ACCESS TO MATERNAL HEALTH CARE AMONG WOMEN OF CHILDBEARING AGE IN RESETTLEMENT AREAS OF FORMER WHITE OWNED FARMS. A CASE STUDY OF A2 FARMS IN WARD 13 OF MAKONDE DISTRICT

BY

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Abstract

This study aimed to examine women of childbearing age's access to maternal healthcare in the resettlement areas of Zimbabwe's former white-owned farms which are now divided into A2 farms. The right to maternal healthcare has been expounded in various international human rights instruments as a critical women's right regardless of their background, race, ethnicity, colour, language, etc. Countries that are members of these human rights instruments have a mandate to uphold the right to access maternal healthcare in all their policies and laws. Zimbabwe is a member state of CEDAW and the Maputo Protocol which specifically provide for member states to provide for the right to maternal healthcare. This international human right duty is very important, especially since Zimbabwe's progressive 2013 Constitution does not specifically provide for this vital human right. Such an omission is very controversial and poses challenges to women who seek to claim it, especially those of childbearing age in the resettlement areas of Zimbabwe's former white-owned farms. The study employed a qualitative study with the use of a purposive sampling method. In-depth interviews and observation were used as methods of data collection. The study seeks to interrogate and unpack how various relevant laws, policies and programmes (e.g., the land reform programme) impacted access to maternal healthcare for these childbearing women. The findings of the study show that breaches of their other human rights had a significant negative impact on their access to maternal healthcare including: their lack of access to sustainable livelihoods (lack of opportunities to sustain a viable livelihood); violations of their right to work (failure to pay or late payment for the low-paying piece work they manage to find); their exposure to various forms of discrimination; their lack of education and access to relevant maternal healthcare information and the state's lack of investment in rural maternal healthcare. Recommendations to assist these women include the need to: improve their maternal healthcare access and quality; address the underlying determinants of their maternal health; eliminate any discrimination they face in accessing maternal healthcare; make the maternal healthcare system accountable and include them as beneficiaries in the maternal healthcare system and empower them by doing so.

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Declaration

I Tafadzwa Mabemba certify that this dissertation is my original work: it is an honest and true effort of my research. I certify that the work has not been presented anywhere else before for any other thesis.

Signed…………………………………………………………..

Date…………………………………………………………..

This dissertation was submitted for examination with my approval as the University Supervisor

Signed……………………………………………………………

Date……………………………………………………………

Dedication

I dedicate this piece of work to my parents. Thank you for believing in me and educating the girl child

&

To my son Henry, you have always been the reason why I wake up to work harder and believe that God works everything for good for those who trust and believe in Him

Acknowledgments

The piece of work was destined to fail along with my dreams of graduating had I not received incredible support and guidance from some wonderful people around me. I hereby acknowledge them and give my deepest thanks.

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List of abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
ESRC	Economic and Social Research Council
ESAP	Economic Structural Adjustment Program
GNI	Gross National Income
GoZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDRC	International Development Research Centre
Maputo Protocol	Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa, 2003 (the African Women's Rights Protocol)
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MRCZ	Medical Research Council of Zimbabwe
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non-governmental organization
STERP	Short Term Economic Recovery Program
STI	Sexually Transmitted Disease
SEARCWL	Southern and Eastern African Regional Centre for Women's Law, University of Zimbabwe
UNICEF	United Nations Childrens Education Fund
UNFPA	United Nations Population Fund
UK	United Kingdom
UZ	University of Zimbabwe
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
UNHCHR	United Nations High Commissioner for Human Rights
VHW	Village Health Worker
WHO	World Health Organization

List of human rights instruments

Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa, 2003 (Maputo Protocol)

Alma Ata Declaration 1978

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

General Recommendation No. 28 of CEDAW

International Covenant on Economic, Social and Cultural Rights (ICESCR)

United Nations Committee on Economic, Social and Cultural Rights (UNCESCR)

List of local legislation

Constitution of Zimbabwe Amendment (No. 20) Act, 2013 (the Constitution)

Medical Services Act [Chapter 15:13]

Public Health Act [Chapter 15:03]

List of local policies and other instruments

National Health Strategy for Zimbabwe 2009-2013

Patient's Charter

Reproductive Health Policy

Reproductive Health Guidelines

Zimbabwe National Maternal and Neonatal Health Road Map (2007-2015)

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CHAPTER ONE

1.0 GENERAL OVERVIEW OF THE STUDY

1.1 Introduction

Poor maternal health care remains a huge stumbling block for most of the women in the sub-Saharan region. Various factors have contributed to high rates of women losing their lives during, before and after pregnancy and child delivery. More so, child mortality has been problematic as well because of the compromised maternal health care system in developing countries (Tawiah, 2011). The International Development Research Centre (IDRC) (2019) states that in sub-Saharan Africa approximately 550 women (or 66% of the world's total) lose their lives every day to avoidable causes connected to pregnancy complications and childbirth. The global maternal mortality ratio decreased by 38 percent from 2000 to 2017, from 342 deaths to 211 deaths per 100, 000 live births, respectively (WHO, UNICEF, UNFPA, and The World Bank, 2019). This computed to an annual reduction of 2.9 percent. While substantial, this is less than half the 6.4 percent annual rate needed to achieve the Sustainable Development Global goal of 70 maternal deaths per 100,000 live births. WHO, UNICEF, UNFPA and the World Bank (2019) further support the view that since 2000 there was some progress, with South Asia recording the greatest MMR percentage reduction with 59 percent (from 395 to 163 maternal deaths per 100,000 live births between 2000-2017). The sub-Saharan region has achieved a considerable reduction of 39 percent of maternal mortality during this period. An overwhelming number of affected women are those from poor sub-Saharan countries which are characterized by poor rural areas with no or inadequate maternal health care services (Africa Renewal, 2014), war-torn countries like the Democratic Republic of Congo (Filippi et al, 2016), and economically unstable countries such as Zimbabwe (UNICEF, 2010b).

1.2 History of colonial rule

Colonial rule occurs when a dominant superpower or empire controls a weaker country. The dominant power overthrows the weaker countries' socio-economic means and installs its own. This occurred, for instance, when the United Kingdom of Great Britain dominated its colony of Rhodesia (as the country was known immediately prior to Zimbabwe's independence in 1980) between the 1880s-1960s. Britain ruled the colony through political domination in pursuit of its

industrial revolution. It colonized countries including Rhodesia to satisfy its need for raw materials and to create a market to which to sell the goods it produced. The country whose population comprising mainly the black indigenous and the white colonists was largely developed along separate racial lines with separate schools, clinics, hospitals and other social amenities for whites and blacks. Also the majority of Zimbabweans (blacks) lost their fertile land and livestock to white colonists. Several wars of independence were fought by black Zimbabweans to win back their land. The final war ended in 1980 when Great Britain negotiated a settlement between the two sides and gave Zimbabwe its independence. Under its new Constitution, the new Zimbabwe government sought to abolish all forms of discrimination and inequality which had characterized the old colonial Rhodesian regime. In essence, African's dignity was restored by efforts to pass laws that ensured the democratization of the Zimbabwe body politic.

1.3 The land redistribution program in Zimbabwe: 2000-2003

The land reform program began in 1980 with the signing of the Lancaster House Agreement. The agreement was meant to distribute the land equally between black subsistence farmers and white Zimbabweans of European descent. As noted above, there was an unequal distribution of resources and this agreement was designed to correct the ethnic imbalance of land ownership. However, as a result of the growth of the population, the depletion of the country's resources and an increase in poverty in subsistence areas, the situation did not change much until the government sought another alternative that seemed to reduce these social ills. The government introduced phases of acquiring land from white owners on a willing seller / willing buyer basis but this process proved very slow. To hasten matters, the government passed the Land Acquisition Act of 1992 which should have made it possible for the government to acquire land required for resettlement.

The fast-track land reform program was characterized by the forced occupation of land and eviction of farm owners and their workers without compensation. The government redistributed the land to black Zimbabweans in the form of A1 and A2 farms. The process was meant to distribute land back to its rightful owners. During this phase only 5% of farm workers were paid and the majority lost their jobs, houses and their dignity. They could not acquire land because

many of them lost their identity documents during the forced evictions and they were immigrants from countries like Malawi, Mozambique, and Zambia without proper documentations. As a result of the massive disruption to its farming industry, the entire economy started to collapse. International sanctions were imposed on Zimbabwe as a punishment for the manner in which this land reform program was undertaken.

The repercussions of the land reform program contributed to the breakdown of the health sector which particularly affected former farm workers. The program was not well planned as the government did not consider its long term impact on the country and its people. Even though the process was short-lived it was devastating and even today people still believe that the land reform program led to the socio-economic ills that the country is still tackling today. As far as access to maternal health is concerned, no provision was made in the government's land reform program to cater for the needs of farm workers which had been previously met by their former white employers. Redistribution of the land meant that masses of people took occupation of the land which did not have sufficient resources to support them. Since the government did not apparently foresee this development, it failed to develop these former commercial white owned areas of land and provide, for example, adequate health care including maternal health care to those occupying what are now A2 farms.

1.4 Background to the study

I knew of the continued existence of compounds (or *"komboni"* in the local dialect of *Shona*) among the migrant communities on farms that used to be owned by former white farmers before the land redistribution program of 2000-2003 when I was a teenager. I used to have relatives who worked for former white farmers when I was still a child. Life for them was good because they received their salaries on time, decent accommodation, health services and in emergencies they could be rushed to Chinhoyi Provincial Hospital for medical treatment. At that time everything went well for my relatives who worked on these commercial white-owned farms, and many of my peers who were not able to continue with their schooling could also obtain work on these farms. Life was good then, pregnant women received maternal health care services in the comfort of their compounds and there was a village health worker (VHW) who would be sent to

attend workshops and come back to educate women on the importance of maternal health care, antenatal care and reproductive health, among others.

Former white farmers provided everything for their workers especially maternal health care services which reduced the burden on their employees. Some of the wives of the former white farmers also operated small concerns on their farms where they provided cheap and affordable basic health care services. My relatives would come telling us this good life they were enjoying in the former white-owned farms and everything seemed good then. That is the reason why there are no health care institutions in current A2 farms because each white farmer would provide his employees with personal health care services. However, this system ceased to exist twenty years ago which made these women vulnerable. Currently, there are no white farmers in these farm areas. I wondered what was happening to the women who used to work and live on these farms and how they were coping in their efforts to access maternal health care.

In 2000, when the land redistribution program was carried out by the government of Zimbabwe, my parents applied for and managed to secure an A2 farm. The A2 farms were given to Zimbabweans who were capable of investing in farming and had the capacity to undertake commercial farming (Rutsate, Derman and Hellum, 2015). Everything changed and we moved to the farm and that is where we still stay. I noticed that a lot of women who were left behind when the white farmers were evicted came looking for piece jobs ("*maricho*" in Shona) so that they could earn money to provide food for their children or to buy clothes. Pregnant women worked to buy what they needed for themselves and their expectant babies (preparation[1]), to pay hospital bills and to pay for transport to and from town, among other things. I noticed that even though my parents helped women of childbearing age as best they could the situation was now worse for them as many of their husbands had left them because they were no longer able to find employment and earn money to support their families. The few men who had remained behind were looking for piece work on A2 farms.

After finishing my Advanced Level examinations I had the opportunity to engage with these women, and find out and understand the challenges they faced particularly accessing maternal

[1] Preparation is material for birth and clothes for the baby.

health care. Since there is no clinic in this ward the majority of the women opted to deliver their babies at home because it was cheap and affordable. Lack of maternal health care was a huge problem. I wanted to help these women but lacked the resources to do so. Over a long period of time I witnessed and observed the lived realities of these women, the tensions between them and the new A2 farm owners. Having realized that little had improved for these child bearing women in this district, by the time I came to choose a research subject for this Masters program I felt that it was now a perfect opportunity for me to find out more about their situation by unpacking the challenges they faced attempting access to maternal health care. I knew that I also needed to interrogate relevant maternal health policies, and maternal health care rights in terms of our Constitution, as well as international and regional human rights instruments. I also felt better equipped to do this having by this time studied social work whose focus is to improve the well-being of my fellow citizens by helping to meet their basic needs. Social work focuses on the needs and empowerment of people who are vulnerable, oppressed and living in poverty. My choice to conduct this particular piece of research was influenced by all these factors and my passion to help people from marginalized backgrounds.

