' June 3, 2014 at *https://www.newsday.co.zw/2014/06/03/mps-concerned-hospital-detentions/*, accessed on 19 April 2016; The Chronicle 'Hospitals Detain Mothers over Maternity Fees' January 22 2013 at *http://www.chronicle.co.zw/hospitals-detain-mothers-over-maternity-fees/*, accessed on 19 April 2016; The Zimbabwean 'Mothers, babies detained at Mpilo for non-payment' 22 February 2012 at *http://reliefweb.int/report/zimbabwe/mothers-babies-detained-mpilo-non-payment*, accessed on 19 April 2016).

discrimination is laudable as these are the areas in which women face unfair discrimination when attempting to access reproductive health care services.[400] This is in line with Article 12 of CEDAW which compels member states to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

There are other rights enshrined in the Constitution that empower individuals in making reproductive health decisions and help promote sexual and reproductive health rights. These include *inter alia*, the right to found a family as provided for in Section 78 (1) and (2) which states that 'every person who has attained the age of eighteen years has the right to found a family' and that 'no person may be compelled to enter into marriage against their will'; and Section 80 (3) which outlaws cultural practices that infringe on women's rights by providing that 'all laws, customs, traditions and cultural practices that infringe the rights of women conferred by this Constitution are void to the extent of the infringement.'[401] These provisions serve as a reminder to the State and its institutions of the need to reach out to rural women for the realisation of reproductive health rights. This remains important considering the vulnerability of rural women to harmful religious and traditional practices, such as child betrothal, early and forced marriage and early pregnancy, which put their rights at risk. This is in line with provisions of the Article 14 of the African Women's Protocol which compels states to ensure that women freely exercise their reproductive rights by deciding when to found a family or what contraceptives to use; as well as Article 14 of CEDAW which requires states to take into cognisance the unique challenges that rural women face in accessing reproductive health services.

Furthermore, section 29 of the Constitution requires the State to provide for health services under the national objectives. Section 29(1) mandates that '[t]he State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe'. Commendably, the provision reinforces the need by the state to expand health service to all parts of the country. This is important for women and their reproductive health, as women in rural areas often have their rights infringed because of inaccessibility. Of particular importance about section 29(1) is its mentioning of 'accessibility', which is a

[400] Oluremi Ajoke Savage-Oyekunle *Female Adolescents' Reproductive Rights: Access to Contraceptive Information and Services in Nigeria and South Africa* (Unpublished PhD Thesis, University of Pretoria) 2014 at 141.
[401] Section 80 (3) of the Constitution.

significant aspect for the protection of reproductive health rights as is provided for under Article 12 of the ICESCR, Article 14 of the African Women's Protocol and Article 12 of CEDAW. This therefore shows that Zimbabwe's Constitution incorporates international provisions on women's right to access reproductive health care services.

The aforementioned constitutional provisions are praiseworthy as they, for the first time in Zimbabwe's constitutional history, protect women's sexual and reproductive health rights. In a way, the constitutionalisation of reproductive rights asserts women's ability to claim[402] their rights and further reduces women's vulnerability to sexual health problems including HIV and AIDS. It is submitted that such provisions bring Zimbabwe into compliance with the ICESCR, CEDAW, African Women's Protocol, and uphold, to some extent, government's commitment to the health of its citizens.

3.3 LEGISLATIVE FRAMEWORK

As was discussed in Chapter 2, states have the obligation to protect, promote and fulfil human rights, in this case, the right to access reproductive healthcare services. Now, the question is, how can states comply with their international human rights obligations? To answer the question in simple terms, there is no single method that a state can employ. Therefore, states may pursue a range of different measures that include legislative, policy and judicial efforts, as well as awareness raising campaigns aimed at educating the public on what the right to access reproductive healthcare services entails.

The notable method that states can adopt to demonstrate their commitment to realizing sexual and reproductive health and rights is the adoption of domestic laws consistent with international standards. Legal codification of international human rights standards into national law is crucial for ensuring the respect, protection and fulfilment of the right to access reproductive healthcare services in practice. Codification of international standards can be done either through the monist or dualist approach. The dualist approach, which Zimbabwe[403] subscribes to, implies that international agreements are not automatically incorporated into domestic law. For international treaties to become part of national law under the dualist

[402] The different ways that rural women can use to claim their rights is discussed in detail in Chapter Five.
[403] This is supported by section 327(2)(a)—(b) of the Constitution which provides that: 'an international treaty which has been concluded by the President does not bind Zimbabwe until it has been approved by Parliament and does not form part of the law of Zimbabwe unless it has been incorporated into the law through an Act of Parliament.'

systems, they must be incorporated through legislation. Incorporation is the process by which state parties to a treaty enact national legislation giving force to the treaty under domestic law.[404]

The significance of incorporation of international treaties into national laws cannot be overemphasized as it is indeed 'an essential first step in fulfilling the aims and provisions of the international treaties.'[405] The Committee on Economic, Social and Cultural Rights has indicated that incorporation is desirable by stating that:

> While the Covenant does not formally oblige States to incorporate its provisions in domestic law, such an approach is desirable. Direct incorporation avoids problems that might arise in the translation of treaty obligations into national law, and provides a basis for the direct invocation of the Covenant rights by individuals in national courts. For these reasons, the Committee strongly encourages formal adoption or incorporation of the Covenant in national law.[406]

Having discussed the dualist approach to incorporation of international law under national law, it is now necessary to discuss the different pieces of legislations that Zimbabwe has enacted for the realisation of the right to access health including reproductive healthcare services.

Initially, the main intention of this discussion on the legislative framework was to assess the extent to which Zimbabwean laws comply with international treaty obligations on the right to access maternal healthcare and family planning services, which are the focus of this study. However, after some research, the study found that apart from section 76 of the Constitution, there are no laws that specifically deal with access to reproductive healthcare services. The available legislation does not deal with the provision of reproductive health care services but focuses only on abortion, prohibition of violence against women, the age of majority when one wants to exercise their right to marry and found a family.

This section therefore presents an analysis of legislation that has an impact on reproductive rights in general, thus assessing Zimbabwe's compliance with her obligation to respect, promote and protect women's rights to reproductive health.

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[404] IW Bennett & J Strug *Introduction to International Law* (2013) 32.
[405] Philip Alston and Gerard Quinn 'The Nature and Scope of States Parties' Obligations Under the International Covenant on Economic, Social and Cultural Rights' (1987) *Human Rights Quarterly* Volume 9 166.
[406] Committee on Economic, Social and Cultural Rights general comment No 9, *The Domestic Application of the Covenant*, 19th Sess., 1998, para 8.

The discussion of the legislative framework is made with the acknowledgement that Zimbabwe is conducting an alignment process of all laws inconsistent with the Constitution and international best practices. Commenting on the process within the context of harmful practices, Sithole and Dziva argue that:

> Although such efforts to align laws are commendable, the snail-pace approach in complying with the dictates of the [Maputo] Protocol and the Constitution is disturbing as women and girls continue to suffer harmful practices without the protection of the law.[407]

The snail-pace approach is therefore evidence of limited political will for the alignment of laws to the Constitution and international best practices. Such limited political will impacts the manner in which Zimbabwe complies with its obligations towards reproductive health rights.

3.3.1 Zimbabwe National Family Planning Council Act [Chapter 15:11] and the Zimbabwe National Family Planning Council

The 1985 Zimbabwe National Family Planning Council Act[408] nationalized family planning activities through the creation of the Zimbabwe National Family Planning Council (the ZNFPC), a parastatal organization under the Ministry of Health and Child Care.[409] The ZNFPC is responsible for the provision of family planning services, treatment and research[410] and for advising government agencies on population and development issues.

Explaining the relevance of the Act and the Family Planning Council, the then Minister of Health and Child Care, David Parirenyatwa stated as follows:

> It is through this long-standing commitment that Zimbabwe achieved remarkable results in increasing the contraceptive prevalence rate to 67 percent, across all methods among married women in 2015, and earning our nation praise as one of the few countries in Africa with the highest rates of contraceptive use. The decline in the total fertility rate from 6.7 children per

[407] L Sithole & C Dziva 'Eliminating harmful practices against women in Zimbabwe: Implementing article 5 of the African Women's Protocol' (2019) *African Human Rights Law Journal* 19: 568-590 at 579.
[408] Zimbabwe National Family Planning Council Act [Chapter 15:11].
[409] Section 3 of the Zimbabwe National Family Planning Council Act.
[410] Section 22 (1) (1) The functions of the Council shall be—(*a*) to popularize and promote the provision of adequate and suitable facilities in Zimbabwe for reproductive health and family planning; (*i*) to co-ordinate and monitor the provision of integrated reproductive health and family planning services in Zimbabwe;(*j*) to plan, design and implement adequate and sustainable reproductive health and family planning services for special target groups such as men and youths in Zimbabwe;(*k*) to procure and distribute adequate and appropriate contraceptive and reproductive health commodities in Zimbabwe;

> woman in 1984 to 4 children per woman in year 2015, is a sign of our nation's embrace of the national family planning programme after realising its associated benefits.[411]

The ZNFPC is commended for providing access to family planning to most people as it provides integrated family planning services through its 13 standalone static clinics at provincial level, and 26 dedicated youth friendly centres at district level.[412] The use of community model centres, which are available in all the 10 Provinces of the country, as the community based distributors of family planning services guarantees women's access to family planning information and contraceptives. This is in line with the provisions of the African Women's Protocol under Article 14(2) which calls upon State parties to take proper measures to provide accessible health services, including information and education to women, especially those in rural areas. It also mirrors the provisions of CEDAW under Article 16 which requires State Parties to ensure, on a basis of equality, men and women have access to the information, education and means to enable them to exercise these rights. This also complies with Zimbabwe's CEDAW concluding observations on its 6th Report which require it to 'ensure that women and girls have affordable access to modern forms of contraception, including in rural areas, intensify efforts to raise awareness of contraceptive use.'[413]

On paper, this is a success as it shows how Zimbabwe has domesticated international provisions into national law. However, the success of such efforts and how well they really work in practice will be discussed in Chapter Four.

3.3.2 Public Health Act [Chapter 15:17]

The Public Health Act 11 of 2018 is the main piece of legislation that regulates health issues. This new Act is a product of the alignment process and thus repeals the Public Health Act of 1924. The purpose of the Public Health Act of 2018 is provided as:

> *To provide for public health; to provide for the conditions for improvement of the health and quality of life and the health care for all people in Zimbabwe*; to provide for the rights, duties, powers and functions of all parties in the public health system, to provide for measures for administration of public health; to repeal the Public Health Act [Chapter 15:09]; and to provide for matters connected therewith.

[411] Ministry of Health and Child Care *Zimbabwe National Family Planning Costed Implementation Plan* 2016 – 2020.
[412] Ministry of Health and Child Care. Zimbabwe National Family Planning Strategy 2016-2020 p14.
[413] Committee on the Elimination of Discrimination against Women Concluding observations on the sixth periodic report of Zimbabwe CEDAW/C/ZWE/CO/6 at Paragraph 40(c).

In its attempt to 'improve the quality of life and health care for all people in Zimbabwe' the Act is guided by the provisions of the Constitution. The provisions relevant to this study are 29(1) which requires 'the State to take all measures to ensure the provision of basic, accessible and adequate health services *throughout Zimbabwe*,' and section 76 which provides for the right to have access to basic health-care services, including reproductive health-care services, among others. This is commendable as it seeks to ensure that reproductive health care services are accessible throughout the country, in line with the provisions of Article 12, 14 and 16 of CEDAW, Article 14 of the African Women's Protocol and Article 12 of the ICESCR. Zimbabwe, as a signatory to these treaties therefore has an obligation to ensure that women throughout the country, have access to adequate reproductive health care services.

In addition to the guiding provisions from the Constitution, the Act also provides for the duties of the Ministry of Health and Child Care as follows:

> a) to determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population; and (c) to take measures to implement and monitor implementation of Zimbabwe's international obligations and commitments in the field of health…

This provision is crucial as it allows the MoHCC to actuate the provisions in the pieces of national legislations and international treaties, as well as to monitor such implementation in the field of health, including reproductive health. This obligates the State to not only enact laws that provide for the right to access reproductive healthcare services, but to put in place measures to implement this right. This is in line with the calls made by the international human rights treaties (for instance Article 14 of African Women's Protocol and Article 12 of the ICESCR) for State parties to put in place measures for the realisation of women's reproductive health rights. If implementation is effectively implemented, then women's rights to access reproductive health care services will be achieved. Therefore, the question whether these national provisions that are compliant with the international treaties on paper, are in fact being implemented in practice as envisaged in the aforementioned provisions. This will be discussed in detail in Chapter 4.

3.3.3 The Termination of Pregnancy Act [Chapter 15:10]

The Constitution, as the supreme law of the land provides for the protection of the unborn child under Section 48 (3) which states that:

> An Act of Parliament must *protect the lives of unborn children*, and that Act must provide that pregnancy may be terminated only in accordance with that law.

The Termination of Pregnancy Act 29 of 1977 is the Act of Parliament referred to in section 48 (3) of the Constitution. It governs the lawful termination of a pregnancy in Zimbabwe. Section 3 of the Act explicitly provides that: '[no] person may terminate a pregnancy except in accordance with the Act'.

The Act lays down a few exceptional and limited circumstances where abortion is legally permitted. In terms of Section 4 of the Act, abortion is permitted only in the following circumstances:

> a. where the continuation of the pregnancy so endangers the life of the woman concerned or so *constitutes a serious threat of permanent impairment of her physical health* that the termination of the pregnancy is necessary to ensure her life or physical health, as the case may be; or
> b. where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped; or
> c. where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse.

The Termination of Pregnancy Act allows for termination of pregnancy where threats to a woman's 'physical health' only exists. It does not allow for termination where a woman's 'mental health' has been established. The omission of mental health as a permissible ground of termination of pregnancy is a loophole that goes against provision of the ICESCR[414] and the ACHPR,[415] which both recognize the right of everyone to the enjoyment of the highest attainable standard of *physical and mental health.* Consequently, the omission shows that Zimbabwe is not in compliance with its international obligations to ensure unrestricted access to reproductive health care services.

The term 'unlawful intercourse' in Section 4 (c) is defined as 'rape, other than rape within a marriage, and sexual intercourse within a prohibited degree of relationship…' The stringent circumstances provided in section 4 are not the end of women's challenges in accessing abortion services as there is another hurdle to cross. Section 5 of the Act provides further rigid conditions under which abortions provided for in terms of section 4 are to be performed. It provides as follows:

> Conditions under which pregnancy may be terminated

[414] Article 12.
[415] Article 16.

1. Subject to section seven, a pregnancy may only be terminated by a medical practitioner in a designated institution with the permission in writing of the superintendent thereof.
2. In the case of the termination of a pregnancy on the grounds referred to in paragraph (a) or (b) of section four, the superintendent shall not give the permission referred to in subsection (1) unless he is satisfied that—
    a) the medical practitioner referred to in subsection (1) and one other medical practitioner; or
    b) any two medical practitioners; who are not members of the same medical partnership or otherwise involved in the same medical practice have certified in the prescribed form that in their opinion the circumstances referred to in paragraph (a) or (b) of section four exist and that, in the case of the circumstances referred to in paragraph (b) of that section, any prescribed investigation, scientific or otherwise, has been carried out.
3. In the case of the termination of a pregnancy on the grounds referred to in paragraph (*c*) of section *our*, the superintendent shall give the permission referred to in subsection (1) on the production to him of the appropriate certificate in terms of subsection (4).
4. A pregnancy may only be terminated on the grounds referred to in paragraph (*c*) of section *four* by a medical practitioner after a certificate has been issued by a magistrate of a court in the jurisdiction of which the pregnancy is terminated to the effect that—
    a) he has satisfied himself— (i) that a complaint relating to the alleged unlawful intercourse in question has been lodged with the authorities; and (ii) after an examination of any relevant documents submitted to him by the authorities and after such interrogation of the woman concerned or any other person as he may consider necessary, that, on a balance of probabilities, unlawful intercourse with the woman concerned has taken place and there is a reasonable possibility that the pregnancy is the result of such degree to the person with whom she is alleged to have had incest; and
    b) in the case of alleged rape or incest, the woman concerned has alleged in an affidavit submitted to the magistrate or in a statement made under oath to the magistrate that the pregnancy could be the result of that rape or incest, as the case may be.

The provision of Section 5 (4) of the Act came under attack in the *Mildred Mapingure*[416] case where the court had this to say:

> Having arrived at this conclusion, I think it necessary to comment on the formulation of the statutory provision under consideration. *It is apparent from the foregoing that s 5(4) of the Act is ineptly framed and lacks sufficient clarity as to what exactly a victim of rape or other unlawful intercourse is required to do when confronted with an unwanted pregnancy. The subsection obviously needs to be amended.*[417]

In the *Mapingure case*, the Supreme Court of Zimbabwe ordered the government to compensate a rape victim, Mildred Mapingure, after the State failed to timeously provide Ms Mapingure access to abortion services. In addition, Ms Mapingure had not been permitted to terminate the pregnancy in terms of section 5(4) until the rape prosecution had secured a

[416] *Mildred Mapingure v The Minister of Health and Others* SC 22/14. Judgment delivered on 25 March 2014.
[417] *Mapingure case* at 28.

conviction. In reaching his judgement, Patel JA, as he then was, made reference to Zimbabwe's international obligations as follows:

> For present purposes, there are several internationally recognised norms that have a direct bearing on the issues at hand. Firstly, there is the Convention on the Elimination of All Forms of Discrimination against Women 1979, which was ratified by Zimbabwe on 13 May 1991. Article 16 of the Convention requires States Parties to eliminate discrimination against women in all matters relating to marriage and family relations. In particular, para. (e) of Article 16.1 guarantees ―the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights... Also relevant are various provisions of the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa 2003. Of special relevance is Article 14 pertaining to health and reproductive rights. Article 14.1 obligates States Parties to respect and promote the rights of women ―to control their fertility … to decide whether to have children, the number of children and the spacing of children [and] … to choose any method of contraception.[418]

This judgment is commendable as the court clearly evaluated and criticized the ambiguity of the law on termination. The limited circumstances when a woman can legally terminate her pregnancy effectively restrict women's access to reproductive health care. Ngwena argues that the grounds for abortion under the Zimbabwean Termination of Pregnancy Act are more restrictive than those provided for in the African Women's Protocol.[419] Such limitations go against Zimbabwe's responsibility not to enact restrictive laws, thus violating its obligation to respect the right to access reproductive healthcare services.

The central flaw of the Termination of Pregnancy Act's list of permitted circumstances to legally terminate pregnancy is its exclusion of the woman's choice to voluntarily terminate the pregnancy. For instance, a woman may not, upon request, terminate her pregnancy if it does not fall within the three categories mentioned in Section 4 of the Act. This in itself is an enormous restriction on women's right to make reproductive decisions. This raises the question: How does a woman become autonomous if she cannot decide freely when to carry a baby to full term and when to terminate her pregnancy? The stringent approach the provision of the Pregnancy Act has towards abortion deprives women of what Nussbaum calls the central capability of bodily integrity.[420] The Act '…simply takes away the ability of a woman to have control over her body, which is critical to her exercise of civil rights. Denying

[418] *Mapingure case* at 15-16.
[419] Charles G Ngwena 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' (2010) *Human Rights Quarterly Volume 32 Number 4* 783 at 835.
[420] Nussbaum M *Women and Human Development: The Capabilities Approach* 2000 at 78.

women the freedom to choose and act on decisions concerning their reproduction treats them as a means to an end and strips them of their human dignity.'[421]

The South African Choice on Termination of Pregnancy Act 92 of 1996 (Choice Act), compared to Zimbabwe's Termination of Pregnancy Act, provides for more relaxed conditions under which pregnancy can be terminated.[422] For instance, Section 2(1)(a) of the Choice Act provides that a pregnancy may be terminated upon the request of a woman during the first twelve weeks of gestation. O'Sullivan states that the restrictions contained in the Choice Act reveal a legislative commitment to balancing the increasingly compelling interests of the foetus (at and after viability) with women's rights to autonomy.[423] The situation in Zimbabwe, where the Constitution clearly provides for the protection of the foetus, is therefore different from the neighbouring jurisdiction of South Africa. In South Africa, 'the system of female reproductive rights progressively shelters foetal interests, albeit to a limited extent.'[424] A case in point is the *Christian Lawyers Association* case[425] which clearly demonstrated the status of the foetus in the context of the South African Constitution. In that case, the plaintiff sought an order declaring the Choice Act unconstitutional in the light of section 11 of the Constitution, which provides that 'everyone' has the right to life. It was argued that the right to life applies to a foetus from the moment of conception. The court held that there are no express provisions affording a foetus legal personality or protection.[426] Taking into consideration the provision of section 12(2) of the South African Constitution, which states that 'everyone has the right to

[421] O'Sullivan Reproductive Rights' in Woolman S et al (eds) *Constitutional Law of South Africa* (2011) 1-37 at 28.
[422] Section 2 of the Choice on Termination of Pregnancy Act 92 of 1996 provides as follows: 2. Circumstances in which and conditions under which pregnancy may be terminated (1) A pregnancy may be terminated- (a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy; (b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that- (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or (ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or (iii) the pregnancy resulted from rape or incest; or (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or (c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy- (i) would endanger the woman's life; (ii) would result in a severe malformation of the foetus; or (iii) would pose a risk of injury to the foetus. Page 5 of 10 (2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course.
[423] O'Sullivan M 'Reproductive Rights' at 28.
[424] C Pickles 'Termination-of-pregnancy rights and foetal interests in continued existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996' (2012) *Potchefstroom Electronic Law Journal* (15)5 at 403. Pickles highlights that foetal interests specifically relates to the benefit of continued existence in an unborn state up to the point of live birth.
[425] *Christian Lawyers Association of SA v Minister of Health* 1998 4 SA 1113 (T).
[426] Paragraph 1121G.

make decisions concerning reproduction,' the court found that nowhere in the Constitution can it be said that this right is qualified in order to protect a foetus.[427]

The Constitution of Zimbabwe and the Termination of Pregnancy Act prioritise the rights of the foetus or unborn child. According to Ngwena, 'laws that seek to liberalize abortion but also recognise the right to life of the foetus, have the effect of inscribing into domestic law a maternal and foetal rights conflict at the cost of clarifying the woman's right to abortion.'[428] It is evidenced that the Constitution in undertaking its duty to protect the life of the foetus, impinges on the civil rights of the pregnant woman when it denies her an opportunity to exercise her reproductive choice.

In addition, any termination of a pregnancy which is not sanctioned under the Act, according to the Constitution of Zimbabwe 2013[429], is illegal, and liable to be dealt with as such in the Criminal Law (Codification and Reform Act),[430] which is discussed in detail under section 3.3.6 below.

One way that a state could comply with its obligation to respect is not interfere with a woman's privacy. On the stringent requirements provided for in Section 5 of the Act, Ngwena argues that the 'danger to the life of the woman must not be viewed through a sanitized medical lens which depends on a prior medical diagnosis but rather it should be viewed through a holistic reproductive lens which renders visible unsafe abortion as a significant cause of maternal mortality.'[431] In the American case of *Griswold v Connecticut*[432], the following was stated:

> If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether or not to bear or beget a child.

Another gap in Zimbabwe's abortion legislation is its oversight for providing for mandatory counselling services prior to abortion taking place. Counselling requirements ensures that a pregnant woman is furnished with information on the risks associated with abortion, the available potential service providers to both married and unmarried mothers, and

[427] Ibid.
[428] Ngwena C 'Inscribing Abortion as a Human Right' at 835.
[429] Section 3(1) of the Termination of Pregnancy Act [Chapter 15:10] and Section 48(3) of the Constitution.
[430] Section 60, of the Criminal Law (Codification and Reform) Act [Chapter 9:23].
[431] Charles G Ngwena 'Inscribing Abortion as a Human Right'.
[432] (1965) 381 US 479.

the avenues to moral and financial support amid challenges resulting from a pregnancy. Failure to ensure access to information for women before they make the decision to abort is in violation of Zimbabwe's obligation under Article 16 of CEDAW, Article 12 of ICESCR and Article 14 of the African Women's Protocol.

3.3.4 The Domestic Violence Act [Chapter 5:16]

Violence against women poses an obstacle to their individual development, violates their rights and limit their freedoms, particularly their reproductive rights.[433] Violence thus hinders the full development of their capacities and autonomy, and limits their public, economic, social, and political participation.[434] For instance, women who have suffered marital rape are much more likely than non-abused women to use family planning clandestinely or to have difficulty using contraceptives effectively.[435] Consequently, they are more likely to have unintended pregnancies and unsafe abortions, and to become pregnant as adolescents.[436] Limitation on women's ability to manage their reproductive health caused by domestic violence and other forms of gender based violence, exposes women to sexually transmitted diseases. A multi-county health survey conducted by Kishor and Johnson found that the prevalence of sexually transmitted infections among women who have experienced violence is at least twice as high as in non-abused women.[437]

The Domestic Violence Act 29 of 1977 (DVA) is the major legislation which makes provision for the protection of domestic violence victims in Zimbabwe. Section 3 of the DVA conceptualises domestic violence as '…any unlawful act, omission or behaviour which results in death or the direct infliction of physical, sexual or mental injury to any complainant by a

[433] Shirin Heidari & Claudia García Moreno 'Gender-based violence: a barrier to sexual and reproductive health and rights' (2016) *Reproductive Health Matters* 24:47.
[434] Inter-American Commission on Women, Declaration of Pachuca 'Strengthening Efforts to Prevent Violence Against Women' (2014) 2.
[435] Garcia-Moreno C, Jansen HA & Ellsberg M *et al* 'Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence' (2006) *The Lancet* 368.
[436] Jacqueline C Campbell 'Health Consequences of Intimate Partner Violence' (2002) *The Lancet Volume* 359 Issue 9314:1331-1336; Lori Heise, Mary Ellsberg & Megan Gotte moeller 'Ending Violence Against Women' (1999) *Population Reports* Volume 27 Issue 4; Rose Grace Grose, Julia S Chen & Katherine A *et al* 'Sexual and Reproductive Health Outcomes of Violence Against Women and Girls in Lower-Income Countries: A Review of Reviews' (2020) *The Journal of Sex Research*; Jonna Cook & Bewley Susan 'Acknowledging a persistent truth: Domestic violence in pregnancy' (2008) *Journal of the Royal Society of Medicine* Volume 101:358-363.
[437] Sunita Kishor & Kiersten Johnson *Profiling Domestic Violence—A Multi-Country Study* (2004). See also: Silverman JG, Decker Michele R & Niranjan Saggurti *et al* 'Intimate Partner Violence and HIV Infection among Married Indian Women' (2008) *The Journal of the American Medical Association* 300(6):703-710, whose report revealed that women who have experienced both physical and sexual violence at the hands of an intimate partner have four times greater risk of HIV infection than non-abused women.

respondent ...'[438] The Act goes on to list other actions such as '…physical, sexual, emotional, verbal and psychological abuse; economic abuse; intimidation and harassment.'[439]

Section 3 (1) (l) further outlaws harmful cultural practices and norms that violate the rights women such as forced or child marriages and the system of child betrothal or the pledging of young women for avenging spirits.[440] Section 3(1)(1) of the DVA is commendable as it extends the definition of domestic violence by clearly including harmful traditional practices as acts of domestic violence. This is compliance with state obligations under Article 5 of CEDAW and Article 5 of the African Women's Protocol. It is also in compliance with the CRC Concluding Observations[441] requiring the State to take all measures to enforce the application of the law prohibiting child and forced marriage and to prevent such marriages from occurring.[442]

The DVA has been hailed as a landmark piece of legislation that would be the panacea for women's domestic violence challenges as, prior to the promulgation of the DVA, 'there had not been any law in Zimbabwe that dealt explicitly and specifically with domestic violence in general and violence against women in particular.'[443] In passing specific legislation on harmful cultural practices such as forced or child marriages and forced wife inheritance, Zimbabwe complied with the CEDAW Committee concluding observations of 1998, precisely recommendation number 157.[444]

[438] Section 3(1) of the Domestic Violence Act.
[439] Section 3 (1)(a)-(k) of the Domestic Violence Act.
[440] This is the Shona customary practice of compensatory payment in inter-family disputes as well as in the appeasement of avenging deceased spirits. The wronged family seek compensation in the form of a woman (from the murderer's family) when one of their own is killed A woman is a child bearer, and this is why a woman is used to go and appease the avenging spirit. A woman will go to the bereaved family and be given a husband who she would then bear children with and when a son was born in the event that a man was killed, he will be given the name of that person and the spirit would rest. See Norman Chivasa '*Kuripa Ngozi* as a conflict resolution model in Shona communities of Zimbabwe: a conceptual analysis' (2019) *Critical African Studies Volume 11 Issue 2* who argues that 'Although giving up of a virgin girl for purposes of *kuripa ngozi* is a criminal offence in Zimbabwe, it appears many girls and women continue to suffer in silence because the practice is administered at the family level.' This practices violates women's right to control when they can get married and whether or not to have children.
[441] Committee on the Rights of the Child Concluding observations on the second periodic report of Zimbabwe CRC/C/ZWE/CO/2 March 2016.
[442] Paragraph 47.
[443] Osirin P *Women's Rights as Human Rights* (2003).
[444]Zimbabwe is a party to CEDAW and filed its first report in 1996. This report was considered by the CEDAW Committee in May 1998. In its concluding observations, the committee expressed its concern that discriminatory traditional practices are still accepted and it called on Zimbabwe to codify only those customary practices that promote gender equality.

Despite the praises the DVA received, Chirawu argues that

> Although that Act is not the best piece of legislation, it is a significant step towards eradicating domestic violence and moving the issue from the private to the public arena. However, the issue of harmful cultural practices potentially presents the greatest challenge to the implementation and acceptance by society of the Act.[445]

This position on challenges of accepting legislation that outlaws cultural practices is supported by Anika Rahman and Nahid Toubia who postulates that;

> One of the highly debated issues is the role − if any − of legislative action against a pervasive social practice that is strongly linked to cultural norms and beliefs.[446]

On paper, the DVA does provide for the prohibition of domestic violence against women in conformity with the state obligations laid out in Article 5 and Article 12 of CEDAW. Prohibition of violence allows women to demand their rights and exercise control over their bodies. However, the major drawback is in the implementation of the DVA because in practice, women still fail to access reproductive health services or control their bodies due to domestic violence and harmful traditional practices in violation of Article 5 and 12 of CEDAW. This will be discussed in detail in Chapter Four.

The DVA further allows for the victims of domestic violence to obtain an Interim Protection Order as well as the final Protection Order on safety. The protection measures system, however, has some weaknesses. For instance, most women withdraw their cases from the courts because they are financially dependent on men.[447] Apart from financial dependence, 'other reasons why women withdraw cases of domestic violence include pressure from the mediation and influence of family members and the delay by the courts in dealing with cases.'[448] The delay by the courts in dealing with cases of domestic violence, coupled with the lack of adequate shelters for victims of domestic violence presents a problem in any efforts to ensure that Zimbabwe deals effectively with the problem of domestic violence. This is because most victims of domestic have nowhere to stay whilst the court case is in process, except to return to the abuser's hands.

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[445] Slyvia Chirawu-Mugomba 'A Reflection on the Domestic Violence Act [Chapter 5:16] and Harmful Cultural Practices in Zimbabwe' (2016) *Zimbabwe Electronic Law Journal* Volume I.
[446] Anika Rahman and Nahid Toubia *Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies* (2000).
[447] Oguli-Oumo Margaret, Imelda Molokomme & Valencia KD Mogegeh *et al Promoting an integrated Approach to combat Gender Based Violence: A Training Manual* New Gender Mainstreaming Series (2002).
[448] L Sithole & C Dziva 'Eliminating Harmful Practices' at 581.

Indeed, the lack of safe shelters to accommodate survivors while perpetrators await trial has seen victims going back to stay with perpetrators. This resulted in the continued high numbers of cases withdrawn and a vicious cycle of violence against women. To remedy this challenge of withdrawal of cases, the National Prosecuting Authority (NPA), through section 258 of the Constitution of Zimbabwe, no longer withdraws cases of domestic violence. Sithole and Dziva clearly explain the implication of section 258 of the Constitution as follows:

> What this effectively means is that when a complainant lodges a complaint of domestic violence, the case becomes a state case and cannot be withdrawn by the complainant. It now becomes the prerogative of the NPA, on behalf of the state, to either prosecute or withdraw, depending on its assessment of available evidence in the matter.[449]

A study conducted by Chuma and Chazovachii revealed that,

> Although the state has enacted a progressive legislation to combat domestic violence in the name of Domestic Violence Act, cases of abuse perpetrated against women continue to increase unabated particularly in the rural communities.[450]

This is direct violation of the obligation to protect which requires the State to protect women's right to sexual and reproductive health from interference by third parties as provided for under Article 24 of the CRC, Article 12 of the ICESCR and Article 14 of the African Women's Protocol.

3.3.5 The Marriage Act [Chapter 5:11]

Zimbabwe has a hybrid legal system composed of customary and statutory law. The law recognises three types of marriage: civil marriage,[451] registered customary marriage[452] and unregistered customary marriage.[453] The Marriage Act, which regulates civil marriages, provides in section 22 as follows:

> Section 22 of the Marriage Act which prohibits marriage of persons under certain ages (1) No boy under the age of eighteen years and no girl under the age of sixteen years shall be capable

[449] L Sithole & C Dziva 'Eliminating Harmful Practices' at 581.
[450] Chuma M & Chazovachii B 'Domestic Violence Act: Opportunities and Challenges for women in rural areas: the case of ward 3, Mwenezi District, Zimbabwe' (2012) *International Journal of Politics and Good Governance* Volume 3 No 3.4 Quarter IV at 13.
[451] This marriage is regulated by the Marriage Act and is conducted at the Magistrate Court or in church by a registered marriage officer. It allows a man to have one wife at any given time.
[452] This marriage is regulated by the Customary Marriages Act and is conducted at the Magistrate Court only. It allows a man to have more than one wife – It is therefore a potentially polygamous marriage in the sense that a man can marry many wives.
[453] This marriage occurs where a man pays the bride price/*lobola* for his wife. Like the customary marriage, a man may also pay *lobola* for many wives under the unregistered customary marriage regime. Legally, this union is given limited recognition because it is not registered. It is equally polygamous like the customary marriage.

> of contracting a valid marriage except with the written permission of the Minister, which he may grant in any particular case in which he considers such marriage desirable

It therefore allows for a girl under the age of 16 to enter into a civil marriage under the Marriage Act, provided there is written permission of the Minister,[454] against the stipulated 18 years for both girls and boys in Section 78(1) of the Constitution of Zimbabwe, which states that '[e]very person who has attained the age of eighteen years has the right to found a family.'

The inconsistency between the Marriage Act and the Constitution was widely blamed for the perpetuation of child marriages in Zimbabwe.[455] However, this inconsistency was cured by the Constitutional Court of Zimbabwe in its landmark ruling in *Mudzuru and Tsopodzi vs Minister of Justice and Legal Parliamentary Affairs NO*[456] The court declared that:

> Section 22(1) of the Marriage Act [Chapter 5:11] or any law, practice or custom authorising a person under eighteen years of age to marry or to be married is inconsistent with the provisions of s 78(1) of the Constitution and therefore invalid to the extent of the inconsistency. The law is hereby struck down; and (3) With effect from 20 January 2016, no person, male or female, may enter into any marriage, including an unregistered customary law union or any other union including one arising out of religion or religious rite, before attaining the age of eighteen (18) years.

