# RURAL WOMEN'S RIGHT TO MATERNAL HEALTH CARE BEFORE, DURING AND AFTER DELIVERY: A FOCUS ON WOMEN IN ROMSLEY RESETTLEMENT AREA OF RUSAPE DISTRICT, MANICALAND, ZIMBABWE

**BY**
**Pracious MUZONDO**

**Supervisor: Ms R.K. Katsande**

**A Dissertation submitted in partial fulfilment of the requirements for a Masters in Women's Law Degree, Southern and Eastern African Regional Centre for Women's Law,**
**University of Zimbabwe**
**2012**

## Abstract

**Zimbabwe has made commitments - global, regional and national - towards the fulfilment of the right to maternal health care by ratifying several international conventions and other regional instruments. According to the Magistrate who writes this dissertation, whilst such commitments are commendable and a significant step toward achieving this goal, for rural women in Romsley (a post-Independent 1980 resettlement area in the Manicaland Province of Zimbabwe), they remain academic. Hailing from this area, the researcher assesses the extent to which rural women within several Romsley villages exercise their right to maternal health care before, during and after delivery and she interrogates issues of, *inter alia*, its accessibility, affordability and availability. This evaluation of the right to health reveal that the State, as the primary duty bearer, is in breach of its duties to provide accessible, affordable, available and good quality maternity services. In particular, the Government has failed to build any medical facility in the Romsley area forcing poor rural women to walk to their nearest understaffed and poorly resourced clinic which lies between 3 and 25 kilometres from their homes. Furthermore, not only does the national legal framework fail to realise adequately the right to maternal health care (which is well recognised at national policy level), other stumbling blocks preventing its enjoyment include certain religious, cultural and traditional beliefs. This study reveals the qualitative research (using gender-sensitive methodologies, such as the Women's Law, Grounded Theory, Pluralities Theory and the Human Rights approaches) undertaken in exploring the unique problems facing these women as they seek maternal health care in Romsley. Complementary methods of data collection (e.g., in-depth interviews, group discussions and personal observations within the context of a case study approach) were used in the physical conducting of the research. Finally the writer suggests some concrete goal-driven recommendations which are to be implemented mainly by the government through the Ministry of Health and Child Welfare (the MOHCW) and the Ministry of Finance as well as other vital stakeholders, including the NGO community. Focus is placed upon elevating the status of the right to maternal health care to a human right protected by the provisions of the Constitution; improving the area's medical and road infrastructure and training more midwives, including those already informally recognised and used by the community.**

## Dedication

This dissertation is dedicated to my children Thelmar Nisha Nyevero, Thami Anisha Tavanashe and Trydon Thanisha Tapiwashe Mukonya (the 'SEARCWL baby'). The standard has been set guys.

To the father of my children Ephraim Mukonya for his moral support when I was down.

To my late father Abel Muzondo, for educating a girl child. They say time heals, but it actually doesn't – some days are just better than others. I believe when you look down from heaven you smile. I am still on track daddy.

To the late Tony Simbarasi, but why? It happened so fast. Four days before I am through with this piece of work, I am hurt. God takes the best. Keep on shinning till we meet again.

To my mother Letween Chakuinga, thank you for the love and carrying on the burden of educating me when daddy was gone. I love you Mom.

## Acknowledgments

My gratitude goes to the Norwegian Ministry of Foreign Affairs for the scholarship. I will use the knowledge to change the lives of women and the girl chid in Zimbabwe.

Special thanks go to my supervisor Rosalie Katsande for her expertise and patient guidance in assisting me coming up with this piece of work. *"Eish Pracious"* she would say, when I had given her something terrible. Thank you for your understanding when I lost my uncle. Thank you to Prof Stewart for bearing with me when I was literally down due to illness. You are wonderful. Dr Tsanga for your teaching method, I am empowered. To all SEARCWL staff and guest lecturers for making my unlearning process interesting.

Thanks to the people I interviewed during the research, your information was of significance. To my employer, the Judicial Service Commission for allowing me to further my education, thank you for the time.

2011- 2012 SEARCWL class, you made my study very interesting. Go and impart the knowledge you have gained to those who really need it. Cheers. Sandie, your love and support throughout the programme especially when I fell sick is appreciated.

To God be the glory forever and ever, Amen.

## Acroynms

| | |
|---|---|
| DFID | Department For International Development |
| HIV/ AIDS | Human Immune-deficiency Virus/ Acquired Immune Deficiency Syndrome |
| WHO | World Health Organisation |
| MIMS | Multiple Indicator Monitoring Survey 2009 |
| MOHCW | Ministry Of Health and Child Welfare |
| MNPI | Maternal Neonatal and Program Effort Index |
| MNH | Maternal and Newborn Health |
| PNC | Post Natal Care |
| PMCTC | Prevention of Mother to Child Transmission Care |
| HTF | Health Transition Fund |
| WLSA | Women and Law in Southern Africa |
| ICPD | International Conference on Population Development |
| TBAs | Traditional Birth Attendants |

## List of Statutes, Interventions and Policies cited

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Convention on the Elimination of All Forms of Discrimination against Women of 1979 (CEDAW)
International Covenant on Economic Social and Cultural Rights, 1996
Convention on the Rights of the Child, 1989
Millennium Development Goals, 2001

### Regional Statutes, Conventions, etc.

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa ('The Women's Protocol')
Cairo Declaration on Population and Development, 2005
Campaign on Accelerated Reduction on Maternal Mortality in Africa, 2009
South African Constitution, 1996

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Campaign on Accelerated Reduction on Maternal Mortality Africa launched in 2010
Medical Services Act, Chapter 15:13
The Patient's Charter
Reproductive Health Policy
Public Health Act, Chapter 15:03
Zimbabwe National Maternal and Neonatal Health Road Map (2007- 2015)
National Health Strategy for Zimbabwe (2009- 2013)

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## Executive Summary

While motherhood is often a positive and fulfilling experience, for many women in Zimbabwe, rural women being the most affected, it is associated with suffering, ill health and even death. Like many other sub- Saharan African countries, Zimbabwe bears a heavy burden of high maternal, neonatal and child mortality when compared to countries in other regions of the world. This is one of the areas most affected by the economic meltdown, whose indicators deteriorated the hardest hit being the vulnerable. According to Multiple Indicator Monitoring Survey (MIMS 2009) the maternal mortality ratio stands at 790 per 100000 live births, compared to 390 in the 1990s. Similarly, infant mortality rate stands at 94 per 1 000 live births, up from 78 in 1990, (MIMS: 2009). This effectively means that pregnancy related complications result in the deaths of eight women daily, while roughly one hundred children die as a result of preventable diseases.

The main aim of the research is to assess the government's progress on the provision of maternal health care to rural women. The research was carried on in Romsley which is a 1980 resettlement area in the Manicaland Province of Zimbabwe. I used qualitative approach in designing, collecting and analyzing the data. It is a research approach that privileges the 'emicperspective' that is, the lived experience of the subject, and the meaning the subjects attaches to the phenomena being investigated (Smith, 1995). In doing so, some gender sensitive methodologies were utilised and these were the women's law approach, human right approach, grounded theory approach and the intersections. Complementary methods of data collection were utilised some of which were in- depth interviews, observations, case study and group discussions. These methodologies and methods were used to collect and analyze the relevant oral and written evidence of the extent to which women in Romsley exercise their right to maternal health care.

Woman's law approach is about how women are conceived and how the law then corresponds to their lived realities. It is also about understanding the legal position of women. Using this perspective, I analysed the provisions in the legal framework and compared it with what was happening on the ground as per women's stories. I then realised that there are gaps between the legal provisions on the right to maternal health care and the lived realities of women. Although the universality of human rights has been criticised left, right and centre, in this case women's rights, they still provide a standard set of measures that keep us informed on the minimum standards that women are entitled to and specify the obligations of the state as a guarantor of women's socio-economic rights and in ensuring the implementation of these abstract rights into substantive rights and real rights, (Maboreke: 1988). The human rights approach makes it mandatory for the state to promote, protect and fulfil the right to maternal health care. There are many factors which affect their decision on whether or not to seek maternal health care. Interrogating certain values that inform women's decisions was critical in understanding the phenomenon that was under study. The most prominent factors that have a bearing on women's maternal decisions are the cultural, religious, traditional practices and the law. In its MDG 2010 Report on goal number five, the GoZ indicated that `health services are organised in a manner that fails to address the religious concerns and beliefs of certain faith groups', as a result of which people will shun the services including women in dire need of maternal health services.