The focus of my study was on women of childbearing age who live on former white-owned farms. Currently, these farms are owned by black A2 farmers through the land distribution program of 2000. There are no health institutions in this ward, they have no sustainable livelihoods to support them, and they lack maternal health care knowledge which has resulted in their encountering various challenges such as unplanned pregnancies, the late registration of pregnancies, exposure to harsh weather conditions due to their poor housing conditions, high rates of sexually transmitted diseases (STIs) infection and other health problems. A2 farmers cannot afford to provide maternal health care because they experience their own farming challenges. Therefore maternal health care has now more than ever become a matter requiring the government's urgent attention. For instance, Musina Farm is a former white-owned farm of over five hundred hectares which the government gave to 24 A2 farm households with each farmer being allocated between 38 and 89 hectares. Although the state allocated the farms, they left the former farm workers with nowhere to go and left them without any social or health services.

The Masters Degree in Women's Socio-Legal Studies' program at the Southern and Eastern African Regional Centre for Women's Law, University of Zimbabwe (SEARCWL) has played a major role in my academic life and I now know the importance of claiming and knowing my rights as a woman which include the right to maternal health care. Like me, every woman has the right to enjoy this right regardless of her situation, background, race, language, ethnicity as guaranteed by sections 29 and 76 of the Constitution of Zimbabwe Amendment (No. 20) Act, 2013 (the Constitution). Furthermore, the knowledge I have received from the various courses I have studied at SEARCWL including those on various women-centered theories and perspectives, human rights, family law, and social justice have all made me realize that women's rights are human rights and so there is a critical need to protect and claim them especially for those who cannot make their voices heard.

The research methods and methodologies course has helped me to articulate the lived realities of the women through this research which I believe will be of use to legal reform strategies when I have finished my dissertation. I now realize that there is a gap in accessing maternal health care by women of childbearing age on former white-owned farms in Ward 13 of Makonde district. It is against this background that I made the decision to undertake a study on access to maternal health care among women of childbearing age in the resettlement areas of former white-owned farms. I hope this study and my findings will inform various actors dealing with maternal health care services about the lived realities and rights of women of childbearing age insofar as their access to maternal health care is concerned.

1.4.1 Social determinants of maternal health care

Batist (2019) postulates that overwhelming maternal health complications are caused by an inequitable and oppressive condition affecting the sub-Saharan region. Bearing in mind that maternal health care provision is a human rights issue across all continents, violating these rights is violating women's rights which hinder their livelihoods. Batist (2019) further argues that maternal health care in the sub-Saharan region is determined by three human rights determinants which are gender, education and literacy and economic factors. These determinants are very important in contextualizing the status of women in societies across the sub-Saharan region.

Gender inequality is an important social determinant of maternal health in the sub-Saharan region because a lot of women have lost their lives or negatively suffered maternal health care issues due to gender biases before, during and after the provision of health services and the marginalization of women in their societies (Chirowa et al, 2013). Okpara (2006) explains that various scholars who have researched gender inequalities in sub-Saharan Africa have found that male dominance has been detrimental to the social ideals and systematic civilization of women. Women have become socially vulnerable and subjected to sexual violence, have been unable to make informed decisions about their own maternal health and have been exposed to infectious diseases, such as HIV/AIDS (Chirowa et al, 2013; Okpara, 2006).

Rural women lack adequate education and literacy on maternal health issues (Batist, 2019) and this is due to family and societal perceptions around women. When communities or families do not prioritize women who face challenges in accessing maternal healthcare it negatively impacts their status women. For instance, a study carried out in Mauritius found that its fairly large population of educated women has translated into lower maternal mortality rates (Alvarez, 2009). On the other hand, other research has shown that women who are unable to read and write face a lot of challenges in accessing maternal health services in that they cannot make autonomous decisions over their health, for instance, concerning the use of contraception and protected sexual activity (Chirowa et al, 2013; Shoola, 2014).

Alvarez (2009) is of the view that economic factors such as per-capita government expenditure on health and gross national income (GNI) per capita have an impact on the maternal health status of women in the sub-Saharan region. A country's economic status has either a positive or negative impact on the maternal health status of its women. Economically developed countries have a lower negative impact of maternal health problems on women as compared to developing countries. Many women in sub-Saharan countries are financially dependent on their husbands who exercise their discretion over who accesses health services. For example, during pregnancy, women need access to sufficient nutrition, health, and hygiene which is determined by their ability to financially afford such goods and services (Odekunle, 2016) and it is their husbands who determine whether or not to provide them with the required resources to access maternal healthcare.

1.5 Problem statement

Sections 29 and 76 of the Constitution of Zimbabwe provide the right to health services and health care services for all Zimbabwean citizens. In addition, Zimbabwe is also a member of various international and regional treaties that serve to uphold and enhance women's rights across the globe including maternal health care services. For instance, Articles 8 & 14.1(g) and 14.2 (a) & (b) of the Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) emphasise the importance of maternal health care services for all women. Women of childbearing age who reside in resettlement areas of former white-owned farms now known as A2 farms encounter challenges in accessing maternal health care because of their illiteracy; the unavailability of health care institutions in the Ward; the remote geographical location of these farms in relation to their nearest health care facilities and the lack of reliable transport to reach these facilities and the women's inability to pay for it; and the village health workers' lack of proper basic knowledge on maternal healthcare which could be used to educate these women.

Section 29(1) of the Constitution, under national objectives, provides that the state must take all practical measures to ensure the provision of basic accessible and adequate health services throughout Zimbabwe; and (3) provides that the state must take all preventive measures within the limits of the resources available to it, including education and public awareness programs, against the spread of diseases. In reality, the state is failing to meet its obligations under these provisions and this study seeks to explore the reasons for its failure and what implications this has for women of childbearing age in resettlement areas of former white-owned farms.

The fact is that women of childbearing age's rights to maternal health care are being violated and such violations also prejudice their overall health. Lack of access to maternal health care threatens their physical, emotional and psychological wellbeing. Due to the fact that clinics are as much as +/- 25km away from the A2 farms on which they live, many of the women have resorted to closer cheaper services and only eventually register their pregnancies as late as their eighth month which poses a threat to the life of both mother and baby. Also if they deliver their babies at home there is no birth record of them and the lack of a birth certificate will later prejudice both mother and child. There is also the risk of mother to child transfer of the

HIV/AIDS virus as well as other health challenges. It was against this background that this research was undertaken. I wanted to unearth, explore and truly understand the challenges faced by these women as well as the efforts made by the responsible Ministries trying to relieve them of their difficulties including their attempts to improve the socio-economic status of these women. In addition the study seeks to explore if these women are fully enjoying their rights as stipulated by the Constitution and other international and regional human rights treaties to which Zimbabwe is a signatory.

1.6 Aim and objectives of the study

The aim of this research is to examine women of childbearing ages' access to maternal healthcare in the resettlement areas of former white-owned farms which are now divided into A2 farms. The objectives of the research are:

1. To find out whether their lack of sustainable livelihoods is a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms.
2. To investigate whether their lack of financial resources is a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms.
3. To examine how women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms are coping with the challenges they face in exercising their rights to access maternal health care.
4. To analyze whether the lack of maternal health care knowledge is a hindrance to accessing maternal health care services for women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms.

1.7 Research assumptions and questions

Table 1 shows the research assumptions and questions on which this research is based.

Table 1:Showing the research assumptions and questions

Research assumptions	Research questions
(1) The lack of sustainable livelihoods is a hindrance to accessing maternal healthcare for women of bearing age in resettlement areas of former white-owned farms now divided into A2 farms.	(1) Is the lack of sustainable livelihoods a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms divided into A2 farms?
(2) The lack of financial resources is a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms.	(2) Is the lack of financial resources a hindrance to in accessing maternal health care for women of childbearing age on resettlement areas of former white-owned farms now divided into A2 farms?
(3) Women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms face challenges when exercising their rights to access maternal health care.	(3) Are women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms facing challenges when exercising their rights to access maternal health care?
(4) The lack of maternal health care knowledge is a hindrance to accessing maternal health care services for women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms.	(4) Is the lack of maternal health care knowledge a hindrance to accessing maternal health care services for women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms?

1.8 Significance of the study

I anticipate that the study will contribute to the growing body of knowledge, debate and law reform on women of childbearing age's access to maternal health care in resettlement areas of former white-owned farms. In the area of development studies, Agarwal (2001), Clever (2001) and Cornwall (2003) have emphasised that "development studies have come far in their

explorations of the gendered dynamics of participatory approaches for women who are the targets of development". Hence, this research is of paramount importance to further research women's legal rights in that it interrogates issues that affect the socio-economic status of women of childbearing age's ability to access maternal health care. The thesis, therefore, seeks to fill a gap in the current literature concerning women of childbearing age's access to maternal health care in the resettlement areas of former white-owned farms. In summary, through this dissertation, I contribute to the current knowledge of the topic as follows.

The study seeks to contribute to the literature on intersecting issues of women of childbearing age's access to maternal health care and human rights. It is my opinion that they have become internally displaced persons by virtue of the serious violations of their rights to maternal health care.

Furthermore, the study seeks to contribute to the knowledge of maternal health care as a human right. This was achieved through situating the human right to maternal health care in a local context and finding out how the human right to maternal health care is conceptualized locally among women of childbearing age. It is projected that the recommendations from this study may bring to the awareness of state actors those areas of human rights surveillance demanding respect, defense, full realization, and promotion of the right to maternal health care, for which state responsibility is gravely lacking and the need to recognize the important role played by the local traditional conceptualization of what the right to maternal health care entails.

Another of this study's contributions to current knowledge is made within the context of gender and maternal health care and studies that enhance development and this is revealed through its analysis of the collected data from the perspective of gender, law and legal pluralism.

The empirical evidence of the research findings will reveal that various groups of women are discriminated against in maternal health care through a wide array of intersecting vulnerabilities that have long gone unnoticed. For example, it is only recent research that has eventually recognized the almost ancient global phenomenon of the feminization of poverty. Chant (2006:2) defines feminization of poverty as "a phenomenon in which women represent disproportionate

percentages of the world's poor.” The characteristics of this reality are lack of income that results from the scarcity of capabilities and gender biases within societies and governments (Fukuda-Parr, 1999:99).

The empirical findings of this study will support a gender-inclusive approach to women of childbearing age’s access to maternal health care so as to encourage the establishment and development of holistic maternal health care management structures that will recognize and seek to serve the best health interests of such women before, during and after policy implementation and to recognize them in all development initiatives (Rutsate, 2016).

1.9 Structure of the dissertation

This chapter provides an introduction and background to the study, the history of colonial rule prior to Zimbabwe’s independence, the post-independent land redistribution program, the problem statement, research questions and assumptions, the aim of the study, its objectives as well as the significance of the study. Chapter two gives a comprehensive methodological and theoretical framework of the study, methods of data collection, location of the study, emerging issues, challenges posed by interviews, challenges and limitations, language problems and ethical considerations. The third chapter discusses the national legal and policy framework as well as regional and international women’s rights concerning women’s access to maternal healthcare. Issues including a review of the state of maternal health care in Zimbabwe since Independence, the state of maternal health care in Zimbabwe in the current political and economic context, mother shelters as a safe motherhood strategy, the role of village health workers and skilled midwives are also discussed. Chapter four presents the study’s findings, interpretation and analysis. The themes of the study are outlined and discussed. Chapter five provides the study’s conclusion and recommendations.

CHAPTER TWO

2.0 METHODOLOGICAL AND THEORETICAL FRAMEWORKS

2.1 Introduction

This chapter outlines and justifies the methodologies, methods of data collection and theoretical perspectives that underline the study. The methodologies describe the principles and methods which were used to answer the research questions (Kumar, 2013). This chapter is divided into two parts, A and B. Part A focuses on the theoretical framework used in the study. The grounded women's law approach forms the backbone of this study which explores and analyzes women's lived realities which remain the central reference point throughout the study. This approach was complemented by others including the human rights approach which was found relevant as it helped to unpack the violations of women's rights by state and non-state actors. Since Zimbabwe has signed many women's human rights instruments, the human rights approach reveals whether Zimbabwe is complying with women's rights, especially their rights to maternal health care. The application of relational feminism and the actors and structures approach expose women's subjection to intersectional discrimination or vulnerabilities. Part B of this chapter focuses on the methods of data collection underpinning the study. A qualitative approach guided the study using an actor, norms, and institutions oriented approach which focuses on the relationships between them and how they positively or negatively impact on the lived realities of women in accessing maternal health care. This will also be discussed from a feminist and legal pluralist point of view.