The judgment is commendable as it protects the reproductive health and life of many potential victims of child and forced marriages in accordance to best international norms, in which the right adults above 18 years enter into relationships of their choice. Zimbabwe's abolition of child marriages is in compliance with its obligations as outlined in Article 21 of the ACRWC and Article 5 of the African Women's Protocol.

3.3.6 The Criminal Law (Codification and Reform) Act [Chapter 9:23]

The Criminal Law (Codification and Reform) Act 23 of 2004 consolidates and amends the criminal law of Zimbabwe in order to set out in a concise and accessible form, which conduct our criminal justice system forbids and punishes and what defences can be raised to criminal charges.[457] The Act prohibits marital rape in Section 68 which provides that:

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[454] Section 22 of the Marriage Act which prohibits marriage of persons under certain ages (1) No boy under the age of eighteen years and no girl under the age of sixteen years shall be capable of contracting a valid marriage except with the written permission of the Minister, which he may grant in any particular case in which he considers such marriage desirable

[455] C Dziva & D Mazambani 'The Constitutional Court ruling against child marriages in Zimbabwe: A landmark decision for advancing the rights of the girl child' (2017) *Eastern Africa Social Science Research Review* 73.

[456] *Mudzuru and Tsopodzi v Minister of Justice and Legal Parliamentary Affairs NO & 2 Others* CCZ 12/2015.

[457] Preamble of the Criminal Code.

> It shall not be a defence to a charge of rape, aggravated indecent assault or indecent assault (a) that the female person was the spouse of the accused person at the time of any sexual intercourse or other act that forms the subject of the charge: Provided that no prosecution shall be instituted against any husband for raping or indecently assaulting his wife in contravention of section sixty-six or sixty-seven *unless the Prosecutor-General has authorised such a prosecution.*

This section, at first glance, seems pro-women's reproductive health rights. However, a closer look at the provision reveals how restrictive the proviso is: marital rape is only a crime when the Prosecutor General decides that it constitutes a crime. The cumulative effect of this position is that marital rape is left entirely at the discretion of the Prosecutor General. This goes against the obligation to protect women' right to reproductive health from the influence of third parties.

Like the Termination Pregnancy Act, the Criminal Law and Codification Act prohibits the unlawful termination of pregnancy under Section 60 (1) by providing that:

> (1) Any person who (a) intentionally terminates a pregnancy; or (b) terminates a pregnancy by conduct which he or she realises involves a real risk or possibility of terminating the pregnancy; shall be guilty of unlawful termination of pregnancy and liable to a fine not exceeding level ten or imprisonment for a period not exceeding five years or both..

Criminalization of abortion is the highest level of violating women's independence and power to make decision concerning their bodies. Section 60 above disables women from having control over their bodies. It denies women the ability to intentionally and freely terminate unwanted pregnancies. Siegel rightly argues that abortion restrictive laws are a telling manifestation of the power of patriarchy and the marginal and subordinate status of women as physiological beings who are expected, as well as required, to bear children in a gendered society'[458] She further argues that a woman has a societal obligation to bear a child and that she can only be excused from that when it is no longer medically practicable – this gives preference to patriarchal and religious assumptions about the role of women in childbearing and this condones gender discrimination.[459]

Through this restrictive law, Zimbabwe has failed to comply with its international obligations as outlined in the CEDAW Concluding Observations which specifically call for Zimbabwe to 'decriminalize abortion in all cases and ensure access to safe abortion and post-

[458] Reva B Siegel 'Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection' (1992) *Stanford Law Review Volume 44* at 371-372.
[459] Siegel 'Reasoning from the Body'.

abortion services in all parts of the State party, as well as confidentiality in the administration of such services.'[460] It is also a failure to comply with obligations under Article 12 of the 1CESCR, which calls for states to abstain from taking measures that result in the denial of or hindrance to the access to reproductive health care services; as well as Article 14(2)(c) of the African Women's Protocol which enjoins State Parties to authorize medical abortion in less stringent cases that include sexual assault, rape, or incest, and when the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

3.4 POLICY FRAMEWORK

In Zimbabwe, issues of reproductive health and rights are dealt with within the context of the country's health and population policies. Thus, an understanding of reproductive rights in Zimbabwe must be based on an investigation of those policies.[461] It is important to note that a policy document is not a law – it is a document that outlines what the Government, through the responsible Ministry, hopes to achieve and the methods and principles it will use to achieve this. Laws on the other hand set out standards, procedures and principles that must be followed. If a law is not followed, those responsible for breaking them can be held to account.

3.4.1 The 2016-2020 National Health Strategy

The 2016-2020 National Health Strategy,[462] which builds on the 2009-2013 strategy[463] and its extension in 2014-15 is the key policy that informs the national health framework in Zimbabwe. Its purpose is explained as follows:

> The 2016-2020 National Health Strategy builds on the 2009-2013 strategy and its extension in 2014- 15 by addressing existing gaps and, more importantly, seeks to sustain the gains achieved thus far through a comprehensive response to the burden of disease and strengthening of the health system to deliver quality health services to all Zimbabweans.[464]

[460] Committee on the Elimination of Discrimination against Women Concluding observations on the sixth periodic report of Zimbabwe at Paragraph 40(d).
[461] Centre for Reproductive Rights. Available at *https://reproductiverights.org/sites/default/files/documents/WOWAA08.pdf*, accessed 15 January 2017.
[462] Ministry of Health and Child *The National Health Strategy for Zimbabwe (2016–2020), Equity and Quality in Health: Leaving No one Behind* (2016).
[463] Ministry of Health and Child Care *The National Health Strategy for Zimbabwe (2009–2013) Equity and Quality in Health: A People's Right'* (2010), whose aim is to provide a framework for immediate resuscitation of the health sector (Health System Strengthening), and secondly, to put Zimbabwe back on track towards achieving the Millennium Development Goals.
[464] Ministry of Health and Child 'The National Health Strategy for Zimbabwe (2016–2020).

The 2016-2020 Health Strategy has three main goals and 21 objectives. Goal number 1 on strengthening priority health programmes has 10 objectives and four priority areas. Reproductive health falls under objective number one as priority number three. The objectives under the reproductive health priority include; reducing maternal mortality ratio from 614 per 100,000 live births in 2014, to 300 per 100,000 live births by 2020; reducing Neonatal Mortality Rate from 29 to 20 deaths per 1,000 live births; reducing the under-five mortality rate from 75 to 50 deaths per 1,000 live births; and reducing mortality and morbidity due to malnutrition by 50%.

The CEDAW Committee general recommendation 24, has explained that the obligations under Article 12(2) requires states to report on maternal mortality rates affecting vulnerable groups of women, and the measures taken to enhance access to safe motherhood services aimed at tackling maternal mortality. Thus, Zimbabwe's inclusion of reproductive health in the National Health Strategy is commendable as it allows the Government to set targets that should be complied with in accordance with treaty obligations under Article 12(2) of CEDAW.

3.4.2 Zimbabwe Maternal and Neonatal Strategy 2017-2021

The Maternal and Neonatal Strategy (2017–2021) was launched in 2017 after the expiry of the National Maternal and Neonatal Health Road Map 2007-2015. The Road Map provided a strategic framework for addressing maternal and neonatal health challenges in Zimbabwe. This was in response to the call by the African Union and the subsequent Special Sessions of the Conference of African Union Ministers of Health.[465] The objectives of the Road Map are to provide skilled attendance during pregnancy, childbirth, and the postnatal period at all levels of the health care delivery system; and to strengthen the capacity of individuals, families, communities, civil society organizations and Governments to improve maternal and new-born health.

The 2017-2021 Strategy is another good policy document which focuses specifically on maternal and child health. However, implementation is crucial if maternal mortality rate is

[465] Special Session of the Conference of African Union Ministers of Health was held in Maputo, 18 -22 September 2006, and was attended by delegates from 46 African Union Member states and representatives from many organisations culminating in the Maputo Plan of Action on Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa. The 2006 Maputo Plan of Action aimed to help African nations to achieve the Millennium Development Goals related to reducing maternal mortality, combatting HIV and AIDS, and reducing infant and child mortality within integrated sexual and reproductive health care plans.

to be reduced. The National Health Strategy provision are in conformity with the obligations in Article 12 of CEDAW, Article 14 of the African Women's Protocol, Article 24 of the CRC, Article 12 of the ICESCR and Article 14 of the ACRWC, which all require State Parties to improve women's access to quality prenatal and postnatal services. Therefore, failure by Zimbabwe to provide skilled attendance during women's pregnancy, childbirth and post natal period, is a breach of the aforementioned provisions.

3.4.3 Zimbabwe National Family Planning Policy 2016-2020

In 2016, the Government of Zimbabwe launched the Zimbabwe National Family Planning Strategy. This was necessitated by the expiry of the Zimbabwe National Family Planning Strategy 2009-2014 and the need for Zimbabwe to renew its commitments made at the London Family Planning 2020 Global Summit in 2012:

> The government committed itself to ensure that women and girls have greater access to quality sexual and reproductive health and rights services and to reduce the unmet need for family planning from 13% to 6.5% by 2020. The family planning budget, including the procurement of contraceptive commodities, would be doubled from 1.7% to 3% of the national health budget. Zimbabwe would improve method mix and strengthen the integration of family planning with reproductive health, HIV and maternal health services. Innovative service delivery models to meet the needs and rights of adolescent girls would be explored and the unmet need for this target group reduced from 16.9% to 8.5% by 2020.[466]

The Strategy, whose aim is to improve on efficiency and effectiveness in the provision of integrated family planning services, acknowledges the significance of family planning as follows:

> Increased access to integrated FP has many essential benefits for individuals, families, societies and the nation at large. By ensuring universal access to integrated FP and related SRHR services we can reduce the levels of maternal mortality, infant mortality, teenage pregnancies and the resulting unsafe abortions.

Further, the Strategy also acknowledged cultural and religious beliefs as obstacles that may hinder access to family planning. It states as follows:

> Despite the high literacy rate (96%, 2012 Population Census National Report) among Zimbabweans, and the spread of accurate information about the use of FP methods at all

[466] The Family Planning Summit in London held in July 2012 was hosted by the United Kingdom Government and the Bill & Melinda Gates Foundation, with the support of United Nations Population Fund. The Summit launched a global movement to give 120 million women in the world's poorest countries access to lifesaving family planning information, services and supplies by 2020. Increasing access will enable these women and girls to choose whether, when and how many children to have. The poorest countries were, for the purposes of the Summit, defined as those with a Gross National Income (GNI) of $2,500 per year or less (based on the World Bank 2010 classification using the Atlas Method).

> levels, widespread religious and cultural beliefs still hinder the use of FP methods. These hindrances have resulted in a static unmet need of FP over the years. The strategy focuses on reform and re-organisation of the way FP services are delivered in Zimbabwe, in order to ensure high quality, comprehensive and integrated services associated with intended outcomes.

The Strategy has five main objectives:

i. Creating an enabling environment,
ii. Strengthening the supply chain management and security of all FP commodities,
iii. Improving availability and access to quality FP Services,
iv. Improving demand for integrated FP services, driven by comprehensive knowledge of FP methods and
v. Improving monitoring, evaluation and research for integrated FP services in Zimbabwe.

Of significance to this study is the objective on improving access to quality family planning services. This is a good policy document which, if implemented will contribute to Zimbabwe's obligations towards women's reproductive health rights. Compliance with international obligations on family planning under Article 12 of the ICESCR, Article 14 of the African Women's Protocol and Article 16 of the CEDAW, is imperative for a number of reasons. For instance, family planning empowers people to take control of their lives, enjoy their basic sexual and reproductive rights contributing meaningfully to their overall development and that of their societies and nations. This is line with the capabilities approach which states that policies should be evaluated on the extent that they enhance the capabilities of individuals and their ability to perform socially accepted functionings.[467] Consequently, investing in the well-being of women empowers them to pursue many different life choices, thus developing their capabilities.[468]

3.4.4 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020

The goal of the National Adolescent and Youth Sexual and Reproductive Health Strategy,[469] is to address sexual and reproductive health challenges among adolescents and young people

[467] Sen A *Inequality re-examined* (1995).
[468] Sen A *Development as Freedom* (2000).
[469] Ministry of Health and Child Care 'National adolescent and youth sexual and reproductive health strategy (ASRH) II: 2016-2020'. The 2016-2020 ASRH Strategy II represents the second generation results-based strategy

between ages of 10-24 years in Zimbabwe. Although specific to adolescents, the government is commended for launching a policy that directly speaks to reproductive health in line with State obligations in Article 10(h), Article 16 of the CEDAW and Article 14 of the ACRWC among others. The only drawback of the Strategy is that if focuses only on adolescents to the exclusion of the rest of the women in Zimbabwe, particularly rural women. There is therefore, a need for a National Policy on Reproductive Health that includes women of all ages and covers all issues on reproductive health in Zimbabwe.

3.5 INSTITUTIONAL FRAMEWORK

The State obligation to fulfil as provided for in international human rights treaties that include Article 12 of the ICESCR, Article 12 of CEDAW, Article 21 of the ACRWC, requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health. The precise content of the obligation to fulfil involves 'establishment by a State of institutional machinery essential for the realisation of rights. This can take different forms. In effect, it mirrors the requirements embodied in the phrase 'all appropriate means' within article 2(1) of the ICESCR.'[470] The previous sections discussed the legislative and policy framework for the realisation of the right to access reproductive health care services in Zimbabwe. This section discusses the administrative, judicial and other measures that Zimbabwe has adopted to realise the right to access reproductive health care services, including relevant parts of the public health infrastructure administered by the state.

3.5.1 The Ministry of Health and Child Care

The Ministry of Health and Child Care (MoHCC), is the line ministry responsible for health issues in Zimbabwe. Within the MoHCC is the Reproductive Health Unit housed under the Family Health Department. The Reproductive Health Unit coordinates provision of comprehensive Sexual and Reproductive Health services in all public health facilities in the country. The Unit is also responsible for developing and implementing policies and strategies

to aim to address SRH challenges among adolescents and young people between ages of 10-24 years in Zimbabwe. The strategy incorporates lessons learned in implementing the first generation strategy and changes in the national and global context with regards ASRH.

[470] International Commission of Jurists 'State obligations stemming from international law' Available at *https://www.icj.org/chapter-2-esc-rights-under-international-law-and-the-role-of-judicial-and-quasi-judicial-bodies-2/2-3-identifying-breaches-of-international-obligations-of-states-pertaining-to-esc-rights/2-3-1-state-obligations-stemming-from-international-law/*, accessed on 23 July 2019.

that guide implementation of sexual and reproductive health interventions. Some of the objectives of the Unit include provision of appropriate, affordable, accessible and friendly adolescent sexual and reproductive health services and reduction of maternal mortality ratio by 2020. One of the strategies employed by the Unit in order to achieve the stated objectives is raising awareness and providing services to families and communities especially the poor, hard-to-reach and marginalized, which is essential to avoid disparities in access to services.

Below is a discussion of some of the programmes that the MoHCC has established in order to ensure that rural women have access to reproductive health services.

3.5.1.1 Maternity Waiting Homes

The World Health Organisation (WHO) defines MWHs as residential facilities located proximate a qualified medical facility, where women, often those at high risk of complications, can await their delivery.[471] WHO highlights the purpose of MWHs as:

> These strategies are typically designed for inaccessible areas to facilitate the timely movement from home to health facility by diminishing barriers that inhibit access to care such as distance, geography, seasonal barriers or the time of day, infrastructure, transport, the cost of transport or communication between referral points.[472]

In Zimbabwe, the concept of MWHs was introduced after independence in 1980 and all rural district hospitals in Zimbabwe have a MWH.[473] However, since 2007 most MWHs were dilapidated resulting in underutilization or disuse. To revitalise the dilapidated MWHs, the Government, through the Ministry of Health and Child Welfare[474] established the Maternity Waiting Homes Operational Guidelines in 2010. The objective of the guidelines was to renew MWHs[475] as a practical strategy and intervention designed to improve access to health institutions, increasing institutional deliveries, improving access to skilled attendance at birth

[471] World Health Organisation *Maternity Waiting Homes: A review of experiences* (1996) Available at *https://apps.who.int/iris/bitstream/handle/10665/63432/WHO_RHT_MSM_96.21.pdf;jsessionid=08EFC506FF8A4DBE615CF223442F1660?sequence=1*, accessed on 14 April 2020.
[472] World Health Organisation 'Recommendation on establishment of maternity waiting homes (MWHs)'. Available at *https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-establishment-maternity-waiting-homes-mwhs, accessed* on 14 April 2020.
[473] United Nations Population Fund 'Maternity Waiting Homes: Promoting Institutional Delivery and Pregnant Women's Access to Skilled Care' Available *at https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/MATERNITYWAITINGHOMES.SUMMARY.pdf,* accessed 21 March 2020.
[474] The Ministry of Health and Child Care is the government ministry responsible for health in Zimbabwe whose purpose is to promote the health and quality of life of the people of Zimbabwe.
[475] Maternity waiting homes are homes that provide a setting where high risk women can be accommodated during the final weeks of their pregnancy near a hospital with essential obstetric facilities.

and thus reducing maternal mortality.[476] Some of the key activities outlined in the MWH Operational Guidelines established in 2010 are:

1. Renovation and refurbishment of 105 MWHs according to specific needs of each MWH. This is aimed at increasing the utilization of MWHs thereby contributing to addressing the 2nd delay as it is expected to promote institutional deliveries through bringing pregnant women closer to the health facility.
2. Procurement and distribution of 62 ambulances suited for rough terrain to strengthen referral services at district level (one ambulance for each district hospital). This will help reduce maternal deaths caused by delays in referrals.
3. Procurement and distribution of commodities including food items for nutritional support to women staying at the MWHs.
4. Training of 800 service providers in emergency obstetric and new born care (EmONC) to strengthen their capacity to manage obstetric complications that are responsible for most maternal deaths. This contributes to addressing the 3rd delay. Health workers will also be trained on how to run MWHs to ensure standardization and compliance with the MWH operational guidelines.

These key activities are applauded because, if effectively executed, they have the potential role of easing women's access to maternal health services. For instance, the benefits of revitalising the MWHs and capacity building was reported in the 2015 Zimbabwe Demographic Health Survey, which states that 71 percent of rural births were assisted by a skilled provider compared to 66 per cent in 2011.[477] Increased assisted delivery in 2015, therefore, shows significant improvement in access to maternal health care services and a reduction in the maternal mortality ratio (MMR).[478] This is commendable as these efforts comply with Zimbabwe's obligation in Article 12 of CEDAW, Article 14 of the African Women's Protocol and Article 12 of the ICESCR, which require State Parties to put in place measures to ensure accessibility of reproductive health care services.

Nonetheless, failure to effectively execute the MWHs Programme activities can defeat the objective of reducing maternal mortality as women will be forced to deliver at home. Home deliveries, although cost effective, have some dangers for the women and their unborn children. The risks associated with home deliveries include deliveries without skilled staff, equipment,

[476] UNFPA. Maternity Waiting Homes. See also Holmes W & Kennedy E. *Reaching emergency obstetric care: overcoming the 'second delay*. 2010 Burnett Institute: Melbourne, Australia; who argue that strategies typically designed for inaccessible areas, like maternity waiting homes, aim to facilitate the timely movement of women from home to health facility by diminishing barriers that inhibit access to care such as distance, geography, seasonal barriers or the time of day. The interventions relate to improving infrastructure or transport, addressing the cost of transport or enabling communication between referral points; Loveday Penn-Kekana *et al* 'Understanding the implementation of maternity waiting homes in low- and middle-income countries: a qualitative thematic synthesis' 2017 *BMC Pregnancy and Childbirth* 17:269.

[477] Zimbabwe National Statistics Agency and ICF International *Zimbabwe Demographic and Health Survey 2015: Final Report* (2016).

[478] Zimbabwe National Statistics Agency *Maternal Health: 2015 Key Findings* (2016).

medicines and conditions that are not safe or conducive for deliveries.[479] The 2015 Zimbabwe Demographic Health Survey Report revealed that 20 per cent of women had given birth at home in the 2 years preceding the survey.[480] Although commendable, 20 percent is still a high number. Therefore, Zimbabwe should put more effort to ensure that women do not give birth at their homes as this will be in direct violation of its obligations.

3.5.1.2 Community Health Workers

Community Health Workers (CHWs) are individuals who either volunteer or are chosen by the community and trained by the Government through the Ministry of Health and Child Care to assist in provision of primary health care within their communities.[481] The concept of CHWs became popular worldwide after the 1978 Alma Ata Health for All Declaration.[482] Highlighting the role of CHWs in primary health care, the Alma-Ata Declaration states that:

> Primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.[483]

The significance of CHWs cannot be emphasised. Tulenko *et al*[484] succinctly summarise the reasons why CHWs are important:

1. They are properly trained, equipped and supported can take on a range of tasks that otherwise depend on mid-level health workers.
2. They extend care to underserved communities, where they enhance access to health services and promote people's trust, demand and use of such services.
3. They who speak the local language and identify with the local community convey health messages more effectively.
4. Their training and service contribute to capacity for community leadership.
5. They can help service users avoid trips to health facilities, which translates into saved transportation costs and time.
6. They can meet some of the needs of homebound patients.

[479] Oona MR Campbell & Wendy J Graham 'Strategies for reducing maternal mortality: getting on with what works' (2006) *Lancet*; Blum LS, Sharmin T & Ronsmans C 'Attending home vs clinic-based deliveries: perspectives of skilled birth attendants in Matlab, Bangladesh' (2006) *Reproductive Health Matters* 14:51–60.
[480] Zimbabwe National Statistics Agency. *Zimbabwe Demographic Health Survey Report*. 2015
[481] Nkonki L *et al* 'Lay health worker attrition.'
[482] World Health Organization *Declaration of Alma-Ata* (1978) Available from: *http://www.who.int/publications/almaata_declaration_en.pdf*, accessed on 12 April 2020.
[483] World Health Organization *Declaration of Alma-Ata*.
[484] Tulenko Kate, Møgedal Sigrun & Muhammad Mahmood Afzal *et al* 'Community health workers for universal health-care coverage: from fragmentation to synergy' (2013) *Bulletin of the World Health Organization* 847-852, available at *https://www.who.int/bulletin/volumes/91/11/13-118745/en/*, accessed on 13 April 2020.

This is confirmed by a study conducted in rural Haiti which revealed that CHWs serve to bridge gaps in access to care which arise from lack of communication in terms of patient follow-up and long distances which patients travel to address health problems.[485] Zimbabwe was one of the first African countries to implement Primary Health Care[486] (PHC) approach which was adopted at the Alma Ata Conference of 1978.[487] The values and principles set down at Alma-Ata continue to be relevant in Zimbabwe today as CHW are still offering services to the underserviced communities. This is a good initiative which has the potential role of assisting Zimbabwe to meet its obligations of providing access to healthcare services to the hard-to-reach areas as provided for under Article 12 of the CEDAW, Article 14 of the African Women's Protocol and Article 12 of the ICESCR. However, the CHW program has faced a number of challenges in its implementation. These challenges are mainly centred on non-payment of the CHW as well as inadequate and inconsistent supply of resources needed by CHWs to execute their duties.[488] Failure to effectively implement the CHW programme leads to inadequate access of health services which in turn leads to a violation of women's right to access reproductive health services.

3.5.2 Ministry of Women's Affairs Gender and Community Development

The Ministry of Women's Affairs Gender and Community Development also plays an important role in community mobilisation as can be seen from its main key result area, which is: mobilisation of women and communities. The Ministry has identified six important dimensions of women's empowerment and opportunities to guide policy formulation and programme design. In line with its mandate and the six dimensions, the Ministry ensures that: educational empowerment of women which is a most fundamental prerequisite for empowering women in all spheres of life; the health and well-being of women through access to sufficient nutrition, healthcare and reproductive health facilities, and to issues of fundamental safety and integrity of persons. Rural women can therefore participate in policy formulation through voicing their concerns in community groups – concerns that can be formally presented to the

[485] Mukherjee JS & Eustache FE 'Community health workers as a cornerstone for integrating HIV and primary healthcare' (2007) *AIDS Care* 19:73–82.
[486] Primary Health Care is defined as: 'Essential care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the country and community can afford'
[487] Ministry of Health and Child Welfare *The Village Health Worker Strategic Plan* 2010.
[488] Oliver Gore, Festus Mukanangana & Collet Muza 'The role of Village Health Workers and challenges faced in providing primary health care in Mutoko and Mudzi Districts in Zimbabwe' (2015) *Global Journal of Biology, Agriculture and Health Sciences* Volume 4(1):129-135.

Ministry, with follow up engagements to ensure that the concerns are taken into consideration. Educational empowerment is commendable as it resonates with the obligation to ensure rural women have access to information as provided for in Article 16 of the CEDAW, Article 24 of the CRC and Article 14 of the African Women's Protocol. It also confirms the significance of empowerment in enhancing one's capabilities as emphasised by the Sen's capabilities approach.

3.5.3 National Human Rights Institution

National human rights institutions (NHRIs) are important domestic mechanisms promoting and protecting human rights.[489] The functions of NHRIs, as provided for by the Principles Relating to the Status of National Institutions, include handling complaints, carrying out investigations, advising the Government and recommending policy or legislative changes and providing training and public education.[490] NHRIs can be categorized as commissions or ombudsmen. In Zimbabwe, we have the Zimbabwe Human Rights Commission (ZHRC)[491] as our NHRI established in terms of section 242 of the Constitution of Zimbabwe. It is mandated to protect, promote and enforce human rights.[492] Two of the crucial functions of the ZHRC are to receive complaints from the populace and raising awareness on human rights, including the reproductive rights, to the citizens of Zimbabwe. The establishment of the ZHRC is in compliance with Zimbabwe's obligation to promote, which requires the State to put in place legislative, administrative and 'other measures' to ensure that women have access to reproductive health services. A detailed discussion of the ZHRC as a possible avenue for use by rural women to realise their rights, appears in Chapter Five.

3.5.4 The Courts

Judicial mechanisms are some of the most crucial measures related to domestic enforcement of socio-economic rights. The courts play an important role in the enforcement of rights. In Zimbabwe, Section 166 of the Constitution establishes the Constitutional Court which plays an

[489] WHO 'The Right to Health: Fact Sheet No 31' Available at *https://www.ohchr.org/Documents/Publications/Factsheet31.pdf*, accessed 1 August 2020.
[490] Principles relating to the status of national institutions ('Paris Principles'), General Assembly Resolution 48/134 of 20 December 1993.
[491] The ZHRC, which is a National Human Rights Institution was established in terms of section 100R of the former Constitution of Zimbabwe Amendment No.19 of 2009. The Constitution of Zimbabwe Amendment (No. 20) Act 2013 continues to qualify the existence of the ZHRC through section 242.
[492] See section 243 of the Constitution of Zimbabwe which provides the functions of the ZHRC.

important role in ensuring that existing laws, policies and actions of the state and government are consistent with the supreme law of the land. The court exercises its role to ensure that laws are consistent with the Constitution when a litigant brings a constitutional challenge to an existing law. At this point, it is important to acknowledge that Zimbabwe, through section 166 of the Constitution complies with its obligation to promote women's right to access reproductive health care services as provided for under Article 12 of the ICESCR. A more detailed discussion on the courts is given in Chapter Five.

3.5.5 The Parliament of Zimbabwe

Parliament is one of the three arms of Government. The significance of its existence cannot be overemphasised as it is a major prospect in as far as the realisation of women's rights is concerned. The mandate of Parliament is provided for in Section 117 of the Constitution, which states 'Parliament shall make laws for the peace, order and good government of Zimbabwe'. The role of Parliament is derived from Section 119 of the Constitution which provides that Parliament must promote democratic governance and ensure that the provisions of the constitution are upheld and all institutions and agencies of government at every level act constitutionally and in national interest.

More importantly, Parliament also plays a role in the national budget. It is responsible for authorising the National Budget and to monitor the performance of the Government in terms of the programmes approved in the Budget. In terms of section 299 of the Constitution of Zimbabwe Parliament has oversight on state revenues and expenditures to ensure that (a) all revenue is accounted for, (b) all expenditure has been properly incurred, and (c) any limits and conditions on appropriations have been observed. Parliament's role of authorising budget application has an impact on the livelihood on the ordinary citizens. Parliament, in authorising application of public funds through the National Budget, has to take into consideration that realisation of socio-economic rights, which include women's right to access reproductive health care services, largely dependent on national revenue. Any misallocation of funds has a negative impact on service delivery.

The existence of Parliament as an institution complies with the obligation to protect which requires states to put in place budgetary measures for the realisation of women's reproductive health rights. Parliament is therefore significant in ensuring that budget

allocations to the Ministry of Health comply with the 15 per cent Abuja requirement in order to ensure that access to appropriate health services is achieved.

3.6 CHAPTER CONCLUSION

This chapter explored the constitutional, legislative, policy and institutional framework for the protection of women's reproductive rights in Zimbabwe. The 2013 Constitution of Zimbabwe is indeed a turning point with regard to the realisation of women's reproductive health rights. Various sections of the Constitution, precisely section 25 (protection of the family); section 26 (Marriage); section 29 (health services); section 56 (equality and non-discrimination); section 76 (right to health care) and section 78 (marriage rights) speak on reproductive health. The Constitution is the only law that expressly recognises the right to reproductive health.

These constitutional provisions are commendable as they domesticate the different obligations to put in place measures for the realisation of reproductive rights placed on Zimbabwe in terms of Article 12 of ICESCR, Articles 5, 12, 14 and 16 of CEDAW, Article 14 of the African Women's Protocol and Article 14 of the ACRWC among others. Recognising access to reproductive health services as a right enshrined in the Declaration of Rights in the Constitution enables women to seek redress in the event of a violation. The significance of such a legally binding human right supports the capabilities approach which states that empowerment enhances women's abilities to have control over their bodies and other spheres of their lives.

Zimbabwe's legislative framework is, to some extent, better described as 'giving with one hand and taking away with the other.' It is acknowledged that the different pieces of legislation discussed do provide for measures to ensure women have access reproductive health services and at the same time provide stringent measures under which such access can be achieved. One example noted in the above discussion is the Termination of Pregnancy Act. The Termination of Pregnancy allows women to terminate pregnancy. This is good and in line with Article 14 of the African Women's Protocol. However, it then provides stringent circumstances under which such termination can occur. This limits women's access to abortion services, breaching its Article 14 of the African Women's Protocol obligations. The Criminal Law (Codification and Reform) Act buttresses the restriction in the Termination of Pregnancy Act. The Code criminalises voluntary abortion with a fine not exceeding six years in prison. Criminalisation cripples women from making autonomous decision about their bodies.

Zimbabwe's policy framework is indeed worth celebrating as it deals with quite a number of reproductive health issues that include maternal health and family planning. However, the major drawback of the current policies is, (apart from the *National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020*, which targets adolescents to the exclusion of other women) their piecemeal approach to reproductive health issues. Reproductive health issues are scattered in all policies with no single National Reproductive Health Policy to provide for reproductive health issues affecting women of all ages Zimbabwe. There is therefore a need for a national policy dedicated to reproductive health issues. Furthermore, many of the commendable laws are commendable on paper only and have not been properly implemented. This will be discussed in Chapter Four.

The institutional framework put in place by Zimbabwe to ensure the realisation of the right to access reproductive health services, is commendable. The institutions include institutions that provide information on human rights in general and on the right to access maternal health care and family planning services. The MoHCC for instance, represents the Government at national, provincial and district levels, which ensure that rural women also have access to any programmes carried by the MoHCC. The ZHRC is particularly important as it ensures access to information on human rights is feasible through information dissemination to the communities. This confirms with the obligation to promote, which requires the State to put in place measures for the realisation of the right to access reproductive health services.

Despite the commendable constitutional provision and a few legislative provisions, Zimbabwe, in reality has a long way to go in implementing the provisions in realisation of women's reproductive health rights. Even though Zimbabwe has made some progress towards achieving its treaty obligations with regard to the right to reproductive health rights, there are also serious inadequacies in practice as will become clear through the empirical discussion in Chapter Four.

CHAPTER 4: RURAL WOMEN'S EXPERIENCES IN ACCESSING FAMILY PLANNING INFORMATION AND SAFE MOTHERHOOD SERVICES IN ZIMBABWE

4.1 INTRODUCTION

This chapter discusses the findings of the study regarding the experiences of rural women in accessing reproductive health services. From the research questions, and the study, the main hypothesis was that although Zimbabwe has an obligation, in terms of the Constitution and the international and regional human rights instruments, to ensure that women have access to reproductive health care services, rural women do not have adequate access to these services. Women's limited access and enjoyment of reproductive health care services, particularly family planning information, contraception, and safe motherhood services, can be attributed to a number of intertwined factors. This Chapter therefore presents and discusses these factors as experienced by women when accessing family planning information, contraception and safe motherhood services in rural Zimbabwe.

The introduction is the first section of the Chapter. The second section discusses the demographic characteristics of the participants. The third section of the chapter discusses the experiences of women in Hwange Rural District in accessing family planning information, contraception and safe motherhood services. In discussing women's experiences, sub-themes of physical accessibility, affordability and availability will be used. The fourth section is a discussion on rural women's knowledge and perception of reproductive health care. The last section of the chapter is the conclusion.

4.2 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Table 1: Socio-Demographic data of 20 women participants

(All the names used have been changed to protect the identity of participants).

Name	Age	Education	Occupation	Living arrangements	Marital status	# of children	Ward
Lwazi	32	Form 2	Unemployed	With husband	Married	4	Simangani
Sihle	28	Form 4	Unemployed	With husband	Married	2	Simangani
Tambu	17	Grade 7	Unemployed	With in-laws	Married	1	Simangani

MaDube	42	Grade 7	Self employed	With parents	Widow	8	Mwemba
Zodwa	24	Form 3	Unemployed	With in-laws	Married	3	Jambezi
Shingi	22	Grade 7	Unemployed	With in-laws	Married	2	Jambezi
Chipo	25	Grade 7	Unemployed	With husband	Married	2	Jambezi
Beauty	35	Grade 7	Unemployed	With parents	Single	4	Jambezi
Nono	33	Form 2	Unemployed	With in-laws	Married	3	Mwemba
Sphiwe	37	N/A	Unemployed	With in-laws	Married	3	Mwemba
MaDube	27	Form 3	Unemployed	With parents	Single	3	Mwemba
Ntombi	30	Form 3	Unemployed	With in-laws	Married	3	Chikandakubi
Beke	32	N/A	Unemployed	With in-laws	Married	4	Chikandakubi
Angela	35	N/A	Unemployed	With husband	Married	5	Chikandakubi
Linda	34	N/A	Unemployed	With parents	Single	2	Mbizha
Beaulah	34	Form 1	Unemployed	With in-laws	Married	2	Mbizha
Dorcas	28	Form 2	Unemployed	With parents	Single	3	Mbizha
Saneh	32	N/A	Unemployed	With husband	Married	4	Simangani
Yolanda	25	Grade 7	Unemployed	With in-laws	Married	3	Mbizha
Cynthia	27	Grade 7	Unemployed	With in-laws	Married	3	Jambezi

Source: Field Data 2019.