Women in exercising their right to maternal health care encounter challenges like long distances, delays at the clinic and poor service delivery at the clinic. Some women have to

walk up to 25km to the nearest heath centre which is more than double the distance in the NHS which provides that no person should walk more than 8km to the nearest rural heath institution. The RHP stipulates that the maximum distance to the nearest clinic should not be more than 10km. In this respect the GoZ as the main duty bearer is in breach of its obligations as it is failing to provide accessible and available maternal health services. Women spend days at the clinic waiting to be served. Most women in Romsley do not have a source of income and as such cannot meet some of the ancillary maternal expenses at health institutions. Although there are no user fees at Nyamidzi clinic, the services are not free *per se*.

As a result of these challenges some women have devised their own coping mechanisms which more often than not are life threatening. Some women visit the apostolic sect members, herbalists and untrained local midwives for their maternal health care. Women are dying in the hands of these untrained midwives as they fail to deal with complications due to the lack of expertise and the necessary apparatus.

The national legal framework does not adequately provide for the right to maternal health care. By omitting the right to maternal health care from the bill of rights, the Constitution resembles the racial discrimination and the oppression that existed during the colonial era. As aptly stated by Scott A et al, (2007):

"A constitution containing only civil and political rights projects an image of truncated humanity symbolically but still brutally, it excludes those segments of society for whom autonomy means little without necessities of life".

The right to maternal health care is a necessity of life but it is not part and parcel of the supreme law of the land. Although the GoZ is making efforts to improve the plight of rural women through the HTF and DFID, among others, as they seek maternal health care, I feel more needs to be done if the right to maternal health care is to become a reality to these women. There is a need for all health players to come together and work on the provision of accessible, affordable, available and good quality maternal health goods and services. Some of the necessary interventions include making the right to maternal health care a justiciable human right, building more and properly resourced clinics (including professional staff and the latest equipment and medicines), consciousness-raising, improving the road network and allocating more money for maternal health care.

# CHAPTER ONE
# 1.0 INTRODUCTION

## 1.1 Introduction

The subject matter of this work is rural women's right to maternal health care and the state's obligation to ensure that women exercise this right without any difficulties. The study identifies the challenges encountered by these women in exercising their right to maternal health care and highlights some interventions so as to make women's right to maternal health care a reality. It is therefore against this background that the study seeks to investigate the extent to which the state has provided maternal healthcare in Romsley. This first chapter is introductory in nature as it deals with the aim, research assumptions, research questions, statement of the problem and the reason why I chose this topic.

## 1.2 Aim of the Research

The main aim of the research is to assess the government's progress on the provision of maternal health care to rural women.

## 1.3 Background to the Study

When my young brother got married, I was happy for him; little did I know that it was an addition to my responsibilities. Within a month his wife fell pregnant. Towards her expected date of delivery, she was sent back to her parents as per our African Shona custom. After about a week, her mother personally brought her back home and informed us that she had brought her daughter. She instructed us not to take my sister-in-law to the clinic for delivery but to the nearest midwife. Despite this having happened two years ago, I vividly remember the exact words she said:

> "The message that I have brought is difficult to pass but I have to as it is of importance to both families. I am here to inform you that she is not supposed to go to the clinic. If you take her there she will

> definitely die. Take her to Mbuya (grandmother or a person who is highly respected like a grandmother) Chisango and she will survive this pregnancy".

This was like drama to me since I failed to understand the logic behind it and before we could say anything, she continued:

> "She will die and you will be responsible for that. I cannot explain to you why but be guided as I do not want to have any problems with you. All I can say is comply with my instruction, which is our tradition".

Despite our being a Christian family who seek medical assistance whenever there is need, we complied with the instruction. Unfortunately, my mother in law had already died at the time I carried the research. I would have liked her to have been one of my respondents as I wanted to have a deeper understanding as to why she acted in such an apparently strange manner. I would have liked her to explain to me the basis of the tradition in terms of which she claimed to have been acting.

This study is also influenced by my experience as a resident in one of the villages in Romsley, namely Village Nine, and what I witnessed the community going through as they seek medical assistance, the most affected being child-bearing women. I still recall the death of a woman in our village who passed away whilst giving birth at home without the assistance of a qualified or even a non-qualified birth attendant. I was only fourteen years old but it was a very disturbing event as I also attended the funeral. Her first child was my classmate then and I really felt the pain and loss since one of her sons happened to be my friend. It is said that she experienced labour pains for more than two days but no action was taken like seeking medical attention or even the assistance of one of the local midwives. What really touched me was that this was not her first pregnancy, she had other six children.

## 1.4 Statement of the Problem

Although the Government of Zimbabwe (GoZ) has ratified a number of International Instruments providing for the right to maternal health, it is extremely far from making the right a living reality for women. Maternal mortality therefore remains a cause for concern as

most maternal deaths are preventable through increased access to antenatal, delivery and post natal care which is first and foremost the government's responsibility. Furthermore, effective interventions to treat the leading causes of maternal deaths, namely HIV/AIDS haemorrhage; hypertension/eclampsia, sepsis, malaria and obstructed labour, already exist. Who then is to blame for women's failure to access maternal health care, the government as the duty bearers or the women as the right holders? Women play a principal role in the rearing of children and the management of family affairs, and their loss from maternity-related causes is a significant social and personal tragedy, (Mekonnen, and Mekonnen: 2002).

While motherhood is often a positive and fulfilling experience, for many women in Zimbabwe, rural women being the most affected, it is associated with suffering, ill health and even death. Major direct causes of maternal morbidity and mortality include haemorrhaging, infection, blood pressure, unsafe abortion and obstructed labour,( WHO :2009). Like many other sub-Saharan African countries, Zimbabwe bears a heavy burden of high maternal, neonatal and child mortality when compared to countries in other regions of the world. This is one of the areas most affected by the economic meltdown (which climaxed in 2008-9), whose indicators deteriorated the hardest hit being the vulnerable. According to Multiple Indicator Monitoring Survey (MIMS 2009) the maternal mortality ratio stands at 790 per 100,000 live births, compared to 390 in the 1990s. Similarly, infant mortality rate stands at 94 per 1,000 live births, up from 78 in 1990, (MIMS: 2009). This effectively means that pregnancy related complications result in ***the deaths of eight women daily, while roughly one hundred children die as a result of preventable diseases.***

## 1.5 Why This Topic?

Soon after independence, the GoZ invested a lot in the health sector. The GoZ made an effort to correct the discrepancies of the colonial era by building more health institutions among other things. This area, despite it being a 1980[1] resettlement, it is still lagging very much behind. Since this is one among the earliest resettlements, one would expect to see much

[1] This was a resettlement scheme embarked on by the GoZ soon after independence as it was correcting the inequalities that were there during the colonial era whereby the black majority occupied unfertile land.

progress especially in the health sector but alas that is not the case. It resembles the fast track[2] type of resettlements which were not followed with the provision of some basics like constructing health institutions. I wanted to interrogate why this was the situation and why women seemed to be reluctant to use the available Nyamidzi Clinic. I also wanted to understand why women were dying whilst discharging a nation's duty, yet it is commonly agreed that pregnancy is not a disease.

### 1.6 Objectives of the Research

The following were my objectives:

1. To critically assess whether or not women in rural areas face challenges in exercising their right to maternal health care.

    1.1 To assess whether women in rural areas have to walk long distances to the nearest clinic which discourages them from going for check-ups.

    1.2 To investigate whether women in rural areas do not have the money required for different maternal services because most of them do not have any source of income.

    1.3 To assess whether women in rural areas seeking maternal health care spent days at the clinic waiting to be attended to.

2 To investigate whether or not rural women resort to unsafe means of delivery because of different challenges they face in accessing maternal health.