2.2 PART A: THEORETICAL FRAMEWORK: USING THE GROUNDED WOMEN'S LAW APPROACH AS A THEORY AND METHODOLOGICAL TOOL

2.2.1 Introduction

The grounded women's law approach was used as the primary theoretical framework of choice in this study because of its focus on the lived realities of women. It is a women-focused approach. Before I started the fieldwork, I asked myself which women to research and why. Having read that women in the global North call women in the South part of one big family, I interrogated the word 'we' and decided to pay less attention to the view of survival that romanticises 'a sisterhood that assumes [the] common oppression of all women' (Stewart,

2011:40, Oloka-Onyango and Tamale, 1995:698) and focus more on an approach which reveals and explains the unique challenges faced by a particular group of women (such as women of child-bearing age on former white-owned farms now divided into A2 farms and their right to access to maternal healthcare) in conformity with the principle that the answers to problems most often lie in a full and proper understanding or diagnosis of the problems themselves. Solutions based on generalisations unsupported by evidence are likely to make problems worse.

In her doctoral study, Hellum (1999) focused on women's rights and legal pluralism. She focused on the state of affairs of different groups of women in order to understand the role played by likeness and dissimilarity between them. The women's law theory also reveals that likeness and dissimilarity can be intersectional which means that women can have dissimilar experiences and identities. Interlocking systems of authority can be found to exist that affect those who are most marginalized in society. For example, when I conducted my study, likeness and dissimilarity were found between the two groups of women being those of childbearing age among women farmers and women farm workers. Gender-based discrimination was found to exist in the form of gender stereotyping. Women of childbearing age of former farm workers experienced serious gender-based discrimination because of their husbands' so-called foreign origin in that they formerly worked for former white farmers. Accordingly, these women encountered dissimilar forms of intersectional discrimination based on gender, income or employment status, origin and ethnicity (Hellum, 2013: 613-615).

The women's law approach influenced my study as well. Dahl (1987:17) postulates that the idea of women's law is to describe, explain and understand the legal location of women with the intent of recuperating the situation of women in law and the public. In fact, feminist approaches dominated the theoretical frameworks of this study because they make every effort to offer a positively discriminatory interim response in an effort to relieve the predicament of women. Each of these theories has its different point of view and its methodological strengths and weaknesses and together they seek to reveal and explain how women have been subjugated, repressed and suppressed (Tong, 1989:11).

2.2.2 The human rights perspective

The World Health Organization (2013) explains that a human rights-based approach is based on seven key principles: availability, accessibility, acceptability, and, as far as the quality of facilities and services is concerned, participation, equality and non-discrimination, and accountability. I adopted the view that if the above key principles were not met there would be a need to interrogate the policies and laws on healthcare to determine how and when these key principles could be fulfilled for its beneficiaries. I realized that the research topic was sensitive and even my parents were concerned for my safety. Many people thought that the research was politically motivated and that I was being funded to expose how the government's land reform programme had violated the rights of the women who had previously worked for former white farmers who had lost their farms. However, I explained that this was not the case at all and that I was genuinely concerned about their plight which everyone could see had drastically deteriorated and it was clear that no one was doing anything about it. It was my intention to determine the extent to which their human rights were being realised, if at all, in terms of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Maputo Protocol and the African Charter on Human and People's Rights. In doing so, I asked myself many questions including, Is there a protected right that is being violated? What is the nature of the violation? Who is the violator? And, Do these women of childbearing age know that their rights are being violated? And, If so, are they tolerating these violations or trying to do something about them? (Thabethe, 2008).

During this question and answer process I discovered that their rights enshrined in the articles of following human rights instruments were indeed being violated: Articles 12(1), and (2) and 14(b) of the Convention on the Elimination of All Forms of Discrimination against Women; Article 16(2) of the African Charter on Human and People's Rights and articles 14(1)(g) and 2(a)(b) of the Maputo Protocol. I discovered that these violations had a serious cumulative negative effect on the overall wellbeing of the women. Aasen (2013) is of the view that lack of access to adequate healthcare services is seen as a violation of women's rights to health and life. This is greatly accelerated by gender-based discrimination and structural disadvantages that affect poor women who come from low income households (Articles 1 and 2 of CEDAW).

I also found that the land redistribution program which was undertaken in 2000-2003 violated the right to equality and non-discrimination and right to health care in that the state failed to build health care institutions on the A2 farms these women continued to occupy. For instance, the relevant health policies suggested that the health care institutions should be about 10km apart. In reality, however, the health institutions surrounding Highway, Kingspeak and Musina farms are about 25km apart making it difficult if not impossible for pregnant women to reach on foot. Furthermore, there are no community health care providers to educate these women on the importance of maternal health care. In the light of these violations, I propose recommendations to positively impact on the well being of these women of childbearing age on resettlement areas of former white-owned farms.

2.2.3 The semi-autonomous social fields

During my field research, I realized that the power relations between men and women play a pivotal role in the control of women's behavior. This power which prevents women from enjoying full health and personal development operates within relationships at the personal and private as well as the social and public level (United Nations Population Fund (UNFPA), 2004). Ganle et al. (2015) also show that within the household, family and community settings women in the sub-Saharan region have limited autonomy and control over their reproductive health decisions. I discovered that even though the state has existing laws to protect women's right to health and maternal health care, in reality the well being of women of childbearing age on resettlement areas of former white-owned farms have been jeopardized for a quite some time. Sometimes they resort to traditional midwives which form part of a normative order. Normative orders have been confirmed in rulemaking capacities which persuade or force compliance regardless of what is enshrined in the statute law, such as the semi-autonomous social fields (Bentzon et al, 1998).

During my field research, I came to realize that traditional midwives had created a normative order that discourages women from giving birth in medical health facilities. All women of childbearing age agree that home delivery is better than clinic/hospital delivery due to the many expenses incurred in accessing formal maternal health care. Ganle et al. (2015)'s research findings of Ghanaian women noted that "access to and use of skilled maternal healthcare services

is strongly influenced by values and opinions of husbands, mothers-in-law, traditional birth attendants, and other family and community members more than those individual childbearing women."

The lack of correct information on the importance of skilled maternal health attendance has prevented these women from appreciating the complications surrounding home delivery. For instance, village health workers complained that these women do not officially register their pregnancy which means that health officials may least know of their existence and that they ought to visit or communicate with them for a safe home delivery. Although the clinic nurse tries to educate and encourage these women to come and register their pregnancies and visit the clinic throughout their pregnancy, it has become the habit of these women, for reasons best known to themselves, to dismiss the importance of antenatal care visits and to choose home deliveries at the hands of traditional midwives over trained midwives in a safer medical institution.

The Ministry of Health and Child Welfare does not encourage home deliveries and village health workers are not allowed to assist them because they are not trained in midwifery. In other words, they lack the necessary maternal health care knowledge which would alert them to the important early telltale signs of a complicated delivery, i.e., an incident or development that is likely to become life-threatening to mother and child and will therefore require the attention of a more experienced trained midwife. I was surprised that First Lady Mai Mnangagwa offered maternal health care services to untrained Mbare midwives as sadly this only serves to discourage rural women from seeking the services of skilled midwives to deliver their babies.

2.2.4 Actors and structures approach

I wanted to know, with the aid of the actors and structures approach, how it was that after almost 20 years after the former white-owned farmers had been removed from the resettlement areas, the situation had become worse for these women of childbearing age. I wanted to know what had gone wrong and what could be changed so that every one of them could have the right to access maternal healthcare services equally and without discrimination on any grounds whatsoever. This meant that I had to interview the health care personnel and beneficiaries in this Ward. The actors and structures approach was used for this purpose as it exposed whether and how women

of child bearing age had been influenced by normative structures in relation to their access to maternal healthcare. I wanted to know the impact of social, family, legal, economic structures on the choices and wellbeing of these women of childbearing age in accessing maternal healthcare on resettlement areas of former white-owned farms. I realized that challenges in accessing maternal health care arose out of the various circumstances surrounding these women, many of which were beyond their control. For example, I saw that there was an urgent need to provide health care institutions to meet their challenge of having to walk for long-distances to their nearest health facility. I also realized that pregnant mothers should be able to make informed decisions without external influences such as a lack of money for transport, that maternal healthcare information should be readily available so that they would learn more about their maternal healthcare rights and learn to choose to deliver their babies in the safe environment of medical institutions rather than at home.

2.2.5 Women's subjection to intersectional discrimination or vulnerabilities

Inter-sectionality recognizes that women can experience discrimination based on multiple and intersecting identities (Campbell, 2015). The theory speaks of about various social identities, like race, gender, sexuality, and class that contribute to the specific type of systemic oppression and discrimination experienced by an individual. I found that women belong to different social classes which were characterized by intersecting and multiple forms of discrimination such as sex, gender, class (social, cultural and economic), origin, marital status and different levels of education which they experience concurrently (Rutsate, 2016). Women of childbearing age were subjected to indirect discrimination because of their sex, economic status, and educational level. This was also found by Derman, Hellum and Sandvik (2013: 133-135)'s research findings which illustrate that "women suffer hardships and injustices not only because they are women, but also because of their race, class or age."

In terms of General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of CEDAW, CEDAW/C/2010/47/GC, the CEDAW Committee defines 'intersectionality' as:

> '…a basic concept for understanding the scope of the general obligations of State parties contained in article 2. The discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste, and sexual orientation and gender identity. Discrimination based on sex or gender may affect women belonging to such groups to a different degree or in different ways than men. States parties must legally recognize and prohibit such intersecting forms of discrimination and their compounded negative impact on the women concerned. They also need to adopt and pursue policies and programs designed to eliminate such occurrences, including, where appropriate, temporary special measures following article 4, paragraph 1, of the Convention and General Recommendation No. 2543.'

Crenshaw (1989) defines inter-sectionality as a term propounded by feminists on the issue of gender as a universal category that perceives women as a homogeneous group with invisible experiences. In this case, rural women encounter discrimination in accessing maternal health care and other social facilities. Banda (2013:359) and Hellum and Kameri-Mbote (2015:16) acknowledge that "article 14 of the CEDAW Convention sets out an intersectional approach to gender discrimination."

The United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) also makes specific reference to intersectionality in respect of women in General Comment No.16 of 2005 (GC16/2005), paragraph 5 which reads as follows:

> 'Women, in particular, are often denied equal enjoyment of their human rights, under the lesser status ascribed to them by tradition and custom or as a result of overt and covert discrimination. Many women experience distinct forms of discrimination, due to the intersection of sex with such factors as race, color, language, religion, political and other opinions, national or social origin, property, birth, or another status, such as age, ethnicity, disability, marital, refugee or migrant status, resulting in compounded disadvantage.'

The findings of this research compare the impact of intersectionality on the maternal healthcare rights of women of childbearing age living on the same land over a period of time, specifically, at a time when it was owned by white commercial farmers and then after the land reform program which redistributed it as A2 farms. I wanted these findings to enrich the growing body of knowledge on this issue and to help policymakers realize the great importance of accessible

maternal health care to these women whose dire situation has so far been almost totally ignored by researchers, policymakers, politicians, the medical fraternity and reformers alike.

2.3 PART B: METHODS OF DATA COLLECTION

2.3.1 Introduction

This part will discuss issues including the research design, the population researched, the data collection methods, ethical considerations, the sample researched and the sampling strategy, the research paradigm, emerging issues and the location of the study.

2.3.2 Research design

Schumacher and McMillan (1993) indicate that a research design is a plan and structure of the inquiry that is used to provide evidence to bring the solution to research questions. The way my research was designed describes the way I was going to carry out my study. I employed a qualitative research method. Hammersley (2013) states that qualitative research is referred to as a form of social investigation that has a flexible data-driven research design. It helped me to examine the women of childbearing age's lived realities in detail using a precise set of research methods such as in-depth interviews and observations, the interpretation and meaning of which identified the subject matter (rights to maternal health care) from the viewpoint of the study participants (women of child bearing age living on A2 farms) in the fullest sense of understanding relevant behavior, events, and objects in this specific context.

2.3.3 Location of the study and Description of the social group

The study took place in the Makonde district of Mashonaland West Province, in north-central Zimbabwe which is located 125km north-west of Harare. Makonde District is a farming district. Crops grown include maize, soya beans, cotton, and tobacco. Beef and dairy cattle are widely prized in the districts which are reared on a commercial scale. Ward 13 of this district is made up of A1 and A2 farms. A2 farms are those which comprise more than 30 hectares of land which have been given to individuals. They are also called plots and intended to support farming on a commercial scale. A1 are smaller pieces of land allocated to those who cannot manage an A2 farm. These A1 farms are different from A2 farms in that they are arranged like a village and managed by a village headman. A2 plot holders are, however, are in personal control of

everything on their plots including the former white-owned compounds where the women of childbearing age (the respondents of this study) stay. They remained after former white farmers left their farms during the 2000-2003 land redistribution programs. These women stay in compounds that were built for them and their families when they worked for their former white farmer employers. They received the accommodation in return for working in their fields. As far as race is concerned, Malawians, Mozambicans and Zambians were the dominant group. The majority of them however cannot go back to their home countries because they no longer know any one there and so are forced to stay in these compounds. Some of them left as soon as the land redistribution program of 2000-2003 began and a few managed to obtain land of their own during the process.