Of the women interviewed, the majority were aged between 25-45 years (17 participants) with the minority of the women aged between 17-24 years. A majority of the women interviewed had attended formal school. However, many of them had abandoned their studies before completing their O-levels (Ordinary Levels). Eight women ceased their formal education at secondary school level, seven ceased formal education at primary school level and the remaining five women had never attended school. None of the women had formal employment. Most relied on subsistence farming and, in some instances, remittances from relatives and friends. Most of the women interviewed were married, while a few were either divorced or single by choice. The few single women stayed with their parents, while the majority of the married women either stayed with their in-laws or with their husbands. Most women interviewed had between 3-5 children, with one mature woman having the highest number of 8 children.

4.3 EXPERIENCES OF RURAL WOMEN IN HWANGE RURAL DISTRICT COUNCIL

This section presents and discusses the experiences of rural women in accessing reproductive health care services. The discussion is presented under three main themes, namely accessibility, affordability and quality of care. The main theme of this study is the right of access to reproductive health services. Therefore, the choice to discuss the research findings under the aforementioned three themes is guided by the human rights framework discussed in Chapter 2, particularly the Committee on Economic, Social and Cultural Right general comment No 14 on The Right to the Highest Attainable Standard of Health (Art. 12) and general comment 22 on the Right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)'.[493] General comments 14 and 22 define a comprehensive sexual and reproductive health care package as one that contains four interrelated and essential elements namely, availability, accessibility, acceptability and quality. It is from these interrelated elements that the current discussion was based. The three themes enabled the researcher to assess whether the rights are being fulfilled.

4.3.1 Accessibility

4.3.1.1 Access to family planning and other reproductive health information

Zimbabwe has made some effort to disseminate family planning information in rural areas by using the radio. This is commendable as it conforms to Zimbabwe's obligations provided for under Article 14 of CEDAW which specifically requires State parties to ensure that rural women have access to information on reproductive health, including, family planning information. Zimbabwe's efforts are also in line with provisions of Article 12 of the ICESCR, Article 24 on the CRC and Article 14 of the African Women's Protocol, which all enjoin State parties to ensure information on reproductive health is accessible to all.

Nonetheless, Zimbabwe needs to improve its infrastructure to ensure that rural women have access to information. Participants in this study revealed that they had no access to electricity or batteries as alternative power sources to enable them to have access to radios. Besides power challenges, transmissions by public and commercial stations are not easily accessible, particularly for the rural communities and this is mainly due to weak radio signals

[493] CESCR general comment No 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)E/C.12/GC/22, 2 May 2016.

in Zimbabwe. This confirms the urban bias theory that people in urban cities are more likely to get radio signal compared to people in rural area. Failure to boost radio signals in rural areas is an infringement of rural women's right to access information in general, and family planning information in particular. This failure is in violation of Zimbabwe's obligations as enshrined in Article 14 of CEDAW, Article 12 of ICESCR, and Article 14(1)(f) of the African Women's Protocol .

Other sources of information were identified by the participants. For instance, few participants with some knowledge about family planning issues indicated that they had accessed this information from their partners and relatives who work in town, as well as nurses from the clinics they visit for reproductive health care services. Community Health Workers (CHWs) were also identified as rural women's source of information on health information in general and family planning information in particular. CHWs are individuals who either volunteer or are chosen by the community and trained by the Government through the Ministry of Health and Child Care to assist in provision of primary health care[494] within their communities.[495] The CHW, as discussed in Chapter 3, have the potential of assisting Zimbabwe meet its treaty obligations of information dissemination to the marginalised rural women. As one participant stated:

> *Ini nyaya dzeFamily planning ndakaudzwa naVillage Health Worker wemunharaunda medu. Ndivo vakandidzidzisa zvese zvinechekuita* neFamily planning. *Izvi zvirinani nekuti maCHW acho togara navo mumisha yedu saka ruzivo nekubetserwa kunoita nyore.* I was told of family planning issues by our Village Health Worker. She is the one who also taught me everything there is to know about family planning methods. The presence of CHWs is an advantage as they stay with us in our villages which makes access to information become easy.

Access to information of reproductive health services is significant as it enables women to make informed decisions on what contraception to use, for example. Lack of

[494] Katharine Shelley 'Zimbabwe's Village Health Worker Program' Available at *https://www.chwcentral.org/blog/zimbabwe per centE2 per cent80 per cent99s-village-health-worker-program*, accessed on 14 May 2019. Katherine states that primary care includes a wide range of duties from 'prevention and health promotion to treating common conditions (including diarrhoea and malaria) and identifying and referring complicated cases to higher levels of the health system.

[495] Nkonki L, Cliff J & Sanders D 'Lay health worker attrition: important but often ignored' (2011) *Bull World Health Organ* 89:919–923.

information leads to violation of the right to access information on reproductive health. Women cannot access services that they have no knowledge of.

4.3.1.2 Distance to the nearest health centre

According to CESCR General Comment No 14 on the Right to Health[496], 'accessibility implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.'[497] In the Hwange Rural District study, the women indicated that clinics were available, albeit located in places that are far from their places of residence. While six of the women indicated that the clinic was easily accessible, 14 indicated problems with access to the clinic. The quotations below reveal this:

> *Thina silenhlanhla ngoba sihlala kuVillage engekho kude kakhulu. Sihamba umango ongafika 2 km ukuthi sifike eClinic.* We are fortunate enough because our village is not too far from the clinic. We only walk about 2 km to access the clinic.
>
> *Isu tinofamba makilomita anosvika kana 12 kuti tiwane kubatsirwa kuClinic. Ndo Clinic itori pedyo nesu.* We walk for about 12 km to get health care services. This is the clinic that is closest to where we stay.
>
> *Kana uchitoda kuenda kuClinic hunge watowana vamwe vanoendako neNgoro nekuti kure zvekuti wakazvitakura unosvika wanzwa.Ukashaya Ngoro kwakutongorega kuyenda.* You can only go to the clinic if you find neighbours with cattle drawn wagons going the direction of the clinic because it is very far. It even worse when you are pregnant, you get to the clinic exhausted from walking the long distance. So if there is no neighbour going to the clinic with the cattle drawn wagons, it is better to just stay at home.

This finding echoes findings by Makuto and James's[498] study on Access to Health Care Services. Makuto and James's study found that 'most communities in rural Zimbabwe live within a 5 km radius from their nearest health facilities, whilst 23 per cent live between 5

[496] Office of the High Commissioner for Human Rights *CESCR General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)* E/C.12/2000/4.
[497] Paragraph 12 (b).
[498] Makuto D and James V *Study on Access to Health Care Services in Zimbabwe* (2007).

and 10 km and 17 per cent are over 10 km from their nearest health centre'.[499] It is clear from the similarity of findings of the study conducted in 2007 and the present study which was conducted in 2018, eleven (11) years later, that very little improvement has been made in transforming the distance factor to improve access to health care. This is violation of Article 12 of the ICESCR as elaborated in General Comment 22 on Sexual and Reproductive Health Rights, which clearly states that reproductive health service should be physically accessible. Other treaties violated include Article 14 of the African Women's Protocol, Article 12, 14 and 16 of CEDAW, which all require states to ensure that reproductive health services are physically accessible to everyone, including rural women.

4.3.1.3 Poor roads, inadequate transport services and high transport fares

The study also revealed that the challenge of clinics located far away from communities is worsened by poor road networks in the study area. Thus, communities find it difficult to reach these clinics as the private cars or taxis that ply the routes to the clinics or to the main road leading to the nearest towns are very few. This mainly affects pregnant women who find it difficult and expensive to hire a motor vehicle to the clinic in case of emergency delivery. In some cases, participants reported incidences when they had to give birth in the community with the help of elderly women when they fail to reach the nearest clinics. The following excerpts explain these issues:

> *Kuno migwagwa yacho haina kuiswa tara saka mota dzofamba kuenda kumaClinic dzishoma saka hadziwanikwi nguva dzose.* Our roads are bad as they are not tarred. Because of these bad roads, only a few vehicles ply the routes to the clinics and the vehicles are not always available.

> *Imota zakhona futhi yikuthi ebusuku azitholakali, zihamba emini kuphela. Ebusuku ungagula sokumele usebenzise inqola ezingekho safe, ikakhulu ebusuku. Kwezinye izikhathi abafazi bazalela enqoleni besendleleni yokuya esibhedlela.* The vehicles are not available at night as they only transport people during the day. At night we are then forced to use cattle drawn wagons which are dangerous and not safe. Sometimes women give birth on their way to the clinics while being transported by oxen drawn wagons.

[499] Makuto D and James V *Study on Access to Health Care*.

While none of the participants reported complications during deliveries in communities, this could potentially result in maternal and child mortality for first pregnancies. Indeed, the participants indicated that delivery of a baby from a first pregnancy is always referred to hospitals in Hwange or Victoria Falls. The problem with such referral is that there is no transport (ambulance) readily available to transport expecting mothers to the hospitals. One of the health workers explained as follows:

> The ambulance is always available at the hospital. However, any patient who needs to use it has to pay for the fuel so that she can be transported to the nearest referral hospital. This is almost always impossible as most rural women are unemployed and do have the financial capabilities to meet such extra costs.

Another participant, confirming what the health worker stated, explained as follows:

> *Nxa kuyisisu sakho sokuqala, bakuhambisa esibhedlela seHwange kumbe eseVictoria Falls ukuthi uyobelethela khona. Yona i-ambulance ihlala ikhona kodwa wena njengesigulane kumele udinge iFuel ezathelwa kuleyo ambulance ukuze ikuthwale ikusa kulezo zibhedlela. Nxa ungela mali yeFuel sokumele usebenzise amakhombi njalo nxa eyekhombi ungelayo awula elinye icebo ngaphandle kokubelethela endlini.* If it is your first pregnancy, you are referred to either Hwange Colliery Hospital or Chinotimba Hospital in Victoria Falls for delivery. The ambulance is always available, however, you as the patient are required to fuel it in order to be ferried to the referral hospital. If you do not have money for fuel, then you have to use public transport. And, if you do not have money for public transport then a home delivery is the only option.

Indeed, transport costs and road networks hamper women's access to reproductive health care services. Dodzo's findings that the absence of reliable transport is one of the challenges that lead rural women to community deliveries[500] are similar to this study's findings. Another study conducted in Ghana further buttresses the above findings by stating that:

> Apart from the long travel distance, which prevents the majority of women from accessing health care, other complicating factors include non-availability or the high cost of transportation, the poor quality road network linking towns to rural settings—compounded by

[500] Dodzo MK & Mhloyi M 'Home is best: Why women in rural Zimbabwe deliver in the community' (2017) *PLoS ONE* 12(8).

> seasonal flooding limiting access to the already existing poor roads—and the dispersed rural settlements common in rural Ghana in particular.[501]

The high costs of transport due to bad roads affects accessibility of reproductive health services as only the financially stable can afford to pay the expensive fares charged by the taxis and private cars plying the routes to the health facilities. The majority of the women interviewed highlighted that they could not afford to pay for transport costs as they were not employed. Below is an explanation from one of the participants:

> *Chimwe chinonetsa ndechekuti sezvo mota dzirishoma and migwagwa isina kunaka, vanotyaira mota idzi vanodhura zvekuti isu kubhadhara mota dzacho tinozodzamara taona kuti kurega kuenda kuClinic kurinani.* The other problem is that since the vehicles are few and the roads are bad, the owners of these vehicles charge huge transport fares, which we can afford. At the end of the day we find it better not to visit these clinics as it is too costly for us.

Similar studies in Kenya, Ghana and Malawi revealed the scarcity of taxis providing public transport resulting in women mainly walking to the clinic and some travelling on their husband's bicycles.[502] Another study[503] carried out in one of Zimbabwe's rural areas also found that unavailability of transport and bad roads which cannot be used especially during the rainy season were major barriers to accessing health care services. All these study findings confirm Robert Chamber's urban bias theory which suggests that governments service urban areas more compared to rural areas. The challenges highlighted by participants, which are unique to rural areas, imply that the government is not servicing rural districts and in this way is violating rural women's rights. Such violations of rural women's rights are a breach of Zimbabwe's obligations provided for under Article 12, 14 of CEDAW, Article 14 of the African Women's Protocol and Article of the CRC which all require Zimbabwe, as a State party to the treaties, to put in place measure to ensure that citizens have access to reproductive health services when they need them.

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[501] Vida Nyagre Yakong 'Ethnographic perspectives on rural women's reproductive health decisions in Ghana: The cultural influences of gender relations, kinship and belief system' (Doctoral Dissertation, The University of British Columbia 2013).

[502] Pell C, Meñaca A & Were F *et al* 'Factors affecting antenatal care attendance: Results from qualitative studies in Ghana, Kenya and Malawi' (2013) *PLoS One* Volume 8: 1–11.

[503] Leoba Nyathi, Augustine K Tugli & Takalani G *et al* 'Investigating the accessibility factors that influence antenatal care services utilisation in Mangwe district, Zimbabwe' (2017) *African Journal of Primary Health Care and Family Medicine 9 (1):*1337.

4.3.1.4 Religion and its impact on rural women's access to, and perception of reproductive rights

The study revealed how women fail to access reproductive services as a result of religious beliefs. Although applicable to a four of the participants, the use of family planning was perceived to be against faith teaching and commands. The common text referred to by the women was Genesis 1:28, which describes God's words to Adam and Eve upon their expulsion from the Garden of Eden: 'God blessed them, and God said to them, 'Be fruitful and multiply, and fill the earth, and subdue it…' One participant narrated her story as follows:

> *Ini chiPostori hachitibvumidze kuenda kuchipatara kunotsvaka rubatsiro kana tarwara. Saka pandakaita mimba, mhuri yekwandaka roorwa yakaramba kuti ndiende kunosunungukira kuchipatara. Ndakabatsirwa naMbuya vekuChuch asi ndakarasikirwa neropa zhinji. Mhuri yemurume wangu yakaramba ichiti munamato ndiwo uchandibatsira. Pakaouya vamwe mai vatinogarisana navo vakaudza amwene vangu kuti vandiendese kuchipatara kana vasingade kusungwa mushure mekunge ndafa nekurasikirwa neropa rakawanda. Ndipo pandakazoendeswa kuchipatara*. My Apostolic religion does not allow me to seek medical help for any ailment. So when I was in labour, my husband's family did not want me to go to the hospital for delivery. They found an elderly woman who assisted me deliver at home but I lost a lot of blood. My husband's family still insisted on praying for my healing. A neighbour convinced my mother in law to take me to the hospital or risk being arrested in the event that I die due to loss of blood. That is how I was then taken to the hospital.

Apart from the participants' religious beliefs, the study also revealed rural women's limited access to reproductive health services like abortion and family planning services as a result of religious principles governing faith-based health facilities. For instance, one health worker at some faith-based health facility indicated that it was against their religion to offer contraceptives, let alone offer abortion services to women who required them. Stated as follows:

> We as Catholics do not believe in family planning. Our religion does not allow us to provide family planning services or abortion services to those that need them. When we receive such patients, we refer them to Government hospitals.

These findings speak to Nussbaum's capability approach which states that women's general capabilities are achieved when they are guarantees of non-interference with certain choices that are especially personal and definitive of selfhood. In this case, religion and religious teachings interferes with women's capabilities to exercise practical reason in violation of Zimbabwe's duty to protect human rights. The duty to protect requires states to put in place measures to curb third party interference in women's right to access reproductive health care services.

It is important to note that when faith-based institutions deny women reproductive health services, Zimbabwe is inadequately protecting women's rights to access reproductive health services. The faith-based organisations do not have a duty to provide services to rural women. Government's failure therefore is in the unavailability of adequate hospitals and clinics to offer reproductive services to rural women. For instance, Catholic hospitals do not offer contraception and abortion services. However, Zimbabwe cannot force a Catholic funded clinic or hospital to perform abortions. Instead, the state, as a duty bearer, has the obligation to ensure that government hospitals have adequate services for use by rural women. Rural women approach mission hospitals as these are the ones that exist in most rural areas.[504] Thus, for Zimbabwe to comply with her obligation, she must ensure that women have alternative health facilities that they can visit.

This study findings further confirm findings from studies by various scholars that religious beliefs and principles are powerful influences on individual behaviours and community actions, including health-related practices.[505] The study findings on the Apostolic sect's belief in prayer instead of seeking medical help confirms findings in a study conducted by UNICEF Zimbabwe which revealed that:

> The religious teaching, doctrine and regulations of the ultra-conservative Apostolic groups which emphasize faith healing and strict adherence to church beliefs and practices undermine

[504] Zimbabwe Association of Church-Related Hospitals 'Mission hospitals and clinics in Zimbabwe' Available at *https://www.zach.org.zw/mission-hospitals-and-clinics/*, accessed 3 August 2020. The Zimbabwe Association of Church-Related Hospitals states that mission hospitals and clinics in Zimbabwe contribute 68% health care delivery in rural Zimbabwe and 35% nationally. Most mission hospitals and clinics are in remote and hard to reach areas and provide services to underserved, marginalized and vulnerable communities.

[505] Akpenpuun Joyce Rumun 'Influence of religious beliefs on healthcare practice' (2014) *International Journal of Education and Research Volume 2 No. 4*. See also: Agnes Cyril Msokaa, Eunice Siaity Pallangyoa & Sharon Brownie *et al* 'My husband will love me more if I give birth to more children: Rural women's perceptions and beliefs on family planning services utilization in a low resource setting' (2019) *International Journal of Africa Nursing Sciences Volume 10* 152-158 – whose study findings revealed that religion was one of the biggest barriers to acceptance of family planning services; O'Brien S and Broom A 'HIV in (and out of) the clinic: Biomedicine, traditional medicine and spiritual healing in Harare' (2014) J*ournal of Social Aspects of HIV/AIDS, 11(1):96.*

> modern healthcare-seeking. Often, violation of church doctrine or regulation on non-use of modern healthcare services attracts sanctions, which include confession, shaming (asked not to wear church regalia or 'kubvisiswa gamenzi', or re-baptism (kujorodwa). These social controls often take a militaristic-type discipline in order to ensure strict adherence to the apostolic group's norms, values, and beliefs.[506]

The research revealed that although women were aware of some reproductive health care services, they were shy to discuss reproductive issues. With heavy socio-cultural and structural overtones in most rural communities, reproductive issues are rarely discussed. Participants indicated that reproductive health issues were synonymous with promiscuity, immorality, associated with adultery and rebellion and thus could only be utilised in accordance with their male counterpart's involvement. One respondent explained as follows:

> *Kushandisa mapiritsi ekudzivirira nhumbu murume achigara kudhorobha kunonetsa. Mubvunzo unobvunzwa ndewekuti: wanga uchirara nani ndisipo? Sei waishandisa mapirtsi e*family planning *ndisipo?* Taking contraceptives in the absence of your husband who works in town can cause trouble in your home. The question asked is: who were you sleeping with in my absence? Why did you need to prevent pregnancy when I was not around?
>
> *Into zamalungelo abomama ezifana lezokuzala zivele azikhulunywa ngazo kakhulu ngoba obaba njengenhloko yemizi yibo abenza izinqumo ezihambelana lokuzala, thina abafazi silandela okukhulunywe ngobaba* Women's rights issues like reproductive health matters are rarely discussed because men, as heads of families, are the ones responsible for making reproductive health decisions and we women just comply and make sure that the decisions are followed out.
>
> *Akula muntu ongakhuluma laye ngendaba zamalungelo amayelana lokuzala ngoba obabakazi kumbe abadala bendawo labo abafuni kuzwa ngendaba abathi zenza thina abafazi sibe yiziqholo ezingahloniphi amadoda, njalo zenza signage ngokulala lamadoda amanengi, sikhipha izisu* The unfortunate thing is there is really no one that you can talk to about reproductive health issues as aunts and other elders in the community are of the view that reproductive rights give us women too much power

[506] Brian Maguranyanga *Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe: A qualitative study on determinants of healthcare-seeking behaviour among the Apostolic Faith community* (2011).

which makes us disrespect men and even be promiscuous by sleeping around and then terminating pregnancies.

A majority of the respondents agreed to the significance of maternal health services in particular, and reproductive health care services in general, for their well-being and were in favour of rural women having access to reproductive health care services. Nonetheless, they believed that rural women had limited ability to exercise their right to access reproductive health care services. One common factor that emerged as the main driver of perceptions on reproductive health, as can be seen from the above quotations, was the patriarchal nature of the social and cultural dynamics in the community which, according to most women interviewed, 'disabled' women from making reproductive decisions.

The negative perception of associating human rights with immorality was also revealed by a Baseline Survey on 'Perceptions, attitudes and understanding on human rights in Zimbabwe' commissioned by the Zimbabwe Human Rights Commission (ZHRC).[507] The Survey revealed that community members, particularly in rural areas, perceived human rights as the cause of 'children's rebellious behaviour and the decay of culture.'[508] Because of the misconceptions surrounding human rights and women's rights in particular, it is probable that women will keep silent and not voice their concerns for fear of being blamed for perpetuating moral decay. This was succinctly stated by one legal practitioner who advocates for women's rights as follows:

> Traditionally, in Zimbabwe, women have not been called on to voice their opinions, so the concept of saying what they want is foreign to them. Human rights organisations will advocate for women's issues, such as the legalisation of abortion, and the government will say, let's ask the women what they want. And, of course, no-one will say a word…This presents a three-pronged dilemma: moral, human right and societal. Few women are going to be brave enough to stand up and be the isolated voice that went against the moral and societal foundations on which the country had been established.*[509]*

Participants in this study also voiced similar concerns noting that they are socialized to respect and obey what their male counterparts say. This can be attributed to the fact that

[507] Zimbabwe Human Rights Commission *Baseline Survey on 'Perceptions, attitudes and understanding on human rights in Zimbabwe*' (2015).
[508] ZHRC 'Baseline Survey' 46.
[509] Pambazuka News 'Our ugly secret: abortion in Zimbabwe, illegal but thriving' available at *http://www.pambazuka.org/governance/our-ugly-secret-abortion-zimbabwe-illegal-thriving*, accessed on 23 October 2016.

Zimbabwe is predominantly a conservative and Christian society[510] which, like many other countries on the continent, supports patriarchal and religious philosophies. According to the 2017 Inter-Censal Demographic Survey (ICDS) report prepared by the Zimbabwe National Statistics Agency (ZIMSTAT), 84 percent of the population age 15 years and above are Christian while 1 percent are Muslim. The largest proportion of Christians belong to the Apostolic sect (34 percent) followed by Pentecostal (20 percent) and Protestant (16 percent).' Women's socialisation to respect men is also in line with biblical teachings which require women to submit to their husbands:

> Wives, submit yourselves to your own husbands as you do to the Lord.**23** For the husband is the head of the wife as Christ is the head of the church, his body, of which he is the Saviour. **24** Now as the church submits to Christ, so also wives should submit to their husbands in everything.[511]

Anything against such teachings leads to them (women) being labelled as shameful and dishonourable to the family and the society as a whole. The perception or fear of moral decadence not only affects policy and legislative considerations, it also affects the women themselves. In other words, women's bodies have become a yardstick of morality in both traditional and religious perspectives. Sexual purity, a principle which, according to religious and cultural beliefs, leads to real womanhood, encourages tight control of a women's sexual body by parents, husbands and religious institutions through strict norms.[512] Any conduct which deviates from these norms attracts a punishment[513] from the family as it is believed to be disgraceful. This, again is a huge burden on women. The use of words such as 'disgrace' in line with women's sexual and reproductive health rights takes away their freedom to freely control their bodies without fear of some sort of reprieve from their homes, their churches and the community as a whole.

In light of the above submissions, there is therefore need to break sexuality taboos so as to inform and empower not just young people, but parents, guardians, teachers and custodians of culture like traditional leaders, if Zimbabwe is to record any success in ensuring rural women have access to reproductive health care services. There is also need to curb third

[510] Masiiwa Ragies Gunda *On the public role of the Bible in Zimbabwe: Unpacking Banana's "re-writing" call for a socially and contextually relevant Biblical Studies* (2015).
[511] Ephesians 5 verse 22 to 24.
[512] Rabah Omer 'The Modern and the Traditional African Women and Colonial Morality*'* (2018) *International Journal of Culture and History Volume 5 No 1* at 33-34.
[513] Punishment comes in different forms which include being disowned by the family for getting pregnant before marriage as this is considered disgraceful to the family

party interference from religious teachings as these, coupled with taboos and societal attitudes, hamper women's efforts to access reproductive health services in direct violation of Zimbabwe' obligation to protect in terms of Article 12 of the ICESCR,[514] Article 5 of CEDAW and Article 5 of the African Women's Protocol.

Indeed, the persistence of negative religious and societal norms that conflict with and undermine implementation of both national legislation and international human rights standards must be addressed. Acknowledging that 'it is an uphill task to change people's minds through law,'[515] this thesis suggests that the State must put in place measures that balance the right to access reproductive health care services and freedom of religion. For instance, the exercise of one's faith or beliefs should not lead to violations of the next person's right to health. Where this happens, the State should put in place laws that punish any religious acts that lead to violations of women's reproductive health rights.

Although such national legislation is vital in dealing with the issue of harmful religious practices, there is an urgent need for parallel programmes that addresses the religious environment from which these practices emerged, in order to eliminate the various justifications used to perpetuate them. Consequently, it is the duty of states to intensify awareness raising and training programmes on human rights in both formal and informal education sectors.

4.3.1.5 Gender power imbalance

Gender power imbalance, which simply means men's control over women, is linked to accessibility of reproductive health services in that men control women's access to contraceptives. Participants stated that the use of contraception (mainly the Pill and the condom) is sometimes negotiated, although it is the men who usually have the final say on which contraceptive methods to be used. Below are some of their explanations:

[514] See ICESCR general comment 22 at paragraph 48 which provides that states must also take affirmative measures to eradicate social barriers in terms of norms or beliefs that inhibit individuals of different ages and genders, women, girls and adolescents from autonomously exercising their right to sexual and reproductive health. Social misconceptions, prejudices and taboos about menstruation, pregnancy, delivery, masturbation, wet dreams, vasectomy and fertility should be modified so that these do not obstruct an individual's enjoyment of the right to sexual and reproductive health.

[515] R Karugonjo-Segawa 'The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women' (2005) *The Danish Institute for Human Rights Research Partnership Series 2*.

Ubaba nguye othatha isinqumo sokuthisizasebenzisa amaphilisi kumbe I condom. Mina ngilandela okukhulunywa yindoda. He decides on whether we are going to use a condom or not… or which type of contraception method I should use. I just comply with his decision to minimise quarrels.

Thina siyake sixoxe ngendaba zeFamily planning kodwa esakhe isinqum yiso engisilandelayo. We usually discuss contraception issues although his decision on which method I should use, is final.

Haungatore maDecisions efamily planning wega woramba wakaroorwa zvakanaka. Ukadaro, murume akazviziva mumba munoita kusawirirana and murume unotokurova kana kukuramba. You cannot have a final say over the husband on issues of contraception and still be happily married. If you do that you would have created serious tension in a marriage and you know the husband will punish you, sometimes by bringing a second wife who is obedient to him, or divorce you. So you have to always give him the right to decide.

The above responses illustrate the limitations on women's ability to control their reproductive rights due to the patriarchal nature of the society they live in. The responses also indicate the prevalence of male control over reproduction and women's lack of reproductive autonomy simply because they are women. These findings expose the fact that men are the decision-makers in as far as reproductive rights are concerned. Women cannot make their own choices−decisions that affect their health and rights are made on their behalf. This reveals the impact of patriarchy on women's rights in general. These study findings relate to Nussbaum's central capability approach of bodily integrity and autonomy which underscores the importance of choice in reproductive matters. Control of women by men does not allow women to exercise choice in matters of reproduction and make decisions free of violence, thus depriving them of their integrity and autonomy capabilities.

The findings of this study further correspond with Ssenyonjo's finding that 'many cultural practices in Africa effectively operate against the dignity, welfare or interests of

women (and) undermine their status.'[516] Such control restricts women's ability to decide for themselves about family planning, pregnancy and antenatal care.

Participants further indicated that sometimes the men want to dictate the type of family planning method to be used without really taking into consideration the pros and cons of each method. When such disagreements ensure, it leads to women using their family planning method of choice clandestinely, without the husband's knowledge.

The following are some of the excerpts from what the interviewees had to say:

> *Dzimwe nguva hamuwirirane pakuti mushandise chii kudzivirira mimba. Pakadaro unotongongwarawo semukadzi woshandisa yako family planning method paside kuitira kuti musazoite gore mwana gore mwana.* Sometimes the men want to dictate what type of family planning method is to be used. In such cases, you as a woman have to be wise enough to secretly use a comfortable family method or else you will be giving birth year in year out.

> *Indoda kwezinye izikhathi iyala ukuthi usebenzise I family planning okwenza ucine ungasebenzisi lutho ngoba uyeseba ukuthi engathola ukuthi usebenzisa I family planning yena engakwazi kuzaba lomsindo endlini*. Sometimes the man does not want you to use and family planning method at all and this leads to you submitting to his demands because you know that if he finds out that you were using family planning method covertly, there will be no peace in the home.

> *Kwesinye isikhathi indoda ayifuni usebenzise amaphilisi kumbe amanye ama contraceptives efuna ukusebenzisa I condom kuphela. Lokhu uyakuvuma ngoba yindoda ekhulumileyo. Kodwa ngenxa yokuthi wena njengomfazi uyakwazi ukuthi I condom ingadabuka, ucina usuzinathela amaphilisi eceleni indoda ingakwazi.* In some cases, he does not want you to use any other contraceptive method and insists on the condom. You agree because he is your partner…But because you know the condom may break and cause an unwanted pregnancy, you decide to secretly use your own method of family planning.

[516] Ssenyonjo M 'Culture and the Human Rights of Women in Africa: Between Light and Shadow' (2007) *Journal of African Law Volume 51, Issue 1* 1.

These findings on the control of women by men leading to women using contraceptives covertly resonate with Nussbaum's capabilities approach, precisely bodily integrity which advocates for removal of social barriers that may deprive women of their capability to move and make decisions freely.[517]

The empirical findings in this study are also in sync with studies conducted in Malawi and Nigeria where scholars found that 'men dominate decision-making regarding family size and their partner's use of contraceptive methods in many traditionally patriarchal settings.'[518] Bankole and Singh also argue that women point to their male partner's resistance to family planning as a significant barrier to uptake and continuation of family planning methods, resulting in decisions to use contraceptive methods covertly or not at all.[519] Similar to this study's findings, Biddlecom and Fapohunda in their study on covert use of contraceptives also found that 'fear of spousal retaliation due to disagreements about whether to use contraception has also been shown to be a significant barrier among women'.[520]

The findings of this study reveal that Zimbabwe is in violation of its obligation to protect women's right to access reproductive health services by curbing interference from third parties. The Committee for Economic, Social and Cultural rights has interpreted ICESCR Article 12 of the ICESCR as follows (on the obligation to protect):

> The obligation to protect requires states to take measures to *prevent third parties from directly or indirectly interfering with the enjoyment of the right to sexual and reproductive health. The duty to protect requires states to put in place and implement laws and policies prohibiting conducts by third-parties that cause harm to physical and mental integrity or undermine the full enjoyment of the right to sexual and reproductive health*, including the conduct of private healthcare facilities, insurance, and pharmaceutical companies and manufacturers of health-related goods and equipment. This includes the prohibition of violence and discriminatory practices, such as the exclusion of particular individuals or groups from the provision of sexual and reproductive health services.[521] (Emphasis mine)

This study in the Hwange Rural District revealed that decisions to seek reproductive health care, precisely family planning and the decision on the number and spacing of children

[517] Nussbaum M 'Women and Human Development' at 78.
[518] Soldan V 'How family planning ideas are spread with social groups in rural Malawi' (2004) *Studies in Family Plann*ing; Oyediran K & Isiugo-Abanihe U 'Husband-wife communication and couple's fertility desires among the Yoruba of Nigeria' (2002) *African Population Studies* Volume 17 No. 2:17.
[519] Bankole A & Singh S 'Couple's fertility and contraceptive decision-making in developing countries: Hearing the man's voice' (1998) *International Family Planning Perspectives 24 (1*): 15-24.
[520] Biddlecom A & Fapohunda B 'Covert contraceptive use: prevalence, motivations, and consequences' (1998) *Studies in Family Planning* 29: 360-372.
[521] General comment 22, paragraph 42.

were made by the husbands rather than by the women themselves. The reason advanced by the majority of the participants on why they did not discuss or have an input into family planning discussions, was that since the man had paid the bride price, the women could not go against what the man as the head of the house said. Custom, in the form of payment of *lobola* therefore demanded that women be submissive to their husbands. Some interviewees had this to say:

> *Kana uchida kuti imba yako igare nekusingaperi, unotongoterera zvataura baba nekuti kuita zvaunoda pamsana penyaya dzekuzvara nedemhuri, unonzi unodherera ukarohwa kana kutorambwa. Ehe ikodzero dzakanaka asi imba yakanakawo futhi.* If you want your marriage to survive till death do you part you just have to follow what your husband says in as far as reproductive health is concerned, because if you decide to do your own decisions, it is regarded as disrespect and you can be beaten or even divorced for that.

> *Ulalela indoda yakho ngoba yabhadala ilobola*[522] *okwenza ibe yinhloko yomuzi. Amalobolo akwenza uhloniphe indoda ngoba ukuphikisana layo kubangela umsindo endlini.* You listen to what the husband says because he paid bride price for you and that makes him the head of the homestead. Bride price pushes you to respect your husband because going against what he says leads to violence in the home.

These findings are in tandem with a study conducted by Mosvela *et al*[523] wherein the authors postulated that:

> Men in African cultures play an important role on family matters. They contribute to ideas, influence decisions and perform various activities including those related to reproductive health. For example, they influence their spouses or personally participate in the adoption of family planning methods.[524]

In line with the effects of *lobola*, Kambarami[525] argues that *lobola*, which is part of the patriarchal society, breeds inequality and widens the gap between men and women, thereby placing women in a subordinate position. For instance, in Zimbabwe, families now charge

[522] Bride price is known as lobola among the Ndebele people and roora among the Shona people in Zimbabwe. Hence the use of word lobola in this study.
[523] Msovela J, Tengia–Kessy A & Mubyazi GM 'Access to Family Planning Information and Contraception Methods Use among Tanzanian Men: A Cross-Sectional Study in Kibaha District' (2016) *Journal of Epidemiology and Preventive Medicine 2(2):* 119.
[524] Adewuyi A, Ogunjuyigbe P 'The Role of Men in Family Planning: An Examination of Men's Knowledge and Attitude to Contraceptive Use among the Yorubas' (2003) *African Population Studies 18 (1)*:35-49.
[525] Kambarami M 'Femininity, Sexuality and Culture: Patriarchy and Female Subordination in Zimbabwe' (2006) *Understanding Human Sexuality Seminar Series* at 8.

exorbitant amounts of bride price[526] and even go to the extent of refusing to 'release' the bride to her husband before certain amounts that constitute *lobola* have been paid in full. Consequently, this leads to women being treated as men's property and their inability to negotiate safe sex and to discuss methods of contraception with their partners, thus hampering the full realisation of their reproductive rights. Chiweshe states that 'through *lobola*, control over young women is vested in elders and also their husbands. *Lobola* is thus related to women's lack of control over their own bodies, either sexually or in terms of their labour.'[527] The aforementioned views from participants imply that *lobola* places women in a position that divests them off of any power to control their lives. It therefore goes without saying that *lobola* is a serious constraint in as far as the realisation of women's reproductive rights is concerned.