3. To examine the impact of religion, tradition and culture on women's access to maternal care.

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[2] Between 2000 and 2004 the GoZ embarked on a land redistribution and resettlement programme comprising of A1 and A2 farms. This exercise was necessiated by the illegal invasion of farms prompting the GoZ to allocate land to Zimbabweans.

4. To analyse whether the Health Act and Reproductive Health Policy adequately cater for the needs of rural women before, during and after pregnancy and if they comply with the ratified International Instruments

5. To assess whether rural women's right to maternal health can be achieved if the duty bearers comply with the International Instruments by:

   5.1 recognising women's right to maternal health as a right to make them justiciable;
   5.2 building more resourced clinics;
   5.3 consciousness raising of the right holders on the importance of accessing maternal health care.

## 1.7 Assumptions

The research was premised on the following assumptions:

1. Women in rural areas face challenges in accessing health care leading to high mortality rates.

   1.1 Women in rural areas have to walk long distances to the nearest clinic which discourages them from going for check-ups.
   1.2 Women in rural areas do not have the money required for different maternal services because most of them do not have any source of income.
   1.3 Women in rural areas seeking maternal health care spend days at the clinic waiting to be attended to.

2. Rural women resort to unsafe means of delivery because of different challenges they face in accessing maternal health.

3. Religion, tradition and culture are obstacles to women's access to maternal care.

4. The Health Act and Reproductive Health Policy do not adequately cater for the needs of rural women before, during and after pregnancy and do not comply with the ratified International Instruments.

5. Rural women's right to maternal health can be achieved if the duty bearers comply with the International Instruments by:

   5.1 recognising women's right to maternal health as a right to make them justiciable;
   5.2 building more resourced clinics;
   5.3 consciousness raising of the right holders on the importance of accessing maternal health care.

## 1.8 Research Questions

The following research questions were formulated based upon the abovementioned assumptions and they guided me in the field as I interrogated women's right to maternal health in Romsley.

1. Do women in rural areas face challenges in accessing health care leading to high mortality rates?

   1.1 Do women in rural areas have to walk long distances to the nearest clinic which discourages them from going for checkups?
   1.2 Do women in rural areas have the money required for different maternal health care services since most of them do not have any source of income?
   1.3 Do women in rural areas seeking maternal health care spend days at the clinic waiting to be attended to?

2. Do rural women resort to unsafe means of delivery because of different challenges they face in accessing maternal health?

3. Does religion, tradition and culture act as obstacles to women's access to maternal care?

4. Does the Health Act and Reproductive Health Policy adequately cater for the needs of rural women before, during and after pregnancy and do they comply with the ratified International Instruments?

5. Can rural women's right to maternal health be achieved if the duty bearers comply with the International Instruments through:

   5.1 recognising women's right to maternal health as a right to make them justiciable?;
   5.2 building more resourced clinics?;
   5.3 consciousness raising of the right holders on the importance of accessing maternal health care?

## 1.9 The Area

### *1.9.1 Brief Background*

The Zimbabwean government's land redistribution programme that followed Independence from the United Kingdom of Great Britain in 1980 set out to effect post-conflict reconstruction and redress the racial inequalities that followed 90 years of colonial rule (Ikdal :2005) during which blacks occupied unfertile and barren land. Romsley is such a resettlement. The resettlement scheme was not very different from the communal set up that previously existed. The plots and peoples' residence are separated from each other. The beneficiaries' yards are very small. The fields which are placed far from the residential area are bunched up at the same place for all villagers within the proximity of the village. The difference between these resettlements and the previous communal set up is the size of the fields. The fields apportioned to the resettled people are much bigger than those under the

communal set up. This is where the name *minda mirefu*[3] (long fields) came from. Their pastures are also far away from the villages as they are situated near the fields.

### *1.9.2 The Location of Romsley*

Romsley is in Rusape district in the Manicaland Province. It has fifteen villages under it namely Village One to Fifteen. The only clinic available is located some kilometres away which is meant for people in Chitenderano area which does not even fall under the ambit of Romsley. In other words, no clinic was constructed specifically for the resettled families. The distances they have to travel range from range 10 to 25 km. There is no other clinic where the resettled people can seek medical assistance. People from Villages One to Six used to visit Maoresa Soldiers' Barracks which was about twelve or more kilometres from the nearest village. Unfortunately it was closed down and they now have to access Nyamidzi Clinic. During the rainy season it is risky to access the clinic for many villagers since they have to cross Nyamidzi River which more often than not is flooded and there are no alternative routes to the Clinic.

[3] *Minda mirefu* means 'long fields'. These fields are long and wide. For instance, one of my mother's fields in the area is about 100m long and 20m wide.

## CHAPTER TWO
## 2.0 THEORETICAL FRAMEWORK, LAW AND LITERATURE REVIEW

### 2.1 Introduction

Worldwide, over 500,000 women and girls die of complications related to pregnancy and childbirth each year[4]. Over 99 percent of those deaths occur in developing countries such as Zimbabwe. But maternal deaths only tell part of the story. For every woman or girl who dies as a result of pregnancy-related causes, between twenty and thirty more will develop short- and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease[5], with rural women being the most affected.

This chapter reviews literature and law related to studies carried on maternal health care. It discusses previous research and surveys that have focused on issues to do with rural maternal health care in Zimbabwe.

### 2.2 Capabilities Perspective

The trend ever since the 1990s is to merge liberalist and welfarist approaches within the framework of sustainable development, (Ikdal: 2005). It was during this period when the 'Capabilities Approach' was developed by Martha Nusbaum and Amartya Sen. The approach sees the right holder as the pillar of the developmental process. This approach does not rank the rights as such but 'approaches them as an integrated and mutually interdependent whole', (Sen, 1999). This whole approach takes all human rights into consideration in the development process. The right to maternal health is not being given the significance it deserves because it is being regarded as a second-generation right. This then explains why it is not even part of the provisions of the Constitution of Zimbabwe. It can therefore be argued that failure to take maternal right as a developmental process also explains why Zimbabwe is still miles away from achieving Millennium Development Goal (MDG)[5].

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[4] www.policyproject.com/pubs/MNPI/Zimbabwe-MNPI.pdf.
[5] Ibid.

## 2.3 Feminist Perspectives

### *2.3.1 What is Feminism?*

The main aim of feminism is to fight women's oppression and their subordination to men. The term defies a precise and concise definition. However many scholars strive to define the term and two definitions from different scholars are given below. It is defined as:

> *"a description of all the movements and women's group that... strive to work against the oppression of women and in general for the improvement of the position of women."*
>
> (Dahl T.S, 1987:18)

She identifies its origins in the politics of nineteenth century France where it was used as a description of many different groups that sought to improve the plight of women. Ferree M. M and Tripp A.M. (2006: vii) defines it as:

> *"The broad goal of challenging and changing gender relations that subordinate women to men ... thereby also differentially advantaging some women and men relative to others."*

For the purposes of this research, the first definition of feminism shall be adopted since I view feminism from the same angle. There is a wide range of feminist theories but I shall dwell on two of them which are of much more significance to my study. These are the existentialist and relational theories and a brief description of them are given below. They shall be looked at intensively in the findings chapter.

### *2.3.2 Existentialist and Relational Theories*

Simone de Beauvoir in her book, The Second Sex offered an existentialist explanation of why women are oppressed by men. She argued that

> *"... woman is oppressed by virtue of 'Otherness'. Woman is the 'Other' because she is not man. Man is the self, the free, determining being who defines the meaning of his existence, and woman is the other whose meaning is determined for her".*

Simone further argued that women have internalised themselves as the inessential whilst men are the essential. When women try to come out of this oppressive position, there is always resistance by the society to women's equal status. She cited wifing and motherhood as being the causes of this otherness view of women. In other words, she problematised wifing and motherhood. When I started the research I wanted to find out if women themselves problematised these issues. It came out during the first group discussion that women find joy in the very issues that Simone problematised. For instance women at the waiting shelters complained that they were missing their children, one woman testified that she had been detected high blood pressure and she explains that it was due to the fact that she was missing her children. Women are therefore more relational as argued by Robin West, as they value relationships. Unlike the existentialist view that marriage destroys love between husband and wife as it turns love feelings into obligatory duties and asserted rights, in one discussion with expecting women at the clinic it came out that one woman was afraid that her prolonged stay at the clinic would mark the end of her marriage. They value some of the issues being problematised by existentialism.