2.3.4 Population

As de Vos et al (2011) defines a population as the totality of persons, events, units, case records or other sampling units with which the research problem is concerned. My study population comprises women of childbearing age in resettlement areas of former white-owned farms, village health workers, district nurse officers, clinic nurses, and men. The population was specifically drawn from Kingspeak, Highway and Musina farms in Ward 13 of Makonde District, Mashonaland West Province.

2.3.5 Sample and sampling strategy

Cooper and Schindler (2006) postulate that sampling is a procedure of selecting some elements from a populace that represents a target population in research. I used a purposive sampling method. Purposive sampling is a process that involves the selection of participants who represent the desired population (Emmel, 2013). The reason why I used this sampling method was that the participants have direct information about their experiences which makes it relevant for the study. The sample size was 28 women of childbearing age on resettlement areas of former white-owned farms, four clinic nurses, one district nurse officer, two village health workers, one environmental health technician, twelve men (husbands) of these women and one district chairman. This sampling method enabled me to notice the gaps in the data collection and to filter ideas so as not to enlarge the original sample (Denzin and Lincoln, 2000 as cited in Ellis et al., 2011).

2.3.6 Data collection instruments

Parahoo (1997:52) as cited in Swart (2012:325) notes that the data collection instruments are the "tools used to collect data, measure knowledge, attitude, and skills". Data were collected using in-depth interviews and observations. I collected data from three A2 farms from different participants having different life experiences so that the information collected was not biased and that the information obtained was of high credibility.

2.3.6.1 In-depth interviews and observation

The interview guide was comprised of unstructured one to one interviews for all the key informants since they possess personal data of what was happening in their daily life experiences. Interviewing the participants allowed me to come up with rich, solid and varied information from the participants. The questions asked of each informant were the same but as the interview continued changes were made to some interview questions to address the issues that arose during the process of the interview. Each interview session lasted for thirty to fifty minutes and the questions were open-ended (Leedy and Ormrod, 2005 as cited in Pacho, 2015). This gave sufficient time to ask questions about issues that arose during the interview which had not been foreseen and it enabled the participants to speak freely about their experiences of women of childbearing age. Towards the end of each interview I invited the interviewee to give his/her opinion regarding the discussion to ensure that they had an opportunity to share their honest views.

The use of in-depth interviews was of paramount importance in my study as they provided me with more detailed information than any other data collection method, for example, surveys. Another reason why I chose in-depth interviews was that they allowed the participants the opportunity to feel relaxed and share their opinions in the comfortable format of a conversation. The participants were given the chance to explore their feelings and perspectives on the research subject, and so I obtained rich background information (Faarup and Hansen, 2010). Whilst I was conducting the interviews I also observed what they were doing as part of their daily activities and taking noted of the physical appearance of the farms. At times there was no need to ask any questions because I would just observe what was happening around me and write down my findings. Table 2 shows details of the respondents who were interviewed for this study.

Table 2:Showing details of respondents who were interviewed

INTERVIEWEE/LOCATION	LOCATION	MALE	FEMALE
Women of childbearing age	Highway Farm	4	10
“	Musina Farm	6	8
“	Kingspeak Farm	2	10
Clinic	Alaska	-	2
Clinic	Murereka	1	1
Makonde District Nurse Officer		-	1
Village health workers (VHWs)			2
Environment Health Technician		1	-
TOTAL		**15**	**34**

2.3.7 Research Paradigm

I used the post-positivist research paradigm. This paradigm does not test the hypothesis but generates a hypothesis through inductive reasoning (McGregor, 2010). My primary reason for using this paradigm was to get as much material and relevant information from participants regarding access to maternal health care in Ward 13 Makonde district as possible. In this study, I managed to capture the voices of the participants. They were central to the research process and the research was carried out in communities where their daily activities were not affected (Thorne, 2000). The post-positivist research paradigm re-conceptualizes academic thoroughness

in that it strives to ensure that results are valid, legitimate and believable (Koch, 1996). It also helped me to gain more understanding and knowledge of the experiences encountered by women of childbearing age and how they are living in this new dispensation of living on A2 farms.

2.3.8 Data analysis

I carried out the analysis of the data after all of it had been collected. I went through the data collected from in-depth interviews and observations to come up with themes. Comparisons were undertaken between themes from in-depth interviews and observations. I constantly reviewed and reflected on the primary data to make sure that the data in the final themes was the same as the primary data from in-depth interviews and observations. The use of this qualitative content analysis was employed to enable a full interpretation of the meaning and understanding of women of childbearing age's experiences. Data was presented thematically.

2.4 Challenges and limitations

The challenges and limitations related to this study included the following:

- ✓ Travelling and its cost was a limitation and at times I was not able to find (public) transport and failed to arrive at appointments when I had promised.
- ✓ Undertaking individual interviews was more tiresome and time-consuming than I had expected and I did not have time to make use of focus group discussions.
- ✓ Some participants asked if they would get paid by participating or receive any incentive for doing so. I explained that their participation was purely voluntary and that they would not receive anything. I explained how their participation would contribute to the positive effects I hoped would flow from the research.
- ✓ Reaching the field without a clearance letter from the Medical Research Council of Zimbabwe (MRCZ)[2] was a challenge. The acting Director for the Ministry of Health and Child Welfare informed me to come with a clearance letter and failing to comply meant that the Ministry would not allow me to conduct the research. It took me three weeks to

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[2] The Medical Research Council of Zimbabwe is a specialized Council of the Research Council of Zimbabwe (RCZ) which provides health researchers and institutions in which health research is conducted with independent ethical oversight of research conducted by those researchers or within institutions.

comply and obtain their permission and by the time I was granted the clearance letter it was already the December festive season.

- ✓ I was not granted permission to access some sensitive information such as statistics of maternal and child mortality. There was a lot of bureaucracy to negotiate to obtain the information I needed.
- ✓ My topic was politicized by officials who thought I was conducting donor-funded research. Hence, most of them did not want to help me as they were under the mistaken impression that I wanted to expose the government's inappropriate channelling of resources from the health sector which has contributed to challenges in accessing maternal healthcare by women of childbearing age in resettlement areas of former white-owned farms.

2.5 Language problem

Shona was the vernacular language that I used to converse with the women of childbearing age during my study. Most of the participants speak and understand *Shona* very well. The challenge was that my interview guides were written in English which meant that before I went into the field I had to translate them all into *Shona*. The reason why I did that was to prevent my participants from gaining an inferiority complex as a result of possibly thinking that the study/research was only for English speaking participants. I wanted them to feel comfortable knowing that the research questions were also in their vernacular language.

2.6 Emerging issues

The following issues emerged as I conducted this research:

- ✓ Lack of identity cards
- ✓ Land redistribution program
- ✓ Men and the husbands of the women who were involved in this research also need access to health care services
- ✓ Families who were chased away from their compounds by the A2 farm owner of Kingspeak farm
- ✓ Use of traditional birth attendants

2.7 Ethical considerations

Research ethics refers to the moral principles guiding research (Economic and Social Research Council (ESRC), 2004). When I was doing my research, I was trusted to be given access to the private lives of the participants which meant that I had to uphold strict ethical guidelines to protect them against the misuse of their reputation or the information they gave me. The Medical Research Council of Zimbabwe (MRCZ) is a body that protects the interests of participants and this is done through complying with their ethical guidelines. I complied with the requirements of this body and I was given an ethical clearance letter allowing me to proceed with my data collection process. Below are some of the ethics I was bound to follow and consider for the safety of the participants.

2.7.1 Confidentiality, privacy, and anonymity

I promised to uphold the confidentiality, privacy, and anonymity of the participants by using pseudonyms for the participants during and after the presentation of data (Gray, 2014). Before the research, I assured the participants that their real names would not be used in the research and doing this also helped to reassure the participants to participate in a friendly and welcoming environment. Furthermore, the participants were assured that their identity would remain anonymous to anyone interested in the research.

2.7.2 Informed consent

Crow et al. (2006) point out that informed consent is providing sufficient true information regarding a study to enable the participants to decide whether to participate or not. When I was carrying out the study informed consent was very important in that the women were vulnerable to coercion, exploitation or harm from the community for participating. So having informed consent yielded an important positive spin-off for the research project. I informed the participants of the data collection methods, purpose, nature, and extent of the research before the commencement of any interaction with them.

2.7.3 Avoidance of harm and risk

Gray (2014:98) asserts that the words “harm and risk” embrace various wide issues ranging from mental, physical and emotional harm. I guaranteed the participants that the study was not going

to cause any form of harm or risk during and after their participation in it. Avoidance of harm and risk will be of greater importance during and after the study has been conducted.

2.7.4 Honest and trust

I adhered to all the research ethical guidelines thereby upholding and enhancing the honesty and trust of the participants. Furthermore, I ensured that the data was gathered and analyzed data in an honest and trustworthy manner.

2.7.5 Voluntary participation

Since the study was conducted for academic purposes only the participants were not forced to participate which meant that they participated voluntarily. I also explained to them that they could stop participating whenever they wanted to do so without fear of suffering any punishment or penalty.

2.8 Conclusion

This chapter is of paramount importance as it shaped how I conducted my research in terms of the mindset behind it. It explains the methodological framework which helped to do justice to my research and my motives which are purely academic and intended solely to improve the lives of the women of child bearing age living on A2 farms by improving their access to safe maternal healthcare. It also guided my methods of data collection so that I remained on track and focused on the research topic all the time. The theories and data collection instruments employed guided me to find relevant participants for the study as well as to obtain as credible and reliable information from them as possible.

CHAPTER THREE

3.0 SITUATING WOMEN'S ACCESS TO MATERNAL HEALTH CARE AT THE INTERFACE OF THE NATIONAL LEGAL AND POLICY FRAMEWORK AND REGIONAL AND INTERNATIONAL WOMEN'S RIGHTS

3.1 INTRODUCTION

The focus of this chapter is to give a comprehensive explanation of where women of childbearing age stand in relation to their access to maternal health care making reference to the human rights instruments to which Zimbabwe is bound as a member. As noted earlier, since women's rights are human rights this chapter will be written from a human rights perspective in an effort to unpack, assess and interrogate our laws and national policies on the importance of maternal health access to the women of childbearing age on resettlement areas of former white-owned farms. It is designed to encourage the government to show more commitment toward protecting, respecting, promoting and fulfilling these human rights at the domestic level in accordance with the exhortation contained in several of human rights instruments to which it is bound, namely, that "states are held accountable", meaning that member states including Zimbabwe "may be held legally and politically accountable for their health policies, programs and strategies, in terms of the state report system, individual complaints procedures and political accountability at the national level" (Aasen, 2013:300-301).

Formerly, urban women of childbearing age's access to maternal health care was far better than their rural counterparts because clinics and hospitals in urban areas were readily accessible and staffed with sufficient numbers of trained maternal health care personnel. However, as a result of the country's current harsh economic situation I have noticed that there is now no difference between rural and urban access to maternal health care as both maternal health care institutions are facing the same predicament of shortages of maternal health care personnel, drugs and services all of which put these women at a high risk of suffering serious maternal healthcare complications including early bleeding, infections, high blood pressure during pregnancy (pre-eclampsia and eclampsia), obstructed labour and unsafe abortion (Aasen, 2013:295).

3.2 THE NATIONAL LEGAL AND POLICY FRAMEWORK ON MATERNAL HEALTH CARE

The nation's legal and policy framework is meant to reduce challenges facing women in accessing maternal health care through its compliance with the regional and international human rights framework on women's rights to healthcare.

3.2.1 The National Legal Framework

3.2.1.1 Constitution of Zimbabwe Amendment (No. 20) Act, 2013 (the Constitution)

Although the Constitution of Zimbabwe Amendment (No. 20) Act, 2013 (the Constitution) is the supreme law of the land and guarantees many important human rights including the right to basic health care (sections 29 and 76), it does not, however, specifically provide for the right to maternal health. Zimbabwe is a member of international human rights treaties that uphold the rights of women to reproductive health care and its inclusion in Zimbabwe's 2013 Constitution has been an important development for Zimbabwean women's access to maternal healthcare. The most significant challenge has been in the implementation of laws and policies to support this human right, especially for rural women who have been historically more prejudiced by the lack of medical investment than their urban counterparts. Schuler (1986) explains that a legal system comprises three components which are structural,[3] substantive[4] and cultural.[5] Increasing quality investments in all three of these components of our system will help reduce challenges faced by women of childbearing age in accessing maternal healthcare. Such investments include advocacy (counseling and representing women), reform (research and legislative initiatives) and education (media campaigns, training of lawyers and paralegals, legal education, legal literacy program, constituency building, and public force).