Furthermore, Rebecca Cook *et al* rightly argue that 'reproductive ill-health does not occur in a vacuum, but is conditioned by cultures, laws and values.'[528] The research findings from this project support this view because different cultural values and rules, for instance, subordination of women through patriarchy, often has consequences that impinge on women's reproductive health. This is largely due to the fact that women are, despite legally having equal status with their male counterparts still culturally viewed as minors and thus denied their rights to control their own bodies and sexuality.[529]

Zimbabwe, as a state party to the Convention on the Elimination of all forms of Discrimination Against Women[530] and Protocol to the African Charter on Human and Peoples'

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[526] Chiweshe M 'Wives at the Market Place: Commercialisation of Lobola and Commodification of Women's bodies in Zimbabwe' (2016) *The Oriental Anthropologist* 16 (2): 229-243.

[527] Chiweshe 'Wives at the Market Place' at 10.

[528] Cook R *et al Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (2003) 4.

[529] A brief history of women's position before the 2013 Constitution is important. Until 1982, women in Zimbabwe were legal minors. In 1982, the Legal Age Majority Act 19 (LAMA) was adopted, giving women majority status and enabling them to administer properties and estates. LAMA provided that all Zimbabweans attain full adult status at the age of twenty one, 'for all purposes, including customary law.' This position was changed by the Supreme Court of Zimbabwe in the case of *Magaya v Magaya1998 ZLR 210 (SC)* which ruled that the Legal Age of Majority Act did not provide for women to be treated as adults under customary law. Ruling on women's rights and inheritance laws, the Court stated obiter that prior cases confirming women's rights to inherit under customary law were wrongly decided. With the *Magaya* decision, women were once again reduced to a legal minority in any matters involving customary law. This position was however changed by the Constitution which provides for equality of spouses during marriage and at its dissolution. See Tsanga AS 'A Critical Analysis of the Women's Constitutional and Legal Rights in Zimbabwe in Relation to the Convention of the Elimination of All Forms of Discrimination Against Women' (2002) *Maine Law Review Volume 54 Number 2.*

[530] Article 16 paragraph (1) (c) provides that 'States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: … The same rights and responsibilities during marriage and at its dissolution…'

Rights on the Rights of Women in Africa[531] has an obligation to put measures in place for the realisation of equality between men and women in marriages, and the elimination of societal barriers against women. Compliantly, the Constitution of Zimbabwe[532] abolishes harmful traditional practices against women. Thus, the express mention of the invalidity of practices that infringe women's rights in section 80 of the Constitution is commendable. This is further operationalized by the Domestic Violence Act [Chapter 5:16] which clearly includes cultural practices as acts of domestic violence.[533] However, there is need to put in place effective measures to implement section 80 of the Constitution and section 3(1)(l) of the Domestic Violence Act. Implementation measures should, in a bid to overcome any reluctance in making use of the law, include training and capacity building assistance for all relevant stakeholders. Human rights education in both the formal and informal sectors is therefore crucial for capacity building purposes. Awareness raising at grassroots level is another possible remedy to curb harmful traditional practices as will be discussed in detail in Chapter 5.

4.3.2 Availability

4.3.2.1 Inadequate health personnel

The study revealed that the nurses at most of the clinics were few, an average of one qualified nurse and several nurse aids per clinic at a time. According to the World Health Organization (WHO), availability refers to the 'sufficient supply and appropriate stock of health workers, with the competencies and skill-mix to match the health needs of the population.'[534] Most of the rural health facilities in the area under study had trained nurses. However, trained and skilled personnel in the form of midwives were rarely available during childbirth. According to a Report by the Commission on Women's Health in the African Region, 'skilled attendance

[531] Article 6 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa states that 'States Parties shall ensure that women and men enjoy equal rights and are regarded as equal partners in marriage.'

[532] Section 80 (3) of the Constitution of Zimbabwe states that 'All laws, customs, traditions and cultural practices that infringe the rights of women conferred by this Constitution are void to the extent of the infringement.

[533]Section 3(1)(*l*) provides that: For the purposes of this Act, domestic violence means any unlawful act, omission or behaviour which results in death or the direct infliction of physical, sexual or mental injury to any complainant by a respondent and includes the following—(l) abuse derived from the following cultural or customary rites or practices that discriminate against or degrade women— (i) forced virginity testing; or (ii) female genital mutilation; or (iii) pledging of women or girls for purposes of appeasing spirits; or (iv) forced marriage; or (v) child marriage; or (vi) forced wife inheritance; or (vii) sexual intercourse between fathers-in-law and newly married daughters-in-law…

[534] World Health Organization 'What do we mean by availability, accessibility, acceptability and quality (AAAQ) of the health workforce?' Available at: *https://www.who.int/workforcealliance/media/qa/04/en/* accessed 18 January 2020.

at birth is known to be crucial for maternal and new born survival; however, the majority of African women do not have access to skilled attendance at birth.'[535]

It further emerged from the study that the small number of trained personnel put pressure on the available ones, hence compromising on quality. This was stated by some health professionals as follows:

> Sometimes it is just the two of us and we have to attend to about 30 to 40 women who visit our clinic for reproductive health services at any given time. We try our best. However, at times fatigue kicks in and patients complain.

> We are always short staffed because nurses are resigning and leaving the country. The conditions are not very pleasant as compared to the salaries we receive. So most people end up deciding to leave for greener pastures and these are hardly replaced due to government freeze on the recruitment of new staff.

Indeed, the health sector has been affected by migration of trained staff. High exodus of staff due to poor remuneration, especially in the rural areas, has left Zimbabwe's health service delivery facing a critical shortage of qualified and experienced health workers.[536] Chikanda argues that 'the brain drain of health professionals from Zimbabwe has had a crippling effect on the country's public health system.'[537] He further states that the marked deterioration in working conditions in Zimbabwe led to the exodus of doctors and nurses. The impact of the deteriorated working conditions was felt by the ordinary citizens during the December 2018 into January 2019 doctors' strike that was widely reported by different media outlets.[538] The strike and exodus of professionals resulted in some health institutions being run by untrained staff or newly-qualified staff who lacked experience to deliver services. Such

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[535] World Health Organization *Report of the Commission on Women's Health in the African Region: Addressing the Challenge of Women's Health in Africa* (2012).

[536] R Gaidzanwa *Voting with their Feet: Migrant Zimbabwean Nurses and Doctors in the Era of Structural Adjustment* (1999); A Chikanda 'Skilled Health Professionals' Migration and Its Impact on Health Delivery in Zimbabwe' (2006) *Journal of Ethnic and Migration Studies* 32: 667-680; A Chikanda 'Medical Migration in the Post-ESAP Era: Magnitude, Causes and Impact on the Poor' (2004) *Development Southern Africa* 24(1):47-60; A Chikanda 'The Migration of Health Professionals from Zimbabwe' in J Connell (ed) *The International Migration of Health Workers* (2008) 110-128.

[537] A Chikanda 'Skilled Health Professionals'.

[538] 'Zimbabwe doctors go on strike demanding better pay and conditions' *Aljazeera* 3 December 2018 Available at *https://www.aljazeera.com/news/2018/12/zimbabwe-doctors-strike-demanding-pay-conditions-181203190559472.html* accessed on 15 January 2019; Nyasha Chingono 'Fears of Zimbabwe health crisis as row over doctors' pay continues' *The Guardian* 31 December 2018; 'Doctors' strike reflect National Crisis' *The Zimbabwe Independent* 21 December 2018.

shortages have serious consequences on the quality of care to be delivered to the patients in need of health care services.

The study also noted the existence of Maternity Waiting Homes (MWHs). These are residential facilities located near a maternity clinic where pregnant women, often those at high risk of developing complications, can go during their third trimester and await labour and delivery. As discussed in Chapter 3, the MWHs are, in principle, an excellent idea and a very good initiative to help women in remote rural districts to have a successful birth, thus realising their right to have access to reproductive health care. While this remains a good initiative, the study noted that there are not enough qualified nurses who routinely monitor and check up on the expecting mothers. One interviewee had this to say:

> *Abo nurse baqeda umsebenzi ngabo 16:35 kumbe 16:45 bazihambele ezindlini abahlala kuzo ezingaba 100m kude le Maternity Waiting Home. Ebusuku, kulo nurse oyedwa okhangela abagulayo labazithwelelyo. Ngakho ke, nxa kungaba lomama osefuna ukuzala, abanye omama asebelethile yibo absuka bayedinga unurse oyabe eku duty*. The nurses dismiss around 16:30 and 16:45hrs and go to their residences which are about 100m away from the Waiting Home. During the night, there is one qualified nurse on duty to attend to outpatients, ordinary wards and also monitor the expecting mothers. So, when a woman goes into labour at night, the other women in the home who have delivered or are not in labour yet are forced to go and look for the nurse on duty.

Another major drawback noted about the MWHs, although linked to the issue of expenses, was that the homes are self-catering. This was clearly explained as follows:

> *Ama Waiting Homes wona aqakathekile kodwa ngenxa yokuthi liyaziphekela, kutsho ukuthi kumele lilethe ukudla elizakusebenzisa okwamalanga amathathu kumbe amen liseWaitin Home. Asenelisi ukuthenga lezizinto ezifunakalayo. Ngakho, ngenxa yokuthi aiskwazi ukuhamba singela kudla kuWaiting Home, sicina sizihlalela ezindlni izisu zize zibe buhlungu. Ezikhathini eziningi, izisu zibabuhlungu isikhathi sesihambe kakhulu, besesicina sesibelethela emzini yethu sincediswa ngogogo labadala bemzini.* The homes are a very good idea. However, the fact that they are self-catering implies that we have to buy our own toiletries and food for consumption during our three or four day stay at the homes. We cannot afford to buy those and because we cannot

afford to carry food to the homes, we decide to stay home until the last day when labour pains kick in. In most instances, this is too late and then we give birth in our homes with the assistance of female village elders.

The limited number of trained health personnel and the self-catering nature of the MWHs, adversely affects ability by rural women to access adequate reproductive health care services. This is in violation of Zimbabwe's obligation to fulfil which requires the State that ensure that health-care providers are adequately trained on the provision of quality and respectful sexual and reproductive health services and ensure that such providers are equitably distributed throughout the State.[539]

4.3.2.2 Methods of contraceptives and their availability

The study revealed that constant availability of contraceptives was a challenge as there are times when stock runs out and women are forced to travel to the nearest referral hospital for contraception services. One of the participants explained as follows:

> *Pamwe pacho unoenda kuClinic uchida maTablets iwawa anoita usabata mimba, asi unoti wasvikapo paClinic wonzi maTablets hapana mozodzoka musiwa kati. Wodzokera zve, wowana kusina. Pakadai unobva waenda kuHospital inova irikure kwazo nekuti ukasadaro mimba inobata.* Sometimes when you visit the clinic for contraception services, you are told that they have run out and you should come back on a certain date when they will be expected to be in stock. You go back on the given date and find nothing. You are then forced to go to the hospital which is far away because failure to do so means that you will get pregnant.

This was confirmed by one health worker who stated that:

> Availability of family planning tablets is always a problem in the rural areas because of lack of resources. The Ministry of Health and Child Care does not have adequate transportation to allow us to timeously and regularly distribute family planning tablets and other medical supplies to rural areas.

The quotations above show that availability of contraceptives in rural areas is heavily dependent on availability of transport to deliver the contraceptives to various clinics. Suffice

[539] General comment 22 paragraph 46.

to say that the availability of personnel and facilities without the requisite medical supplies is a barrier to women's access to reproductive healthcare services. Indeed, the provision of quality health care and maternal healthcare in particular heavily 'relies upon the presence of skilled health attendants working in an environment where drugs and medical supplies are available when needed and in adequate quantity and of assured quality.'[540] The non-availability of family planning tablets in rural areas especially speaks to the 'unmet needs of contraceptives…which make it difficult for those women who want to limit their fertility but are unable to do so due to resources.'[541] This is a blatant violation of women's right to have access to reproductive health care services as clearly provided for in the Zimbabwean Constitution,[542] as well as Article 12 of the ICESCR, Article 14 of the African Women's Protocol and Article 12 of CEDAW.

Another participant, explained the unavailability of different contraception methods as follows:

> *MaCondom ndiwo atinoshandisa nekuti haanetsi kuwana. Kazhinji anowanika kumaClinic edu. Zvasiyana nanaJadele vanowanikwa mumadhorobha, anoda kubhadharwa kuti uiswe jadele yacho. Mari yacho inonetsa kuwana saka zvirinani kushandisa maCondoms atinopiwa pasina kubhadhara.* We use condoms because they are usually available in our local clinics. The other injectable contraception like Jadele is unavailable and is only found in towns and they cost a fee. It is difficult to raise funds for such services as we are not employed and depend on our families and husbands.
>
> *AmaPills lamaCondom yikho esikusebenzisayo. Ngaphandle kokuthi alula ukuthola, yiwo esiwaziyo.* Pills and condoms are the common methods that we use. Besides the fact that they are easy to access, they are the main one that we know and are used to.

The above excerpts confirm a study by Kurebwa in Gutu Rural District of Zimbabwe in showing that the common methods of family planning used in rural Zimbabwe are the condom and pills. Although his study was focused on adolescents and the current study is

[540] Dickson Ally Mkoka, Isabel Goicolea & Angwara Kiwara *et al* 'Availability of drugs and medical supplies for emergency obstetric care: experience of health facility managers in a rural District of Tanzania' (2014) *BMC Pregnancy Childbirth* 14: 108.
[541] Sonia Sultan 'The Effects of Education, Poverty, and Resources on Family Planning in Developing Countries' (2018) *Clinics in Mother Child Health, Volume 15 Issue 1*: 289.
[542] Section 76 of the Constitution of Zimbabwe.

focused on adult women, his study found that adolescents showed little knowledge about injectable family planning methods such as *depo provera* and intrauterine device (*loop)* as they acknowledged the condom, which helps prevent sexually transmitted diseases and AIDS, as the method they knew.[543] According to the study, the reason for adolescents' lack of knowledge of other family planning methods was attributed to the fact that the other methods were believed to be for use by married people.[544] For rural women, Stanback *et al*[545] argue that '…in most of sub-Saharan Africa, *depo provera* provision is restricted to medically trained and skilled providers…' making the condom and pills, which do not require medically trained health providers, the most common family methods in rural communities. It has been argued that the limitation of injectable contraceptive provision to skilled health workers was due to the fact it was unsafe for women to receive contraceptive injections from non-clinically trained personnel.[546] The World Health Organisation has however argued that formal delegation of responsibility to health workers with shorter, focused training and fewer credentials, a practice known today as task shifting, is an effective strategy for increasing health sector outputs in the face of dire workforce shortages.[547]

Zimbabwe, as a State Party to the ICESCR, CEDAW and African Women's Protocol, which all call for states to ensure that health facilities have trained health workers and adequate medical supplies, has an obligation to provide trained health workers and adequate medical supplies to ensure that the realisation of women's right to access reproductive health care services is achieved. Therefore, provision of inadequate contraceptives and the limited number of health personnel is a breach of the international obligations.

4.3.3 Affordability: Ancillary expenses

The research found that in Hwange Rural District in Matabeleland North Province, maternity services, precisely the prenatal services, are free. Consequently, affordability does not arise as a serious cause for concern if the women can get to the clinic, bearing in mind the distance and transport barriers already discussed. Most of the participants indicated as follows:

[543] Jeffrey Kurebwa 'Knowledge and Perceptions of Adolescent Sexual and Reproductive Health Issues among Rural Adolescence in Gutu Rural District Of Zimbabwe' (2018) *International Journal of Advanced Research and Publications.*
[544] Kurebwa 'Knowledge and Perceptions' 23.
[545] Stanback J, Mbonye AK & Bekiita M 'Contraceptive injections by community health workers in Uganda: a nonrandomized community trial' (2007) *Bulletin of the World Health Organisation 85*:768–773.
[546] Stanback J et al 'Contraceptive injections by community health workers'.
[547] WHO *Task shifting to tackle health worker shortage* (2007).

> *Nxa uzithwele ungayahlolwa eClinic akula mali ebhadalwayo. Lokhu kungcono ngoba kusenza lathi sikwanisa ukuhlolwa sizithwele, singethuki ukudinga imali zokuhlolwa.* When you are pregnant, you get free prenatal healthcare services. This is good news for us as it allows us to go for the recommended prenatal check-ups without the fear of raising any money for such check-ups.

Despite the prenatal services being free, the study found that secondary and ancillary expenses, which include requirements that women should buy their own materials to be used during delivery, distance to clinics, transport challenges, prove to be too expensive for the women. The majority of the participants shared the following view:

> *Izinto okumele zithengwe nxa ususiya beletha ezinjengabo cotton wool lama gloves ziyabiza. Thina emakhaya imali yakhona asila njalo ayilula ukuthola. Nxa ungela mali yokuthenga izinto okumele zithengwe, ucina usubelethela endlini.* Things that have to be bought when one is going to deliver their baby include cotton wool and gloves. These things are expensive. We do not have money and it is not easy to get money here in the rural areas. At the end of the day, we decide to give birth at home.

The findings of this study reveal that monetary and time costs of travel to a local clinic, due to long distances, pose substantial obstacles for rural women, leading to overall poorer health as these obstacles hinder rural women from visiting the clinic often enough to get the reproductive health care needed. The requirement to buy supplies such as cotton wool for instance, acts as an obstacle to women's right to have access to reproductive health care services as most rural women are poor and do not have the means to raise money for these things. As a result, women turn to unsafe home deliveries and thus lose out on the state provided maternity services. Rural women's perception is that home deliveries are better as they are performed purely on compassionate basis than on business terms. This is aptly described by Dodzo and Mhloyi as follows:

> With community deliveries, user fees are minimal and in some cases non-existent. Where clients are charged for services, some costs are indiscernible because service providers charge for tangible and visible items and products used in providing the service, unlike health facilities which charge consultation and professional fees.[548]

[548] Campbell OMR and Graham WJ 'Strategies for reducing maternal mortality: getting on with what works' 2006 *The Lancet*; Blum LS, Sharmin T & Ronsmans C 'Attending home vs clinic-based deliveries: perspectives of skilled birth attendants in Matlab, Bangladesh' (2006) *Reproductive Health Matters* 14:51–60; Adejumo AO,

Dodzo and Mhluyi further argue that 'where clients are charged for services, some costs are indiscernible because service providers charge for tangible and visible items and products used in providing the service, unlike health facilities which charge consultation and professional fees.'[549] Although cost effective, it has been argued that home deliveries are risky as they occur without skilled staff in attendance, no equipment, medicines and unsafe environments, which leads to maternal deaths.[550]

The study further revealed that on the payment of services, participants' failure to pay for services is because of their economic dependence on men. A majority of participants do not have formal jobs like their male counterparts. The men are the ones who work in towns and visit the family in the rural areas. Most of the participants stay with their in-laws. The following excerpt from participant interviews explain this position:

> *Isu madzimai mazhinji emuno munharaunda tinopedza nguvai yedu zhinji pamba, tichikudza nekuchengeta mhuri nekuzvirimira hedu muminda yedu nemaGhadheni edu. Mukatarisa muchaona kuti varume vedu vanoshanda kuTown and vanouya neNguva irikure kuzotibatsira, asi nguva zhinji tisu vakadzi nevana tinoita basa rekurima* We as the women spend most of our time at home, taking care of the family as well as ensuring that the field are tilled and monitored. Our husbands come to visit for a short period of time where they assist with farming activities. However, most of the work is done by us females and the children.

The situation portrayed in the above quote places women at a disadvantage as they have to depend on men financially. This was also discussed by Bhutta and Haider's who stated that 'Rural women are trapped in a web of dependency and subordination due to their low social, economic and status in society.'[551] Their findings, which are similar to this study's findings were to the effect that most rural women are economically dependent on their husbands and family which perpetuates gender inequality in marriages, another factor which reduces their chances of making any meaningful decisions in the home. Thus, showing a

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Faluyi M & Adejuwon A 'Role of Socio-Psychological Factors in Perceived Quality of Care Rendered by Traditional Medical Practitioners in Ibadan, Nigeria' (2013) *Global Journal of Health Science* Volume 5 No 6; Munyaradzi Kenneth Dodzo & Marvellous Mhloyi 'Home is best: Why women in rural Zimbabwe deliver in the community' (2017) *PLoS One* 12(8).

[549] Dodzo & Mhloyi 'Home is best'.

[550] Campbell OMR & Graham WJ 'Strategies for reducing maternal mortality.'

[551] Roomana Naz Bhutta & Jahanzaib Haider 'Effects of Economic Dependency on Decision Making Power of Women in Rural Areas of Tehsil Dera Ghazi Khan' (2013) *International Journal of Academic Research in Business and Social Sciences Volume 3 Issue 2.*

correlation between economic dependency and decision-making power. Women's economic dependence on their husbands takes away their power to negotiate as negotiation is considered as disrespect. Consequently, women remain silent even when their rights are violated for the fear of removal of economic protection. It is submitted that women's dependence on men for almost anything they need defeats any efforts to empower women to be autonomous citizens.

The existence of ancillary expenses and women's economic dependence on men hinders rural women's access to reproductive health care services. Nussbaum's capabilities approach which emphasises that the capabilities of individuals can be inhibited or enhanced by internal and external factors is of relevance here. In this case, poverty is a factor inhibiting women's capabilities to exercise their right to access reproductive health care services. Lack of financial resources limits women's access to reproductive health services as they cannot afford to travel to health centres or pay for the required ancillary expenses to access reproductive health care services. The existence of ancillary expenses limiting women's access to reproductive health care services is in in breach of Zimbabwe's obligations under Article 12 of the ICESCR and Article 14 of the African Women's Protocol Although Zimbabwe has enacted a progressive Constitution which provides for the right to equality and non-discrimination in section 56 (in compliance with its Article 12 of the ICESCR and Article 14 of the African Women's Protocol), practice on the ground shows that there is violation of both section 56 of the Constitution which prohibits discrimination on a number of grounds, including economic grounds; and the ICESCR as well as the African Women's Protocol, which enjoin states to put in place measures to ensure affordability of reproductive health services.

To improve the economic disadvantages faced by women, the State should therefore endeavour to eliminate barriers that rural women face in accessing reproductive health care services. For instance, the Ministry of Health and Child Care should ensure that women are not required to bring their own cotton wool and gloves for delivery and transport to referral hospitals and clinics is available at subsidised rates, or for free. Although it is acknowledged that realisation of the right to have access to reproductive health care services, which is part of the right to health, depends on the availability of resources, the State should at least put in place some measures that ensure that this right does not remain a pipe dream, especially for rural women. This resonates with the minimum core obligation as provided for in general comment 22 which calls upon states to guarantee universal and equitable access to affordable, acceptable

and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups.[552]

4.3.4 Quality of care

It emerged from the study that quality of care differed from one clinic to another, depending on the attitude and work ethics of the health professionals available. For instance, the participants explained as follows:

> *AmaNurse asebenza eClinic eseduzane lathi abajayeleki. Mina ngakubona lokhu ngize ngihambe ukuyabeletha, oNusre bakhona babengancedi nxa ufuna usizo. Ngelinye ilanga ngahambise umntwana ukuyahlatshwa. Ngathi ngifika, oNurse bakhona babenyeya besithi umntanami ulegcikwane ngenxa yokuthi ucakile. Angiyithandanga indlela abangibamba ngayo ngakho esikhathi esalandelayo ngaya kwenye iClinic ekude lami ngoba lapho kungcono.* Health staff at our nearest clinic are not friendly at all. I realised this when I gave birth to my baby, and they were rough on me, sometimes not helping when I wanted assistance. One day I went there with my six months baby for the usual vaccinations to the clinic. When we got there, the same nurses had an attitude, and I heard them whispering among themselves that my baby was HIV positive because he was thin. I did not like the way they treated me and so for the subsequent visits, I went with him to a mission clinic which was about 12 km from where I stay. At the mission clinic, they try to treat you like a human being.

> *AmaNurse akhona eClinic yethu le asehlale kakhulu la bengatshintshwanga ukuti baye kwezinye ndawo. Lokhu kwenza abo nurse laba bakhethe abantu abokwelapha bekhangelele ukuthi bazaphiwani. Umuntu engafika elenhlanzi kumbe umumbu, nguye olatshwa kuqala aphinde anakekelwe kuhle. Wena ongabuyanga lalutho awunakekelwa.* The nurses at our clinic have overstayed without being transferred to other clinics. Such overstay has made them selective in their treatment of villagers. They build alliances with community members who bring goodies, for instance fish and maize meal at the expense of poor villagers who cannot afford to bring anything. If you bring the nurses something, you get preferential treatment.

[552] General comment 22 paragraph 49(c).

Corruption, attitude of health professionals and discrimination undoubtedly plays a critical role in as far quality of care is concerned. The above quotations show the disparities in treatment that exists between public and mission sector health care facilities. Public opinion as well as anecdotal evidence suggests that mission sector services provide quality care compared to public health care service. While this situation has often been overlooked, the majority of the women interviewed in this study confirmed this argument. They indicated that they preferred travelling long distances to attend a particular mission clinic rather than a public clinic that was closer to them.[553]

Access to a health facility also speaks to the quality of care given by the clinics and hospitals that offer these services. The study revealed that although health facilities do exist, they are far away from the people, poorly serviced and with poor power supply, thus affecting the quality of services offered. With regards to power supply, Zimbabwe is currently facing energy supply challenges. This has forced Zimbabwe to resort to load shedding with most cities going without electricity for up to a maximum of 18 to 21 hours a day in urban areas.[554] In the rural areas, 90 percent live without access to electricity. Further, 62 per cent percent of the un-electrified households use wood as the main source of energy for cooking.[555] The percentages of citizens without access to electricity in rural Zimbabwe paints a dire picture in the context of reproductive rights. This is the case because a woman might go into labour at any time. If a woman goes into labour at night, light is critical for delivery to take place and to store vaccines or sterilise medical supplies. Power supply therefore plays a major role in ensuring rural women's access to reproductive health. In this case, Zimbabwe has an obligation emanating from Article 12 of the CEDAW, Article 12 of ICESCR, Article 14 of the African Women's Protocol, Article 24 of the CRC and Article 14 of the ACRWC, which all require states to provide appropriate maternal health services. Maternity wards in rural areas without electricity means women cannot deliver safely at night and is thus inappropriate maternal health service, in violation of the aforementioned international obligations. To ensure that rural women receive appropriate maternal health services, Zimbabwe should take steps to provide rural clinics with alternative power supply, for instance solar power and diesel generators.[556]

[553] See the interview excepts discussed under 4.3.4 above
[554] Zimbabwe Electricity Transmission and Distribution Company '2019 Load Shedding Programmes' Available at *https://zetdc.co.zw/customer-care/notices/* accessed on 26 May 2019.
[555] Ministry of Foreign Affairs *Report on Renewable Energy Market in Zimbabwe* (2017).
[556] Although ideal, diesel generators may pose a problem considering the fuel problems that has bedevilled the country for the past 3 years. This would be more effective where fuel is accessible and always available.

4.4 RURAL WOMEN'S KNOWLEDGE OF THE RIGHT TO HAVE ACCESS TO REPRODUCTIVE HEALTH CARE

This section presents and discusses the knowledge of the right to access reproductive health care service and perceptions of rural women towards reproductive health care services. The discussion is presented under the major theme of knowledge. This discussion on women's knowledge of their human rights is significant because lack of knowledge or appreciation of what the right to reproductive health care entails – and that it is a right provided for in the Constitution of Zimbabwe as well as in regional and international treaties to which Zimbabwe is a party – is problematic for two major reasons, namely: 1) lack of knowledge is a barrier to women's access to reproductive health care services 2) Because they lack knowledge on their human rights, the women have no way of knowing if these rights are being respected, protected or enforced. Awareness and acceptance of human rights norms among the general public can put pressure on administrations to comply with their international obligations. Knowledge of the right itself is an essential pre-requisite for women to use different ways of ensuring that the Government complies with its constitutional and international obligations as will be discussed in Chapter Five. Flowers argues that

> …education in human rights is itself a fundamental human right and also a responsibility: People who do not know their rights are more vulnerable to having them abused and often lack the language and conceptual framework to effectively advocate for them.[557]

The United Nations Educational, Scientific, Cultural Organization (UNESCO) also states that 'human rights education not only provides knowledge about human rights and the mechanisms that protect them, but also develops the skills needed to promote, defend and apply human rights in daily life.'[558] Community Mobilization for Post abortion Care in Kenya (COMMPAC) underscores the significance of knowledge of human rights in reducing maternal mortality by arguing that 'successful prevention of maternal deaths hinges on a combination of community awareness and the availability of adequate and quality emergency obstetric care.'[559]

[557] Nancy Flowers (ed) *Human Rights Here and Now: Celebrating the Universal Declaration of Human Rights* (1998).
[558] UNESCO *World Programme for Human Rights Education: Plan of Action* (2012).
[559] COMMPAC Kenya *A Guide to Action for Community Mobilization and Empowerment Focused on Postabortion Complications: Facilitator's Manual* (2010) Available at *http://respond-project.org/pages/files/6_pubs/curricula-manuals/COMMPAC-Facilitator-Manual-May2010.pdf*, accessed 11 April 2020.

Community awareness of human rights is made possible through community mobilisation programs where communities are capacitated through education on what human rights are and what they can achieve in practice. Such capacitation empowers communities to participate and engage in different fora where human rights issues affecting them on a daily basis are discussed.[560] Community participation and input is significant for holding government accountable for human rights violations. This is significant as it is one of the remedies available to rural women for the realisation of their rights to access maternal and family planning services in Zimbabwe. Various judicial and extra-judicial remedies that rural women can resort to in the event of a violation are discussed in detail in Chapter Five.

Knowledge of human rights and the right to reproductive health

Results of this study showed that only a few people understand what human rights are. Most participants indicated that they had never heard of any human rights. This study suggested that one reason for lack of knowledge and awareness of human rights is the lack of community awareness programmes on the subject. Another reason seems to be that children are exposed to traditional teachings from a young age. These different explanations for lack of awareness of their human rights emerge from the responses of the interviews, as can be seen in the quotations below:

> *Safundiswa ukuhlonipha abadala lamadoda ethu kuqonqoselwa ukuthi indoda yinhloko yomuzi, ayidelelwa. Ungafuna ukuphikisana lokutshiwo yindoda bathi awulanhlonipho and aukhuliswanga kuhle ngabazali bakho.* We were and still are, always taught to respect our elders as well as our male partners. The emphasis is that the man is the head of the family and what he says should be respected. If you try to oppose what the man says, you are labelled a rebel who was not properly raised by her parents.
>
> *Todzdidziswa kuchengeta varume vedu nemhuri dzedu. Ruremekedzo ndo chinhu chakakosha chatodzidziswa kubva tiri vechidiki. Nedzidziso dzakadai, ukapinda musvitsa zvirinani kuchengetedza svitsa pane kusaremekedza murume.* We are taught to take care of our husbands and families. Respect is also an important factor that we

[560] Ackerman J 'Co-governance for Accountability: Beyond 'Exit' and 'Voice' (2003) *World Development* Volume 32 No 3:447-463.

are taught off from a tender age. With those teachings in mind, when we get married, it is better to protect our marriages than to disrespect our husbands.

Akula abantu ababfika emzini yethu kumbe inhlelo zesigabeni ezimayelana ngokusifundisa ngendaba youkuzala le family planning. Sithemba imfundiso esiyiphiwa ngabadala. There are no health workers or organizations visiting our communities or any community programmes specifically aimed at educating us on the subject of reproductive rights. We depend on what our elders tell us about marriage and giving birth.

The above findings confirm previous studies showing limited women's knowledge about their rights. For instance, a baseline study by the Zimbabwe Human Rights Commission (ZHRC)[561] revealed that a majority of women are not aware of human rights in Zimbabwe, especially in rural areas. The few with an understanding of what human rights entail had received the basic human rights knowledge from their relatives and non-governmental organisations. In their explanations of rights, those who showed some knowledge of what rights are gave the right to education and the right to health as examples of human rights. The above issues were revealed in the responses below:

Mina ngatshelwa ngumzala wami ohlala edolobheni ukuthi amalungelo ngawabantu bonke, awakhethi bala lomuntu My cousin who works in the city once told me that human rights are for every human being, they are non-discriminatory in nature.

Ini ndakamboenda kumsangano wemaNGO aiitwa kudhorobha pandanga ndakashanyira sekuru vangu. Ikoko ndokwandakanzwa nezve maHuman rights zvichinzi munhu wese, vakadzi, varume, vana, vanambuya, vakaremara vanekodzero nekuti vanhu I once attended a meeting organised by an NGO when I had visited my uncle who stays in town. It is at this meeting that I learnt that human rights are for everyone: women, men, children, the elderly and people living with disabilities.

Mina ngezwa ngokwamalungelo abantu emhlanganweni wabomama esontweni. Kwakubuye omama ababesifundisa ngokwamalungelo besithi amalungelo ayisipho sokuqala indalo esipha umuntu ekuzalweni kwakhe. Basipha imifanekiso yaamalungelo abafazi okulotsholwa lokuzala. I learnt about human rights at a

[561] ZHRC 'Baseline Survey on Perceptions.'

women's meeting at church. They were some visitors who had been invited to come and teach women about human rights, and they explained to us that human rights are naturally given to all human beings at birth. They gave us examples of women's rights to found a family and have children.

In relation to the right to reproductive health care, many of the participants, including those who had some knowledge about human rights in general, were not aware of 'rights' associated with reproductive health care per se. Many of the participants were not familiar with the term reproductive health care services. However, they had a fairly good idea of what ought to happen before a woman becomes pregnant, during pregnancy and after delivery and where to access such services. A majority of the sampled women identified family planning information and services, including the right to decide the number and spacing of children as well as maternity services as elements of a good health for women. Some of the women respondents highlighted as follows:

Umuntu wesifazane nxa ezithwele kumele enelise ukuya esibhedlela ukuyahlolwa ngomongikazi A woman should be able to go to the clinic or hospital for regular check-ups when pregnant.

Isikhathi sokubeletha nxa sesifikile, kumele kubekhona omongikazi abafundela indaba zokuzalisa abazancedisa ozithweleyo. When the time to deliver has come, there should at least be a midwife in attendance.

This clearly shows that rural women in the area under study just know basic knowledge of reproductive health rights without, however, knowing that these rights are enforceable human rights. The fact that women have some knowledge of the services available to a pregnant woman is commendable. However, women are still left in a position where they cannot defend against any violations and fight for fulfilment because they do not know the entitlements that come with the right to have access to reproductive health care services. Akin to Sen's capability theory, this study found that the most basic capability is the capability to be knowledgeable as results revealed that knowledge is a means to further rural women's capabilities. This underscores the importance of grassroots knowledge of human rights as will be discussed in Chapter 5.

4.5 CHAPTER CONCLUSION

This chapter presented and discussed the experiences of women in accessing reproductive health care services in rural Zimbabwe. The main finding that emerged from the study was that rural women have little or no enjoyment of their right to have access to reproductive health care services. This is attributed mainly to the fact that rural women are still regarded as perpetual minors who are controlled by men, financially and reproductively. Some other factors that inhibit rural women from exercising their right to have access to reproductive health care services revealed by the study include, distance, lack of quality of care, unavailability of skilled health workers, corruption and lack of constant supply of contraceptives.