She also problematises motherhood as she sees it as adding more demands on women to be care givers to their children. The very issues Simone find problematical are the issues in which women find joy. In an interview as to why the interviewee gave birth whilst weeding her maize crop was because she did not want to leave her children thus being in conformity to the relational view that women find joy in care giving.

Women are dying from minor and preventable complications which could have been avoided had it been that someone had done his or her duties well with women at heart. During the research I learnt that a certain woman died just after delivery at home having been assisted by an untrained midwife as she could not walk to the clinic because of the distance. The provisions in our Constitution shows how the legislators take women's issues for granted. The supremacy of culture and the need to domesticate ratified international instruments most of which deals with women's issues are a good example. Most of the cultural practises are to the disadvantage of women because they disempower them. Women are therefore not taken as full human beings at par with men. They are taken as second class citizens who have a perpetual minority status. Unfortunately women have internalised this inessential view and as such do not voice the oppression especially culturally and religiously but end up giving self for the happiness of other people as argued by West. Women's right to maternal health is not

recognised and given the attention it requires. I believe the situation would have been different had it been that men also fall pregnant.

## 2.4 The Right to Maternal Healthcare

According to an Oxford Dictionary of the current English, ‘a right’ is an entitlement which can either be moral or legal. On the other hand, `maternal health’ refers to the health of women during pregnancy, childbirth and the post partum period as defined by the World Health Organisation (WHO: 2009). Care involves looking after something or someone, as per the above mentioned dictionary. Maternal healthcare is a legal right constitutionally provided for in some jurisdictions under the right to health like South Africa and Kenya.

The right to maternal healthcare is a legal entitlement of women to be looked after during pregnancy, childbirth and the post partum period. The government is the main duty bearer through the provision of the necessary health facilities that fully cater for the needs of these women. These facilities include free services, availability of medication, standard clinics within a reasonable distance, and skilled staff with midwifery expertise, transport and nutritional supplements. It is the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant,( ICPD:1994).

## 2.5 The Human Rights Perspective

Human rights are meant for the protection of individuals against actions interfering with ‘fundamental freedoms and human dignity’. Human rights are indivisible and interdependent meant for the protection of citizens. Thus the right to health is closely related to other rights, especially right to life and right to non-discrimination. Zimbabwe is a signatory to some regional and international instruments which treat health as a human right, some of which implore governments to create a conducive environment for the delivery of maternal and neonatal health services. These include Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Women’s Protocol, Vienna Declaration, International Conference on Population and Development Program of Action, the Millennium

Declaration, Abuja Declaration Maputo Plan of Action, African Charter on the Rights and Welfare of the Child, International Covenant on Economic and Cultural Rights, International Covenant on Civil and Political Rights and Universal Declaration on Human Rights. By ratifying these treaties, Zimbabwe is expected to comply with their provisions by making national laws which enshrine them and policies and laws which promote, fulfil and protect those rights.

Individuals are the holders of civil, political, economic, social and cultural rights. Governments have corresponding obligations to respect, promote, protect and fulfil these rights, (Asher, J, and P: 2004). The legal and normative standards for these rights and the governmental obligations associated with them are based on the relevant human rights instruments and national constitutional provisions concerned, (Asher, J, P: 2004).

The 'obligation to promote' requires that Zimbabwe, by ratifying the treaties, refrains from interfering directly or indirectly with the women's enjoyment of their right to maternal healthcare. The 'duty to protect' demands the state to prevent any interference by third parties to the exercise of the right to maternal health. Third parties include the family and other players in the health industry. The 'obligation to fulfil' calls upon the government to do whatever possible to achieve the realisation of such right by rural women like enacting enabling laws, and having more accessible, more equipped clinics with enough nurses with midwifery skills.

Human rights encompass civil and political rights and economic, cultural and social rights. Maternal health falls into the economic, cultural and social rights category, generally known as second generation rights. They are not given the same weight as that accorded to the civil and political rights and the reasons for this vary. According to Davis, D, M (1992) three major arguments had been raised against their inclusion under the bill of rights in the constitution namely *'the absolute nature of rights, the question of negative duties and problems of impracticability and unenforceability'*. However these reasons lack logic since human rights are interdependent. It is argued that they are not absolute since their enforcement in each circumstance depends on the hierarchy of rights recognised by the presiding officer, Cappelletti M (1992). He further argued that a number of the negative rights impose positive duties upon the state and make a substantial claim on its resources. It can further be argued that most of the social and economic rights do not impose positive but

negative duties. The difference between a negative and a positive duty is that a negative duty are liberties against which other parties within the society have no claim whilst positive duties imposes a duty upon another party to provide certain resources, Dworkin (1987). The distinction between the first and second generation rights is not logical, since rights are interdependent. For instance women cannot exercise their right to life fully if their right to maternal health is in jeopardy. In fact in this respect their right to life depends on their right to maternal health care.

The human rights perspective affords women acceptable maternal healthcare as the state will be afraid of being sued in cases of violation of the right. It demands the state as the main duty bearer,

> *"to move beyond the kind of description and prescription found in traditional human rights reporting and engage with the much messier and more context-specific questions of how rights are made real, how services are revised and policymakers and local authorities are convinced that their practice must change, and how affected persons are moved to act as if these rights can in fact underpin their actions and demands."*
>
> (Miller A: 2005)

The effectiveness of the ratified instruments is hampered by the Constitutional provision which makes it mandatory for the said instruments to be domesticated before they become part of our law, section 111(b). However, in *Juvenile vs. State*, the presiding judge held that,

> *"...the courts of this country are free to import into the interpretation of...the Declaration of Rights, interpretations of similar provisions in International and Regional Human Rights Instruments such as among others, the International Bill of Rights, The European Convention for the Protection of Human Rights and Fundamental Freedoms... In this end, international human rights norms will become part of our domestic human rights law. In this way, our domestic human rights jurisdiction is enriched".*[6]

The same Constitution also provides in section 23(3) (b) for the supremacy of customary law in personal matters thus disadvantaging women who are almost always prejudiced by enforcement of such laws.

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[6] *Juvenile v The State 1989(2) ZLR 61,72.*

## 2.6 International Health Provisions

The international instruments that shall be used for purposes of the study are highlighted below.

### *2.6.1 Convention on the Elimination of All Forms of Discrimination against Women of 1979 (CEDAW)*

This came into effect in 1981 and Zimbabwe acceded to its provisions by appending its signature on the document. Provisions which are relevant to the current study are found in Article 12(2) which makes it mandatory for the participating States to ensure that women have:

> *"appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".*

The state is therefore obliged to make such provisions. The provisions do not give a guideline as to what are appropriate services as it can be interpreted differently by the duty bearers and the right holders. Therefore a closer look at the provisions do not take maternal right anywhere because of its ambiguity. Be that as it may, Zimbabwe is still in the process of complying with the provisions. At Nyamidzi Clinic, user fees had been scrapped in the case of maternal health care services.

### *2.6.2 Millennium Development Goals (MDGs)*

In September 2001, 147 heads of states collectively endorsed Millennium Development Goals 4 and 5 in terms of which they, on behalf of their Governments, undertook to reduce the child mortality rate by two- thirds and the maternal mortality ratio by three quarters between 1990 and 2015[7]. As a participating state in this undertaking, Zimbabwe adopted the National Maternal and Neonatal Roadmap in order to achieve these goals. A closer look on the experiences of rural women as they exercise their right to maternal health care shows that

[7] MDG Report 2010.

Zimbabwe might not attain these goals within the stipulated timeframe due to a variety of reasons.