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[3] A strategy focusing on the structural component of the legal system will have its objective making the law functional for those who have least access to resources within the legal system and thus are the most vulnerable to injustices.

[4] A strategy focusing on the substance of the law is made up of activities geared toward changing discriminatory or unjust legislation or policy.

[5] A strategy focusing on the change of attitudes and behaviors by raising awareness about the legal status of women and how the law functions to women's detriment.

3.2.2 Policies and Strategies

3.2.2.1 National Health Strategy for Zimbabwe 2009-2013 (Equity and Quality in Health: A People's Right)

The National Health Strategy was implemented in order to address six critical factors that hinder healthcare delivery. These include the health workforce, medicines and supplies, equipment and infrastructure, transportation, financial resources, governance and leadership at all levels. The Ministry of Health and Child Welfare is committed to providing adequate health care services to all people from its available resources. In terms of the National Health Strategy, the Ministry's plan was to reduce the maternal mortality ratio from 750 to 300 per 100,000 live births by 2015. Although some reduction has been achieved, challenges in accessing maternal healthcare services have not changed much, especially for rural women. In essence, the health sector has been struggling to meet its goals and objectives largely due to the fact it was affected by so many factors.

3.2.2.2 The Patient's Charter, Reproductive Health Policy and Reproductive Health Guidelines

The Patient's Charter, Reproductive Health Policy and Reproductive Health Guidelines provide for free immunization for pregnant women which is only one of the many other services required by women in the exercise of their rights to maternal healthcare. While Murereka and Alaska clinics offer free antenatal care services, services such as family planning methods are not offered for free. The low economic status of the majority of women who make use of this healthcare institution means that they cannot afford to buy these family planning methods on a monthly basis. In other words, the Ministry is failing to provide free and accessible maternal healthcare services to women and all the women at Musina, Highway and Kingspeak farms in Ward 13 of Makonde district agreed that this was the case when I interviewed them.

3.2.2.3 Zimbabwe National Maternal and Neonatal Health Road Map (2007-2015)

This national framework provides for planned activities intended to significantly improve maternal and newborn health services at institutional and program levels in line with the Millennium Development Goal (MDG) health-related targets. Due to an increase in the neonatal and maternal levels, this road map seeks to provide continuing investment in efforts to zeroing

neonatal and maternal morbidity and mortality rates. It seeks to encourage all partners and stakeholders to coordinate with each other in a multi-sectoral and national approach to achieve a better health service delivery system with the intention of building fully equipped and staffed institutions all the way from and through community-based services, rural health facilities, district and provincial referral centers and all the way to a highly dedicated and advanced tertiary hospital.

3.2.3 Other Statutes

3.2.3.1 The Public Health Act [Chapter 15:03]

Although the Public Health Act is the main piece of legislation that deals with health issues, maternal healthcare is not even mentioned in it revealing that such issues are not considered of much importance. A regular review of laws and policies and law reform is necessary to update outdated health policies and legislation.

3.2.3.2 The Medical Services Act [Chapter 15:13]

The Medical Services Act makes the Minister of Health responsible for all the country's health facilities. The Minister is supposed to provide medical facilities and encourage local authorities and other persons to provide such services. Also Members of Parliament are responsible for maintaining the general health and welfare of their constituents and this includes ensuring that the health budget is allocated and managed in a gender sensitive manner in order to ensure that women of childbearing age have reasonable access to maternal healthcare. The Minister of Health, however, remains ultimately responsible for the medical sector.

3.3 REGIONAL AND INTERNATIONAL WOMEN'S RIGHTS TO MATERNAL HEALTH CARE

3.3.1 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR)

While there are some references to health rights (article 12), but no direct reference to maternal healthcare in the ICESCR, we find that there are some specific provisions on the subject in article 12(1) of CEDAW which are particularly women-centered. While paragraph 1 of article 12

of CEDAW refers to formal equality in general national health care systems, paragraph 2 recommends sex-specific healthcare services to achieve substantive equality for women.

Article 14 of CEDAW is very vital because poor women in rural areas are more vulnerable to the lack of access to healthcare services. This article thankfully recognizes the tragic reality that many women die in child-birth and suffer critical, life-threatening conditions due to what should be easily preventable obstacles such as the lack of transportation to clinics and hospitals or, worse still, the lack of money to pay for such transportation. Women from both farms supported this view by saying that *"…they end up having home delivery because of lack of affordable transport and communications to make the ambulance come on time and fetch them to the hospital."* Due to poor and damaged roads, no ambulance is prepared to fetch them which forces them to opt for cheaper home deliveries, a state of affairs which the Ministry of Health and Child Welfare does not encourage but does little to mitigate.

Zimbabwe is obliged to make such provisions available and its failure to do so is a violation of women's right to health care since articles 12 and 14 do not specifically state what is and how to put in place 'appropriate services for women' and this gives rise to controversial arguments on the subject. In Ward 13 there are no clinics and this makes it difficult for women of child bearing age to have any access to any health care services. In its General Comment No. 14 with reference to article 12(2)(a) of the ICESCR, the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) defines health services as including "access to family planning, pre- and postnatal care, emergency obstetric services and access to information as well as to resources necessary to act on that information." What I found on the ground is not what is supposed to be happening which means the state is still required to "strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances" (Committee on Economic, Social and Cultural Rights, 1999).

3.3.2 The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol)

The Maputo Protocol was the first human right instrument to explicitly provide that women's reproductive rights are human rights and guarantee that women have a human right to family planning education (article 14). From the interviews I conducted, women of childbearing age

lack the right to family planning education as a result of which they may have decided to have more children than they could afford to maintain. While contraceptives are available on sale many of the women cannot afford them. Since the Maputo Protocol places great emphasis on the importance of women's reproductive rights, the State has failed to fulfill its duty to comply with its provisions especially in respect of rural women who face many insurmountable obstacles in their attempts to access to maternal healthcare services.

3.4 A LOOK BACK AT THE STATE OF MATERNAL HEALTH CARE IN ZIMBABWE SINCE INDEPENDENCE

The health system of pre-colonial Zimbabwe was characterized by black marginalization accompanied by skewed resource allocation and distribution processes which largely favored the whites and mixed races (Zhou and Zvoushe 2012:4). In 1980, the infant mortality ratio (IMR) was 1:3:5 between whites, urban blacks and rural blacks corresponding to a ratio of 39:5:1 in their incomes (Ministry of Health, 1984a). The IMR of 17 per 1,000 for the white population compared to 120 per 1,000 for blacks. It was this reality and background that informed Zimbabwe's health policy interventions after independence starting with the Plan for Equity in Health in 1980 drafted in pursuit of the ideal to bring health to all races.

3.4.1 Plan for Equity in Health

The Plan for Equity in Health was the first health policy intervention that was implemented soon after independence. The drivers of this intervention were the Alma Ata Declaration of 1978 which strongly emphasized the importance of primary healthcare and that access to healthcare is a basic human right that every citizen has the right to enjoy. Primary healthcare was the primary goal for this intervention as it was also supported by the International Conference on Primary Health Care which also called for critical and efficient national and international action to develop and put into practice primary healthcare all over the world especially in developing countries, such as Zimbabwe (Alma Ata Declaration 1978:2). Although positive changes took place, their costs greatly increased the nation's foreign debt since the Plan required large amounts of international donor funding (Sanders 1990:7).

3.4.2 Economic Structural Adjustment Program (ESAP) 1992 to 1996

The 1992 to 1996 ESA Programme (ESAP) was the second major health policy intervention after independence and its goal was to restructure the economy in pursuit of health equity which the first intervention failed to accomplish. After realizing the failure of the first policy, this policy was guided by strict measures that aimed to bring economic growth through reductions in government expenditures under the recommendations of the international monetary institutions such as the International Monetary Fund and the World Bank (Zhou and Zvoushe 2012:5). This policy ushered in the removal of subsidies; the reduction of public expenditures, privatization, and market-based health care, among others. Health services were made more expensive as subsidies were removed and equity was undermined through reduced funding and privatization reduced the accessibility of health care by the majority populace and the poor and low earners were excluded from market-based health care (Ministry of Health and Child Welfare, 1998). These results spelt the failure of this intervention and in a quest to pursue economic efficiency, the National Health Strategy of 1997-2007 was implemented.

3.4.3 The National Health Strategy (NHS) 1997-2007

The NHS was implemented on the back of the realization that equity in health under ESAP had failed and so the government sought once again to build capacity in the health sector. Emphasis this time was on the coordinated participation of all sectors, communities, and individuals in health care provision, financing service standards setting, and the regulation, monitoring and evaluation of performance (Ministry of Health and Child Welfare 1998). Various sub-policies and programs were implemented in pursuit of health care equity, mortality and morbidity, among others. The National HIV/AIDS policy of Zimbabwe was implemented in response to gender inequality, an increase in HIV/AIDS cases (including for example a 25% increase in HIV/AIDS of people aged 15-49 years) and HIV/AIDS being the main source of illness and increased deaths in young and middle-aged adults (Ministry of Health and Child Welfare, 2001). In pursuit of this, a multi-sector approach was adopted with the involvement of the public sector, private corporations, non-governmental organizations, churches and community groups participating in the HIV/AIDS policy through the National AIDS Council (NAC).

3.4.4 The National Health Strategy of 2009-2013

The theme of this strategy was "equity and quality in health, a people's right". In 2008, the country experienced the peak of the economic crisis resulting in a sharp decrease in funding for social services by both government and development partners (Ministry of Health and Child Welfare, 2009). This directly contributed towards an unprecedented deterioration of health infrastructure, loss of experienced health professionals, drug shortages and a drastic decline in the quality of public health services. This Strategy was implemented under the Short-Term Emergency and Recovery Program (STERP) as a strategy to rehabilitate the country. Under this intervention, two main objectives were to be pursued, that is, the provision for a framework for immediate resuscitation of the health sector to put Zimbabwe back on track towards achieving regional and international policy objectives (Ministry of Health and Child Welfare, 2009). Major programs under this intervention engaged in a sector-wide approach through the country's cooperation strategy with the World Health Organisation of 2009-2013, a rights-based approach and people-centred frameworks adopted in pursuit of comprehensive coverage of the entire population and the crafting of all health interventions within the entire health system as building blocks in a bid to reconstruct it. The systematic approach towards policy implementation, a Health Transition Fund and monitoring and evaluation frameworks were also adopted.

3.5 THE STATE OF MATERNAL HEALTH CARE IN ZIMBABWE IN THE CURRENT POLITICAL AND ECONOMIC CONTEXT

The current standard of Zimbabwe's maternal health care is poor. Countrywide access to maternal health care is not as efficient as it used to be in that public hospitals and clinics do not have adequate healthcare personnel, equipment or drugs. This has resulted in the majority of women being unable to afford to go to private hospitals or clinics. Doctors and nurses are often on strike, and patients are often referred to private pharmacies to buy drugs whose prices are so high that the majority cannot afford them. In other words, the state of maternal healthcare is in such urgent need of resuscitation that if this does not occur soon the government will be unable to restore Zimbabwe's once good and viable maternal healthcare system. For example, the lack of trained midwives has already caused many and growing numbers of women and unborn children to lose their lives due to entirely preventable circumstances. For instance, one of the wards in the Makonde district called Cheuchi is a new resettlement area which is very far away

from Chinhoyi town, and has no available telecommunication network, no safe roads for the easy transportation of patients and only one clinic for the entire new resettlement area.

One of the field officers from Pamuhacha (which is a nongovernmental organization that provides various forms of support to young women and girls) pointed out that the state of this clinic needs immediate state intervention as many pregnant women struggle to reach to it. Recently, a pregnant mother and her baby died due to the unavailability of trained maternal healthcare personnel to advise her and many of the women residents on basic yet critical information concerning their pregnancies. In addition the long distances that these women have to walk to access maternal healthcare, there is only one mother shelter at Murereka clinic but is under a great deal of pressure serving many surrounding wards. The former good state of maternal health care has been so taken for granted over the years that now, and in response to this persistent neglect, it has deteriorated almost to the point of collapse. The government seems to have lost sight of its first duty to save and preserve the lives of mothers and their babies, our nation's next generation.