Unavailability of skilled workers and inadequate health facilities (hospitals and clinics) were some of the barriers identified by the participants as limiting their access reproductive health care services. The participants underscored the importance of infrastructure development, precisely social infrastructure through the building of more health facilities as well as staffing the health facilities with adequate number of skilled health workers to the advancement of their right to access reproductive health services.

Lack of knowledge about the right to reproductive health also emerged as a barrier to accessing reproductive health care services. The remedy for this lacuna is community mobilisation and awareness raising. The community mobilization is based on the fact that the women have a binding right to have access to reproductive health services and the government is obliged, in terms of international law and the Constitution of Zimbabwe, to fulfil it. The existence of the right and knowledge of its existence is central to community or grassroots mobilization to allow women to demand them as will be discussed in Chapter 5.

CHAPTER 5: OPPORTUNITIES FOR ENSURING RURAL WOMEN HAVE ACCESS TO REPRODUCTIVE HEALTHCARE SERVICES IN RURAL ZIMBABWE

5.1 INTRODUCTION

Chapter Four presented findings from interviews carried out with women and girls in Hwange Rural District, Zimbabwe. The findings revealed challenges faced by rural women in accessing reproductive healthcare services. This evidence should be considered in the light of the previous chapters: Chapter Two demonstrated that Zimbabwe has an obligation to provide access to reproductive health services in terms of the international human rights treaties that Zimbabwe has ratified. Chapter Three showed that Zimbabwe's implementation of its treaty obligations into domestic law in terms of legislation and its policy framework has been somewhat uneven. However, the Constitution of 2013 has expressly provided a right to reproductive health, thus giving effect to Zimbabwe's international obligations and providing a potentially justiciable claim in terms of domestic constitutional law in the case of non-compliance.

The findings set out in Chapter Four suggest that Zimbabwe is not meeting its obligations to respect, protect and fulfil the right to reproductive health in Hwange Rural District. Therefore, the question now is: What remedies do rural women have when their socio-economic rights to reproductive healthcare services are violated? Chapter Five seeks to answer this question by considering the potential legal, administrative or political remedies available for the realisation of women's rights to access maternal and family planning services in Zimbabwe. The Chapter begins by examining the possibility of constitutional litigation. In this regard, the Chapter seeks to analyse cases on access to maternal healthcare and family planning services that have been dealt with by the Zimbabwean courts. This was a very challenging task because unlike other economic, social and cultural rights, (for instance the right to water and the right to adequate shelter) where cases have been brought before the courts and judgements delivered, there has been a very limited number of cases in which the right of access reproductive health care services has been invoked. Thus, Zimbabwean constitutional jurisprudence on health care is not as well-developed as in other Southern African countries such as South Africa and Namibia.[562] Accordingly, this Chapter's discussion about the possibility of constitutional litigation of reproductive health rights will be comparatively brief

[562] The Zimbabwean Constitutional Court has heard 108 cases to date while the South African Constitutional Court has heard 808 cases.

because it is still largely speculative. In the course of discussing the potential success of a constitutional claim, the researcher relied on case law from South Africa since the constitutional provisions on the right to access health including reproductive healthcare are similar in Zimbabwe and South Africa, and the South African jurisprudence should provide useful guidance to the Zimbabwean courts.[563]

The second section of this Chapter acknowledges that direct constitutional litigation is an expensive remedy for rural women. Rural women can therefore rely on various organisations for legal representation in court. In this regard, Chapter Five examines the potential contributions of the Legal Aid Directorate which falls under the Ministry of Justice, Legal and Parliamentary Affairs and vibrant civil society and non-governmental organizations working in the field of women's rights and human rights in general. These act on behalf of rural women as litigants or amicus curiae in cases involving women's reproductive health rights.

There are non-judicial avenues that rural women can utilise in pursuit of remedies for violations of their reproductive health rights. This is discussed in the third section of this Chapter. The discussion considers independent commissions namely: the Zimbabwe Gender Commission and the Zimbabwe Human Rights Commission; the line Ministry responsible for health issues in the country, namely, the Ministry of Health and Child Care, traditional leadership and community mobilisation as possible avenues that women can use for the realisation of their right to access reproductive health care services. The last section concludes the Chapter.

5.2 JUSTICIABLE CONSTITUTION AND THE COURTS

As discussed in Chapter Three, the 2013 Constitution of Zimbabwe was a turning point with regard to the realisation of women's reproductive health rights as it now clearly provides for the right to health and reproductive health services in Section 76(1). The explicit provision of the right to have access to reproductive healthcare in the Declaration of Rights in the Constitution presents an opportunity that did not exist in Zimbabwe's previous Lancaster House Constitution. Enshrining the right to have access to reproductive health in a Declaration

[563] The South African Constitution has, in section (27)(a), entrenched the right of access to health care services, including reproductive health care services. Section 27(2) obliges the state "to take reasonable legislative and other measures, within its available resources to achieve the progressive realisation" of, among others, health care rights. Section 27(3) provides that no-one "may be refused emergency medical treatment".

of Rights identifies it as 'fundamental and places it beyond the depredations of a transient electoral majority.'[564] A justiciable Declaration of Rights makes it possible for aggrieved parties to sue the government for a breach thereof. The 2013 Constitution is therefore a good foundation upon which citizens can ensure that its provisions, particularly those in the Declaration of Rights, are implemented.

The constitutionalisation of women's reproductive rights under the Declaration of Rights provides domestic accountability for obligations that Zimbabwe has already undertaken through its ratification of numerous international and regional human rights treaties. The courts play a crucial role in holding the State accountable through the judicial enforcement of human rights in general, and the right to reproductive health in particular. This is an opportunity for the realisation of rural women's right to access reproductive health care because justiciability of these rights strengthens accountability and ensures that rural women can approach the courts of law for determination and relief when their rights have been violated. The courts therefore have the task of upholding constitutional values and rights.[565] That is, where the right to reproductive health is constitutionalised, courts have the duty to enforce the protection, vindication and advancement of that right. More broadly, the justiciability of economic, social and cultural rights 'offers the best opportunity to develop a jurisprudence which engages seriously *with the content* of these rights and the nature and scope of the obligations they impose.'[566]

While it is agreed that socio-economic rights are justiciable, their justiciability means little without domestic legal systems that afford access to effective remedies for rights violations.[567] Section 85 of the Constitution gives courts wide remedial powers by providing that 'the court may grant appropriate relief including a declaration of rights and an award of compensation…' Section 85 further gives everyone *locus standi*

[564] Mureinik E 'Beyond a Charter of Luxuries: Economic Rights in the Constitution' (1992) *South African Law Journal* 8,464.
[565] May James R & Daly Erin *Global Judicial Handbook on Environmental Constitutionalism* 3 ed (2017) 5.
[566] Ndlovu N *Protection of socio-economic rights in Zimbabwe: A critical assessment of the domestic framework under the 2013 Constitution of Zimbabwe* (2016).
[567] Wiles Ellen 'Aspirational Principles or Enforceable Rights? The Future for Socio-Economic Rights in National Law' (2006) *American University International Law Review* Volume 22 Issue 1.

> to approach a court, alleging that a fundamental right or freedom enshrined in this Chapter has been, is being or is likely to be infringed, and the court may grant appropriate relief…[568]

Consequently, anyone can approach the courts where there has been an infringement of a right enshrined in the Declaration of Rights, and the court can grant an appropriate relief. In *Fose v Minister of Safety and Security*,[569] the Constitutional Court of South Africa, in explaining the court's remedial powers, stated that:

> It is left to the courts to decide what would be appropriate relief in any particular case …Appropriate relief will in essence be relief that is required to protect and enforce the Constitution. Depending on the circumstances of each particular case the relief may be a declaration of rights, an interdict, a mandamus or such other relief as may be required to ensure that the rights enshrined in the Constitution are protected and enforced. If it is necessary to do so, the courts may even have to fashion new remedies to secure the protection of these all important rights.

Section 46 of the Constitution of Zimbabwe allows courts, when interpreting the Declaration of Rights in Chapter 4, to consider relevant foreign law. Therefore, this thesis argues that the South African jurisprudence on court's remedial powers as explained above, falls under foreign law. Furthermore, the South African jurisprudence would be helpful in determining the meaning of remedial powers within the Zimbabwean context given the similarities between our section 85 of the Constitution and section 38 of the South African Constitution which provides for court's remedial powers when giving remedies for infringement of rights in the bill of rights.

The courts also play an important role in the legislation process. Sections 116, 117 of the Constitution of Zimbabwe spell out the complementary roles which Parliament and the President play in Zimbabwe's law-making process. They check and balance each other's work. Further, 'the fact that the President can, in terms of section 131 (8) (b) as read with subsection (9) of the section, refer a Bill to the Constitutional Court for advice on its constitutionality shows that the judiciary is, to some extent, involved in the law-making

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[568] Section 85(1) provides as follows: 85 Enforcement of fundamental human rights and freedoms. (1) Any of the following persons, namely—
(a) any person acting in their own interests;
(b) any person acting on behalf of another person who cannot act for themselves;
(c) any person acting as a member, or in the interests, of a group or class of persons;
(d) any person acting in the public interest;
(e) any association acting in the interests of its members;
is entitled to approach a court, alleging that a fundamental right or freedom enshrined in this Chapter has been, is being or is likely to be infringed, and the court may grant appropriate relief, including a declaration of rights and an award of compensation.

[569] 1997 (3) SA 786 (CC).

process.'[570] It holds the Government accountable by ensuring that all Bills which Parliament and the President pass into law comply with the Constitution of Zimbabwe, and that Government complies with its constitution and legislative obligations. Holding the Government accountable for its constitutional obligations is an opportunity for the rural populace, working through the relevant Commissions or non-governmental organisations (as will be fully discussed under section 5.3.1 below), to ensure that their right to have access to reproductive health care services is realised.

Section 166 of the Constitution of Zimbabwe (2013) establishes the Constitutional Court which plays an important role in ensuring that existing laws, policies and actions of the state and government are consistent with the supreme law of the land. The court's role to ensure that laws are consistent with the Constitution are exercised when a litigant brings a constitutional challenge to an existing law. An example is the *Mudzuru & Another v Ministry of Justice, Legal & Parliamentary Affairs (NO) & Others*[571] case where the court, relying on section 78 of the Constitution, declared section 22 of the Marriage Act, which allowed a girl under the age of 16 to enter into a civil marriage, unconstitutional and thus outlawing child marriages.

Section 46 enjoins the courts, when interpreting the Declaration of Rights, to give full effect to the rights and freedoms in the Declaration of Human Rights and must promote the values and principles that underlie a democratic society based on openness, justice, human dignity, equality and freedom. Section 46 of the Constitution requires the courts, when protecting the Declaration of Rights, to observe the following:

> 46 Interpretation of Chapter 4 (1) When interpreting this Chapter, a court, tribunal, forum or body— (a) must give full effect to the rights and freedoms enshrined in this Chapter; (b) must promote the values and principles that underlie a democratic society based on openness, justice, human dignity, equality and freedom, and in particular, the values and principles set out in section 3; (c) must take into account international law and all treaties and conventions to which Zimbabwe is a party; (d) must pay due regard to all the provisions of this Constitution, in particular the principles and objectives set out in Chapter 2; and (e) may consider relevant foreign law.

Section 46(1)(c) of the Constitution is of significance to this study. It imposes a duty on courts to rely on international law when interpreting the provisions in the Declaration of Rights. This means that the relevant provisions in the Zimbabwean Constitution can be 'given

[570] *Mlilo v The President of the Republic of Zimbabwe* (HH 236-18, HC 9829/17) [2018].
[571] CC 12-15) [2015] ZWCC 12 (20 January 2016)

meaning' by interpreting them through the international treaties that Zimbabwe is a party to, and the persuasive General comments discussed in Chapter Two. In explaining the import of section 46(1)(c) of the Constitution, Malaba DCJ (as he then was), stated as follows in *Mudzuru & Another v Ministry of Justice, Legal & Parliamentary Affairs (NO) & Others*[572]:

> Section 46(1)(c) of the Constitution requires a court, when interpreting any provision of the Constitution contained in Chapter 4, to take into account international law and all treaties and conventions to which Zimbabwe is a party…*In deciding whether s 22(1) of the Marriage Act, or any other law which authorises child marriage, infringes the fundamental rights of girl children, regard…must also be had to the emerging consensus of values in the international community, of which Zimbabwe is a party, on how children should be treated and their wellbeing protected so that they can play productive roles in society upon attaining adulthood*. The constitutional provisions should be interpreted so as to resonate with the founding values and principles of a democratic society based on openness, justice, human dignity, equality and freedom set out in s 3 of the Constitution, and regional and international human rights law.[573]

In Mildred *Mapingure v The Minister of Health and Others* SC 22/14, the court also emphasised the significance of section 46(1)(c) of the Constitution. In this case, a woman who had been raped by robbers sought access to termination of pregnancy services in terms of the Termination of Pregnancy Act [Chapter 15:10].[574] The court held that the police failed in their duty to assist the Appellant in accessing timely services in order to prevent pregnancy and the doctor failed to carry out his professional duty to terminate the pregnancy when it could have been reasonably prevented and terminated respectively. The court underscored the importance of relying on international human rights treaties by stating as follows:

> It is proper and necessary for national courts, as part of the judicial process, to have regard to the country's international obligations, whether or not they have been incorporated into domestic law. By the same token, it is perfectly proper in the construction of municipal statutes to take into account the prevailing international human rights jurisprudence. In the present context, relevant international instruments include the Convention on the Elimination of All Forms of Discrimination against Women 1979, ratified by Zimbabwe on 13 May 1991… Of special relevance is Article 14 pertaining to health and reproductive rights. Article 14.1 obligates States Parties to respect and promote the rights of women "to control their fertility … to decide whether to have children, the number of children and the spacing of children [and] … to choose any method of contraception'. Equally significantly, in terms of Article 14.2(c), States Parties must take all appropriate measures to "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest…

Armed with the section 46(1)(c) of the Constitution and other legal provisions supporting women's health, the courts are poised to effectively play a crucial role in

[572] Constitutional Application No. 79/14, CC 12-15) [2015] ZWCC 12 (20 January 2016).
[573] Page 26 of the judgment.
[574] See Chapter 3, section 3.3.3 for a discussion on the relevant provisions of the Act.

safeguarding women's health rights, by relying on both national and international human rights law to produce enforceable judgments that can be used by litigants for the realisation of their rights. The judgments from courts also provide jurisprudence that can be used in continuous lobbying and advocacy for the long-term realisation of rural women's reproductive health rights, as discussed in detail under section 5.4.2 below.

The two judgements on women's reproductive rights are commendable. They show that the existence of the court system is a step in the right direction as courts give women the platform to sue for violation of their reproductive rights. Unfortunately, there have been very few Zimbabwean cases where the courts have had the opportunity to consider the rights to health or the right to reproductive health.

In contrast to the Zimbabwean scarcity of judicial authority on the interpretation of the right to healthcare services, South African jurisprudence has been hailed for providing progressive judicial authority on the interpretation of the content and scope of the right. The first case in which the South African Constitutional Court had to decide on the constitutional right to health care for everybody in light of the problem of scarce resources for the funding of the health care system was *Soobramoney v Minister of Health (Kwazulu-Natal).*[575] This was a claim alleging violation of health rights by South African health authorities when refusing renal dialysis treatment to a patient suffering from terminal illness. The court held that:

> What is apparent from these provisions is that the obligations imposed on the state by sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed.[576]

In the *Minister of Health v. Treatment Action Campaign (TAC),*[577] the TAC instituted action against the Government for its refusal to make nevirapine (an antiretroviral drug used for the prevention of mother to child transmission of HIV/AIDS) accessible to the public where medically indicated. TAC contended that the policy restricting the availability of the drug was unreasonable, and accordingly that the State was in breach of its obligation to take 'reasonable legislative and other measures' to progressively realise the right to have access to health care

[575] (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997).
[576] *Soobramoney case* paragraph 11.
[577] 2002 10 BCLR 1033 (CC).

services under section 27(1)(a) read with section 27(2) of the Constitution of South Africa, which provide as follows:

> 27(1) Everyone has the right to have access to – (a) health care services, including reproductive health care…(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

In determining the reasonableness of the policy on confining nevirapine to research and training sites, the court relied on the case of *Government of the Republic of South Africa and Others v Grootboom and Others*[578] where it was stated that:

> [t]o be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.

The court therefore found that the policy of confining nevirapine to research and training sites

> …fails to address the needs of mothers and their new born children who do not have access to these sites. It fails to distinguish between the evaluation of programmes for reducing mother-to-child transmission and the need to provide access to health care services required by those who do not have access to the sites.[579]

The court also explained what the State's obligations to 'respect, protect, promote and fulfil' socio-economic rights in the Constitution entails. The court, made reference to the *Grootboom case* where the Court stressed that in so far as socio-economic rights are concerned,

> [t]he State is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the Executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the State's obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations.[580]

[578] [2000] ZACC 19; 2001 (1) SA 46 (CC).
[579] TAC case para 67.
[580] *Government of the Republic of South Africa and Others v Grootboom and Others* [2000] ZACC 19; 2001 (1) SA 46 (CC) at para 46.

The Constitutional Court confirmed that the government had not fulfilled its constitutional mandate to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation' of the right to access to health care services.

Apart from the constitutional cases that have interpreted what the right to health in general entails, South African courts have also dealt with cases on access to maternal health services.[581] However, the cases have largely been dealt with based on the law of delict and not on reproductive health rights. For example, in his discussion of *Ntsele v MEC for Health, Gauteng Provincial Government* [2012] ZAGPJHC 208, Kangaude concludes that:

> In its judgment the South African Court perfunctorily paid attention to the issue of reproductive rights. However, the case was essentially decided on the private law of tort or delict. In order to address the challenges that women face in Africa, there is need to build strong jurisprudence to hold governments accountable for respect, protection and fulfilment of the reproductive rights of women in Africa.[582]

In other African counties, courts have made progress in handing down decisions on reproductive health rights. For instance, the Ugandan High Court in the case of *Centre for Health, Human Rights and Development & 3 Others v. Attorney General*,[583] affirmed that failure of the government to adequately provide for maternal health care and emergency obstetric care in public facilities was in violation of the rights to health and life. The decision highlights the need for states to address the reproductive health rights/needs of women from marginalised communities or rural areas. Similarly, the Kenyan Courts passed a landmark ruling on access to abortion services in the case of *Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General & 2 others*.[584] The court held that the withdrawal of the 2012 Guidelines and Standards and the Training Curriculum was prejudicial to the petitioners – It led to confusion and lack of clarity on the part of health care providers as to when an abortion is permissible under the law and thus violated the rights of the petitioners and other women and adolescent girls of reproductive age whose interest they represent to the highest attainable standard of health.

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[581] See generally; *Ntsele v MEC for Health, Gauteng Provincial Government* [2012] ZAGPJHC 208; *D v MEC for Health for the Province of KwaZulu-Natal* (8700/2013) [2019]

[582] Godfrey Dalitso Kangaude (ed) *Legal Grounds III: Reproductive and Sexual Rights in Sub-Saharan African Courts* (2017).

[583] Constitutional Petition No. 16 of 2013.

[584] Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR Petition Number 266 of 2015.

The aforementioned cases show the development of socio-economic rights adjudication in the South African Constitutional Court. Zimbabwe, whose constitutional jurisprudence on socio-economic rights is still young as compared to South Africa, can take a leaf from these South African cases on access to reproductive health services, in its future adjudication of socio-economic rights.

It is important to note, however, that Zimbabwe has already sought guidance and relied on South African jurisprudence in explaining state obligations in realising socio-economic rights. Although the cases by the Zimbabwean courts were on the right to water, they are significant to show the progress made in interpreting socio-economic rights, and their reliance on South African jurisprudence. In the case of *City of Harare v Mushoriwa*,[585] the Supreme Court of Zimbabwe, siting as the Constitutional Court, had the chance to discuss the enforceability of the right to clean water as provided in section 77 of the Constitution of Zimbabwe. The facts of the case, briefly, are as follows: Sometime in May 2013, the appellant sent to the respondent a bill of $1,700 for water services rendered. The respondent disputed the bill claiming that it related to a bulk meter not connected to his leased premises. On 31 May 2013, the appellant disconnected the respondent's water supply. The respondent then filed an urgent chamber application, based on section 77 of the Constitution, to order the appellant to restore his water supply pending the resolution of the dispute. Patel JA, as he then was, stated as follows:

> The first point to note about s 77 of the Constitution is that it is a fundamental human right enshrined in Part 2 of the Declaration of Rights. As such, it is directly enforceable in terms of s 85 of the Constitution if it has been, is being or is likely to be infringed. Nevertheless, being in the nature of a social right, I do not think that it is susceptible to unqualified application and enforcement. This emerges clearly from the wording of the section itself. What the State is enjoined to do is to take reasonable legislative and other measures to achieve the progressive realisation of the rights to sufficient food and potable water. Moreover, its obligations in this regard are confined to measures within the limits of the resources available to it. In light of the relatively inchoate and somewhat nebulous scope of the rights conferred and the concomitant obligations imposed, I am inclined to regard s 77 as being essentially policy-oriented and hortatory in nature. This is not to render the provision entirely nugatory but rather to recognise that the extent of its practical enforceability is not necessarily self-evident in every circumstance…Bearing in mind the enormous economic and budgetary considerations that would ordinarily arise in the provision of safe and clean water to a large populace, it cannot be said that the disconnection of water supply by reason of non-payment for water consumed in any specific instance constitutes an infringement of the constitutional right to water.[586]

[585] (SC 54/18, Case No. SC 228/14) [2018] ZWSC 54 (20 September 2018).
[586] Page 27 of the judgment.

The court acknowledged that the realisation the socio-economic right to clean water relied on the availability of State resources. Be that as it may, it concluded that the disconnection of water supply by reason of non-payment for water consumed in any specific instance did not constitute a violation of the right to clean water.

Another case worth mentioning is *Hopcik Investments (Pvt) Ltd v Minister, Environment, Water & Climate & Another*[587] in which the applicant sought an order compelling the respondents to supply water to its premises which they had failed to supply for about three years. Dube J, as he then was, explained the State obligation vis-à-vis the right to water as follows:

> The primary obligation to ensure and protect the right to water rests on the state. The first respondent is expected to fulfil its obligations by taking meaningful steps to address the shortage of water within the resources available to it. It must ensure that local authorities have adequate powers and resources to perform their duties. It must adopt appropriate legislative and administrative and financial measures to fully realize the right to water. Government must also ensure that organisations such as the first respondent that has a responsibility to supply and distribute water in accordance with the law are afforded the resources to enable them to do so. It must ensure that the local authority has adequate resources to maintain quality water resources.[588]

It is important to note that both Patel JA and Bube J in the abovementioned cases, relied on the South African case of *Mazibuko & Others v City of Johannesburg & Others*[589] which clearly explained the principle of availability of resources as follows:

> …section 27(1) and (2) of the Constitution must be read together to delineate the scope of the positive obligation to provide access to sufficient water imposed upon the state. That obligation requires the state to take reasonable legislative and other measures progressively to achieve the right of access to sufficient water within available resources. It does not confer a right to claim "sufficient water" from the state immediately…. The fact that the state must take steps progressively to realise the right implicitly recognises that the right of access to sufficient water cannot be achieved immediately…The Constitution envisages that legislative and other measures will be the primary instrument for the achievement of social and economic rights. Thus it places a positive obligation upon the state to respond to the basic social and economic needs of the people by adopting reasonable legislative and other measures. By adopting such measures, the rights set out in the Constitution acquire content, and that content is subject to the constitutional standard of reasonableness. Thus the positive obligations imposed upon government by the social and economic rights in our Constitution will be enforced by courts in at least the following ways. If government takes no steps to realise the rights, the courts will require government to take steps. If government's adopted measures are unreasonable, the courts will 26 Judgment No. SC 54/2018 Case No. SC 228/14 similarly require that they be reviewed so as to meet the constitutional standard of reasonableness. ….

[587] (HH 137-16, HC 1796/14) [2016] ZWHHC 137 (17 February 2016).
[588] Page 4 of the Hopcik judgment.
[589] [2009] ZACC 28 [2010 (4) SA

> Finally, the obligation of progressive realisation imposes a duty upon government continually to review its policies to ensure that the achievement of the right is progressively realised.[590]

It is clear that the South African case on the right to water relied on by our courts has explained the obligations of the State and the meaning of 'available resources' in a clearer and detailed manner. The discussion on the right to water as decided in South African courts is significant because, the realisation of right to access health care services, like the right to water, is also dependent on the availability of resources. This is why the Zimbabwean court's reliance on South African cases discussed here are important as setting a precedent. Zimbabwe should therefore continue taking guidance from South Africa's rich socio-economic jurisprudence for its future work on socio-economic rights.

5.3 HOW DO RURAL WOMEN ACCESS THE COURTS FOR REMEDIES?

Now that it is clear that socio-economic rights are justiciable and that courts have powers to give remedies, the question is: how can a rural woman whose socio-economic right to reproductive health has been violated, gain access to the courts for remedies? Biltchitz argues that access to justice is conceived of as the ability to make claims – but what conditions, institutions, or resources are necessary to enable individuals to make their claims?[591] These questions are pertinent because of problems facing the poor when seeking redress through the court system which include lack of information; high costs; excessive formalism; fear and mistrust; inordinate delays; and geographical distance.[592] This section discusses how rural women can gain direct access to the courts. This section should be considered together with section 5.4 which examines non-judicial mechanisms through which rural women can hold government accountable for its human rights obligations. Direct litigation against the State is not the only mechanism available for the realisation of human rights.

5.3.1 Litigation through organisations and amicus briefs

It can be very difficult for an individual woman to bring legal action against the State on the grounds that her right to reproductive health has been infringed. While the provision of legal

[590] Paragraph 57, 66 and 67 of the *Mazibuko* judgment.
[591] David Biltchitz 'Expanding Access to Justice for Socio-Economic Rights Complaints in South Africa Which Direction Should We Head in?' (2017) Paper presented at the University of Berlin Conference on The Global South in Comparative Constitutional Law.
[592] Roberto Gargarella 'Too far removed from the people Access to Justice for the Poor: The Case of Latin America' Available at *https://www.ucl.ac.uk/dpu-projects/drivers_urb_change/urb_society/pdf_violence_rights/gargarella_removed_from_people.pdf*, accessed on 18 April 2020.

aid (discussed below) might theoretically assist women in bringing court cases of this kind, it is far more likely that the case will be channelled through a community organisation such as the Zimbabwe Women Lawyers Association (ZWLA),[593] the Legal Resources Foundation (LRF),[594] and Women and Law Southern Africa (Zimbabwe).[595] The organisations are not only involved in litigation of the human rights disputes, but have also made invaluable contributions in human rights education and community mobilisation, and thus, the organisations will be discussed in more detail in Section 5.4.2.

It is also essential to note that few human rights cases are brought against the State unless alternative mechanisms have failed. Thus, a woman who has a complaint based on the State's non-compliance with its obligations to provide for reproductive health rights will probably lodge a complaint with the relevant Constitutional Commission (for example the Human Rights Commission or the Gender Commission) rather than instituting legal action though the court system. The Constitutional Commissions are discussed below in Section 5.4.1 as an example of non-judicial avenues for the realisation of reproductive rights. In theory, however, it is possible for a Commission itself to escalate the issue into the formal court system. This possibility is discussed in Section 5.4.1

5.3.2 Legal Aid

The economic costs of justice also play a huge role in hindering rural women's access to justice. In Zimbabwe, this problem is, to some extent solved by the existence of the Legal Aid Directorate (LAD), a department in the Ministry of Justice, Legal & Parliamentary Affairs set up in terms of the Legal Aid Act [Chapter 7:16] as well as the Zimbabwe Human Rights Commission. These institutions present opportunities that can be employed to ensure that rural women's right to access reproductive health care services is realised.

[593] Zimbabwe Women Lawyers Association is a non-profit making organization, which strives to create a just world free from injustice and inequality. In its mission to defend and dialogue on women and children's rights, Zimbabwe Women Lawyers Association seeks to provide legal aid and education to millions of women and communities, lobby and advocate communities, institutions, government and policy makers to be sensitive to women and children's rights as well as raise awareness on matters of its interest.

[594] The LRF, through its permanent offices, mobile legal aid clinics and help desks at magistrates' courts, most of which are located away from the main cities, provides legal assistance to the marginalised and vulnerable.

[595] The purpose of the network is to contribute to sustained well-being of women and girl children through action-oriented research in the socio-legal field and advocating for women's rights. WLSA work incorporates action into research by questioning and challenging the law, instigating campaigns for changes in laws, policies and plans of action, educating women and girls about their rights, providing legal advice and gender sensitizing communities and leadership.

The Legal Aid Act provides 'for the granting of legal aid to indigent persons; the establishment and functions of the Legal Aid Directorate and a Legal Aid Fund….' Section 3(2) provides for the functions of the LAD as follows:

> 2. Subject to this Act, the functions of the Legal Aid Directorate shall be— (*a*) to provide legal aid to persons who are eligible for such aid in connection with any criminal, civil or other related matter; (*b*) to do all things necessary to promote the provision of legal aid under this Act.[596]

In line with its purpose of granting legal aid to indigent persons, the Legal Aid Act lays down three requirements to be met for one to be eligible for legal aid services, namely: (a) insufficient means to obtain the services of a legal practitioner on his own account; (b) applicant has reasonable grounds for initiating, carrying on, defending or being a party to the proceedings for which he applies for legal aid; and (c) applicant is in need of or would benefit from the services provided in terms of this Act in respect of the proceedings for which he seeks legal aid.[597]

Indeed, the significance of the existence of the LAD cannot be overemphasised. It is an important tool in any democratic state as it allows the less fortunate, in this case rural women, to have access to justice on an equal basis to everyone else. Through LAD, rural women can afford to hold the State accountable for its non-compliance to its obligations to ensure they have access to reproductive healthcare services.

5.4 NON-JUDICIAL AVENUES FOR REALISATION OF REPRODUCTIVE RIGHTS

This section acknowledges that the formal court system is not the only effective avenue for the realisation of reproductive health rights. Put differently, litigation is not the only avenue that can be used to ensure the realisation of women's right to access reproductive health care services. Consequently, the section investigates the non-judicial mechanisms available to women whose right to reproductive health has been infringed. In practice, it would be extremely difficult for an individual woman to bring a human rights case through the formal court system because of cost and other barriers despite the possibility of Legal Aid. Challenges based on the right to reproductive health are more likely to arise through the various Constitutional Commissions established under the Constitution, which are more accessible

[596] Legal Aid Act preamble.
[597] Section 8.

than the formal court system. The role of the Constitutional Commissions is examined below in Section 5.4.1.

Challenges are also more likely to emerge through community organisations and NGOs. Community mobilization can be an effective avenue for the realisation of reproductive health care rights as discussed below in Section 5.4.2.

This section also discusses one other important avenue through which the right to reproductive health can be realized, particularly in rural areas: traditional leadership structures. Pressure can be placed upon these structures, particularly where a community has mobilized effectively.

5.4.1 Constitutional Commissions

The protection and enforcement of human rights generally and socio-economic rights particularly, including the right to have access to reproductive health care services, are not confined to the legislature and judiciary. Chapter 12 of the 2013 Constitution[598] establishes independent institutions supporting constitutional democracy. Of these, the Zimbabwe Human Rights Commission and the Gender Commission are particularly significant in the protection and enforcement of socio-economic rights.

5.4.1.1 Zimbabwe Human Rights Commission

The Zimbabwe Human Rights Commission (ZHRC)[599] is a National Human Rights Institution established in terms of section 242 of the Constitution of Zimbabwe. It is mandated to protect, promote and enforce human rights and acts as a bridge between the citizens and the Government, thus allowing the populace to lodge complaints on human rights on one hand, and raising awareness on the right to reproductive health to the rural populace.[600] To execute

[598] The objectives of the Independent Institutions are set out in Section 233 of the Constitution as: To support and entrench human rights and democracy; To protect the sovereignty and interests of the people; To promote constitutionalism; To promote transparency and accountability in public institutions; To secure the observance of democratic values and principles by the State and all institutions and agencies of government, and government-controlled entities; and To ensure that injustices are remedied.

[599] The ZHRC, which is a National Human Rights Institution was established in terms of section 100R of the former Constitution of Zimbabwe Amendment No.19 of 2009. The Constitution of Zimbabwe Amendment (No. 20) Act 2013 continues to qualify the existence of the ZHRC through section 242.

[600] See section 243 of the Constitution of Zimbabwe which provides the functions of the ZHRC as follows: (a) to promote awareness of and respect for human rights and freedoms at all levels of society; (b) to promote the protection, development and attainment of human rights and freedoms; (c) to monitor, assess and ensure observance of human rights and freedoms; (d) to receive and consider complaints from the public and to take such action in regard to the complaints as it considers appropriate; (e) to protect the public against abuse of power and

its mandate, the ZHRC has three Units, namely the Complaints Handling and Investigations Unit (CHI), the Education Promotion and Research Unit (EPR) and the Monitoring and Inspections Unit (M&I).

Complaints Handling and Investigations Unit

The CHI Unit is responsible for receiving all complaints that come to the Commission and for conducting investigations into the reported cases.[601] The Commission deals with complaints of abuses and violations of rights and freedoms that are enshrined in the Constitution of Zimbabwe and in any international human rights agreements that the country is a party to.[602] Complainants can lodge their complaints through email, visiting the ZHRC offices, phone call, and Whatsapp or through civil society organisations that the ZHRC has partnered with.[603] These different ways of lodging complaints are commendable as they ensure access for the marginalised groups. One of the many success stories for the ZHRC is when it successfully intervened in the case of 94 Hopley residents who were being denied their right to acquire national identity documents and birth certificates on the alleged basis that they were aliens.[604] The ZHRC wrote to the Registrar General to issue the required documentation. ZHRC's intervention resulted in the 94 residents obtaining identity documents and eventually registering as voters in the elections.[605]

After investigations, the ZHRC can only make recommendations and these include recommendations of: payment of compensation to the individual or their family; the release of a person from prison; prosecution of offenders.[606] Apart from conducting investigations, the

maladministration by State and public institutions and by officers of those institutions (f) to investigate the conduct of any authority or person where it is alleged that any of the human rights and freedoms set out in the Declaration of Rights has been violated by that authority or person; (g) to secure appropriate redress, including recommending the prosecution of offenders, where human rights and freedoms have been violated; (h) to direct the Commissioner-General of Police to investigate cases of suspected criminal violations of human rights or freedoms and to report to the Commission the results of any such investigations; (i) to recommend to Parliament effective measures to promote human rights and freedoms (j) to conduct research into issues relating to human rights and freedoms and social justice; and (k) to visit and inspect- (i) prisons, places of detention, refugee camps and related facilities; and (ii) places where mentally disordered, or intellectually handicapped persons are detained; in order to ascertain the conditions under which persons are kept there, and to make recommendations regarding those conditions to the Minister responsible for administering the law relating to those places. The Commissioner-General of Police must comply with any directive given to him or her by the Zimbabwe Human Rights Commission under Subsection (1) (h).

[601] Section 4(1) of the ZHRC Act.

[602] Section 4 of the ZHRC Act and section 243 of the Constitution.

[603] Zimbabwe Human Rights Commission Complaints Handling Manual.