### *2.6.3 The International Covenant on Economic Social and Cultural Rights of 1996 (ICESCR)*

The International Covenant on Economic Social and Cultural Rights (ICESCR) was adopted on the 16th of December 1996 by the UN General Assembly and entered into force on 29 March 1976, (Kapindu R.E 2009). The ICESCR provides a range of socio-economic rights, including the right to health which also covers the right to maternal health. Article 12 of the ICESCR provides for State Parties to the present convention to recognise the right of everyone to the highest attainable standard of physical and mental health. Moreover, Article 10 (2) provides that mother should be protected for ‘a reasonable period before and after child birth’. Article 12(2) (a) ICESCR requires states parties shall take the steps necessary for ‘the provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child’. In General Comment 14, the ICESCR Committee defines this as requiring ‘measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information...’

However its provisions on the implementation of socio-economic rights, in Article 2 (1), which reads,

> *“Each State Party to the present Convention undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieve progressively the full realisation of the rights recognised in the present Convention by all appropriate means, including particularly the adoption of legislative measures”*

are not satisfactory since lack of resources does not excuse the failure to implement the duties stipulated in the ICESCR. The obligation still remains for a State party to ‘strive to ensure the

widest possible enjoyment of the relevant rights under the prevailing circumstances.'[8] These provisions made me realise that states are obliged to undertake steps to the maximum of its available resources with a view to achieving progressively the full realization of the rights recognized in the conventions (Matsheza , Zulu 1997: 13). The unfortunate thing is that states might escape responsibility arguing that their resources are inadequate. The state can easily escape its duties.

### *2.6.4 Convention on the Rights of the Child (CRC) of 1989*

The United Nations Convention on the Rights of the Child (the CRC) was adopted on 20 November 1989. Zimbabwe it ratified on 21 January 1991 without reservations thus it is bound to fulfil its obligations. The right of children to 'the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' is provided for in Article 24 (1). To implement this right, Article 4 obliges state parties to:

> *"Undertake all legislative, administrative and other measures for the implementation of the rights recognised in the present convention. With regard to economic, social and cultural rights, State Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation".*

There is an acceptance that lack of financial and other resources can hinder effective implementation of socio-economic rights, including the right to health.[9] This does not however exempt the State Parties from implementation regardless of their economic circumstances. Poor countries like Zimbabwe are obliged to take measures to ensure the provision of the 'highest attainable standard of health' within their respective jurisdiction.

States are also required to 'ensure appropriate pre-natal and post natal health care for mothers' in accordance with Article 24(2)(d). Unfortunately no guidelines are given as to how this should be done and no minimum standards were defined as being acceptable. These omissions leave women in a precarious position as shall be shown in the next chapter.

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[8] Committee on Economic, Social and Cultural Rights (1990) *General Comment No 3 The Nature of State Parties' Obligations (Article 2, Paragraph 1 of the Convention)* Office of the High Commissioner for Human Rights para 11.

[9] Committee on the Rights of the Child (2003) *General Comment No 5: General Measures of Implementation of the Convention on the Rights of the Child (Arts 4, 42 and 44, Para 6)* United Nations 3.

## 2.7 Regional Framework

### *2.7.1 The Women's Protocol to the African Charter*

This protocol was ratified by Zimbabwe without any reservations. Art 14(2) expressly makes provision for a right to maternal health and defines what the package is made up of in the following terms:

> *"(2) States Parties shall take all appropriate measures to:*
>
> *(a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;*
>
> *(b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding....".*

These progressive provisions were captured in the Reproductive Health Policy Chapter 4, which unfortunately is not legally binding by its nature as it only shows the desires of the government not necessarily obligations. Just like the international provisions as shown above, the provisions are not clear as to what really is supposed to be done and how.

### *2.7.2 Cairo Declaration on Population and Development 2005 (Cairo Declaration)*

Of relevance to maternal health care is Principle 8, wherein the parties acceded to the fact that mortality rate was high since 'at least half a million women dying annually from the complications of pregnancy and childbirth and 99.5% of these maternal deaths occur in developing countries'. The members then made a commitment to reduce maternal mortality.

### *2.7.3 Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) 2009*

This is an African Union initiative which grew out of a commitment made at the 12th AU Assembly of Heads of State and Government held in Addis Ababa, Ethiopia in 2009. Its roots

are in the 2005 African Union Policy Framework which is meant for the promotion of reproductive and sexual health rights in Africa and Maputo Plan of Action (2006) which calls for the reduction of maternal mortality in Africa[10]. CARMMA recognises that improvement in women's health and the reduction of maternal mortality remains critical and is the number one priority for Africa, without which it will be impossible to achieve the millennium development goals and the objectives of the International Conference on Population Development (ICPD: 1994) and the Maputo Plan of Action[11]. This was launched in Zimbabwe on 30 June 2010 at Chivi District Hospital in Masvingo under the theme "Zimbabwe Cares: No Woman Should Die While Giving Life!"

## 2.8 National Legal and Policy Framework

The main players in the regulation of maternal health care are various state ministries, such as the Ministry of:

(a) Health and Child Welfare (for the provision of medical care);

(b) Transport and Communication (for the provision of good road networks and the smooth flow of transport);

(c) Finance (for the provision of sufficient funds to pay for the resources necessary to make adequate maternal health services a reality);

(d) Women Affairs, Gender and Community Development (to fight for women's issues including the right to maternal health care).

The Government enacted a series of laws and regulations to try and ameliorate women's plight as they seek maternal health care. Among them are the Medical Services Act, Health Charter and Reproductive Health Policy, Public Health Act, Zimbabwe National Maternal and Neonatal Health Road Map (2007-2015) and the National Health Strategy for Zimbabwe (2009-2013).

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[10] http://www.safaids.net/pt-pt/node/2430Zimbabwe to Launch CARMMA "No Woman Should Die While Giving Life."

[11] Ibid.

#### *2.8.1 The Public Health Act Chapter 15:03*

Despite this Act being the main piece of legislation dealing with health issues in Zimbabwe, it does not provide for maternal health care. This alone shows the lack of political will by the government in taking women's issues seriously. Also by doing so, it is escaping its obligation to provide maternal health care as it cannot be sued under its policies.

#### *2.8.2 The Medical Services Act Chapter 15:13*

This Act requires the Minister to:

> *"(a) provide and maintain comprehensive and constantly developing medical services; and*
>
> *(b) encourage local authorities and other persons to provide such services".*

It is therefore obligatory for the Minister of Health to provide health facilities to the nation, failing which he will be in contravention of the Medical Services Act.

#### *2.8.3 National Health Strategy for Zimbabwe 2009-2013 (Equity and Quality in Healthy: A people's right)*

The Ministry of Health and Child Welfare (MOHCW) committed itself *"to increase inter-sectional coordination and collaboration with relevant sectors and other organizations, towards improving health and quality of life of the population".* In respect of maternal and child health it wishes to reduce the Maternal Mortality Ratio from 725 to 300 per 100 000 live births by 2015 by increasing *'the availability and utilization of quality focused antenatal care including PMCTC services… improve access to skilled attendance at delivery… to strengthen the capacity of health system for the planning and management of MNH (Maternal and Newborn Health) services.'*

### *2.8.4 The Patient's Charter*

This Charter provides for free immunisation of pregnant women only among all other services required by women in the exercise of their maternal health care. This then means that they have to pay for all other services. However at Nyamidzi Clinic there are no user fees for women seeking maternal health care. It can be argued that the government has some progressive provisions for maternal health care, unfortunately they are not, however, justiciable.

### *2.8.5 Reproductive Health Policy and the Reproductive Health Guidelines*

Attempts have been made to improve maternal healthcare. The Government has made efforts to create an enabling policy environment for the implementation of various maternal, neonatal and child health programmes. Reproductive Health Policy (RHP) and Reproductive Health Guidelines (RHG) have been developed.

These are the most progressive policies in Zimbabwe which provide for maternal healthcare. The RHP aims at improving maternal health among other aims. It provides for the essentials required for the realisation of good maternal healthcare. Some steps have already been taken. It must be conceded, however, that the training of traditional birth attendants (TBAs), antenatal screening for high risk pregnant women and the provision of simple kits are insufficient and that something more needs to be done. Pregnant women must have waiting shelters, access to skilled personnel at delivery and good post partum care. In the case of complications, there must be effective referral and transport to well staffed and equipped district hospitals.