The mother shelter was an intervention meant to reduce challenges faced by women of childbearing age in accessing maternal healthcare. First preference was given to those who were pregnant with their first baby, needed a cesarean section, had previous difficult deliveries, and suffered from high blood pressure and those having their fifth child. The primary goals of this initiative was to: (1) make sure that pregnant women receive close monitoring when they are due for delivery (any time during their last six weeks of pregnancy) since many mothers stay far from nearby clinics; (2) reduce home delivery and (3) to make sure no mother or baby lose their lives either during or soon after delivery. They would be closely monitored by trained midwives and in case of any critical condition the patient would be quickly referred to the nearby hospital with trained medical health personnel and advanced equipment. However, there is still a great need to manage, monitor and evaluate whether these mother shelters are helping women of childbearing age or whether they ought to be modified to meet the challenges faced by rural women.

I discovered during this research that often the most economically challenged of these women cannot afford to have a decent meal every day or to meet their own basic needs. Therefore, rather

than staying in a mother shelter and thus creating a second household which they cannot feed, these women prefer to have home deliveries to avoid incurring such additional expenses. Their choice however means that they make use of untrained village health workers who do not have access to or use all the essential maternal healthcare delivery services such as surgical, cord clippers, gloves among other necessary items. Also, when these pregnant mothers came to the clinics, they were advised to bring along baby preparation materials which most of them could not do because they could not afford them. So most pregnant mothers opted for home deliveries to avoid the embarrassment of arriving with nothing at mother shelters or clinics in order to save costs and to prevent splitting up their homes.

3.6 MOTHER SHELTERS (MATERNITY WAITING HOMES) AS A SAFE MOTHERHOOD STRATEGY

Mother shelters (or maternity waiting homes) were designed to cater for women who cannot afford to go to hospitals or clinics for delivery. Usually, pregnant women were advised to stay in mother shelters when their pregnancy still had six week to run. The program was established by the government and funded by the European Union (EU) and other stakeholders in response to challenges faced by pregnant rural women who failed to access formal healthcare facilities. Mother shelters have proved to reduce child mortality and maternal mortality especially among those women who have come on time to receive monitored delivery by trained healthcare personnel at the clinics. They have registered a positive impact across the country, helping rural women to receive ante-natal check-ups, newborn care and identify problems during their labor. These facilities were also designed to prevent the risk of hemorrhages, which health experts say are the major contributing factor to the deaths of mothers during delivery.

However, these mother shelters face challenges such as a lack of safe water to drink, and food to eat, warm blankets and comfortable beds. In Zimbabwe’s current poor economic climate, many shelters are no longer working according to expected standards. For example, in Ward 13, there are no clinics or mother shelters as a result of which many women in this Ward have been forced to travel long distances to receive any form of maternal healthcare including antenatal care services, maternal healthcare education and the registering and monitoring of their pregnancy. Those with critical conditions are advised to go to Chinhoyi Provincial Hospital. Pregnant

women from the three farms (Kingspeak, Highway and Musina) have to travel a distance of about 25km to the nearest clinics which are either at Murereka or Alaska to receive maternal health care services. Only Murereka clinic has a mother shelter. There is a desperate need to increase healthcare institutions in this district to reduce the huge challenges these women encounter. Mother shelters play a critical role in the reduction of maternal mortality as they help curb three types of critical delay which are: the delay in making the decision to seek, the delay in reaching and the delay in receiving adequate health care.

3.7 THE ROLE OF VILLAGE HEALTH WORKERS (VHWs) VERSUS SKILLED MIDWIVES

Village health workers are women and men who are recognized by their neighbors and communities. They receive formal training to promote and maintain the health of their communities. They learn to diagnose and treat common illnesses, they learn about prevention and public health, and they participate in major health initiatives carried out by the national government, local health post and/or non-governmental organizations. Whether paid or voluntary, village health workers are critical to any effort to improve the health and well-being of people at the local level. Village health workers are also known as community health workers who work with the community at the grassroots level and have experienced the lived realities of their communities. I found that in Ward 13 there are no specific village health workers to provide maternal healthcare for those living on A2 farms which was a challenge for women of childbearing age who were therefore denied knowledge of their important human rights to access maternal health care. Kingspeak farm does not have a village health worker which has meant that its households do not prioritize the importance of accessing maternal healthcare and of living in a safe and healthy environment.

There are no toilets and no safe running water and everyone uses bush toilets all of which increases the risk of contracting diseases especially during the rainy season. Village health workers have an important role to play but sadly they are looked down upon by people and even by their own Ministry. They are not treated with the respect and dignity they deserve so there is a need to educate the community to improve how they are treated. The two village health workers I met were not even designated to serve those farms. They are so dedicated to the people they

serve, however, that they carry out voluntary work for their communities. Unfortunately, they are not trained to provide maternal health care services. They confirmed that many pregnant women opt for home deliveries in this Ward because of the inaccessibility to healthcare institutions. Even though as village health workers they are not trained to provide maternal health care, they have felt compelled to help when emergencies have occurred (e.g., in the middle of the night) among the many women who have given birth at home.

Skilled midwives are trained individuals who offer professional delivery services to pregnant women at clinics or hospitals. They offer skilled services as set out by the World Health Organization, for instance, when the baby is in the breach position, and they can make referrals when a complication reaches the clinical level. They try to minimize child and maternal mortality by the use of advanced equipment which is able to detect abnormalities and they make sure pregnant mothers receive adequate maternal health care services on time. I found that there are two trained midwives at each of Alaska and Murereka clinics. From the interviews I had with them, they said that they were overwhelmed with work because they served such a large surrounding population. Therefore, there is definitely a need to increase more trained and skilled midwives in this area. They had no recorded case of maternal or child mortality at either clinic largely due to their skilled maternal healthcare personnel. They spoke of only one case of child mortality which had occurred during a home delivery in the nearby village of Cheuchi which was not in their Ward.

3.8 CONCLUSION

This chapter discussed the state of women’s right to accessing maternal healthcare in accordance with national, regional and international human rights provisions. It is of paramount importance to note that the severely challenged socio-economic status of this country has greatly undermined and almost destroyed rural women’s right to access maternal healthcare. Although Zimbabwe has been a long time member of many international human rights treaties protecting women’s rights to maternal healthcare, its apparent lack of concern to protect, promote and realize this critical right sadly seems to reflect an attitude that rural women’s challenges to access to maternal health care is more of a personal obligation rather than a national crisis.

CHAPTER FOUR

4.0 FINDINGS AND ANALYSIS

4.1 INTRODUCTION

This chapter combines the data collected through in-depth interviews and observations and presents them in a manner that aligns with the research questions of this study. The style adopted for this chapter aims to confirm connections between the research questions and the themes which emerged from the summarized data to present the significant responses and insights obtained from the analysis of the data. The study specifically tried to answer the objectives, namely:

1. To find out whether the lack of sustainable livelihoods is a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms.
2. To investigate whether the lack of financial resources is a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms.
3. To examine how women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms are coping with challenges they face in exercising their rights to access maternal health care.
4. To analyze whether the lack of maternal health care knowledge is a hindrance to accessing maternal health care services for women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms.

The data obtained is presented according to biographical data and major themes which include the following: (1) the importance of sustainable livelihoods for the women and the exercise of their right to access maternal health care, (2) violations of the women's right to remunerative employment is contributing to violations of their right to access maternal health care, (3) the influence of discrimination against the women in exercising their maternal health care rights, and (4) violations of the women's right to receive meaningful education and relevant information is violating their right to maternal health care.

4.2 BIOGRAPHICAL DATA

To understand and explain their social meaning, I investigated the factors which influenced the participants who supplied the data in terms of their socio-economic backgrounds, specific social contexts and so on (Seale, Gobo, Gubrium & Silverman, 2004). The biographical data was used to assess the maturity of the participants in terms of their experiences, their competence in terms of age, their level of education and their period of stay in the resettlement areas of former white-owned farmers. Table 3 shows the characteristics of women of childbearing age who were sampled for the study in terms of their age, period of stay in the resettlement areas of former white-owned farms, language spoken, level of education and number of children.

As shown in Table 3, twenty-eight women were interviewed. All of them were women of childbearing age who have been wives or former wives of former farm workers. Also these women have been staying on the current A2 farms for more than 10 years, since the time when they still belonged to former white-owned commercial farmers. So they had experience or lived realities of life under both dispensations. Each woman represented each of the families they headed. These women were as young as seventeen years old and most of them had reached but not written their final exams for Grade 7 (usually for students aged 12 in their final year of primary school) or Ordinary Level (for students aged 16). These women could only read and write basic *Shona* and found English a challenge. All the households consisted of families who had migrated from one farm to another. Their husbands had originated from Malawi, Mozambique and Zambia seeking greener pastures in Zimbabwe. Half of their husbands did not have identity documents whereas their wives were citizens of Zimbabwe. One challenge they faced was a lack of birth certificates for their children and some as old as twenty years old still did not have them. A major reason for this was that their husbands did not want their children to have their mother's surname which they would have had to put on their birth certificates if they applied for them. I found that women have internalized the challenges they face in accessing maternal healthcare. In an interview I had with one pregnant woman she said:

> 'I have only managed to register my pregnancy. [As far as clinic visits are concerned], I cannot afford to walk or afford transport costs every month, hence home delivery is the only and better delivery method I will use. My husband does not work and the only money he got we buy necessities.'

Table 3: Showing details of the women of childbearing age involved in this research

Women of childbearing age	Age	Period of stay (years)	Language is spoken	Level of education	Number of children
Woman 1	18	18	*Shona*	Ordinary Level	Expecting
Woman 2	38	20	*Shona*	Grade 7	3
Woman 3	22	20	*Shona*	Grade 7	2
Woman 4	22	22	*Shona*	Ordinary Level	1
Woman 5	30	15	*Shona*	Grade 7	3
Woman 6	44	30	*Shona*	Grade 7	4
Woman 7	24	24	*Shona*	Grade 7	3
Woman 8	36	30	*Shona*	Ordinary Level	5
Woman 9	26	20	*Shona*	Ordinary Level	2
Woman 10	41	15	*Shona*	Grade 7	7
Woman 11	31	20	*Shona*	Grade 7	5
Woman 12	18	18	*Shona*	Grade 7	1
Woman 13	25	25	*Shona*	Grade 7	4
Woman 14	38	38	*Shona*	-	5
Woman 15	17	17	*Shona*	-	Expecting
Woman 16	21	19	*Shona*	-	3 & expecting
Woman 17	21	21	*Shona*	-	2
Woman 18	32	16	*Shona*	-	6
Woman 19	36	10	*Shona*	Ordinary Level	3
Woman 20	32	18	*Shona*	Ordinary Level	4
Woman 21	17	10	*Shona*	Grade 7	2
Woman 22	19	12	*Shona*	Grade 7	2
Woman 23	19	7	*Shona*	Ordinary Level	-
Woman 24	23	15	*Shona*	Ordinary Level	3
Woman 25	31	20	*Shona*	Grade 7	4 & expecting
Woman 26	30	3	*Shona*	Ordinary Level	3
Woman 27	29	10	*Shona*	Grade 7	4
Woman 28	33	22	*Shona*	Ordinary Level	3 & expecting

I found that the women of child bearing age who were covered by my study fell within the 17 to 40 year old age group. I found that not only had they given birth, but they had also been exposed to various challenges that affected them emotionally, physically, psychologically and verbally. In addition they have been exposed to a great deal of government policy and legal changes which have affected their communities, such as changes of their community leaders, land reform program changes which impacted their standard of living as a result of which they no longer receive maternal healthcare within their compounds. This has contributed to an increase in the incidence of diseases including tuberculosis, blood pressure conditions, diabetes, HIV/AIDS, and strokes among other health-related diseases that have dominated these compounds. Furthermore, I found that the majority of them were struggling to buy medication and others had defaulted on their tuberculosis medication. Tuberculosis medication is not readily available in clinics or pharmacies; as a result, the women cannot afford to travel every day to check to see whether the medication is available and most of them do not have the money to buy the medication. Many have resorted to traditional remedies of treating some of their ailments which expose them to a high risk of unmonitored health problems.

4.3 FINDINGS CONCERNING THE MAJOR THEMES OF THE STUDY

4.3.1 The importance of sustainable livelihoods for the women and the exercise of their right to access maternal health care.

My first research assumption upon which the study was based was to find out whether the lack of sustainable livelihoods is a hindrance to accessing maternal health care for women of childbearing age in resettlement areas of former white-owned farms which are now divided into A2 farms. I came up with sub-themes under this main assumption which is how socio-economically loaded factors influence access to maternal healthcare. These include delivery facilities, maternal education, geographical location, housing, and the status of women (socialization). These sub-assumptions will be discussed below.

Before I go any further I will begin by defining what is meant by ‘sustainable livelihoods.’ Scoones (1998) defines a ‘livelihood’ as comprising the capabilities, assets (including both material and social resources) and activities required for the means to earn a living. A livelihood is ‘sustainable’ when it can cope with and recover from stresses and shocks, maintain or enhance

its capabilities and assets, while not undermining the natural resource base. According to this study, when I use the words 'sustainable livelihood,' I refer to any resources that enhance the attainment of and access to maternal healthcare by women of childbearing age in resettlement areas of former white-owned farms.