[604] Zimbabwe Human Rights Commission 2018 Annual Report.

[605] Ibid.

[606] Section 14(2) of the ZHRC Act.

ZHRC can resolve complaints through negotiation, conciliation or mediation.[607] This is a welcome development as Alternative Dispute Resolution mechanisms are generally accessible, less formal and efficient in terms of time.[608]

The existence of a unit specifically dedicated to complaints is important as it allows rural women to lodge complaints of violations. The only drawback of such a unit in the ZHRC is the lack of decentralization. The ZHRC only has two offices, one in the Northern and one in the Southern Region, making it inaccessible to the rural women. Another disadvantage is the fact that the ZHRC, through its CHI Unit can only make recommendations and reports to the Minister of Justice, Legal and Parliamentary Affairs – it does not have the power to make binding decision. Despite the fact that ZHRC's decisions or findings are not legally binding or enforceable (as respondents can choose not to comply with the recommendations proffered), this thesis argues that the decisions do have 'soft power'. An adverse report on human rights violations will have an impact on the reputation of the government. Therefore, to protect its reputation and to be seen as a Government that upholds the Constitution and its international obligations, the Government might feel obliged to follow ZHRC findings and recommendations, hence the 'soft power' of ZHRC decisions.

A remedy to the non-compliance of ZHRC's recommendations is provided for in section 15 of the ZHRC Act which states that:

> (1) The Commission may, if it thinks fit, where it has completed an investigation of any human rights violation—(*a*) *on its own initiative in terms of section 9(1); or(b) on the basis of a complaint; in its own name or on behalf of any complainant or class of complainants pursue any action in any court of competent jurisdiction for the redress of any human rights violation*, for which purpose it shall, where it acts on the basis a complaint, be cited as a joint party with the complainant or class of complainants in question.

This provision allows the ZHRC to institute public interest litigation cases on any human rights violations, either on its own initiative or on behalf of complainants. Although this is a powerful tool to exert pressure on government and thus hold it accountable for human rights violations, the ZHRC has yet to initiate proceedings in the courts. This thesis argues that some political pressure on the ZHRC, arising from community mobilisation, may be the

[607] Part IV of the Zimbabwe Human Rights Commission (General) Regulations, 2016 (Statutory Instrument 77 of 2016).
[608] Matsikidze R *Alternative Dispute Resolution in Zimbabwe: A practical approach to arbitration mediation and negotiation* (2013).

appropriate means to push the ZHRC to pursue action in any court of competent jurisdiction for the redress of any human rights violation in Zimbabwe.

Education, Promotion and Research Unit

The EPR Unit is the community mobilisation unit. It is responsible for educating people on human rights issues through various media channels, conducting community outreach programmes, seminars and training workshops. The Unit is also responsible for developing Information, Education and Communication (IEC) materials for use by the Commission in order to promote awareness of, and respect for all human rights and freedoms. The important aspect of the EPR Unit is its ability to translate human rights information into vernacular languages (for instance, Khalanga, Shona, Ndebele, Tonga), which makes it easy to read for the rural communities. This guarantees that rural communities get access to information in a language they understand. This is crucial because only an educated citizenry has the power to hold its government accountable for human rights violations.[609] Put differently, holding a state accountable is impossible where the citizens have no knowledge of their human rights and the state obligations.

The EPR Unit's role is also significant in that awareness raising is not only limited to the rights holders (rural women) but to the duty bearers in the form of health workers responsible for delivering the reproductive health care services. As discussed in Chapter Two, the human right to healthcare means that hospitals, clinics, medical services and medicines must be accessible, available, affordable and of good quality for everyone, on a non-discriminatory basis, where and when needed.[610] Therefore,

> The design of a healthcare system must be guided by key standards and principles in accordance with human rights, which incorporate universality, indivisibility, participation, transparency, non-discrimination and accountability.[611]

Health personnel constitute an essential element to ensuring fulfilment of the right to health. Therefore, the significance of human rights education for health personnel is to make

[609] Roberto Gargarella 'Too far removed from the people Access to Justice for the Poor: The Case of Latin America' Available at *https://www.ucl.ac.uk/dpu-projects/drivers_urb_change/urb_society/pdf_violence_rights/gargarella_removed_from_people.pdf*, accessed on 18 April 2020.
[610] CESCR General Comment No. 14: The Right to the highest attainable standard of health, (2000), para 12.
[611] Aleksandra Jovic Vranes, Vesna Bjegovic Mikanovic & Dejana Vukovic *et al* 'Education on human rights and healthcare: evidence from Serbia' *Health Promotion International*, Volume 30, Issue 1, 2015, 101–105.

them aware that the manner in which they perform their jobs has implications for the human rights of the rural communities that they serve. According to WHO, failure to adhere to human rights standards in health service delivery has serious implications on the right to health:

> Overt or implicit discrimination in the delivery of health services – both within the health workforce and between health workers and service users – acts as a powerful barrier to health services, and contributes to poor quality care.[612]

Accordingly, increasing the health care professionals' knowledge and understanding of human rights empowers them to protect human rights by integrating the principles of human rights into their everyday practice.[613]

Thematic Working Groups

The First Schedule, clause 7(1), of the Zimbabwe Human Rights Commission Act [Chapter 10:30] allows the ZHRC to establish Thematic Working Groups (TWGs) to deal with specific human rights themes and issues. The ZHRC has established eight TWGs,[614] one of which is the Thematic Working Group on Gender Equality and Women's Rights (TWG on GEWR). The TWG on GEWR, which was operationalized sometime in 2015, is established to promote and raise awareness on gender and women's rights within the broader mandate of the ZHRC to do with protection, promotion and enforcement of human rights so as to achieve gender equality. Some of its functions include conducting research into women's rights, referring for litigation, cases that involve any infringements of women's rights, reproductive rights included. For instance, where there are violations of rural women's right to access reproductive healthcare services, the ZHRC can refer such cases for litigation, that is, sue the Government on behalf of the rural women for non-compliance of its constitutional and international human rights obligations. Litigation, as indicated above, has yet to be done by the ZHRC.

[612] WHO. 'Human Rights and Health.' Available *at https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health,* accessed on 31 July 2020.
[613] Abbas Rashid 'Human Rights and Education' Paper prepared for Open Society Institute Education Conference 2005: 'Education and Open Society: A Critical Look at New Perspectives and Demands' Available at *https://www.opensocietyfoundations.org/uploads/2d38b843-8c7c-4a8b-91cc-afe0544319a1/rashid_english.pdf*, accessed 31 July 2020.
[614] ZHRC has established 8 Thematic Working Groups which are: Gender Equality and Women's Rights; Children's Rights; Capacity Building; Special Interest Groups; Environmental Rights; Civil and Political Rights; Economic, Social and Cultural Rights and Treaties and International Agreements.

Another function of the TWG is advocating for change in legislation[615] to ensure that women's rights are protected. This is provided for in section 14 of the ZHRC Act which states that,

> (1) If, after conducting an investigation, the Commission is of the opinion that the action or omission which was the subject-matter of the investigation constitutes a human rights violation and that— *any law on which the act or omission was based should be reconsidered*… the Commission shall report its opinion, together with its reasons, to the authority or person against whom the complaint was made and may make such recommendations as it thinks fit and shall also send a copy of its report and recommendations to the Minister.[616]

This function to lobby and advocate for alignment or repeal of laws inconsistent with the Constitution of Zimbabwe and international best practices speaks to the ZHRC's soft power. Litigation and lobbying for the repeal of restrictive laws are potential avenues of holding the State accountable for human rights violations, and thus ensuring that rural women's reproductive rights are realised.

Despite the different provisions empowering the ZHRC to exercise its mandate towards the realisation of human rights, there are major drawbacks that continue to hinder its proper functioning, namely: inadequacy of human and financial resources. For instance, a study conducted by Dziva, bemoaned how the ZHRC, soon after its operationalisation in 2014, received an insignificant budget which affected its operations.[617] Dziva further argued that despite the presence of section 322 of the Constitution directing the Parliament to ensure adequate funds to independent institutions such as the ZHRC to effectively execute their mandates, the ZHRC has been receiving limited budget. The ZHRC continues to be troubled by high staff turnover, which has serious implications on its human resources to execute its mandate. Insufficiency of financial and human resources for institutions such as the ZHRC are a hindrance to the successful realisation of human rights, and thus, a violation of the international human obligations enshrined in human rights treaties, such as CEDAW, ICESCR, CRC, ACRWC, that Zimbabwe is a party to.

[615] The ZHRC may influence the legislators to preserve human rights. For example, in the case of abortion, to amend legislation by removing the stringent conditions under which abortion can be legally performed.
[616] Section 14(1)(d) of the ZHRC Act.
[617] Dziva C 'The 2013 Constitutional Reform and the Protection of Women's Rights in Zimbabwe' (2018) *Journal of Eastern Africa Social Science Research Review*, Vol. 34, No. 2, 21-35.

5.4.1.2 Zimbabwe Gender Commission

The Zimbabwe Gender Commission (ZGC) is another fundamental institution for the advancement of women's human rights. The functions of the ZGC as provided for in section 246 of the Constitution include:

> a) To monitor issues concerning gender equality to ensure gender equality as provided in this Constitution;
> b) To investigate possible violations of rights relating to gender;
> c) To receive and consider complaints from the public and to take such action in regard to the complaints as it considers appropriate;
> d) To conduct research into issues relating to gender and social justice, and to recommend changes to laws and practices which lead to discrimination based on gender…

These functions are of significance in tackling gender disparities which are as result of socially constructed roles and responsibilities of men and women. These functions allow the ZGC to receive and investigate complaints on any systemic barriers prejudicial to gender equality. This is significant for women's reproductive health rights because it allows the ZGC to unearth gender disparities in accessing reproductive health services as women and men have unique health needs. To address these unique needs ensures that women do not miss out on health services because of their gender.

Further, the ZGC also has the power to conduct research into issue relating to gender and to recommend changes to laws and practices which lead to discrimination based on gender. Consequently, where they are laws discriminating against women by impeding women's access to health services because of gender, the ZGC can lobby and advocate for the change of such laws. This is a potentially excellent way in which the State can be held to account for its obligations and thus ensure that women's right to access reproductive health care services is achieved.

However, the success of the ZGC is adversely affected by limited funding. For the year 2019, the ZGC was only given a budget of US$2 million for employment costs, operation costs and maintenance as well as capital expenditure.[618] This amount is inadequate to ensure that the ZGC effectively carries out its constitutional mandate. Therefore, the ZGC's prospects

[618] Zimbabwe 2019 Budget Highlights. Available at *http://www.zimtreasury.gov.zw/index.php/resources/2019-budget?download=21:2019-national-budget-highlights* accessed 2on 4 April 2019.

of successfully executing its mandate are low due to resource constraints and the exhibited limited political will by government.

5.4.2 Community or grassroots mobilization

Lack of information or knowledge, as revealed by this study in Chapter Four, is always a major obstacle to accessing justice. Gargarella describes this as follows:

> The general problem of lack of information encompasses many subsidiary ones: not knowing what rights one has; not knowing where to go and what to do in order to demand one's rights; not knowing the legal language and the legal procedures.[619]

An important potential remedy for lack of such knowledge in rural communities is community or social mobilization. Community mobilisation is the process of bringing together societal and personal influences to raise awareness and to co-ordinate action. Community mobilization can help to raise awareness around the meaning of the right to health and the right to reproductive health particularly. Community mobilization can enhance the co-ordination of demands for the realisation of these rights in the form of delivery of resources and services, and it can cultivate sustainable individual and community involvement.[620] Community mobilization is therefore significant in that it empowers communities with knowledge about the rights and provides them with the human rights vocabulary that they can use to voice their demands and engage with the Government.[621]

A useful example of community engagement could be public expenditure tracking, which would allow communities to be directly involved in monitoring government performance, generating evidence and demanding accountability.[622] The Community Working Group on Health (CWGH)[623] is one organisation instrumental in mobilising communities for expenditure tracking. The CWGH seeks to enhance community participation in health through advocacy, networking and capacity development for the attainment of the right to health and equitable health services in Zimbabwe. This is significant in holding the Parliament of

[619] Gargarella 'Too far removed from the people.'
[620] WHO 'Health promotion: Social mobilisation' Available *at https://www.who.int/healthpromotion/social-mobilization/en/*, accessed on 17 April 2020.
[621] Gargarella 'Too far removed from the people.'
[622] Ackerman J 'Co-governance for Accountability: Beyond 'Exit' and 'Voice' (2003) *World Development* Volume 32 Number 3:447-463
[623] The Community Working Group on Health is a network of civic / community based organization that was formed in early 1998 to take up health issues of common concern. There are approximately thirty-five (35) organizations in the CWGH include national membership organizations that have branches across the country, while others have areas specific membership (such as the residents associations).

Zimbabwe to account on budgetary issues[624] because the formulation of the National Budget is an area that requires greater participation of the community. Community participation in health matters and in budget formulation gives the citizens an opportunity for their voices to be incorporated in the National Budget. For instance, the CWGH made input to the 2018 National Budget after consultations in the 10 provinces of the country respondents included community members and District Health Executive (DHE) members among others. This consultation led to the production of a report which detailed the state of health in the country, its social determinants and what must be done to address the challenges plaguing the health care system.[625]

In its input to the 2018 National Budget, the CWGH advocated for:

> Strengthening the district health system by improving institutions (governance), enhancing human resource capacity (especially community based health workers) and addressing infrastructure deficits. This will help to adequately address the lack of access to quality healthcare, particularly for those living in rural communities and other vulnerable groups.[626]

Such inclusive consultations give rural women the opportunity to voice their concerns, thus ensuring that their raised concerns are taken into consideration. Continuous engagements with Parliament therefore has the potential of someday changing the health budget to comply with the Abuja Declaration requirement of 15% of National Budget allocation.

An important question that needs to be addressed at this juncture is: how do ordinary rural women voice their concerns? This is achieved through grassroots organisations which are defined as community level organisations or groups made up of community members advocating for a cause to spur change at local, national, or international levels.[627] Participation

[624] Parliament plays a role in the national budget. It is responsible for authorising the National Budget and to monitor the performance of the Government in terms of the programmes approved in the Budget. In terms of section 299 of the Constitution of Zimbabwe Parliament has oversight on state revenues and expenditures to ensure that (a) all revenue is accounted for, (b) all expenditure has been properly incurred; and (c) any limits and conditions on appropriations have been observed. Parliament's role of authorising budget application has an impact on the livelihood on the ordinary citizens. Parliament, in authorising application of public funds through the National Budget, has to take into consideration that realisation of socio-economic rights, which include women's right to access reproductive health care services, largely depend on national revenue. Any misallocation of funds has a negative impact on service delivery.

[625] Community Working Group on Health (CWGH) 'Position Paper on the Budget for Health – 2018 and Beyond' Available *at https://www.cwgh.co.zw/wp-content/uploads/2017/10/CWGH-Input-to-the-2018-National-Health-Budget.pdf*, accessed on 18 April 2020.

[626] CWGH 'Position Paper on the Budget for Health.'

[627] Alexandra Bettencourt 'Grassroots organizations are just as important as seed money for innovation' Available at *https://www.unhcr.org/innovation/grassroots-organizations-are-just-as-important-as-seed-money-for-innovation/,* accessed 1 August 2020.

of the rural women in any initiative involving issues affecting them is achieved through grassroots organising which is defined as:

> A process of building power by involving a constituency in identifying both the problems they share and the solutions to those problems, identifying the targets that could make those solutions possible, engaging with those targets through negotiation, confrontation and pressure, and developing the capacity to take on further problems.[628]

Grassroots organisations allow community members to launch projects or initiatives on issues affecting them by identifying a problem affecting the realisation of their rights, then to defining their own goals to solve the problem and measures on how to achieve the set goals.[629] For instance, it can be a project to address cultural issues and norms that hinder their access to reproductive health services. The importance of these grassroots groups in grassroots initiatives cannot be overemphasised. They deal with practical experiences in communities which are critical for development of solutions that are suitable to their context.

The existence of a vibrant non-governmental and civil society legal organizations in Zimbabwe is significant for community mobilisation and awareness raising purposes. Organizations like Zimbabwe Women Lawyers Association (ZWLA),[630] Legal Resources Foundation (LRF),[631] and Women and Law Southern Africa (Zimbabwe)[632] provide platforms that allow rural women to have access to information on the right to family planning services and maternal health care services, by raising awareness on the subject and distributing fliers with reproductive health information to women. These organizations also play an important role of acting as *amicus curiae* in court cases that involve women's rights; representing women whose rights have been violated in court; conducting and documenting research into different human rights issues, particularly women's rights issues which is essential in the promotion of

[628] Community Catalyst. What is Grassroots Organizing? Available at *https://www.communitycatalyst.org/resources/tools/copy-of-grassroots/what-is-grassroots-organizing,* accessed 1 August 202.
[629] Alexandra Bettencourt 'Grassroots organizations are just as important as seed money for innovation'.
[630] Zimbabwe Women Lawyers Association is a non-profit making organization, which strives to create a just world free from injustice and inequality. In its mission to defend and dialogue on women and children's rights, Zimbabwe Women Lawyers Association seeks to provide legal aid and education to millions of women and communities, lobby and advocate communities, institutions, government and policy makers to be sensitive to women and children's rights as well as raise awareness on matters of its interest.
[631] The LRF, through its permanent offices, mobile legal aid clinics and help desks at magistrates' courts, most of which are located away from the main cities, provides legal assistance to the marginalised and vulnerable.
[632] The purpose of the network is to contribute to sustained well-being of women and girl children through action-oriented research in the socio-legal field and advocating for women's rights. WLSA work incorporates action into research by questioning and challenging the law, instigating campaigns for changes in laws, policies and plans of action, educating women and girls about their rights, providing legal advice and gender sensitizing communities and leadership.

women's rights; as well as lobbying for alignment of laws to the Constitution and international human rights instruments. An example of successful community mobilisation to hold the State accountable for socio-economic rights violations through representing women in litigation is the *Mapingure case* where Mildred Mapingure was represented in court by ZWLA.

When lobbying for alignment of laws to the Constitution and international human rights instruments, NGOs such as ZWLA also rely on court jurisprudence. This was underscored by the Constitutional Court in the *Mudzuru* case, where the court stated that jurisprudence is a good opportunity for the advancement of human rights because:

> When the judiciary makes equitable decisions, those decisions set a valuable precedent for the future resolution of disputes between individuals or between the State and individuals. The judicial process emanating therefrom provides for the effective implementation of the law, the protection of the rights of individuals and groups, and sets a standard for the subsequent equitable enforcement of the law. Consequently, human rights receive effective protection in the courts.[633]

This shows how significant civil society organisations are in community mobilisation and lobbying for the advancement of rural women's health rights. However, it should be noted that despite the existence of these organizations, it is significant to note a core drawback: their operations do not cover many of Zimbabwe's rural areas. The organizations operate primarily in the Southern Region of the country, leaving out the Northern Region. Suffice to say that the presence of the civil society organisations and the NGOs, although not decentralized at the moment, is an opportunity that can be taken advantage of to ensure that the services are spread across all parts of the country.

Community mobilisation is therefore significant in that:

1. It raises awareness on human rights and reproductive rights;
2. Empowers women to participate in different national engagements that have an impact on their reproductive rights;
3. When there is a violation, rural women can approach relevant CSOs for assistance;
4. CSOs then, after receiving complaints of violations from rural women, investigate, produce reports which are then used to lobby and advocate for change.

[633] Fahed Abul-Ethem 'The Role of the Judiciary in the Protection of Human Rights and Development: A Middle Eastern Perspective' (2002) *Fordham International Law Journal* Volume 26 Issue 3: 761.

5. CSOs can also apply to court for appropriate relief which includes law repeal, compensation, capacity building and service provision (for instance family planning services), depending on the violation in question.

5.4.3 Traditional leadership

In Zimbabwe, traditional leaders' alleged alignment with the ruling Zimbabwe African National Unity-Patriotic Front (ZANU-PF) has seen their institution being criticised for lack of impartiality.[634] Further, most traditional leaders in Zimbabwe have been criticised for having a vision of society based on male domination.[635] Despite this criticism, traditional leaders still remain influential actors in contemporary Zimbabwe. It is because of their influence that this study finds the institution of traditional leadership to be an opportunity for the realisation of women's right to access reproductive health services in Zimbabwe. As custodians of culture and tradition, traditional leaders are important in ending harmful traditional practices that are anti-reproductive health, like child marriages, *ukungena*[636] and domestic violence.

In Zimbabwe, the institution of traditional leaders is established through the Constitution[637] and the Traditional Leaders Act.[638] The institution includes the 271 chiefs, 452 headman and 2500 village heads,[639] who operate at lower levels of rural governance and development. These local leaders are widely respected in rural communities such that their encouragements, orders and coercive means can positively advance women's reproductive health issues. Traditional leaders are constitutionally established, and have local courts that are provided in terms of the law. Based on these advantages, chiefs and their decentralized

[634] See, Tompson Makahamadze, Nesbeth Grand & Baxter Tavuyanago 'The Role of Traditional Leaders in Fostering Democracy, Justice and Human Rights in Zimbabwe' (2009) *The African Anthropologist*, Volume 16, Nos 1&2; Chigwata, Tinashe. 'The role of traditional leaders in Zimbabwe: are they still relevant? (2016) *Law, Democracy and Development*, *20*, 69-90; Chakunda Vincent and Chikerema A.F 'Indeginisation of Democracy: Harnessing Traditional Leadership in Promoting Democratic Values in Zimbabwe' (2014) *Journal of Power, Politics & Governance* Volume 2(1).

[635] International Labour Organisation 'Traditional leaders from Zimbabwe become gender activists' Available at *https://www.ilo.org/global/about-the-ilo/newsroom/features/WCMS_635912/lang--en/index.htm*, accessed 2 August 2020.

[636] Levirate union.

[637] Section 280 – 283 of the Constitution of Zimbabwe.

[638] [Chapter 27:17]. The Preamble of the Act explains the purpose of the Act as follows: to provide for the appointment of village heads, headmen and chiefs; to provide for the establishment of a Council of Chiefs and village, ward and provincial assemblies and to define their functions; to provide for the issue of village registration certificates and settlement permits.

[639] Centre for Conflict Management and Transformation (CCMT) *Role and responsibilities in rural local governance in Zimbabwe: parallels, overlaps and conflict* (2014) 10 Available at https://www.africaportal.org/publications/roles-and-responsibilities-in-rural-local-governance-in-zimbabwe-parallels-overlaps-and-conflict/, accessed 5 May 2020; N Musekiwa 'The role of local authorities in democratic transition' in E Masunungure & J Shumba (eds) *Zimbabwe: Mired in Transition* (2012) 242.

structures can be relied on in advocating and driving social mobilisation initiatives, awareness raising on human rights issues and women's reproductive health services. The only drawback for traditional leaders remains their limited education and knowledge on these rights.

Traditional leaders are also the gate keepers of their communities. If any positive change in empowering women is to be achieved, traditional leaders, as gate keepers and custodians of custom and tradition, should be educated on human rights issues. To underscore the significance of educating traditional leaders, Mahtar Ba argues that 'by leading the effort to break down negative norms that currently leave half of the population consigned to roles and circumstances unjustly dictated by their gender, these leaders can inspire countless others to act and effect positive change.'[640] It is for these reasons that many CSOs working on reproductive health in rural areas can rely on traditional leaders for awareness raising. Walsh *et al*'s study in Malawi found that CSOs operating in rural areas relied on chiefs for delivering services to communities including the distribution of IEC materials.[641] With increased cases of maternal mortality in some areas, traditional leaders in rural areas can request families with women who give birth at home to pay fines. In Malawi, mothers were fined 500 to 3000 Malawian Kwacha (US$1-$5) for giving birth at home instead of going to the clinic.[642] These interventions by traditional leaders can go a long way ensuring that rural women access reproductive health services in rural communities.

5.5 CHAPTER CONCLUSION

This chapter discussed the justiciability of reproductive health rights and considered the different legal, administrative or political remedies available for the realisation of women's rights to access maternal and family planning services in Zimbabwe. Indeed, reproductive rights are justiciable as they are enshrined in the Declaration of Rights of the 2013 Constitution. Despite such constitutionalisation, it emerged that the Zimbabwean constitutional jurisprudence on socio-economic rights is still fairly new as only a few cases have been decided by the apex court. It was noted that from the few cases on socio-economic rights decided by the Zimbabwean courts, guidance on the interpretation of the scope and content of socio-

[640] Amadou Mahtar Ba, Joannes Yimbesalu & Margo Thomas 'Engaging Religious & Traditional Leaders Is Crucial If We Are to Achieve SDG5 By 2030' available at *https://www.weiforward.org/engaging-religious-traditional-leaders-crucial-achieve-sdg5-2030/*, accessed 5 May 2020.
[641] Walsh A, Matthews A & Manda-Taylor L *et al* 'The role of the traditional leaders in implementing maternal, new-born and child health policy in Malawi' (2018) *Health Policy and Planning*.
[642] Ibid.

economic rights as well as the meaning of state obligations, was sought from the South African jurisprudence. This is significant for Zimbabwean courts as they grow their own jurisprudence.

One of the ways that rural women can access reproductive health services is through the courts. However, the Chapter noted that this route, despite being expensive, it is not easily accessible to rural women. Therefore, the Chapter discussed the use of the Legal Aid and litigating through civil society organisations like ZWLA and LRF as possible avenues to ensure that rural women do access the courts for remedies. Indeed, litigation through organisations only becomes feasible where the organisations involved have offices in rural areas. Absence of offices in rural areas hinders women from accessing the organisations and the courts.

Nevertheless, the Chapter noted that courts are not the only avenue that rural women can use for the realisation of their rights. In this regard, constitutional commissions, grassroots organisations and traditional leaders were discussed as possible non-judicial avenues that rural women can use to ensure realisation of their rights. It was noted that grassroots organisations play a crucial role in women's participation in activities that help assess Government's compliance with its international and constitutional obligations. Grassroots feed into civil society organisations which in turn submit the grassroots contributions to the relevant authorities. The national commissions are instrumental in disseminating information on human rights, thus making the right to access information on human rights a reality. However, the only drawback was the centralised nature of the commissions and CSOs. As long as most institutions and organisations are centralised in one place, in this case, the capital Harare, then the rural women will remain marginalised and the realisation of their rights will remain a pipedream. Decentralisation is therefore a must if rural women's rights are to be realised.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents the overall study conclusions and implications thereof. It summarises the national efforts made to comply with international obligations towards women's right to access reproductive health care services. It also provides an overview of rural women's experiences in accessing reproductive health care services. The chapter then provides recommendations on what needs to be done to address identified obstacles that hinder effective access to reproductive health care services for rural women in Zimbabwe and recommendations for future research.

6.2 GENERAL CONCLUSIONS

Women remain one marginalised group that suffers different forms of discrimination in society. Of all groups of women, rural women suffer double discrimination and exclusion resulting from their location in rural areas and their being female in a patriarchal society that largely ignores their voices and devalues them based on gender. Despite such an acknowledgement, there remains a dearth of empirical studies that seek to understand, from the women's perspectives, the challenges of this disadvantaged group in accessing reproductive healthcare services. This research was aimed at understanding the experiences of rural women in accessing reproductive healthcare services, precisely, access to family planning and maternal healthcare services. An investigation into their lived experiences in accessing reproductive healthcare services was therefore imperative so as to document and adequately inform policy making.

The study also reviewed efforts made by government to ensure that rural women do have access to maternal health and family planning services. The study found that Zimbabwe has a progressive Constitution which, for the first time in its constitutional history, expressly provides for the right to reproductive health. Zimbabwe has also enacted different laws and policies that talk to women's reproductive health issues, established the Legal Aid Directorate responsible for representing indigent citizens and has established the Zimbabwe Human Rights Commission, mandated to promote, protect and fulfil human rights. Although not adequate to ensure rural women's access to reproductive health services, the study found the efforts commendable.

6.2.1 Conclusions on the history of the right to reproductive health in international human rights law and Zimbabwe's obligations

The first objective of the study was two pronged: to analyse the historical development of the concept of the right to reproductive health and Zimbabwe's obligations under the international human rights treaties that it is party to.

The study found that the right to reproductive health is a binding right provided for in the ICESCR, CEDAW, African Women's Protocol, the ACRWC and the CRC. Because Zimbabwe has ratified these international human rights treaties, it has obligations which are: the obligation to respect, protect and fulfil women's right to access reproductive health care services. All three obligations combined generally require Zimbabwe to put different measures in place, including enacting laws, eradicating societal barriers, ensuring availability and accessibility of health facilities, in order to realise rural women's access to reproductive health services.

6.2.2 Conclusions on Zimbabwe's legislative, policy and institutional frameworks

The second objective of the study was to assess whether Zimbabwe's legislative and policy framework complies with Zimbabwe's obligations as provided for in the international and regional human rights instruments. It was found that no piece of legislation (apart from the Constitution of Zimbabwe) expressly recognises the right to have access to reproductive health care services. Legislation that Zimbabwe has in place is not in compliance with its Constitution or with its international treaty obligations. For instance, the duty to respect requires it to enact progressive legislation. However, it was this study's finding that Zimbabwe current laws have restrictive provisions that violate women's right to access reproductive health services which inhibit women's capabilities to lead healthy lives. Such inadequate laws speak to Sen's capabilities theory which states that laws should be assessed based on whether or not they enhance the capabilities of individuals and their ability to perform socially accepted functionings.[643]

Additionally, Zimbabwe Termination of Pregnancy Act, which provides for access to abortion is indeed commendable. However, its stringent requirements to be met before women can be legally allowed to terminate pregnancy go against the core obligation of not enacting

[643] See Chapter 1, section 1.11.1 of this study.

legislation that limits or denies women access to reproductive healthcare services. Also, the study found that while Zimbabwe is currently conducting an alignment process to align laws that are archaic and not in sync with the Constitution and international best practices, the process is being done at a snail-pace. The study confirms previous studies that have been conducted on state obligations and lack of political will in complying with human rights obligations in general.[644]

The various policies reviewed by this study include the National Health Strategy and the National Adolescent Reproductive Health Strategy. The review revealed that although there is a policy that is dedicated to reproductive health issues, the policy is limited to adolescents to the exclusion of women, particularly rural women who face different challenges in accessing reproductive health services. Failure to expressly provide for rural women's concerns means that rural women cannot benefit from these policies, thus maintaining their right to access reproductive health services a pipe dream.

In addition, the study also reviewed the institutional framework for the realisation of women's right to access reproductive health services. This review identified the Ministry of Health and Child Care (MoHCC) as the main institution responsible for health issues in Zimbabwe. The Ministry has programmes that include Maternity Waiting Homes and Community Health workers, in compliance with Zimbabwe's obligations to ensure women have access to maternal health and family planning information and services. Other institutions include the ZHRC, the ZGC and the courts, which are crucial in information dissemination and providing remedies for violations of women's rights. These institutions enhance women's capabilities to exercise their right to access reproductive health care services.

6.2.3 Conclusions on rural women's experiences

This study investigated whether women in the Hwange Rural District had access to reproductive health care services as guaranteed by their right to such services under the Constitution of Zimbabwe and the treaties that Zimbabwe is a party to. To that end, the study explored rural women's experiences in accessing reproductive healthcare services. The results revealed that although women do have access to reproductive healthcare services, such access is met with a plethora of challenges. For instance, gender power relations perpetuated by

[644] L Sithole & C Dziva 'Eliminating harmful practices against women in Zimbabwe: Implementing article 5 of the African Women's Protocol' (2019) *African Human Rights Law Journal* 19: 568-590 at 579.

patriarchy emerged as a leading barrier to women's access to reproductive health services. Other challenges identified include, distance to the nearest health facility, costs for health services, lack of transportation to the health facility, unavailability of contraceptives and inadequate skilled health workers. All these challenges experienced by rural women are indicative of the fact that Zimbabwe is in violation of its obligations to protect, respect and fulfil reproductive rights as provided for in ICESCR, CEDAW, CRC and the African Women's Protocol. The study findings resonate with Sen's capabilities approach that for women to exercise their basic capabilities and functionings, they need to have access to the resources and social services required for a decent standard of living.

Similar to Nussbaum's capabilities approach which stipulates that subordination to men in society and the legal culture of patriarchy deprives women of their capabilities to make autonomous reproductive health decisions, the study found that patriarchy and religion affects women's participation and contribution in decision making. This is buttressed by the absence of measures to eradicate societal barriers, insubordination of women included, to women's access of reproductive health services. To deal with such hindrances, women use different strategies that include using contraception without their partners' knowledge to avoid unwanted pregnancies. The study's findings add to the body of knowledge around women's reproductive health rights, particularly on the different challenges faced by rural women in accessing reproductive health care services.

Rural women have no access to constant supply of electricity, they have poor road networks, no one raises awareness on human rights issues and many are illiterate. The barrier presented by poor road networks was emphasised by a majority of the participants, thus reinforcing the urban bias theory which underscores the point that with rural development, the hazards of dirt roads, dictate a preference for tarmac roads and for travel close to urban centres. Such neglect by the Government to service rural areas is a violation of women's right to access reproductive health services. This implies Zimbabwe is not in compliance with its obligations to protect, respect and fulfil rural women's right to access reproductive health services.

The study findings further revealed that rural women have lack of knowledge of the right to reproductive health. They know of what ought to happen when they get pregnant, but they do not understand that they have rights in this regard – binding and enforceable rights to have access to reproductive health care services as enshrined in section 76 of the Zimbabwean Constitution and Article 12 of the ICESCR, Articles 12, 14, 16 of the CEDAW, Article 14 of

the African Women's Protocol. It is important to note the applicability of Sen's capability theory which states that the most basic capability is the capability to be knowledgeable. Without knowledge, women cannot defend their rights against any violations and thus cannot hold the State accountable for the violations.

6.2.4 Conclusions on opportunities available to protect women's right to access reproductive healthcare services

The study reviewed the potential legal, administrative or political remedies available for the realisation of women's rights to access maternal and family planning services in Zimbabwe. The study found the courts, community mobilisation and traditional leaders as the most effective avenues that rural women can use to access remedies for violations of their rights and thus hold the State accountable for the violations. Courts, although granting orders that are enforceable, were found to be expensive and inaccessible to the rural women. The study found that the existence of the Legal Aid Directorate and different organisations play a crucial role in curing the hurdle as these organisations offer free legal services (litigating on behalf of the rural women). However, the study revealed that the major disadvantage about these organisations is their lack of presence at grassroots level, particularly in rural areas. This is where grassroots mobilisation comes in by engaging rural women themselves to participate in activities that affect them. The study found that awareness raising plays an important role in grassroots mobilisation as informed women are in a better position to fight and defend their rights. This confirms the capabilities approach which emphasises on empowering the individual to enhance her capabilities.

6.3 RECOMMENDATIONS

This section provides recommendations for the study. The recommendations are made in relation to general recommendations and recommendations for future research.