These provisions if implemented will go a long way in ameliorating the plight of women especially that of rural women in the exercise of their right to maternal health. It also provides for infant and child health with the main objective being to reduce infant mortality and morbidity also to protect them from the major diseases as well as ensuring adequate nutrition and growth. Strategies on how this is going to be achieved are given, whether or not this is being done is a different issue which merits interrogation. Also the feasibility of some

of the strategies is questionable taking into account the fact that our economy is not stable and most of the resources are donor funded. The RHPG concretise the provisions of the RHP.

### *2.8.6 Zimbabwe National Maternal and Neonatal Health Road Map (2007 2015)*

The MNH Road Map is a national framework for planned activities aimed at significantly improving maternal and newborn health services at institutional and programme levels, in line with the MDG health related targets. The Road Map is meant to provide the basis for an increased and long term investment to reduce the current levels of maternal and neonatal mortality and morbidity, and to provide guidance to all strategic partners, stakeholders and programmes for a more coordinated, multi-sectoral and national response to improved health service delivery at all levels: from community based services to rural health facilities, to district and provincial referral centres, through to highly specialized tertiary hospitals.

### *2.8.7 The Constitution*

The main reason for including a right under the bill of rights is to identify it as *'fundamental and to place it beyond the depredations of a transient electoral majority'* (Mureinik E. 1992). Sachs A, (1991) supported this view when he wrote that constitutionalising social and economic rights '*forbids the constitution under the guise of a false libertarianism, from becoming an instrument of human abandonment, heartlessness and neglect, it prevents good constitutional concepts... to be turned on their heads so as to promote the privatisation of misery'*. Therefore once it becomes part and parcel of the Bill of Rights, the government will be held accountable for its failure to comply with and for any breach of its constitutional obligations.

Although the Constitution of Zimbabwe is the supreme law of the land, it does not provide for the right to maternal healthcare, just like other economic, social and cultural rights which are viewed as being of less importance than civil and political rights which are provided for in the bill of rights. This is so despite having appended its signature on the said instruments. The Republic of South Africa in its constitution, section 27(1) explicitly provides for the *'right to have access to, health care services, including reproductive health care'*. The right

to maternal health care is specifically provided for under reproductive health care. Since the right to maternal health care is not part of the bill of rights in the Zimbabwean constitution, it is not a justiciable right and the Government cannot be sued in a court of law for failing to fulfil its obligation. This scenario flies in the face of the principle that human rights are indivisible, inter-dependent, inter-related and inter-linked.

Failure to make maternal health care a right in itself shows the lack of political will by the government to recognise that economic, social and cultural rights are legal rights and have the same status as civil and political rights. It is a fact that the treaties which provide for these rights were ratified after the promulgation of the Lancaster House Constitution which is the current Constitution. It has undergone nineteen (19) amendments. The right to maternal health effectively remains a dream for women especially rural women who more often than not do not have any other option like going to private hospitals because of the challenges, especially the economic and geographical ones, that confront them. During the first group discussion it emerged that, although women would like to visit their nearest clinic, the distance to it alone discourages them from doing so as they often have to embark on a long and dangerous journey on foot. More often than not there will be no transport plying the route and if the transport is available, most of them cannot afford the bus fare which is one US dollar for the trip.

### *2.8.8 Case Law*

Unlike other economic, social and cultural rights (like environmental rights and right to water) where test cases have been brought before the courts and progressive judgements made which have accorded them internationally recognised rights status in the country, I am yet to identify any similar recognition in relation to maternal healthcare by rural or urban women. Had the right to maternal health care been accorded Constitutional protection, it would be possible for aggrieved parties to sue the government for any breach thereof as is the case in South Africa. I managed to find one case where South African women successfully sued the government (Minister of Health) for failure to provide medicines which had an impact on their right to maternal health in terms of their right to health[12].

[12] *Minister of Health and Others v TAC and Another (No.2) 2002 (5) SA721( CC).*

Although the case was decided before the South African Constitution specifically provided for a right to reproductive health, it is still of significance to the current study since their right to maternal health was in jeopardy. The women sued under their right to health care which was specifically provided for in the Constitution. In the case of *Minister of Health and Others v TAC*, it was held by the court that the failure by the government to provide medication which prevents mother to child transmission of HIV/AIDS was unconstitutional. It was therefore ordered to provide such treatment. Similarly, if the Zimbabwe Constitution specifically recognised the right to maternal health care as a right under the Bill of Rights, the women of Romsley would at least have the right, in theory, of suing the government for breaching their right.

## 2.9 Conclusion

If ever the right to maternal healthcare in Zimbabwe is to become meaningful to women especially the rural population, Zimbabwe must comply with the ratified instruments by enshrining it in the Constitution by following in the footsteps of other jurisdictions such as South Africa and Kenya. As a result, the right to maternal health care would become justiciable and the government would be bound to provide an enabling environment for the exercise of such a right, failing which it would be held accountable.

The next chapter will deal with the methodology and the methods used during the research. It will show how each methodology was utilised and whether it was effective. This will also be done in respect of each and every instrument used in data collection.

# CHAPTER THREE
# 3.0 RESEARCH METHODOLOGIES AND METHODS

## 3.1 Introduction

This chapter discusses the methodological framework that informed my study. It also discusses the research methods employed as well as an assessment of the efficacy, limitations and practical utility of each method. Different methodologies and methods of data collection were used for the purpose of gathering information which is essential to the understanding of the phenomenon being studied. The methodological approach used drew mainly on four perspectives outlined below.

## 3.2 Methodological Framework

*"Methodology is merely an operational framework within which the facts are placed so that their meaning may be seen more clearly."*
(Leedy 1981:75).

### *3.2.1 Women's Law Approach*

The women's law approach was a key methodological framework that was employed. I started with the women themselves as the main participants and informers. Women are the most affected directly or indirectly in the exercise of their right to maternal health. They are affected directly as they seek maternal health care for their personal benefit, for instance, if they are pregnant. On the other hand, they are indirectly affected if they are seeking the right for a second party for example, their daughters or daughters in law in discharging their traditional responsibilities as care givers. I used this approach to assess whether or not they as women were facing any challenges in accessing maternal health care. This approach take women's actual lived experiences and life situations based on sexuality, birth care and domestic work as a starting point for the analysis of the position of women in law and in society (Dahl T.S 1987) .

This approach was useful to me as I collected empirical data about the lived experiences of women and realities. I looked and critically analyzed the existing practice to verify what is really happening on the ground and then proceeded to hear from the women themselves what problems they faced as a result of religious, traditional and cultural beliefs and practices. The main sources of information were women themselves narrating their own stories and experiences in their own words. Thus the women's law approach was useful as it records and analyses female life situations and values and reveals issues and dynamics that are seldom evident in the male dominated legal culture. Such a basket approach offered me a variety of tools to engage with in light of the lived realities of women who seek to 'enforce their right' to maternal health.

The Woman's law approach is about how women are conceived and how the law then corresponds to their lived realities. It is also about understanding the legal position of women. Using this perspective, I analysed the provisions in the legal framework and compared it with what was happening on the ground as per women's stories. I approached the women to find out whether the legal provisions were being effected. There was a glaring gap between the policies and the reality on the ground. For instance, the Reproductive Health Policy, Chapter 4 (4)(1) provides for the availability of a clinic within 10km radius whilst the National Health Strategy provides for an 8km radius (as per section 3.1.1). The reality, however, is that people are walking more than the said distance to access a clinic with those coming from village one walking 25km. The gap between the legal provisions and the reality is wide. The framework which covers for the right to maternal health care is in place but it is not being implemented. There are no trained midwives; women are not given nutritional food when pregnant or during the lactation period as provided for in the said policy in Chapter 4. In fact, the opposite of the provisions in the available legal framework is what is happening out in the field.