The accumulative effects of the abovementioned socio-economic factors have proved to have a negative impact on the livelihoods of women of childbearing age in accessing maternal healthcare. In terms of the above definition, livelihoods should not be short-lived but sufficiently well established, developed and passed down to sustain even future generations. I found that issues such as delivery facilities have been a challenge to these women for a long time. In Ward 13 there is no clinic or mobile clinic for women to visit. One of the village health workers said:

> 'The lack of a clinic in this Ward has caused many women to deliver at home without proper and expected delivery resources which puts them at risk of contracting treated and non-treated infections. As well the mother will suffer difficult complications during childbirth resulting in losing a lot of blood or even losing the baby as well; although, at the moment, I have not recorded any [such] case, it is possible … If the Ministry builds us a clinic in this Ward such issues would be avoidable and only in complicated maternal care cases will referrals be made to Chinhoyi Provincial Hospital.'

Lack of maternal health education has also proved to be a challenge in many ways. For instance, it is apparent from the biographical data, that the majority of the women are between seventeen and thirty-five years old which means that they qualify to receive maternal health education every time they visit a health facility. Such maternal education would remind them of their need and right to visit a medicinal institution like a clinic during their pregnancy, to give birth there and to continue visiting it with their child for check-ups thereafter. Maternal education could be promoted by educating a few women who could return to their homes and empower other women by teaching them what they learn. One of the women I interviewed at Kingspeak farm said:

> 'We do not have a village/community health worker on this farm and there is no one who comes to educate us on the importance of maternal healthcare hence the problems we encounter here are as the result of lack of proper maternal healthcare knowledge.'

It would be ideal if these women could afford to visit a nearby clinic like the one at Murereka/ Alaska when they are supposed to do so depending on the progress of the their pregnancy. Unfortunately, the issue of long distances and the lack of money for transport to reach such a medical facility was a challenge to all of them. All three farms where the women of the study reside are geographically located not only far from the nearest clinic (which is about 25km away) but also on a very poor inaccessible road. They are situated on the old Mhangura road and this road is not maintained by the relevant authorities. It used to be maintained by the former white farmers but is now full of potholes. Because of that, there is no regular transportation along this road and the cost of taxis that do use it is expensive. The travel of less than 20km costs ZW$25 cash or ZW$35 EcoCash (electronic cash). Nobody can afford this costly expense every month. The cost of hiring a vehicle from an A2 farmer to be taken to the nearby clinic is ZW$350 cash or ZW$400 EcoCash. These amounts are more than what these women earn.

According to the National Health Strategy of Zimbabwe, the country's main Health Policy, *no person should walk for more than 8km to the nearest health facility.* The remote geographical location of these farms have exacerbated the challenges in accessing maternal health care for women of childbearing age on resettlement areas of former white-owned farms now divided into A2 farms.

The breach of their right to adequate housing and shelter contributed to challenges in accessing maternal healthcare by women of childbearing age on resettlement areas of former white-owned farms. Human rights are interdependent, indivisible and interrelated. In other words, the violation of one right, such as the right to adequate housing, may affect the enjoyment of a wide range of other human rights and vice versa (United Nations High Commissioner for Human Rights, 2014). The human right to adequate housing as provided by Article 11 of the International Covenant on Economic, Social and Cultural Rights encompasses more than simply four walls and a roof. The Covenant affirms that States parties must "recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing, and housing, and to the continuous improvement of living conditions," and also requires that governments must "take appropriate steps to ensure the realization of this right". The

characteristics of the right to adequate housing are clarified mainly in the Committee's General Comments No. 4 (1991) on the right to adequate housing and No. 7 (1997) on forced evictions.

I discovered that the right to adequate housing was very important in this study because women of childbearing age encounter several challenges in this respect. The houses in which they stay were built by the former white farmers and some of them are not made of durable materials and often need to be repaired. The women at Kingspeak farm live in fear of being evicted from their homes. The A2 farmer who owns the place does not want them to stay yet these women and their families have nowhere to go. These women do not know which authorities they should consult on the way forward. In addition, the A2 farmers on whose land they reside are nor responsible for ensuring that they receive decent housing because it is not their duty to look after them. There is a need to redress the problems that both parties face and come up with viable law reforms and policies for both of them. One of the women said:

> 'I wish I could have my piece of land where I would be able to build sustainable houses, grow crops and rear livestock for future use.'

She complained that even if she tried to apply for land from the Ministry of Lands she would probably not succeed because the process is so involved that she would not be able to manage her existing responsibilities and also comply with the process. She said that since men have the time to complete the process, land is allocated to them over women.

4.3.2 Violations of the women's right to remunerative employment is contributing to violations of their right to access maternal health care

My second assumption upon which the study was based was to investigate whether the lack of financial resources or remunerative employment is a hindrance to women of childbearing age in accessing health care in resettlement areas of former white-owned farms which are now divided into A2 farms. Within this main theme, I managed to come up with the following sub-themes: the historical background of these women; the significance of the change of those in control of land on which they live from white to black; delays in receiving payment for their performance of piecework; their lack of permanent remunerative employment; paying for healthcare which

was formerly provided for free. All these factors present challenges to these women in accessing maternal healthcare.

Remuneration refers to money paid for work or a service. I found that the women of childbearing age are paid late for the work they render to A2 farm owners. They perform piecework including tilling the land, harvesting, picking and drying tobacco, fetching firewood and clearing land. When I interviewed them they told me the A2 farmers do not pay them on time and by the time they do receive their money it has devalued as a result of Zimbabwe's inflation. They cannot secure permanent jobs because these are only available to men and include such positions as tractor drivers, mechanics and livestock herders. As a result of these women being unable to secure stable permanent remunerative employment, they cannot afford to access maternal healthcare. I also found that the husbands' salaries are inadequate to sustain their families and for this reason these women have to do piece work to help support their families and themselves.

The historical background of these women has an impact on access to maternal healthcare as well. Before the land redistribution program occurred, the former white farmers would provide maternal healthcare to these women for free and it was readily available. The situation is different no they have to look after themselves. One of the women from Musina farm said:

> 'I delivered all of my four children here at this farm and everything was free of charge. I was taken good care of by my husband's employer and when I wanted to go to the hospital he would offer transport for us all and then things were affordable. We had no problems in transport issues and minor maternal healthcare issues were easily solved at the community level.'

These families were used to a system under which their employer would provide them with necessary and crucial maternal healthcare services (dependence syndrome). The situation has deteriorated for them since the land reform program exposing them to life-threatening healthcare challenges that now require immediate attention from relevant service providers.

I came across a white farmer who managed to survive the land redistribution program and he assists both permanent and temporary women employees in accessing maternal healthcare by providing them with transport free of charge to medical facilities in cases of emergency (to

deliver their babies or to seek attention in the case of serious illness). This helps to lighten the burden on women of childbearing age in accessing maternal healthcare. The overpopulation of compounds of former white-owned farms has increased the incidence of sexually transmitted diseases that harm the maternal health status of women of childbearing age. For instance, one of the village health workers said:

> 'You could find that a pregnant mother is HIV positive and she is not taking her medication and has not visited the clinic to receive proper education on ways not to transmit HIV/AIDS to the unborn baby. Pregnant women will end up having home delivery with their health status which poses a threat to the baby, mother and village health worker's health.'

In the period between independence and the land reform programme, white commercial farmers provided health care services for their employees which meant there was no need for the government to develop medical care infrastructures in these areas. Instead, the government focused its attention on building health care institutions in rural areas (those not occupied by white commercial farmers) in order to reduce the unequal access to medical services between the races. When or before the government conducted the land reform programme, however, nobody seemed to realize that there was a need to build healthcare facilities on the former white owned farms in order to cater for the growing population migrating to it from the less fertile rural lands.

As a result of this lack of foresight, nearby clinics on former white owned land are too small and understaffed to serve the large surrounding population whose demands overwhelm them. One of the Murereka clinic's nurses said:

> 'Ward 7 clinics used to cater for a reasonable population and things used to be enough, however, since the land redistribution program was ventured this clinic has been exposed to too much pressure of patients coming as far as Pondoro, Athens, Gambuli and East Range among other surrounding farms. Since then the clinic was not developed to suit this growing population, we have a shortfall of clinic nurses and midwives. Thankfully, we have a mother shelter but the situation is still overwhelming. There is a need to reduce the challenges these women are facing in accessing maternal healthcare. We are trying by all means but the pressure is just too much for us.'

The sudden increase in the demand for medical resources from A2 farmers and their communities as a result of the land reform programme was sudden and drastic and needed to be addressed through long term planning and infrastructural medical investment. Such failure has resulted in competition between former farm workers of white commercial farmers and new A2 farmers for the scarce, overwhelmed and deteriorating medical resources. Those who lack sufficient finances, such as the child bearing women considered by this study, will continue to lose this conflict and fail to access the maternal health care services which they so desperately need and are entitled.

4.3.3 The Influence of discrimination against the women in excising their maternal health care rights

My third assumption upon which the study was based was to examine women of childbearing age in resettlement areas of former white-owned farms encountering challenges in exercising their rights in accessing maternal health care in A2 farms. The United Nation Human Rights Office of the High Commissioner (2014) indicates that discrimination according to the Convention on the Elimination of All Forms of Discrimination against Women includes a diversity of doable discriminatory actions (any distinction, exclusion or restriction) having the express purpose of the actual effect of discrimination against women. The Convention also explains the State obligations and actions to be taken to achieve gender equality in practice. Any practice that escalates women's inequality and discrimination is prohibited by this Convention. Substantive gender equality and formal gender equality as well as *de facto* discrimination and *de jure* discrimination are central concepts in the Convention's equality framework.

Discrimination may take the form of direct or indirect discrimination. Discrimination can happen in the form of *de jure* or direct discrimination provisions when, for instance, a law or policy restricts or distinguishes between certain groups. I found that the law discriminates between women of childbearing age on resettlement areas of former white-owned farms and A2 farm women. The two types of women in this study receive different treatment within their communities. When it comes to food relief programmes, A2 farm women are treated and receive it individually whereas women from former white-owned farms are not treated individually; instead they are ordered into groups and treated and receive it in such groups. Formal equality

between these two types of women means eliminating such discriminatory laws and practices. I also realized that there is a need to educate these two women on their right to non-discriminatory practices that will affect their access to maternal healthcare and other resources that benefit them.

I also found that women of childbearing age encounter discrimination when their employers prevent them from visiting the clinic to register their pregnancy and immunize their children. One of the women said:

> 'I went to register my pregnancy when I was five months pregnant the reason being that I was told that no one was going to take up my duty if I go to the clinic. Clinic nurses have advised me not to skip any clinic visits because of my pregnancy shows signs of complications.'

Since clinic nurses have tried to educate A2 farm owners on the importance of non-discriminatory practices the effects are seen when these women do not register their pregnancy or immunize their children on time. One of the village health workers noted:

> 'When its day child immunization these women came late in the afternoon and would ask why and these women will respond to the issues of finishing off on their piece jobs as agreed by their employer.'

These women cannot fully exercise their rights which expose them and their children to harm. Another form of discrimination I found was *de facto* discrimination. I found this occurring when programs, laws, policies and practices which appear to be gender-neutral were being applied and actually being found to exacerbate discrimination against women of childbearing age on resettlement areas of former white-owned farms. I found that pregnant women are told by clinic nurses to come with their husbands so they can both be tested for HIV/AIDS on their first visit to register the women's pregnancy. In response to this most husbands do not accompany their wives. So while the practice seems to be gender-neutral and helpful in seeking to protect the health of both husbands and wives, the husbands are not co-operating. A nurse from the clinic confirmed this. Therefore, the nurses should respond in turn by continuing to educate these women and reaching the men by visiting their communities, going from door to door and testing

both partners in their own homes. This will help to minimize the risk of pregnant women contracting sexually transmitted related diseases.

The Human Rights Committee [in its General Comment No. 18 (1989) on non-discrimination] and the Committee on Economic, Social and Cultural Rights [in its General Comments No. 16 (2005) on the equal right of men and women to the enjoyment of all economic, social and cultural rights and No. 20 (2009) on non-discrimination in economic, social and cultural rights] have also adopted the same principle of substantive equality when guaranteeing non-discrimination and equal enjoyment by men and women of civil and political, as well as economic, social and cultural rights. The Committee on Economic, Social and Cultural Rights explained in its General Comment No. 16 (2005) that States parties to the Covenant are obliged to eliminate both direct and indirect discrimination. They must refrain from engaging in discriminatory practices, ensure that third parties do not discriminate in a forbidden manner and take positive action to guarantee women's equality. The Committee further outlines how the obligation to ensure equality relates to the different provisions of the Covenant. Its General Comment No. 20 (2009) also notes the importance of addressing both direct and indirect discrimination in laws, policies and practices, and several discriminatory practices that particularly affect women.