6.3.1 General Recommendations

To the Government of Zimbabwe:

a) **Grassroots organisations and awareness raising** *(ZHRC & MoHCC)* – to deal with the problem of lack of knowledge of reproductive health care services, it is recommended that the State prioritises grassroots organisations and awareness raising

to ensure that rural women are equipped with human rights knowledge required to make decisions about their bodies, health, and lives; negotiate healthy sexual and social relationships and to defend their rights. Such efforts, which should be continuous, and done using finances from the Ministry of Finance in collaboration with various donors – produce a knowledgeable populace capable of questioning the conduct of public institutions in terms of accountability, transparency, rule of law, effectiveness and for citizens to be able to stand for their rights through the seeking of remedies in the event of violation of their rights and freedoms.

b) **Human rights education** *(ZHRC)* – to curb harmful traditional, religious and health practices, the State should intensify human rights education programmes in both formal and informal sectors. Traditional leaders, men, religious leaders and health workers should be taught about human rights on a continuous basis.

c) Improve infrastructure *(Ministry of Transport and Infrastructure Development)* – the absence of roads and hospitals remains a major barrier to women's access of reproductive health care services. Therefore, the State should, through the Ministry of Transport, put effort in infrastructure development.

d) **Effective implementation measures** *(Ministry of Health and Child Care, Ministry of Finance, Ministry of Legal and Parliamentary Affairs, Chiefs Council)*– Zimbabwe complies with its obligations on paper as most of its policies and laws have domesticated international human rights provisions. However, implementation on the ground is lagging far behind. Therefore, successful implementation of MWHs for instance, requires factors such as male involvement, financial sustainability, strong management, community engagement, and, above all, the quality of the services provided. An adequate supply of essential resources and a properly trained health workforce are critical to ensuring that women receive high quality, respectful maternity care once they arrive at the facility from the MWH.

e) **Alternative sources of electricity** *(Zimbabwe Electricity Supply Authority, (ZESA) under the Ministry of Energy and Power Development)* **–** The enhancement of the quality of reproductive healthcare services in rural areas is, without a doubt, a prerequisite for achieving desired outcomes in maternal health in Zimbabwe. Therefore, Zimbabwe must ensure that rural health facilities are adequately equipped, particularly with skilled health workers and alternative sources of electricity.

f) **Adequately resourcing national commissions** *(Ministry of Finance and Economic Development)* – It is of paramount importance for national institutions concerned with

reproductive health rights to be fully supported in terms of financial and human resources as this is the only way for them to effectively implement their mandates. Such institutions will go a long way to ensure that all health professionals are trained in reproductive health rights.

To the Government of Zimbabwe (through the ZHRC) and; CSOs on human rights:

g) **Research** – There is need for re-thinking research and documentation of the experiences of this disadvantaged group by the Ministry of Health and Child Care and the Zimbabwe Human Rights Commission, looking deep into the different socio-economic and political variables peculiar to rural areas. This can be achieved through conducting situational analysis on the status of rural women's access to reproductive health care services through grassroots organisations. Information of this nature is a prerequisite for implementing successful intervention measures. Without a thorough understanding of women's perceptions of reproductive health in specific contexts, the State runs the risk of incorrectly homogenising and universalising women and their needs, which would weaken the effectiveness of reproductive health programmes. This is particularly important because, decades after the ICPD, the MDGs and now the SDGs, rural women still have inadequate access to reproductive health care.

6.3.2 Limitations and recommendations for future research

There is one major limitation to this study that has implications for further research. The limitation relates to the fact that this study was conducted in Hwange Rural District, Matabeleland North Province in Zimbabwe. Zimbabwe has 10 provinces with different cultural practices. The challenges rural women face in accessing reproductive healthcare services in the 10 Provinces are multifaceted and different. If feasible legislative and policy strategies are to be made, there is need for more empirical studies to be done in rural areas situated in the different provinces of the country. This is because challenges faced by women in, for instance, rural Matabeleland North may be different from the challenges faced by women in rural Mashonaland East. Consequently, exploring the following as future research strategies can facilitate the attainment of this goal:

1. Situational analysis of women's right to reproductive health in rural Zimbabwe;
2. Survey on knowledge and perceptions of reproductive health in rural Zimbabwe;

3. Using Geographical Information Systems and the law to determine the number of, and distance between health facilities in rural Zimbabwe.

6.4 CONCLUSION

This research aimed to identify challenges faced by women in Hwange Rural District, Zimbabwe, in accessing reproductive healthcare services, precisely, access to family planning and maternal healthcare services. Based on a qualitative analysis of women's experiences, it can be concluded that cultural and geographical barriers are important factors to consider when enacting legislation and policies on rural women's access to reproductive health. The results indicate that a number of intertwined challenges faced by rural women are as a result of cultural barriers while a few of the challenges are as a result of geographical locations of most health facilities. In the words of Thoraya Ahmed Obaid:

> The world can do better. The solutions are well known and effective. They include…the removal of barriers to women's equal participation in social, cultural, economic and political life…and the implementation of laws and policies that promote and protect the full range of internationally agreed human rights, including the right to sexual and reproductive health. All of these actions fall under the banner of "equality". Equality is an end in itself and a cornerstone of development.[645]

[645] Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund (UNFPA) Statement on the Occasion of World Population Day (July 11, 2005).

BIBLIOGRAPHY

PRIMARY SOURCES

LIST OF INTERNATIONAL AND DOMESTIC LEGAL INSTRUMENTS

International instruments

African Charter on Human and Peoples' Rights, concluded June 27 1981, entered into force October 21 1986 (1982) 21 *ILM* 58. [Banjul Charter]

African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990).

Convention on the Rights of the Child, concluded November 20 1989, entered into force, September 2 1990 (1989) 28 *ILM* 1456. [Children's Convention]

International Covenant on Economic, Social and Cultural Rights, GA res. 2200A (XXI), UN Doc. A/6316 (1966)

International Covenant on Civil and Political Rights, adopted 16 December 1966, entered into force 23 March 1976 (1967) 6 *ILM* 368. [ICCPR]

International Convention on the Elimination of All Forms of Discrimination Against Women, concluded December 18 1979, entered into force March 9 1981 (1980) 19 *ILM* 33. [Women's Convention; CEDAW]

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005

Universal Declaration of Human Rights, adopted 10 December 1948. GA Res 217A (III), UN Doc A/810 71 (1948). [UDHR]

Vienna Declaration and Programme of Action, adopted June 25, 1993 (UN Doc A/CONF 157/23). World Conference on Human Rights. [Vienna Declaration and Programme of Action]

Domestic legal instruments

Constitution of Zimbabwe Amendment (No. 20) Act of 2013.

Customary Marriages Act [Chapter 5:07].

Criminal Law (Codification and Reform) Act [Chapter 9:23].

Domestic Violence Act [Chapter 5:16].

Marriage Act [Chapter 56:11].

The Medical Services Act [Chapter 15:13]

Termination of Pregnancy Act [Chapter 15:10].

Zimbabwe Human Rights Commission Act [Chapter 10:30]

Zimbabwe Human Rights Commission (General) Regulations, 2016 (Statutory Instrument 77 of 2016)

OFFICIAL DOCUMENTS

General

Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (UN Doc. E/CN.4/1987/17, Annex; and (1987) 9 *Human Rights Q* 122. [*Limburg Principles*].

Organization of African Unity (OAU) *The Constitutive Act of the African Union* adopted at Lome, Togo, on the 11th day of July, 2000.

United Nations *Claiming the Millennium Development Goals: A Human Rights Approach* 2008, HR/PUB/08/3.

United Nations General Assembly *Transforming our world: The 2030 Agenda for Sustainable Development*, 21 October 2015, A/RES/70/1.

UN Programme of Action adopted at the International Conference on Population and Development [Cairo, 5-13 September 1994] A/CONF.171113/Rev.

United Nations '*Improvement of the situation of women in rural areas: Report of the Secretary General'* United Nations General Assembly Document A/62/202 (2007).

United Nations Economic and Social Council. *The empowerment of rural women and their role in poverty and hunger eradication, development and current challenge*. United Nations General Assembly Document E/CN.6/2012/3 (2011).

United Nations Report of the International Conference on Population E/CONF.76119 [Adopted at the World Population Conference. Mexico. 6 to 14 August 1984].

Proclamation of Teheran Resolution XVIII: Human Rights Aspects of Family Planning, Final Act of the International Conference on Human Rights. UN. Doc. A/CONF. 32/41

General comments

Committee on Economic, Social and Cultural Rights (CESCR), *General comment No 20 Non-discrimination in economic, social and cultural rights* (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, E/C.12/GC/20.

Committee on Economic, Social and Cultural Rights *General Comment No 3 The Nature of StatesParties' Obligations* ((Art. 2, Para. 1 of the International Covenant on Economic, Social and Cultural Rights, 1990) UN Doc E/1991/23.

Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14: The Right to the Highest Attainable Standard of Health* (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.

Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 9: The Domestic Application of the Covenant*, 3 December 1998, E/C.12/1998/24

Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15.

Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant), 20 January 2003, E/C.12/2002/11.

Committee on Economic, Social and Cultural Rights, General Comment No 22: The Right to Sexual and Reproductive Health UN Doc. No. E/C.12/GC/22) (2016).

General Recommendations

Joint general recommendation/general comment No 31 of the Committee on the Elimination of Discrimination against Women and No 18 of the Committee on the Rights of the Child on harmful practices CEDAW/C/GC/31-CRC/C/GC/18 2014.

Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1.

Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 19: Violence against women*, 1992.

Committee on the Elimination of Discrimination Against Women (CEDAW) *General Recommendation No 35 on gender-based violence against women, updating General Recommendation No 19* CEDAW/C/GC/35, 14 July 2017.

Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No 21: Equality in Marriage and Family Relations*, 1994 CEDAW A/49/38.

Other United Nations documents

Hunt, Paul *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: report of the Special Rapporteur*' (UN Doc E/CN.4/2004/49/Add.1 (2004)). [Hunt '*Report of the Special Rapporteur*']

UNFPA. *State of world population 2005: The Promise of Equality Gender Equity, Reproductive Health and the Millennium Development Goals*. (2005).

UNFPA. *Child Marriage by Sub-National Regions*. New York: UNFPA, 2011.

UNFPA. *Integrating Reproductive Rights into the work of National Human Rights Institutions of the Asia Pacific Region: A Preliminary study of current views and practices, challenges opportunities* (2011)

United Nations Department of Economic and Social Affairs Population Division *Abortion policies: A global review Volume 3* (2002).

UN Secretary-General. 2007. *Improvement of the situation of women in rural areas, Rep, of the Secretary General* U.N. Doc. A/62/202 (2007).

UN Secretary-General. *The empowerment of rural women and their role in poverty and hunger eradication, development and current challenge*: Report of the Secretary-General U.N. Doc. E/CN.6/2012/3 (2011).

UNESCO (2012). World Programme for Human Rights Education: Plan of Action.

United Nations Food and Agriculture Organization. Gender and Land rights Database: Zimbabwe.

United Nations Zimbabwe 'Zimbabwe Launches a Four Year Sexual and Reproductive Health and HIV Prevention Programme

International Fund for Agricultural Development

Rural Poverty Report 2011: New realities, new challenges, new opportunities for tomorrow's generation (2011) IFAD.

World Bank

Global Monitoring Report 2009: A Development Emergency. (Washington, DC: The World Bank.).

World Health Organisation

World Health Statistics 2009. (Geneva: World Health Organization.)

World health statistics 2019. (Geneva: World Health Organization.)

World Health Organisation *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* 6 ed (2011) Geneva, WHO

World Health Organisation *Medical eligibility criteria for contraceptive use* 5 ed (2015)

World Health Organization (2012). *Report of the Commission on Women's Health in the African Region: Addressing the Challenge of Women's Health in Africa.*

World Health Organization *International Statistical Classification of Diseases and Related Health Problems* 10th Revision (1992).

Zimbabwe

Government of Zimbabwe & United Nations Zimbabwe '*Zimbabwe Millennium Development Goals Progress Report 2012'*

Central Statistics Office '*Zimbabwe Demographic and Health Survey Report 2005 -2006*.

Media Monitors *Radio Landscape in Zimbabwe: A report by Media Monitors on the typology of radio in Zimbabwe* (2018).

Ministry of Foreign Affairs *Report on Renewable Energy Market in Zimbabwe* (2017).

Ministry of Health and Child Care 'The National Health Strategy for Zimbabwe (2009–2013), Equity and Quality in Health: A People's Right' (2010)

Ministry of Health and Child 'The National Health Strategy for Zimbabwe (2016–2020), Equity and Quality in Health: Leaving No one Behind' (2016).

Ministry of Health and Child Care 'National adolescent and youth sexual and reproductive health strategy (ASRH) II: 2016-2020'.

Ministry of Women Affairs, Gender and Community Development *The national gender-based violence strategy 2012-2015*.

Zimbabwe National Statistics Agency '*Multiple Indicator Monitoring Survey 2009 (MIMS)*'

UNICEF, CASS & The Zimbabwean Government 2010, *A Situational Analysis on the Status of Women's' and Children's Rights In Zimbabwe 2005-2010: A Call for Reducing Disparities and Improving Equity*

Zimbabwe National Statistics Agency 'Provincial Census Report: Matabeleland North Province' 2012.

Zimbabwe National Maternal and Neonatal Health Road Map 2007-2015

Zimbabwe National Statistics Agency and ICF International. *Zimbabwe Demographic and Health Survey 2015: Final Report* (2016) Rockville, Maryland, USA

Zimbabwe 2012 Millennium Development Goals Status Report (United Nations 2012)

Zimbabwe Treasury. Zimbabwe 2019 Budget Highlights.

Zimbabwe National Statistics Agency (2016) *Maternal Health: 2015 Key Findings.*

Zimbabwe Human Rights Commission *Baseline Survey on 'Perceptions, attitudes and understanding on human rights in Zimbabwe (2015).*

LIST OF INTERNATIONAL AND DOMESTIC CASES

Domestic cases

Zimbabwe

City of Harare v Mushoriwa (SC 54/18, Case No. SC 228/14) [2018] ZWSC 54 (20 September 2018).

Hopcik Investments (Pvt) Ltd v Minister, Environment, Water & Climate & Another (HH 137-16, HC 1796/14) [2016] ZWHHC 137 (17 February 2016).

Loveness Mudzuru & Another v Minister of Justice Legal and Parliamentary Affairs NO & 2 Others CC 12-15) [2015] ZWCC 12 (20 January 2016)

Mildred Mapingure v The Minister of Health and Others SC 22/14.

Mlilo v The President of the Republic of Zimbabwe (HH 236-18, HC 9829/17) [2018].

South Africa

Christian Lawyers Association of SA v Minister of Health 1998 4 SA 1113 (T).

Fose v Minister of Safety and Security 1997 (3) SA 786 (CC).

Government of the Republic of South Africa and Others v Grootboom and Others [2000] ZACC 19; 2001 (1) SA 46 (CC).

Mazibuko & Others v City of Johannesburg & Others [2009] ZACC 28 [2010 (4) SA

Minister of Health v Treatment Action Campaign 2002 10 BCLR 1033 (CC).

Ntsele v MEC for Health, Gauteng Provincial Government [2012] ZAGPJHC 20.

Soobramoney v Minister of Health (Kwazulu-Natal) (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997).

International cases

Committee on the Elimination of Discrimination Against Women (CEDAW)

Alyne da Silva Pimentel Teixeira (deceased) v razil, CEDAW/ C/49/D/17/ 2008, August 10, 2011

African Commission on Human and People's Rights

Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, Les Témoins de Jehovah vs Zaire Communications Nos. 25/89, 47/90, 56/91, 100/93 (1996), 9th Activity Report.

The Social and Economic Rights Action Center and the Center for Economic and Social Rights vs Nigeria Communication 155/96, (2001), 15th Activity Report, Annex V.

Purohit and others v The Gambia 2003) AHRLR 96 (ACHPR 2003).

SECONDARY SOURCES

Books

Alston Philip 'The Historical Origins of the Concept of "General comments" in Human Rights Law' in Laurence Boisson de Chazournes and Vera Gowland-Debbas (eds) *The International Legal System in Quest of Equity and* Universality: *Liber Amicorum Georges Abi-Saab* (2001) Martinus Nijhoff.

Antrobus Peggy 'Critiquing the MDGs from a Caribbean Perspective' in Caroline Sweetman (ed) *Gender and the Millennium Development Goals* (2005) Taylor & Francis Inc, Philadephia USA.

Bennett IW and Strug J *Introduction to International Law* (2013) Juta, Cape Town.

Britten Nicky 'Qualitative Interviews in Healthcare' in Pope C & Mays N (eds) *Qualitative Research in Health Care* 2 ed (1999) BMJ Books, London.

Cerna CM and Wallace JC 'Women and Culture' in Askin KD & Koenig DM (eds) *Women and International Human Rights Law, Human Rights Issues Vol 1* (1999) Transnational Publishers.

Chambers, R *Rural Development: Putting the last first* (1983) New York: Longman Inc.

Chapman Audrey R and Sage Russell 'Introduction' in Audrey Chapman and Russell Sage (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (2002) Antwerp, New York: Intersentia.

Chapman, Audrey R 'Core Obligations Related to the Right to Health', Audrey Chapman and Russell Sage (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (2002) Antwerp, New York: Intersentia.

Chikanda A 'The Migration of Health Professionals from Zimbabwe' In J Connell (ed) *The International Migration of Health Workers* (2008) London: Routledge

Choruma T *The forgotten tribe: People with disabilities in Zimbabwe* (2007) Progression London

Cook Rebecca J, Dickens Bernard M, Wilson Andrew FO, & Scarrow Susan E *Advancing Safe Motherhood through Human Rights* (2001) WHO, Geneva Switzerland.

Cook Rebecca J *Women's Health and Human Rights: The Promotion and Protection of Women's Health through International Human Rights law* (1994) World Health Organization, Geneva.

Cook Rebecca J 'International human rights to improve women's health' in Cook, RJ *Women's health and human rights: The promotion and protection of women's health through international human rights law* (1994) Geneva, World Health Organization.

Cook Rebecca J, Dickens Bernard M, and Fathalla Mahmoud F *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (2003) Clarendon Press, Oxford.

Correa S & Petchesky R 'Reproductive and Sexual Rights: A Feminist Perspective,' in Sen G, Germain A & Chen LC (eds) *Population policies reconsidered: Health, Empowerment, and right* (1994) Harvard University Press.

Creswell John W *Qualitative enquiry and research design: choosing among five traditions* (1998) Thousand Oaks, CA, US: Sage Publications, Inc.

Creswell John W *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* 3 ed (2008) Pearson/Merrill Prentice Hall.

Craven Matthew CR *The International Covenant on Economic, Social, and Cultural Rights: A Perspective on Its Development* (1998) Clarendon Press.

DeWalt Kathleen M & DeWalt Billie R. *Participant observation: a guide for fieldworkers* (2002) Walnut Creek, CA: AltaMira Press.

Dreyer Kruger *An introduction to phenomenological psychology* 2 ed (1988) Juta, South Africa.

Dworkin Gerald *The Theory and Practice of Autonomy* (1988) Cambridge: Cambridge University Press.

Eide A, & Eide, WB ‘Article 24, The Right to Health’ in Alen A, Van de Lanotte J, Verhellen E et al (eds) *A Commentary on the United Nations Convention on the Rights of the Child Leiden* (2006) Martinus Nijhoff Publishers.

Flowers Nancy (ed) *Human Rights Here and Now: Celebrating the Universal Declaration of Human Rights* (1998). Minneapolis: Human Rights Educators’ Network, Amnesty International USA.

Gaidzanwa R *Voting with their Feet: Migrant Zimbabwean Nurses and Doctors in the Era of Structural Adjustment* (1999) Uppsala: Nordiska Afrikainstitutet.

Greene M ‘The lived world, literature and education’ in Donald Vandenberg (ed) *Phenomenology & education discourse* (1997) Heinemann.

Holmes W & Kennedy E *Reaching emergency obstetric care: overcoming the ‘second delay* (2010) Burnett Institute: Melbourne, Australia.

Holloway Immy *Basic concepts for qualitative research* (1997) Wiley-Blackwell.

Humphrey JP ‘The Universal Declaration of Human Rights: Its history, impact and juridical character’ in BG Ramcharam (ed) *Human rights: Thirty years after the Universal Declaration* (1979) Brill Nijhoff.

Jesani Amar & Jaitly Tejal-Barai (eds) *Ethical Guidelines for Social Science Research in Health* (2000) Centre for Studies in Ethics and Rights Candelar, Mumbai.

Kangaude, Godfrey D (ed) *Legal Grounds III: Reproductive and Sexual Rights in Sub-Saharan African Courts* (2017) Pretoria University Law Press, South Africa.

Keetharuth Sheila B ‘Major African legal instruments and human rights’ in Anton Bosl and Joseph Diescho (eds) *Human Rights in Africa* (2009) Windhoek: MacMillan Education

Khanna J, Bergsjo P, Lashley K, Peters C, Sherrat D and Villar J *WHO antenatal care randomized trial: manual for the implementation of the new model* (2002) Geneva, WHO.

Kishor Sunita and Kiersten Johnson *Profiling Domestic Violence—A Multi-Country Study* (2004) Calverton, MD: ORC Macro.

Kishor S & Subaiya L *Understanding women's empowerment: a comparative analysis of demographic and health surveys data.* DHS comparative reports No 20 (2008) Calverton, Maryland, USA: Macro International.

Kufuor, KO *The African human rights system: origin and evolution* (2010) New York, Palgrave Macmillan.

Kvale Steinar *Interviews: An introduction to qualitative research interviewing* (1996) SAGE Publications.

MacKinnon C *Toward a feminist theory of the state* (1989) Cambridge, MA: Harvard University Press.

Maguranyanga Brian *Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe: A qualitative study on determinants of healthcare-seeking behaviour among the Apostolic Faith community* (2011) UNICEF Zimbabwe.

Maine D *Studying Maternal Mortality in Developing Countries: A Guidebook on Rates and Causes* (1987) Geneva, World Health Organization.

Makuto D and James V *Study on Access to Health Care Services in Zimbabwe* (2007) CORYS Nederland BV, European Union.

Mathur, JS *Preventive and Social Medicine* (2007) CRB Publisher, New Delhi, India.

Marshall Catherine & Rossman Gretchen B *Designing Qualitative Research* 4 ed (2006) Thousand Oaks, CA, US: Sage Publications, Inc.

Masiiwa Ragies G. *On the public role of the Bible in Zimbabwe: Unpacking Banana's "re-writing" call for a socially and contextually relevant Biblical Studies* (2015) University of Bamberg Press.

Maxwell Joseph A 'Designing a qualitative study' in Leonard Bickman & Debra J Rog (eds) *Handbook of applied social research methods* (1998) Thousand Oaks, Sage.

May James R and Daly Erin *Global Judicial Handbook on Environmental Constitutionalism* 3 ed (2017) United Nations Environment Programme.

Matsikidze R *Alternative Dispute Resolution in Zimbabwe: A Practical Approach to Arbitration Mediation and Negotiation* (2013) Molhurst Printers and Publishers, Harare.

Mathur JS *Preventive and Social Medicine*: *A Comprehensive Textbook With Special Focus on Nepal* (2007) CBS Publishers & Distributors Pvt Ltd, India.

Miles Mathew B & Huberman Michael A *Qualitative Data Analysis* 2 ed (1994) Thousand Oaks, CA, US: Sage Publications, Inc.

Moreland S and Talbird S *Achieving the millennium development goals: the contribution of fulfilling the unmet need for family planning* (2006) Washington, DC: Constella Futures, Policy.

Morrow Susan L & Smith ML 'Qualitative research for counselling psychology' in SD Brown & RW Lent (eds) *Handbook of counselling psychology* 3 ed (2000) John Wiley & Sons Inc.

Müller Amrei 'An Analysis of Health-Related Issues in Non-International Armed Conflicts' in Michael O'Flaherty and David Harris (eds) *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law* (Nottingham Studies on Human Rights Volume 2, 2013) Brill Nijhoff Publishers.

Munjanja Stephen P *Maternal and Perinatal Mortality Study 2007* (2009) United Nations Population Fund.

Musekiwa N 'The role of local authorities in democratic transition' in E Masunungure & J Shumba (eds) *Zimbabwe: Mired in Transition* (2012) Harare: Weaver Press.

Ndlovu N *Protection of socio-economic rights in Zimbabwe: A critical assessment of the domestic framework under the 2013 Constitution of Zimbabwe* (2016) Hamburg: Anchor Academic Publishing.

Nussbaum M *Women and Human Development: The Capabilities Approach* (2000) Cambridge: Cambridge University Press.

Nussbaum Martha C 'Human Capabilities, Female Human Beings' in M Nussbaum & J Glover (eds) *Women, Culture, and Development* (1995) Delhi: Oxford University Press.

Oguli-Oumo Margaret, Imelda Molokomme, Valencia KD Mogegeh, Monde M Gwaba and Lucia Kiwala *Promoting an integrated Approach to combat Gender Based Violence: A Training Manual* New Gender Mainstreaming Series (2002) Commonwealth Secretariat.

Okon Etim E *Religion and Human Rights Education* (2011) University of Calabar Press.

Osirin P *Women's Rights as Human Rights* (2003) London: Zed Books

O'Sullivan M 'Reproductive Rights' in Woolman S & Bishop M (eds) *Constitutional Law of South Africa* 2 ed (2012) Juta Cape Town Revised Service

Patton Michael Quinn. *Qualitative Research and Evaluation Methods* 3 ed (2002) Thousand Oaks CA, Sage.

Petchesky R P and Judd K (eds) *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (1998) Zed Books, New York

Pizzarossa Lucía Berro & Perehudoff Katrina S. 'Mapping Constitutional Commitments on Sexual and Reproductive Health and Rights: A Global Survey' in Sambine Klotz, Heinr Bielefedt, Martina Schmidhuber & Andreas Frewe (eds) *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation* (2017) Majuskel Medienproduktion GmbH, Wetzlar.

Rahman Anika and Nahid Toubia *Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies* (2000) Zed Books Ltd, London and New York.

Robinson David & Reed Val (eds) *The A – Z of social research jargon (1998) A*rena Publishers.

Sanders D ‘The potential and limits of health sector reform in Zimbabwe’ in Rohde J, Chatterjee M and Morley D (eds) *Reaching Health for All* 1993 New Delhi, India: Oxford University Press.

Seidman Irving E *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (1991) New York, NY, US: Teachers College Press.

Seidman Irving. *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences* 3 ed (2006) Teachers College Press.

Sen S & Batliwala S ‘Empowering women for reproductive rights’ in Presser HB & Sen G (eds) *Female empowerment and demographic processes: Moving beyond Cairo* (2000) New York: Oxford University Press.

Sensoy N, Korkut YS, Akturan Yilmaz M, Tuz C and Tuncel B ‘Factors Affecting the Attitudes of Women toward Family Planning’ in Zouhair Amarin (ed) *Family Planning* (2018) IntechOpen Limited, London.

Sen, Amartya ‘Equality of what?’ in McMurring SM (ed) *Tanner Lectures on Human Values* Volume 1 (1980) Cambridge, Cambridge University Press.

Sen Amartya ‘Capability and Well-being’ in Sen and Nussbaum *The Quality of Life* (1993) Oxford: Clarendon Press.

Sen A *Development as freedom* (2000) New Delhi: Oxford University Press.

Sen A *Inequality re-examined* (1995) New Delhi: Oxford University Press.

Shanthi K ‘Feminist Bioethics and Reproductive Rights of Women in India: Myth and Reality’ in D Tong (ed) *Linking Visions: Feminist Bioethics, Human Rights and the Developing World* (2004) Rowman & Littlefield, Lanham, Maryland.

Shelton Dinah ‘Commentary and Conclusions’ in Dinah Shelton (ed) *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System* (2003) Oxford University Press.

Shue Henry *Basic Rights: Subsistence, Affluence and US Foreign Policy* 2 ed (1996) Princeton, NJ: Princeton University Press.

Smedley BD, Stith AY & Nelson AR (ed) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) Washington (DC): National Academies Press.

Welman Johannes C & Kruger Fanie SJ *Research methodology for the business and administrative sciences* (1999) Oxford University Press.

Journal Articles

Adejumo AO, Faluyi M, and Adejuwon A 'Role of Socio-Psychological Factors in Perceived Quality of Care Rendered by Traditional Medical Practitioners in Ibadan, Nigeria' (2013) *Global Journal of Health Science* Volume 5 No 6.

Adewuyi, A & Ogunjuyigbe P 'The Role of Men in Family Planning: An Examination of Men's Knowledge and Attitude to Contraceptive Use among the Yorubas' (2003) *African Population Studies* 18 (1).

Akpenpuun Joyce R 'Influence of religious beliefs on healthcare practice' (2014) *International Journal of Education and Research Volume 2 No 4*.

Alston Philip and Quinn Gerard. 'The Nature and Scope of StatesParties' Obligations under the International Covenant on Economic, Social and Cultural Rights' (1987)*Human Rights Quarterly, Vol. 9*.

Armiger Bernadette 'Ethics in Nursing Research: Profile, Principles, Perspective' (1997) *Nursing Research Volume 26 Issue 5*.

Asia Pacific Forum of National Human Rights Institutions '*Integrating Reproductive Rights into the work of National Human Rights Institutions of the Asia Pacific Region: A Preliminary study of current views and practices, challenges opportunities'*

Badul Chantal J & Ann Strode 'LM and Others v Government of the Republic of Namibia: The first sub-Saharan African case dealing with coerced sterilisations of HIV-positive women - Quo vadis?' (2013) *African Human Rights Law Journal* Volume 10.

Banda, Fareda ‘Blazing a Trail: The African Protocol on Women's Rights Comes into Force’ (2006): *Journal of African Law* 50, No 1.

Bankole, A & Singh S ‘Couple’s fertility and contraceptive decision-making in developing countries: hearing the man’s voice’ (1998) *International Family Planning Perspectives 24 (1)*

Belsey, MA ‘Maternal and Child Health: A Basic Part of Public Health’ (2009) *Medical Sciences Volume 1*.

Bhutta R N and Haider Jahanzaib ‘Effects of Economic Dependency on Decision Making Power of Women in Rural Areas of Tehsil Dera Ghazi Khan’ (2013) *International Journal of Academic Research in Business and Social Sciences Volume 3 Issue 2*.

Biddlecom A & Fapohunda B ‘Covert contraceptive use: prevalence, motivations, and consequences’ 1998 *Studies in Family Planning Volume 29 No 4.*

Brunson EK, Shell-Duncan B and Steele M ‘Women’s autonomy and its relationship to children’s nutrition among the Rendille of Northern Kenya’ (2009) A*merican Journal of Human Biology 21(1).*

Campbell Oona MR & Graham Wendy J ‘Strategies for reducing maternal mortality: getting on with what works’ (2006) *The Lancet Maternal Survival Series Volume 368,* No 954.

Campbell Jacqueline C ‘Health Consequences of Intimate Partner Violence’ (2002) *The Lancet* 359, No 9314.

Chapman Audrey R ‘Violations Approach’ for Monitoring the International Covenant on Economic, Social and Cultural Rights’ (1996) *Human Rights Quarterly 18* (1).

Chikanda A ‘Skilled Health Professionals’ Migration and Its Impact on Health Delivery in Zimbabwe’ (2006) *Journal of Ethnic and Migration Studies 32*.

Chikovore Jeremiah ‘Gender Power Dynamics in Sexual and Reproductive Health: A Qualitative Study in Chiredzi District, Zimbabwe’ (2004) *Umea University Medical Dissertations New Series No 876.*

Chirawu-Mugomba, Slyvia ‘A Reflection on the Domestic Violence Act [Chapter 5:16] and Harmful Cultural Practices in Zimbabwe’ (2016) *Zimbabwe Electronic Law Journal Volume I.*

Chivasa Norman ‘*Kuripa Ngozi* as a conflict resolution model in Shona communities of Zimbabwe: a conceptual analysis’ (2019) *Critical African Studies Volume 11 Issue 2.*

Chiweshe M ‘Wives at the Market Place: Commercialisation of Lobola and Commodification of Women's bodies in Zimbabwe’ (2016) *The Oriental Anthropologist,* 16 (2).

Choguya Naume Zorodzai. ‘Traditional and Skilled Birth Attendants in Zimbabwe: A Situational Analysis and Some Policy Considerations’ (2015) *Journal of Anthropology Volume 2015.*

Chuma M & Chazovachii B ‘Domestic Violence Act: Opportunities and Challenges for women in rural areas: The case of Ward 3, Mwenezi District, Zimbabwe’ (2012) *International Journal of Politics and Good Governance Volume 3, No. 3.4 Quarter IV.*

Cohen, C ‘The Developing Jurisprudence of the Rights of the Child’ (1993) *St Thomas Law Review 1:6.*

Cook Rebecca J & Mahmoud Fathalla F ‘Advancing Reproductive Rights Beyond Cairo and Beijing’ (1996) *International Family Planning Perspectives. Volume 22 No. 3.*

Cook Rebecca J ‘International Human Rights and Women's Reproductive Health’ (1993) *Studies in Family Planning Volume 24 No 2.*

Cook Rebecca J, Ortega-Ortiz A, Romans S and Ross LE ‘Legal Abortion for Mental Health Indications’ *International Journal of Gynaecology & Obstetrics 95 (2)* (2006).

Cook Rebecca J & Bewley S ‘Acknowledging a persistent truth: Domestic violence in pregnancy’ (2008) *Journal of Royal Society of Medicine.*

Crossette B ‘Reproductive health and the Millennium Development Goals: the missing link’ (2005) *Studies in Family Planning.*

Dodzo MK, Mhloyi M ‘Home is best: Why women in rural Zimbabwe deliver in the community’ (2017) *PLoS ONE 12(8)*.

Durojaye Ebenezer and Murungi Lucyline N ‘The African Women's Protocol and sexual rights’ (2014) *The International Journal of Human Rights Volume 18*.

Dziva C & Mazambani D 'The Constitutional Court ruling against child marriages in Zimbabwe: A landmark decision for advancing the rights of the girl child' (2017) 33 *Eastern Africa Social Science Research Review*.

Eide A ‘Realisation of Social and Economic Rights and the Minimum Threshold Approach’ (1989) *Human Rights Law Journal* 1-2.

Ekundayo Osifunke ‘Does the African Charter on the Rights and Welfare of the Child (ACRWC) only Underlines and Repeats the Convention on the Rights of the Child (CRC)’s Provisions?: Examining the Similarities and the Differences between the ACRWC and the CRC’ (2015) *International Journal of Humanities and Social Science* Volume 5 No 7(1)

Esser Charlotte ‘Neither bad luck nor chance: the health crisis in Zimbabwe in the context of human rights’ (2011) *Menschenrechte und Gesundheit Amnesty-Aktionsnetz Heilberufe, Jg. 1.*

Fahed Abul-Ethem ‘The Role of the Judiciary in the Protection of Human Rights and Development: A Middle Eastern Perspective’ (2002) *Fordham International Law Journal Volume 26 Issue 3*.

Forman Lisa, Luljeta Caraoshi, Audrey R Chapman & Everaldo Lamprea ‘Conceptualising minimum core obligations under the right to health: How should we define and implement the ‘morality of the depths’ (2016) *The International Journal of Human Rights.*

Galati A ‘Sexual and reproductive health and rights in the context of the Sustainable Development Goals’ (2015) *Guttmacher Policy Rev*iew.

Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L & Watts CH 'Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence' (2006) *The Lancet*.

Gerber Paula, Joanna Kyriakakis and Katie O'byrne 'General comment 16 on state obligations regarding the impact of the business sector on children's rights: what is its standing, meaning and effect?' (2013) *Melbourne Journal of International Law Volume 14*.