This methodology included capturing women's voices from different backgrounds with different religious, cultural and traditional beliefs. This was necessary as it assisted me in seeing that these women do not all agree on the right to maternal health care. The women 'leaders' of Johane Marange during a group discussion said that seeking any form of medical assistance at health institutions is demonic whilst those from other religions like Anglican found nothing demonic about the issue. The approach also assisted me in realising that not all Johane Marange followers had such a view. I interviewed a couple which indicated that they

had no problems with seeking maternal health care. The wife had this to say, *"we need a liberalised approach to the issue of hospitalisation...I visit medical institutions"* and their child was born at Harare hospital and had been immunised.

Using the women's law approach, I was able to interview women, listen to them and, if necessary, ask them for more information about what they said. Most of them were anxious to share their experiences in relation to maternal health care.

### *3.2.2 Grounded Theory Approach*

The Grounded theory approach is a grounded research process which helped me to collect data, sift and analyze it, consider the implications of the findings, determine what to collect next to meet women's needs and to continue with the collection and analysis cycle (Bentzon, et al 1998:18). Using my assumptions, the grounded theory approach helped me to check on the realities of women's lives on the ground. For example when it was stated during a group discussion that one woman died just after giving birth whilst being assisted by an untrained midwife, I sought to find out why she did not visit the clinic. I then interviewed the midwife who had assisted the deceased and who told me that she was a 'para O'. When she visited the clinic she was referred to Rusape General Hospital but had no money so she decided to be assisted by her since she was a midwife. This was a confirmation of sub-assumption 1.2 which states that women do not seek maternal health care because they do not have the money to meet the expenses as well as assumption two which states that as a result of different challenges encountered by women in accessing maternal health care they resort to unsafe methods.

This was a useful approach which was critical in as far as it allowed me to constantly engage with the data I had collected and determine what data to collect next basing mainly on the emerging issues. It was a useful method as it uses empirical data to define a problem and use this empirical data to propose appropriate intervention measures to address the problem. The knowledge of grounded theory helped me to see the situation on the ground through exploring the realities of women and their experiences. Some of my assumptions were challenged. For example one of my assumptions was that religion is a stumbling block to

women's exercise of their right to maternal health care. This was challenged as it emerged that some of the Johane Marange followers sought medical assistance.

### *3.2.3 Human Rights Approach*

Although the universality of human rights has been criticised left, right and centre, in this case women's rights, they still provide a standard set of measures that keep us informed on the minimum standards that women are entitled to and specify the obligations of the state as a guarantor of women's socio-economic rights and in ensuring the implementation of these abstract rights into substantive rights and real rights, (Maboreke: 1988). Human rights approach was a very useful method in data collection as it measures the state's compliance with the ratified international and regional instruments. Human Rights provides for a right to maternal health in terms of its affordability, accessibility and availability. Thus by ratifying these instruments without reservations Zimbabwe is expected to comply by turning those substantive rights into a reality. The approach was useful as it helped me to compare the provisions with reality. In doing so I analysed the provisions of the Zimbabwean Constitution, the Public Health Act, The Strategy, The Plan, Health Charter and the Reproductive Health Policy against the reality on the ground. Rural women face challenges like walking long distances to the nearest clinic, they do not have money to meet the ancillary maternal expenses and they are delayed at the clinic. Their right to maternal health care falls far below basic human right standards.

The government which is the main duty bearer is expected to take positive steps in the provision of maternal health care to an extent of making sure that third parties do not interfere with such a right. It is under an obligation to protect, fulfil and respect the right to maternal health care. Although Zimbabwe has ratified regional and international instruments which provide for this maternal right, it remains beyond the grasp of its most needy and deserving beneficiaries, i.e., its rural women; consequently, urgent steps need to be taken to remedy this unacceptable situation.

### *3.2.4 Intersections*

This form of methodology was also utilised during the research and it proved to be very useful. Women in their quest to seek for maternal health care find themselves at an intersection. There are many factors which affects their decision on whether or not to seek maternal health care. Interrogating certain values that inform women's decisions was critical in understanding the phenomenon that was under study. The most prominent factors that have a bearing on women's maternal decisions are the cultural, religious, traditional practices and the law. During the interviews and the discussions it became quite evident that it is taboo in our culture to have a male who is currently 'midwife' available at the clinic. This alone, 'bars' women from going to the clinic for their deliveries and for the mandatory ten day and six week checkups after delivery. For instance one woman indicated that in as much as she wanted to seek maternal health care at the clinic, she could do so. The reason she gave is that she could not imagine herself showing her whole body to another man who is not her husband. *"It is unheard of in our culture"*, she said.

## 3.3 Study Target Population

For the purposes of the study I focused mainly on women in some villages of Romsley regardless of their age. Initially I wanted to carry out my research in the whole area but later failed to do so due to circumstances beyond my control. I later focused on villages nine, five, three, eight, ten, eleven and twelve. Since it was during the rainy season, I could not visit villages one, two, four, six and seven because I could not cross the Nyadzonya River. There was no transport plying the route since there is no bridge. Villages thirteen, fourteen and fifteen could not be accessed I found it risky to go there. The villages are not arranged in a chronological order but haphazardly. For instance, village nine is close to villages twelve and three. Although women were the main focus, men were also interviewed since they also had an impact on women's right to maternal health care. The information gathered during the research made it mandatory for me to hear their side of the story. The sample of the respondents is shown in the table below.

**Table 1: Showing Respondents involved in the research**

| RESPONDENTS | FEMALES | MALES | TOTAL |
|---|---|---|---|
| Nurses | 1 | - | 1 |
| Midwives | 2 | - | 2 |
| Village heads | - | 2 | 2 |
| *Johane Marange Sect members | 7 | 5 | 12 |
| Community | 14 | 8 | 22 |
| Total | | | 39 |
| | | | |

*The number includes the leaders of the sect, both male and female then ordinary followers.

### *3.3.1 Sampling*

I used purposive sampling in selecting my respondents. This was done based on my knowledge of the people since that is my home area. It was also based on the purpose of the study as it assisted me in eliminating people who were not of any assistance. Strydom and Venter (1996) describe sampling as the process of taking a portion of a population as a representative of that population. The process of sampling is necessary due to large size of a population and the consequent impracticality and prohibitive cost of testing each member of any population (Denzin, 2000). This method proved to be useful during my research.

## 3.4 Research Methods

The following methods were employed case study, observations, in depth individual interviews, and group discussions.

### *3.4.1 Case Study*

A case study research method can be defined as *"an empirical inquiry that investigates a contemporary phenomenon within its real life context ...in which multiple sources of evidence are used."* (Yin 1984:23). Simply defined, it is *"a research strategy that focuses on exploration of a complex phenomenon and related context"*[13]. This method assisted me in my research as it narrowed down the research to a specific area, in this case Romsley. It was impossible for me to carry the research countrywide. The assumption is that the results that I got are reflective of what is happening in other rural areas especially in 1980 resettlements regarding how women are exercising the right to maternal health. The other assumption is that the interventions required in Romsley are the same interventions required in other rural areas. Case study as a method is especially suited to capturing the experiential descriptions by studying the uniqueness of the particular and understanding the universal, (Elliot: 1990). It assisted me to have a deeper and clear understanding of the topic I was researching on since it gave me the allowance to collect data from a small community which had the knowledge of what women in their community go through whilst seeking maternal health care. These people gave me different views with different justifications on the same issue thus helping me in my triangulation of data. For example at one group discussion it was alleged that women do not seek maternal health care at the nearest clinic since it was very far and could not walk such a distance. Others were of the view that it was not only the distance which deterred women from visiting the clinic but their beliefs, religious, traditional and cultural. It helped me to get different perceptions on the right to maternal health from people staying in the same community.

### *3.4.2 Observations*

This method was employed so that I could get some information which I could not have obtained had I introduced myself as a researcher. Taking advantage of my protruding stomach as I was pregnant at the relevant period, I visited Nyamidzi clinic. My intention was to observe what the system offers and how the services were offered. Their services are not up to standard, as per International requirements. On the day in question, the clinic was

[13] http://www.beckyfiedler.com/edf6481/litreview/casestudies.pdf.

opened at 9:45 a.m. yet it is supposed to be opened at 8:00 a.m. and no explanation was given to the 'clients'. The staff did not even give priority to emergencies and I was not able to ask the nursing staff as to why. There was an expectant woman who was in the advanced stages of labour who arrived just after me. She was left lying on the wooden bench outside the premises only to be attended to after I intervened and almost gave birth outside the labour room. These negative attitudes do scare away women.