I also found multi-level and intersecting forms of discrimination on women of childbearing age in resettlement areas of former white-owned farms. Issues like age, socio-economic status, racial or ethnic background, religion, national origin, citizenship, status, health particularly HIV/AIDS are some of the other examples that increase the influence of discrimination faced by these women. At the Fourth World Conference on Women, States recognized that "many women face additional barriers to the enjoyment of their human rights because of such factors as mentioned above including women migrant workers''. The Committee on the Elimination of Racial Discrimination also addressed this in its General Recommendation No. 25 (2000) on gender-related dimensions of racial discrimination, in which it noted that "racial discrimination does not always affect women and men equally or in the same way. There are circumstances in which racial discrimination only or primarily affects women, or affects women in a different way, or to a different degree than men. Such racial discrimination will often escape detection if there is no

explicit recognition or acknowledgment of the different life experiences of women and men, in areas of both public and private life." The Committee on the Elimination of Discrimination against Women, in its General Recommendation No. 25 (2004), also emphasized that State parties should address multiple discrimination against women by adopting temporary special measures.

4.3.4 Violations of the women's right to receive meaningful education and relevant information are violating their right to maternal health care

My fourth assumption upon which the study was based was to analyze the lack of maternal health care knowledge as a hindrance in accessing maternal health care services by women of childbearing age in resettlement areas of former white-owned farms now divided into A2 farms. With this theme, I found out that all women of childbearing age lack meaningful education and relevant information on maternal healthcare. Failure to provide maternal healthcare education and relevant information has contributed many challenges faced by these women. For instance, unable to visit the clinic on time has made unsafe home and traditional delivery an option. Traditional home delivery is not recommended by the Ministry of Health and Child Welfare nor is the service of untrained village health workers. The Ministry has failed to uphold and enhance its obligation towards these women. In addition, the Ministry cannot implement mechanisms that favour the background of these women to reduce challenges in accessing maternal health care.

The State is unable to provide adult education to women of childbearing age on resettlement areas of former white-owned farms as stipulated in section 29(3) of the the Constitution of Zimbabwe. Since they suffer from a high rate of illiteracy, maternal healthcare services need to adjust to accommodate this weakness. Some of the participants in Kingspeak farm managed to complete Grade 7 but did not write their Ordinary Level examinations. I found that maternal healthcare information was written in *Shona* at Murereka and Alaska clinic however no patient wants to read them. To meet this weakness, clinic nurses should visit these communities at their grassroots level and educate them by interacting with them verbally in their own comfortable environment about the importance of maternal health care. This would make them stay informed about anything that has to do with access to maternal healthcare.

There is also a need to make use of existing community-based solutions. For instance, village health workers that used to work under former white farmers should be identified and empowered with relevant maternal healthcare knowledge and allowed to attend workshops and other maternal healthcare informative programs so that when they come back to the communities they serve, they can educate their counterparts. This is a very affordable solution and cheaper than the alternative of hiring trained professionals from towns and cities who do not know the culture, socio-economic background or political sentiments of the community. Village health workers reside among these communities and are likely to feel more dedicated to serving them to help improve their general health. Since the Ministry of Health and Child Welfare does not allow village health workers to offer delivery services for women of childbearing age there is a need to increase their education on maternal healthcare. The reason is that these VHWs are on the ground and encounter challenges which could benefit from their help if only they were better educated and authorised to offer and give their assistance. One of the village health workers said:

> ‘We only receive minor maternal healthcare information and we are not allowed to carry out home delivery, we only offer child immunization and other related childcare services”.

As mentioned earlier in this chapter, clinics are about 25km away, so how will these pregnant women get instant maternal healthcare services on time? Therefore, VHWs should be encouraged to increase their knowledge base. For example, they should be offered free maternal healthcare education so that they can return to and be of even greater help to their communities. The provision of mobile clinics and the need for the State to address the general lack of legal and human rights awareness is another way of providing the right to meaningful education and relevant information.

4.3.5 The State’s failure to provide adequate resources is violating the women’s right to maternal health care

My fifth and final assumption upon which the study was based is on assessing whether the state’s failure to provide adequate resources is violating the women’s right to maternal health care and also possibly contributing to or causing an increase in the death rate of pregnant women of childbearing age in resettlement areas of former white-owned farms in A2 farms. It is the duty

and obligation of the State usually through the Ministry of Health and Child Welfare to provide adequate resources for its citizens to access maternal healthcare. In this study, maternal healthcare begins with the state's provision of adequate resources for the women concerned at primary right up to national level and its failure to provide them violates their right to maternal health care. The resources which the state should provide through its national health budget include the sufficient maternal health care equipment (e.g., beds, ambulances) and supplies (e.g., drugs, syringes, bandages) and properly trained healthcare personnel at each state clinic and hospital and if necessary it should build sufficient hospitals and clinics in rural areas. If necessary, the state should also co-ordinate with other ministries (e.g., those in charge of roads and telecommunications) and provide them with sufficient resources to ensure that women, such as those considered in this study, can access their right to maternal health care.

I found out that Ward 13 does not have a clinic, does not have village healthcare workers trained in maternal health care and has no mobile clinics. The women covered by this study live down roads that are dilapidated and would be difficult for an ambulance to use and the telecommunications in the area are also poor. So, in not so uncommon emergencies, pregnant women cannot make a quick phone call (there is no free hotline service) for an ambulance to come and whisk her off to deliver her baby or to receive life-saving treatment from the nearest clinic or hospital. This is not a far-fetched scenario and should be part of the state's maternal health care services. The research's evidence, however, sadly shows that persistent failure to meet even the most basic maternal healthcare needs of the women of this study is tantamount to an admission by the State that it has failed its citizens.

I found that when the Ministry of Health wanted to build a clinic in Ward 13, the district chairman and councillors were found to have conflicts of interests resulting in plans for the clinic to be at one of the far ends of the Ward which had a poor road, no electricity, and no telecommunications. In other words very difficult for the residents of the Ward to access. There is such a controversy surrounding the project that until now no clinic has been built and discussions but no action is taken place. So now, conflicts of interest between public servants can be added to the list of challenges preventing the women covered by this study from being able to access maternal healthcare. It is unfortunate but true that many public servants have lost sight of

the fact that they are servants of the public, those who voted them into power or over whom the government has appointed them to govern, and that their overriding duty is to utilise the state's resources to meet the needs of their electorate, and not to corruptly serve their private interests or agendas. I also discovered that because the lived realities of the women involved in this study are not properly covered or reported in various reports and the news, their plight goes largely ignored and they simply learn to suffer in silence and carry on with their lives as best they can. It would appear that the only hope for them is the publication of research of this kind which might attract the attention of other well-intentioned benefactors.

4.4 CONCLUSION

In this chapter I have managed to identify the main themes which have helped me to discuss the challenges faced by women of childbearing age in resettlement areas of former white-owned farmed in accessing maternal health care. Identifying these challenges proved a difficult task as so many factors impact upon this vital right. I hope I have shed sufficient light on other factors which also affect this right so that they may be investigated by future researchers.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

In this final chapter I present the conclusion and recommendations of the study and consider the broader issue of whether access to maternal healthcare has created an enabling environment for the women of childbearing age in resettlement areas of former white-owned farms in Ward 13 of Makonde district. The material in this chapter will be considered in the light of the following seven key principles of the human rights perspective, namely: the availability, accessibility, acceptability, and quality of maternal health care facilities and services, and the participation, equality and non-discrimination, and accountability of the women's access to them. The inclusion of international and national human rights and legal frameworks will be of great importance as it will enhance a holistic approach to access to sufficient maternal health.

5.2 Conclusion

From the findings discussed in the previous chapter, the following conclusions can be drawn:

1. Generally, rural women have not been accessing maternal healthcare as their urban counterparts have done. The state's failure to give priority to rural healthcare institutions from primary to national level has jeopardized the maternal health of these women. The lack of secure sustainable livelihoods among rural women of childbearing age means that they do not have adequate resources, like savings which they could access to protect themselves from common contingencies such as the risks associated with pregnancy, child birth. So there is a great need to empower them economically (through various projects, skills training) so that they can become more independent and able to overcome some of the challenges they face in accessing maternal healthcare while the wait for the state to meet its obligations toward them.

2. A violation of the women's right to remunerative employment contributes to the violation of their right to access maternal health care. For instance, they rely on seasonal piecework and when they are paid late for their work or they cannot work out of season they are less

able to access maternal health care. Therefore, there is a need for various stakeholders to help create employment opportunities for them so that they can become more economically independent and less dependent on others.

3. The influence of discrimination, stereotypes, and prejudice has also greatly affected these women's livelihoods. Being the farm workers of the former white owned commercial farmers attracts name-calling which exposes them to discrimination, prejudice and stereotypes which ultimately undermine their right to access maternal healthcare.

4. Meaningful education and relevant information on maternal health care is not but ought to be distributed equally among rural child bearing women. For instance, the study found that there was a challenge in being unable to tune into radio stations and television programs which educate women on the importance of maternal healthcare. It is of paramount importance to increase the coverage of radio and television in remote rural areas and to all other former white-owned farms so that national programs including those on maternal health care can be easily accessed by the entire population.

5. Maternal health which has serious lifelong implications for women (half the nation's workforce) as well as Zimbabwe's future generations is very important to the overall health and well-being of the nation's people and that is the reason why international and regional human rights instruments place so much emphasis on it. An unhealthy people place a massive drain on the resources of an already compromised health sector of an already struggling economy like that of Zimbabwe and, in order to arrest this downward trend, it is in the nations' best interests for it to increase its budget and make sure that rural women, the majority yet most marginalized and vulnerable of its population, (including those covered by this study), receive the best maternal healthcare free of charge.

6. In order to ensure that vital maternal health care resources reach these rural women as soon as possible politics must be separated from this national sustainable development initiative. This critical initiative needs to be scrupulously managed, monitored and

evaluated and all those (public and private, individual and co-operate, national and even possibly international) who are not committed to its success, swiftly removed from the process as time is of the essence. This may require a deeper investigation into the structure of Zimbabwe's economy and a re-visitation of the land reform exercise to identify and find ways to narrow the widening economic, social, cultural gaps between farm owners and former farm workers.

5.3 Recommendations

I found it helpful and important to follow the approach of Black Mamas Matter's (2015) study which shows how the state can implement the abovementioned human rights standards through administrative measures, legislation, allocation of resources and comprehensive policies and programs that support women and their access to maternal healthcare.

5.3.1 Improve Health Care Access & Quality

- ✓ Remove existing barriers to care during and after pregnancy and throughout the lifespan of women
- ✓ Develop a more diverse health care workforce that is trained in human rights standards and engaged in generating solutions to maternal health problems
- ✓ Ensure that every woman receives quality care, regardless of the site or setting of care
- ✓ Facilitate greater availability of obstetric care and family planning services

5.3.2 Address Underlying Determinants of Health

- ✓ Prioritize social support for women and communities
- ✓ Address nutrition and food security for pregnant women
- ✓ Ensure adequate, safe housing and safe communities
- ✓ Facilitate healthy occupational and environmental conditions

5.3.3 Eliminate Discrimination in Law and Practice

- ✓ Reform discriminatory laws and policies that impact women's health and well-being
- ✓ Take proactive measures to address discrimination in practice, particularly for groups that have faced historical discrimination or injustice

- ✓ Address racial bias, stereotypes, stigma, discrimination, and disrespect in health care encounters
- ✓ Eliminate disparities in maternal health safety and survival outcomes for women

5.3.4 Ensure Accountability

- ✓ Collect and disseminate adequate, disaggregated data on maternal mortality and morbidity
- ✓ Set targeted goals and benchmarks for improved maternal health outcomes
- ✓ Design state plans to improve maternal health that considers the specific needs of vulnerable populations, especially rural women and girls
- ✓ Develop policy solutions aimed at the conditions that make it unlikely for maternal health violations to re-occur
- ✓ Provide remedies for violations of the right to access safe and respectful maternal health care

5.3.5 Include and Empower

- ✓ Encourage human rights education and outreach to women on their sexual and reproductive health and rights
- ✓ Involve women, especially at the community level, in maternal health policy design, budgeting, monitoring, and review processes
- ✓ Build partnerships between government, civil society, and other key stakeholders to assess maternal health needs and devise solutions

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