Gerntholtz Liesl, Gibbs Andrew and Willan Samantha 'The African Women's Protocol: Bringing Attention to Reproductive Rights and the MDGs' (2011) *Plos Medicine Journal Volume 8 (4).*

Getachew Assefa A and Ngankam Kameni 'Celebrating 25 Years of the African Charter on the Rights and Welfare of the Child: Lookin back to look ahead' (2016) *AU ECHO Newsletter 2016: African Year of Human Rights with Particular Focus on the Rights of Women*.

Gore Oliver, Mukanangana Festus, Muza Collet & Chiweshe Manase K 'The role of Village Health Workers and challenges faced in providing primary health care in Mutoko and Mudzi Districts in Zimbabwe (2015) *Global Journal of Biology, Agriculture and Health Sciences Volume 4(1).*

Greene Margaret E & Biddlecom Ann E 'Absent and problematic men: demographic accounts of male reproductive roles' (2000) *Population and Development Review Volume 26 No. 1*.

Grieser M, Gittelsohn Joel, Shankar Anita V, Koppenhaver Todd, Legrand Thomas K, Marindo Ravai, Mavhu Webster M and Hill Kenneth 'Reproductive decision making and the HIV/AIDS epidemic in Zimbabwe' *Journal of Southern African Studies, Volume. 27 No. 2* (2001).

Grose Rose G, Chen Julia S, Roof Katherine A, Rachel Sharon and Yount Kathryn M 'Sexual and Reproductive Health Outcomes of Violence against Women and Girls in Lower-Income Countries: A Review of Reviews' (2020) *The Journal of Sex Research.*

Haslegrave Marianne & Bernstein Stan 'ICPD Goals: Essential to the Millennium Development Goals' (2005) *Reproductive Health Matters.*

Heidari Shirin & García-Moreno Claudia 'Gender-based violence: a barrier to sexual and reproductive health and rights' (2016) *Reproductive Health Matters, 24:47.*

Hindin Michele J 'Understanding Women's attitudes towards wife beating in Zimbabwe' (2003) *Bulletin of the World Health Organization*.

Isbell Thomas and Krönke Matthias 'Ill-prepared? Health-care service delivery in Zimbabwe' (2018) *Afrobarometer Dispatch No. 240*.

Izugbara Chimaraoke O 'Women's Understanding of Factors Affecting their Reproductive Health in a Rural Ngwa Community' (2000) *African Journal of Reproductive Health. Volume 4 No. 2.*

Jejeebhoy Shireen J & Sathar Zeba A 'Women's Autonomy in India and Pakistan: The Influence of Religion and Region' (2001) *Population and Development Review Journal Volume 27 Issue 4.*

Julien Hélène 'Is There a Human Right to Safe Motherhood within the United Nations Legal System?' (2015) *Queen Marry Human Rights Rights Volume 2 No1*.

Kambarami M 'Femininity, Sexuality and Culture: Patriarchy and Female Subordination in Zimbabwe' *Understanding Human Sexuality Seminar Series (2006)* Africa Regional Sexuality Resource Center.

Kawulich Barbara B 'Participant Observation as a Data Collection Method' (2005) *Forum: Qualitative Social Research Volume 6 No. 2.*

Kofuor E, Darteh Maafo, David Teye Doku and Kobina Esia-Donkoh 'Reproductive health decision making among Ghanaian women' (2014) *Reproductive Health Volume 11 Issue 23.*

Kurebwa Jeffrey 'Knowledge and Perceptions of Adolescent Sexual and Reproductive Health Issues Among Rural Adolescence in Gutu Rural District Of Zimbabwe' (2018) *International Journal of Advanced Research and Publications.*

Kvale Steinar ‘Dominance through Interviews and Dialogues’ (2006) *Qualitative Inquiry Volume 12 Number 3*.

Majumdar Sumon, Anandi Mani & Sharun Mukand ‘Politics, Information and Urban Bias’ (2004) J*ournal of Development Economics Volume 75(1).*

Mahomed K, Healy J, & Tandon S ‘A comparison of manual vacuum aspiration (MVA) and sharp curettage in the management of incomplete abortion’ (1994) *International Journal of Gynaecology and Obstetrics 46(1)*.

Maite San G ‘The Human Right to Equal Access to Health Care’ (2012) *School of Human Rights Research Series Volume 53*.

Makwara V and Kaseke KE ‘The Role of Culture on Violence against Women in Zimbabwe: A Case Study of Domboshava, Dunya Village’ (2015) *The International Journal of Humanities & Social Studies Volume 3 Issue 2.*

Maluleke MJ ‘Culture, tradition, custom, law and gender equality’ (2012) *Potchefstroom Electronic Law Journal Volume 15 No 1.*

Mkoka DA, Goicolea Isabel, Angwara Kiwara, Mughwira Mwangu, and Anna-Karin Hurtig ‘Availability of drugs and medical supplies for emergency obstetric care: experience of health facility managers in a rural District of Tanzania’ (2014) *BMC Pregnancy Childbirth* 14.

Monir Islam ‘The Safe Motherhood Initiative and beyond’ (2007) *Bulletin of the World Health Organization* Volume 85 Number 10.

Msokaa AC, Pallangyoa Eunice S, Brownie Sharon and Eleanor Holroydd ‘My husband will love me more if I give birth to more children: Rural women’s perceptions and beliefs on family planning services utilization in a low resource setting’ (2019) *International Journal of Africa Nursing Sciences* Volume 10, 152-158.

Msovela J, Tengia–Kessy A & Mubyazi GM ‘Access to Family Planning Information and Contraception Methods Use among Tanzanian Men: A Cross-Sectional Study in Kibaha District’ (2016) *Journal of Epidemology Preventive Medicine 2(2).*

Mugweni Esther, Omar Mayeh & Pearson Stephen 'Understanding barriers to safer sex practice in Zimbabwean marriages: implications for future HIV prevention interventions' (2014) *Health Education Research*.

Mukanangana F, Moyo S, Zvoushe A and Rusinga O 'Gender Based Violence and its Effects on Women's Reproductive Health: The Case of Hatcliffe, Harare, Zimbabwe' (2014) *African Journal of Reproductive Health Volume 18 Issue 1*.

Mukherjee JS & Eustache FE 'Community health workers as a cornerstone for integrating HIV and primary healthcare' (2007) *AIDS Care*.

Mureinik Etienne 'Beyond a Charter of Luxuries: Economic Rights in the Constitution' (2017) *South African Law Journal* 8:4.

Murungi LN & Durojaye E 'The sexual and reproductive health rights of women with disabilities in Africa: Linkages between the CRPD and the African Women's Protocol' (2015) *African Disability Rights Yearbook (3).*

Nawal Nour M 'Child Marriage: A Silent Health and Human Rights Issue' (2009) *Reviews in Obstetrics and Gynaecology Journal Volume 2*.

Nussbaum Martha 'Human Rights and Human Capabilities' (2007) *Harvard Human Rights Journal* 20.

Nussbaum Martha C 'Women and Equality: The Capabilities Approach' (1999) *International Labour Review Volume 138 No.3.*

Ndlovu V 'Communication and the Decision Making Process among Couples with HIV/AIDS in Bulawayo, Zimbabwe' (2014) *International Scholarly Research Notices Infectious Diseases Volume 2014*.

Ngwena CG, Eunice Brookman-Amissah & Patty Skuster 'Human rights advances in women's reproductive health in Africa' (2015) *International Journal of Gynecology & Obstetrics, Volume 129, Issue 2.*

Ngwena C 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' (2010) *Human Rights Quarterly Volume 32, Number 4*.

Ngwena Charles G ‘Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa’ (2010) *Human Rights Quarterly Vol. 32*, No. 4

Ngwena Charles G ‘Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level’ (2010) *International Journal of Gynecology and Obstetrics*, 110 (2).

Ngwenya Similo ‘Communication of reproductive health information to the rural girl child in Filabusi, Zimbabwe’ (2016) *African Health Sciences Volume 16 (2)*.

Nkonki L, Cliff J & Sanders D ‘Lay health worker attrition: important but often ignored’ (2011) *Bulletin of the World Health Organ*, 89 (12).

Nyathi Leoba, Tugli Augustine K, Takalani G. Tshitangano, and Molyn Mpofu ‘Investigating the accessibility factors that influence antenatal care services utilisation in Mangwe district, Zimbabwe’(2017) *African Journal of Primary Health Care and Family Medicine 9 (1).*

O’Brien S and Broom A ‘HIV in (and out of) the clinic: Biomedicine, traditional medicine and spiritual healing in Harare’ (2014) *Journal of Social Aspects of HIV/AIDS 11(1).*

O’Donnell Owen ‘Access to health care in developing countries: breaking down demand side barriers’ (2007) *Cad Saúde Pública, Rio de Janeiro Volume 23 No. 12.*

Oyediran K & Isiugo-Abanihe U ‘Husband-wife communication and couple’s fertility desires among the Yoruba of Nigeria’ (2002) *African Population Studies Volume 17 No. 2*.

Pell C, Meñaca A, Were F, Afrah NA, Chatio S, Manda-Taylor L, Hamel MJ, Hodgson A, Tagbor H, Kalilani L, Ouma P and Pool R ‘Factors affecting antenatal care attendance: Results from qualitative studies in Ghana, Kenya and Malawi’ (2013) *PLoS One* Voulme 8.

Walsh A, Matthews A, Manda-Taylor L, Brugha R, Mwale D, Phiri T, Byrne E ‘The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi’ (2018) *Health Policy and Planning*.

Wigley Jenny 'Politics and Fertility: The Evolution of Sexual and Reproductive Rights' *Human Rights Research Journal Volume 3*.

Penn-Kekana L, Pereira S, Hussein J, Bontogon H, Chersich M, Munjanja S and Portela A 'Understanding the implementation of maternity waiting homes in low- and middle-income countries: a qualitative thematic synthesis' (2017) *BMC Pregnancy and Childbirth* 17 (1).

Pickles C 'Termination-of-pregnancy rights and foetal interests in continued existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996' (2012) *Potchefstroom Electronic Law Journal (15)5.*

Pyles L 'The capabilities approach and violence against women: Implications for social development' (2008) *International Social Work, 51*.

Pizzarossa Lucía B and Katrina Perehudoff 'Global Survey of National Constitutions: Mapping Constitutional Commitments to Sexual and Reproductive Health and Rights' (2017) *Health and Human Rights Journal Volume 19 Number 2*.

Polkinghorne Donald E 'Language and meaning: Data collection in qualitative research' (2005) *Journal of Counselling Psychology Volume 52 (2).*

Price NL & Hawkins K 'A Conceptual Framework for the Social Analysis of Reproductive Health' (2007) *Journal of Health Population and Nutrition, 25*.

Rabah Omer 'The Modern and the Traditional African Women and Colonial Morality' (2018) *International Journal of Culture and History Volume 5 No 1*.

Research and Advocacy Unit *Let them grow first: Early Marriage in Goromonzi, Zimbabwe'* (2011) The Research and Advocacy Unit.

Rice Sabriya 'Hospitals often ignore policies on using qualified medical interpreters' (2014) *Modern HealthCare*.

Rogers A, Flowers J, Pencheon D 'Improving access needs a whole systems approach. And will be important in averting crises in the millennium winter' (1999) *British Medical Jourbal*.

Rothenberg Karen H 'New Perspectives for Teaching and Scholarship: the Role of Gender in Law and Health Care' (1995) *Maryland Law Review Volume 54 Issue 2.*

Rugoho Tafadzwa and France Maphosa 'Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe: The case of Chitungwiza town' (2017) *African Journal of Disability Volume 6*.

Rugoho T & Siziba B 'Rejected people: Beggars with disabilities in the City of Harare, Zimbabwe' (2014) *Developing Country Studies 4(26).*

Saona H 'The Protection of Reproductive Rights Under International Law: The Bush Administration's Policy Shift and China's Family Planning Practices' (2004) *Pacific Rim Law and Policy Journal*.

Schöpp-Schilling Hanna Beate 'The Role of the Convention on the Elimination of All Forms of Discrimination Against Women and its Monitoring Procedures for Achieving Gender Equality in Political Representation' (2004) *International Institute for Democracy and Electoral Assistance*.

Schaalma HP, Abraham C, Gillmore MR & Kok G 'Sex Education as Health Promotion: What does it take?' (2004) *Archives of Sexual Behavior 33*.

Shah I and Ahman E 'Unsafe abortion: global and regional incidence, trends, consequences and challenges' (2009) *Journal of Obstetrics and Gynaecology Canada Volume 31 No. 2*.

Silverman JG, Decker Michele R, Niranjan Saggurti, Donta Balaiah and Anita Raj 'Intimate Partner Violence and HIV Infection among Married Indian Women' (2008) *The Journal of the American Medical Association* 300(6).

Sithole L & Dziva C 'Eliminating harmful practices against women in Zimbabwe: Implementing article 5 of the African Women's Protocol' (2019) *African Human Rights Law Journal* Volume 19.

Siegel Reva B 'Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection' (1992) *Stanford Law Review Volume 44*

Soldan V ‘How family planning ideas are spread with social groups in rural Malawi’ (2004) *Studies in Family Plann*ing 35.

Speizer Ilene S, Whittle Lisa & Marion Carter ‘Gender relations and reproductive decision making in Honduras’ (2005) *International Perspectives on sexual and reproductive health Volume 31 No 3* .

Ssenyonjo M ‘Analysing the Economic, Social and Cultural rights jurisprudence of the African Commission: 30 years since the adoption of the African Charter’ (2011) *Netherlands Quarterly of Human Rights 3*.

Ssenyonjo M ‘Culture and the Human Rights of Women in Africa: Between Light and Shadow’ (2007) *Journal of African Law Vol 51, Issue1*.

Stanback J, Mbonye AK, Bekiita M ‘Contraceptive injections by community health workers in Uganda: a nonrandomized community trial’ (2007) *Bulletin of the World Health Organisation 85.*

Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, Coll-Seck AM, Grover A, Laski L and Roa M ‘Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission’ (2018) *The Lancet*.

Sultan Sonia ‘The Effects of Education, Poverty, and Resources on Family Planning in Developing Countries’ (2018) *Clinics in Mother Child Health, Volume 15(1).*

Todres Jonathan ‘Emerging Limitations on the Rights of the Child: the UN and Its Early Case Law’ (1998) *Columbia Human Rights Law Review*.

Tsanga AS ‘A Critical Analysis of the Women's Constitutional and Legal Rights in Zimbabwe in Relation to the Convention of the Elimination of All Forms of Discrimination Against Women’ (2002) *Maine Law Review Volume 54 Number 2*.

Tulenko Kate, Sigrun Møgedal, Muhammad Mahmood Afzal, Diana Frymus, Adetokunbo Oshin, Muhammad Pate, Estelle Quain, Arletty Pinel, Shona Wynd & Sanjay Zodpey ‘Community health workers for universal health-care coverage: from fragmentation to synergy’(2013) *Bulletin of the World Health Organization*.

Turmen Tomris ‘Reproductive rights: How to move forward?’ (2015) *Health and Human Rights Law Journal*.

Vizard Polly, Sakiko Fukuda-Parr & Diane Elson ‘Introduction: The Capability Approach and Human Rights’ (2011) *Journal of Human Development and Capabilities* 12:1.

Wells Susan ‘Our Bodies, Ourselves: Reading the Written Body’ (2008) *Signs Volume 33 No 3*.

Wiles Ellen ‘Aspirational Principles or Enforceable Rights? The Future for Socio-Economic Rights in National Law’ (2006) *American University International Law Review* Volume 22 Issue 1.

Woelk GB ‘Primary health care in Zimbabwe: Can it survive? An exploration of the political and historical developments affecting the implementation of PHC’ (1994) *Journal of Social Science and Medicine* Volume 39 Issue 8.

Yamin Alicia E & Maine Deborah P ‘Maternal mortality as a human rights issue: measuring compliance with international treaty obligations’ (1999) *Human Rights Quarterly Volume 21 No 3*.

Yelland J, Riggs E, Szwarc J, Casey S, Duell-Piening P, Chesters D and Brown S (2016) Compromised communication: A qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care’ *BMJ Quality and Safety*, 25(4).

Theses

Yakong Vida, N *Ethnographic perspectives on rural women’s reproductive health decisions in Ghana: The cultural influences of gender relations, kinship and belief system* (Doctoral Dissertation, The University of British Columbia 2013).

Ferguson Claire ‘Reproductive rights and citizenship: Family planning in Zimbabwe. (Published PhD thesis, University of London, 1999).

Nilses Carin ‘Health in women of reproductive age. A survey in rural Zimbabwe’ (PhD thesis, Uppsala University, 2000).

Oluremi Ajoke Savage-Oyekunle 'Female Adolescents' Reproductive Rights: Access to Contraceptive Information and Services in Nigeria and South Africa' (Unpublished PhD Thesis, University of Pretoria, 2014).

Newspaper Articles

Chingono Nyasha 'Fears of Zimbabwe health crisis as row over doctors' pay continues.' *The Guardian* 31 December 2018.

Chris Muronzi 'As Zimbabwe's doctors strike, pregnant women search for care' Aljazeera 17 December 2019.

Jonga Kandemiiri 'Poverty wears the face of rural women' *Nehanda Radio* 16 October 2013.

Newsday "MPs concerned over 'hospital detentions" June 3, 2014

Paidamoyo Chipunza 'Woman delivers 100 babies in 8 days' *The Herald* 15 November 2019.

Phyllis Mbanje 'To legalise abortion or improve access to contraceptives?' News Day April 13, 2016.

Pambazuka News 'Our ugly secret: abortion in Zimbabwe, illegal but thriving.' May 16, 2012. Available at *http://www.pambazuka.org/governance/our-ugly-secret-abortion-zimbabwe-illegal-thriving,* accessed on 23 October 2016.

The Chronicle "Hospitals Detain Mothers over Maternity Fees" January 22 2013

The Zimbabwean "Mothers, babies detained at Mpilo for non-payment" 22 February 2012

'Zimbabwe doctors go on strike demanding better pay and conditions.' *Aljazeera* 3 December 2018.

Internet sources

Biltchitz David 'Expanding Access to Justice for Socio-Economic Rights Complaints in South Africa Which Direction Should We Head in?' (2017) available at *https://voelkerrechtsblog.org/expanding-access-to-justice-for-socio-economic-rights-complaints-in-south-africa/,* accessed 15 April 2020.

Bobo, T 'Challenges Facing Rural Women' available at *http://www.masimanyane.org.za/sites/default/files/Challenges%20facing%20rural%20women.doc*, accessed on 17 March 2016.

Centre for Conflict Management and Transformation (CCMT) Role and responsibilities in rural local governance in Zimbabwe: parallels, overlaps and conflict (2014) Available at *https://www.africaportal.org/publications/roles-and-responsibilities-in-rural-local-governance-in-zimbabwe-parallels-overlaps-and-conflict/*, accessed 5 May 2020.

Centre for Reproductive Rights 'Submission for the CEDAW Committee's Half Day of General Discussion on Rural Women' available at *http://www.ohchr.org/Documents/HRBodies/CEDAW/RuralWomen/CRR.pdf*, accessed on 19 February 2016.

Community Mobilization for Postabortion Care (COMMPAC) Kenya. A Guide to Action for Community Mobilization and Empowerment Focused on Postabortion Complications: Facilitator's Manual. Available at *http://respond-project.org/pages/files/6_pubs/curricula-manuals/COMMPAC-Facilitator-Manual-May2010.pdf*, accessed 11 April 2020

Community Working Group on Health (CWGH) Position Paper on the Budget for Health – 2018 and Beyond. Available *at https://www.cwgh.co.zw/wp-content/uploads/2017/10/CWGH-Input-to-the-2018-National-Health-Budget.pdf*, accessed on 18 April 2020.

Gargarella Roberto 'Too far removed from the people: Access to Justice for the Poor: The Case of Latin America' Available at *https://www.ucl.ac.uk/dpu-projects/drivers_urb_change/urb_society/pdf_violence_rights/gargarella_removed_from_people.pdf*, accessed on 18 April 2020.

Frohmader, Carolyn and Ortoleva, Stephanie 'The Sexual and Reproductive Rights of Women and Girls with Disabilities' ICPD International Conference on Population and Development Beyond 2014, July 2012. Available at SSRN: https://ssrn.com/abstract=2444170

Human Rights and Reproductive Health Matrix 'Safe Motherhood' available at *http://www.policyproject.com/matrix/safemotherhood.cfm*, accessed on 12 March 2016.

Kezia Batisai (2015). 'The Politics of Control and Ownership over Women's Bodies' Available at http://thisisafrica.me/politics-control-ownership-womens-bodies/, accessed on 23 October 2016.

Sabriya Rice 'Hospitals often ignore policies on using qualified medical interpreters' *Modern HealthCare August 30 2014*. Available at https://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945 (accessed 18 January 2019)

Shelley Katharine. 'Zimbabwe's Village Health Worker Program' Available at https://www.chwcentral.org/blog/zimbabwe%E2%80%99s-village-health-worker-program (last accessed 14 May 2019)

Tiwari M & Kumar K 'Women's Autonomy and Utilization of Maternal and Child Health Care Services in India' 2006 Population Association of America. Available at http://paa2012.princeton.edu/papers/121376, accessed 3 April 2020.

The International Planned Parenthood Federation (IPPF). 'Sexual and reproductive health and rights – the key to gender equality and women's empowerment.' Available at http://www.ippf.org/sites/default/files/2020_gender_equality_report_web.pdf, accessed 19 November 2016.

United Nations Zimbabwe 'Zimbabwe Launches a Four Year Sexual and Reproductive Health and HIV Prevention Programme' available at: *http://www.zw.one.un.org/newsroom/news/zimbabwe-launches-four-year-sexual-and-reproductive-health-and-hiv-prevention*, accessed on 18 March 2016.

UN Women. Frequently asked questions about CEDAW, available at http://asiapacific.unwomen.org/en/focus-areas/cedaw-human-rights/faq#sthash.WkHeDhSr.dpuf, accessed on 10 April 2017.

UNFPA From commitment to action on sexual and reproductive health and rights: Lessons from the Second Cycle of the Universal Periodic Review. Available *at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2019_EN_Lessons_from_the_second_cycle_of_the_universal_periodic_review.pdf*, accessed on 18 April 2020.

WHO Recommendation on establishment of maternity waiting homes (MWHs) *https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-establishment-maternity-waiting-homes-mwhs, accessed* on 14 April 2020.

World Health Organization. Global Health Workforce Alliance 'What do we mean by availability, accessibility, acceptability and quality (AAAQ) of the health workforce?' Available at: *https://www.who.int/workforcealliance/media/qa/04/en/*, accessed on 18 January 2020

WHO Health promotion: Social mobilisation. Available *at https://www.who.int/healthpromotion/social-mobilization/en/*, accessed on 17 April 2020.

WHO 'Perspectives on Maternal Mortality in Zimbabwe: A Reflection of the Year 2014' Available at *https://www.afro.who.int/news/who-perspectives-maternal-mortality-zimbabwe-reflection-year-2014*, accessed 13 April 2020.

Zimbabwe Broadcasting Corporation 'Covid-19 team visits Madzibaba with 30 wives, 23 children' Available at *https://www.zbcnews.co.zw/covid-19-team-visits-madzibaba-with-30-wives-23-children/*, accessed on 24 July 2020.

Zimbabwe Electricity Transmission and Distribution Company. 2019 *Load Shedding Programmes* Available at *https://zetdc.co.zw/customer-care/notices/*, accessed on 26 May 2019.

APPENDIX I: SAMPLE LETTER TO REQUEST PERMISSION TO CONDUCT STUDY

University of Cape Town
Law Faculty
Kramer Law Building,
Private Bag, Rondebosch 7701
South Africa

16 November 2017

The Permanent Secretary
Ministry of Health and Child Care
4th Floor Kaguvi Building
Central Avenue
Harare

Dear Sir/Madam

Re: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Reference is made to the above. I kindly approach your honourable offices seeking your consent to interview personnel from your Ministry to enable me to gather information critical for my law doctoral research being conducted through the Faculty of Law at the University of Cape Town, South Africa.

I am a registered PhD student in the Department of Private Law at the University of Cape Town. A copy of my letter form the Higher Degrees Committee is enclosed and attached as **Annexure 'A'**. My doctoral supervisor is Professor Amanda Barratt. The proposed topic of my research is: 'Women's access to reproductive health services in rural Zimbabwe: Rationale, Challenges and Opportunities. The overall aim of the research is to understand what challenges rural women face in accessing reproductive health services as well as the rationale and opportunities for rural women to have access to reproductive health services. In an effort to understand the overall aim, the study will also address the following objectives:

- What are Zimbabwe's human rights obligations vis-à-vis women's reproductive rights in terms of international and regional treaties ratified by Zimbabwe?
- What are the national legislative, institutional and policy frameworks governing women's reproductive rights in Zimbabwe?
- What are the challenges of State and non-state actors in ensuring the enjoyment of the rights / provision of reproductive rights and services?
- What are the experiences of rural women in accessing reproductive health care and services?
- What suggestions can be proffered to ensure they have access to reproductive health services?

The information obtained will be treated with the strictest confidentiality and will be used solely for this research purposes only. It is my presumption that the research findings will make valuable contribution towards identifying different strategies, policies and legislative measures to advance women's reproductive rights in rural Zimbabwe.

To assist you in reaching a decision, and for ease of reference, I have attached to this letter: (i) A copy of an ethical clearance certificate issued by the University of Cape Town marked as **Annexure 'B'**; and (ii) A copy of the research instrument(s) which I intend to use in my research marked as **Annexure 'C'**.

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows:

Linet Sithole: leeyandah@gmail.com +263 773 562 098;

Prof. A. Barratt: amanda.barratt@uct.ac.za

Upon completion of the study, I undertake to provide you with a bound copy of the thesis. Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

_____

Linet Sithole

APPENDIX II: LETTER GRANTING PERMISSION TO CONDUCT STUDY

Telephone: +263-4-798537-80

All correspondences should be Addressed to the Permanent Secretary for Health and Child Care

ZIMBABWE

Reference:

Ministry of Health and Child Care
P.O. Box CY1122
Causeway
Zimbabwe

24 November 2017

Linet Sithole
University of Cape Town
Law Faculty
Kramer Law Building
P. Bag Rondebosch 7701
South Africa

RE: Request for Permission to Conduct Research by Interviewing Ministry of Health and Child Care Personnel

We acknowledge receipt of your letter on the above subject.

Permission is hereby granted for you to Interview Ministry of Health and Child Care personnel for your law doctoral research.

Could you please submit a final write up to the Ministry of Health and Child Care.

Thanking you.

SECRETARY FOR HEALTH & C/C
(PRINCIPAL DIRECTOR) POLICY
PLANN. MONITORING & EVALUA.
27 NOV 2017
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

signature removed

Dr R. F. Mudyiradima
Principal Director, Policy, Planning, Monitoring and Evaluation
FOR: SECRETARY FOR HEALTH AND CHILD CARE

/pm

APPENDIX III: INFORMATION SHEET

Title: Women's right to access maternal health and family planning services in Hwange Rural District, Zimbabwe: Challenges and Opportunities

Supervisor's name: Professor Amanda Barratt

Student Name: Linet Sithole (STHLIN018)

Introduction and Purpose of Study: My name is Linet Sithole. I am conducting this research for a doctoral degree. I am researching on the following: challenges faced by rural women in accessing reproductive rights services; the reasons and benefits of having access to reproductive health services as well as the chances available to access these rights and would like to invite you to participate in this research project. I am interested in finding out what is considered to be the challenges or problems within your community that block your access to reproductive health rights services. I would like to interview sexually active women and girls who reside in Hwange East Constituency.

Procedures: You will be asked to participate in in-depth interviews that will ask you about what you consider to be the challenges blocking your access to reproductive health rights and services. We are also interested in your opinions on women's reproductive health rights in general. Therefore, the in-depth interviews will take approximately 30 minutes.

Confidentiality: All the information you provide will be strictly confidential, and your name will not appear anyway in the research findings or anywhere else. The information gathered (recordings and transcripts) will be stored in a safe, completely secure place, so that

no one will be able to access the data who is not meant to. Further, your identities will not be linked with personal responses given during the data gathering process.

Voluntary Participation and Statement about Compensation: Your participation is out of your free will and is not forced. You may refuse to participate or may discontinue your participation at any time during the interview. While we cannot compensate you for your time, your participation will be invaluable to our project as we seek an understanding of the challenges rural women face in accessing their reproductive health rights, and how these can be addressed.

Information about this Study: You will have the opportunity to ask, and to have answered, all your questions about this research during the in-depth interviews. All inquiries are confidential.

Potential risks: As the interviews will deal with the topic of reproductive rights and your lived experiences, it is possible that it may raise issues or feelings that you would like support in dealing with. If this happens, the researcher can refer you to a free counsellor, or to other resources in the community that can help you. You can leave the interview or focus group at any time, and you do not have to answer any questions that make you feel uncomfortable. You can also withdraw your participation in the project at any time.

Benefits: By participating in this project, participants will add to their knowledge of what reproductive rights are and, more specifically, learn about the different ways that can be used to lighten challenges blocking their access to reproductive rights.

Thank you.

Linet Sithole

0773562098

APPENDIX IV: PARTICIPANT CONSENT FORM

If you have read and understood the information about this study and agree to join and take part in our study, we would appreciate if you sign your name and date on this form and submit it to us.

****

I, _____ (your name), have read and understood the information in the project information sheet.

I understand what the project is about and what the results will be used for.

I am fully aware of all the procedures involved in the research and of any risks and benefits associated with the study;

I know that my participation is voluntary and that I can withdraw from the research at any given time without giving any reasons;

I am aware and understand that the interview will be audio taped.

I am aware that my information will be kept confidential.

I understand that I will be interviewed about this topic for approximately one hour at a venue and time that will suit me, but that will not interfere with my work or personal schedule.

I therefore agree to participate in the study.

_____ _____

Name & Signature **Date**

Thank you.

Sincerely,

_____ _____

Amanda Barratt **Linet Sithole**

Supervisor **Student**

APPENDIX V: UNIVERSITY ETHICS APPROVAL LETTER

Faculty of Law
Research Ethics Committee
Private Bag X3 Rondebosch, 7701 South Africa
Room 6.29 Kramer Building, Middle Campus

Tel: +27 021 650 3080 Fax: +27 021 650 5660
E-mail: lamize.viljoen@uct.ac.za
Internet: www.law.uct.ac.za

13 November 2017

Ms Linet

Sithole/STHLIN018 *c/o*

Assoc Prof Amanda Barratt's

Office

Private Law Department,

Level 4 Faculty of Law

Kramer Law Building

Contact information

Tel: +263 773 562 098 or email: leeyandah@gmail.com

Re: Clearance Process Report for L0060-2017: "Women's access to reproductive health services in rural Zimbabwe: Rationale, Challenges and Opportunities"

Thank you for your revised application submitted on 10/11/2017. The Faculty's Research Ethics Committee very much appreciates the considerable effort put into the documentation.

This study has been carefully considered and all ethical issues have been adequately addressed.

Ethics clearance is hereby granted as of 10 November 2017 for a period of 12 months and is subject to renewal for another 12 months.

Please note that any material changes to the proposal will need to be cleared as an amendment.

**Kindly quote your reference number when communicating to the REC regarding this research project.*

With best wishes,

Signature removed to avoid exposure online

ASSOCIATE PROFESSOR JULIE BERG

REC: CHAIRPERSON

UCT Law Faculty

cc: Assoc Prof Amanda Barratt – Supervisor - Private Law Department, UCT

"Our Mission is to be an outstanding teaching and research university, educating for life and addressing the challenges facing our society."

APPENDIX VI: RESEARCH COUNCIL OF ZIMBABWE ETHICS APPROVAL LETTER

Telephone: 791792/791193
Telefax: (263) - 4 – 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/A/2285 **10 April, 2018**

Linet Sithole
University of Cape Town
Department of Private Law
South Africa

RE:- Women's Access To Reproductive Health Services In Rural Zimbabwe: Rationale, Challenges And Opportunities

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

a) Study Protocol
b) Informed Consent Forms (English and Tonga)
c) Data collection tools (English and Tonga)

- **APPROVAL NUMBER** : **MRCZ/A/2285**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : **Full Board**
- **EFFECTIVE APPROVAL DATE** : **10 April, 2018**
- **EXPIRATION DATE:-** : **09 April, 2019**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

.....
MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2018 -04- 10
APPROVED
P.O. BOX CY 573 CAUSEWAY HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

APPENDIX VII: INTERVIEW GUIDES

Checklist 1: Interviews with women and girls in the community

1. How old are you?
   1.1 What language do you speak
   1.2 Village of origin?
   1.3 Level of education?
   1.4 Employment? What do you do to make a living?
   1.5 Marital status? Do you have children? If yes, how many?
2. What is your understanding of reproductive health services?
3. How often do you access family planning information and services, maternity services and any other reproductive health services?
4. How and from what sources do you obtain information about accessing reproductive health care, if they do so at all?
5. What are your experiences in accessing the aforementioned reproductive health services? Please explain in relation to:
   5.1 Affordability;
   5.2 Availability;
   5.3 Quality
   5.4 Accessibility.
6. What other factors affect your access to reproductive health services?
7. Who makes reproductive decisions such as:
   7.1 When to have children?
   7.2 How many children to have?
   7.3 Spacing of the children?
   7.4 What contraceptives to use?
8. What, in your opinion should be done to ensure that the abovementioned challenges in relation to availability, accessibility, affordability and quality of reproductive health care services are improved?

Checklist 2: Interview guide for State aligned Stakeholders

1. Background information

1.1 Which ministry or department do you work for?

1.2 What is your position level and role within your ministry or department?

1.3 How long have you worked for this Ministry or department?

1.4 What is the mandate of your ministry or department in relation to women's reproductive health issues?

2. International and national human rights and policy frameworks

2.1 How is your ministry or department utilising or implementing international provisions relating to women's reproductive health at national, provincial and rural levels?

2.2 Please tell me about any other national instruments for reproductive health, and the extent to which they are utilised at national, provincial and rural levels?

2.3 What activities are you conducting to raise awareness on these instruments and policies to all women, especially those in rural areas?

2.4 Which stakeholders is your Ministry/Department working with to ensure rural women, in this case, women from Hwange Rural, have access to reproductive health care services?

2.5 What challenges does your Ministry or department face in ensuring that rural women have access to reproductive health care services or are aware of the existence of international and national instruments on reproductive health?

2.6 What opportunities are there for your ministry and department in ensuring rural women have access to reproductive health services?

Checklist 3: Interview guide for Non-State Actors (NGOs and CSOs)

1. What is your position level within the organisation?

2. What motivated you to get involved in this sector?

3**.** For how long has your organisation been in the reproductive health rights movement?

4. Which geographical areas do you operate in within Zimbabwe?

5. How big is your organisation?

- Micro (1-5 employees)
- Small (5-55 employees)
- Medium (55 – 250 employees)
- Large (over 250 employees)

6. What has been your role, experiences and challenges in women's reproductive health issues, in relation to the following?

- service provision to rural women?
- awareness raising to rural women?

a) Which communities has your organization targeted for awareness raising and provision of reproductive health services?

7. To what extent is your work guided by global and national instruments? List the guiding instruments and explain how they are mainstreamed in your work.

8. What opportunities do you foresee or can be taken advantage of in advancing and ensuring rural women have access to reproductive health services?