The clinic is understaffed. On the day in question there was only one nurse manning the station but she had no midwifery skills. The other nurse who had midwifery skills had gone to Rusape District to collect the clinics medication. I failed to complete the registration as I would risk missing my transport to return home. There is no suitable equipment for expecting mothers especially in emergency cases. The clinic does not even have a scale for weighing adults. The beds are no longer fit for human usage. The only bed in the ward room no longer had the protective plastic over it, thus blood from different patients had soaked through into the mattress. Although there are no user fees at the hospital, the services are not free at all since you are given a prescription for and have to pay hard cash for iron tablets. There is no pharmacy nearby and the nearest pharmacy is some eighty (80) kilometres away. There is no reticulated water at the clinic and the waiting shelters were overcrowded since four women were sharing a small room meant for two people.

### *3.4.3 In-depth Individual Interviews*

These face to face discussions with the individuals allowed flexibility in both the scope and the depth of the subject under discussion. This technique was very useful since it *'allows for an open interview that enables the subject to speak freely'* (Babbie and Mouton 2001). I realised that women feel comfortable using this technique since they consider the issues under discussion as confidential. I did in-depth individual interviews with the key informants who include midwives, women, nurses and some Johane Marange Sect[14] followers as well as two village heads. This method was very useful in that it helped me to have a variety of ideas from different people those who did not directly feel the impact of women's failure to access

[14] Johane Marange Sect is one of the white garmented sects in Zimbabwe. Its followers conduct their church sessions in an open space, wearing white garments but no shoes. The founder of the church is ...... and they do not believe in medication as they believe in the Anointed One for their healing.

maternal health and the women themselves who were failing or facing challenges in accessing such medical care. I felt that they were comfortable talking to me on a one to one basis. I had promised them that it was going to be private and confidential. More often than not I would give them fictitious names. Because of the assurance they would talk freely with no reservations. I triangulated the data I collected from the different sources and had a deeper understanding of women's challenges in accessing maternal health care which include walking long distances, culture and the delays at the clinic. All the people interviewed talked from their experiences and observation and their information was useful as they were all well versed with what was happening on the ground in relation to maternal health care. They therefore gave first hand information thus its credibility could not be doubted. This tool also assisted me as it created a conducive environment for conducting confidential discussions. They proved to be the most effective way of data collection by creating space for the interviewees to express their views responses and experiences, (Stewart et al: 1997).

### *3.4.4 Group Discussions*

An impromptu group discussion was held with ordinary men and women at Nyamidzi clinic. This was not very fruitful as men dominated and women only confirmed what the men said. It comprised of seven men and eight women. They voluntarily assembled and I led the discussion by asking questions which were specifically on the right to maternal health. Questions were open ended but women were not comfortable to open up in the presence of men. The opposite was true for the men who freely narrated their experiences as husbands.

During the discussions and interviews, I observed women's behaviour. Women feel comfortable and more confident if they are either in a group of women or if they are being interviewed one on one as they considered the subject that was under discussion private and confidential. The proceedings being informal gave them the chance to say whatever they wanted to say. Participants were able to point out the need for a well functioning, central health centre. They were also eager to learn more about their right to maternal health and what should be done to alleviate women's situation.

### 3.5 Challenges Encountered

During the research period I faced some problems most of which I failed to solve. The main problem was bureaucracy within the government institutions. This had a negative impact on the quality of my work. I only managed to have one side of the story and could not get anything from the state which was always blamed for its failure to efficiently discharge its duties. There was need to have the other side of the story from the 'accuseds' themselves for me to be able to make a conclusion which is not biased. It is therefore my view that instead of the researcher manoeuvring on his or her own there should be prior director to director arrangements to make it easy for the researcher also to avoid inconveniencies. Due to my failure to get the state's side of the story, I do not have the statistics. In short, I failed to get critical information from the duty bearer. Despite this challenge, my findings are still valid as they show what women go through as they seek maternal health care in Romsley.

Sometimes there was mistrust especially with the untrained midwives as they thought that I was there to either arrest them or cause their arrest. The reason for their fear of being arrested was because they all knew very well that they are supposed to be professionally trained for them to be midwives and that it was illegal for them to operate without the said training. This was worsened by the fact that they were all aware that I am a magistrate. It was very difficult for me to gain their confidence. To boost their confidence in both occasions I had to go with someone known to the midwife for me to be able to interview them. I never expected to encounter such a challenge since I am part and parcel of the community; it is my home area and I am known to almost everyone. Be that as it may, I managed to get some information which would assist in changing women's plight as they seek maternal health care.

### 3.6 Conclusion

Having dealt with the methodology and the tools used in data collection, the next chapter, Chapter Four looks at the results of the research. It attempts to highlight, discuss and analyse the findings as they relate to the assumptions.

# CHAPTER FOUR
# 4.0 DISCUSSIONS AND ANALYSIS OF THE PRODUCTS

## 4.1 Introduction

*"International human rights law has not yet been applied effectively to redress the disadvantages and injustices experienced by women by reason only of their being women; in this respect human rights fail to be universal. The reasons for this general failure to enforce women's human rights are complex and they vary from country to country."*

(Cook: 1994:3)

Chapter Three dealt with the methodology and tools employed during the research. The present chapter deals with an analysis of the findings as they relate to the assumptions. It will be presented in the chronological order of the assumptions. The analysis shall be done bearing in mind that the right to health is not necessarily the right to be healthy since it is impossible for the government as the duty bearer to guarantee it. Instead the right obliges the government to provide or create the conditions necessary to encourage the general populace to be healthy. The right to health therefore demands accessible, available, acceptable and good quality health care services and facilities. An analysis will be made based on these requirements and whether or not these standards are being fulfilled in respect of the right to maternal health which falls within the category of the right to health. However before this can be done the term *'midwife'*, which shall feature frequently and prominently in my work, shall be defined and its origins briefly traced.

## 4.2 A Definition of the term 'Midwife'

This is a type of a word whose meaning seems very clear until one actually attempts to give it a meaning. It is a word which cannot easily be defined as it appears. The American Heritage Dictionary of the English Language (2000) defines it as a person, usually a woman, who is trained to assist women in childbirth. It is also used regionally to refer to a granny, or granny woman or one who assists in or takes part in bringing a result. Whilst it is defined as a person qualified to deliver babies and to care for women before, during and after childbirth by the

Collins English Dictionary (2009, Farlex clipart collection (2011) gives the definition as a woman skilled in aiding the delivery of babies[15]. It seems the first definition is the understanding of a midwife in our Shona culture and I was socialised into that belief as well. Be that as it may, for the purposes of this study, the second definition shall be used since it covers anyone skilled to deliver babies regardless of his/her biological make up and it gives a broad understanding of the duties of a midwife. This is so because the word seems to be used in that sense with the advent of male midwives. At Nyamidzi Clinic which is the only clinic near the area under study there was a male midwife in attendance when the research was done.

### *4.2.1 World History*

Since Zimbabwe inherited almost everything from its former colonisers, it can also be assumed that this word is also inherited from them. The word 'wife' seems to refer to a woman giving birth, who is more often than not married, hence, she is a wife. Wife in its earlier history meant "woman," as it still did when the compound midwife was formed in Middle English (first recorded around thirteen hundred)[16]. 'Mid' is probably a preposition, meaning "together with." Thus a midwife was literally a "with woman" or "a woman who assists other women in childbirth"[17]. In Zimbabwe the woman who assists in giving birth is called *mbuya nyamukuta* in the vernacular. The other version is that the word "midwife" originated from Old English, its meaning is just like the above "with woman."[18] It is alleged that midwives have been assisting women to give birth since time in memorial. References to midwives are found in ancient Hindu records, in Greek and Roman manuscripts, and even in the Bible[19]. Whether or not it originated in the middle or old English is of no significance. What is important is that it is not a thing of our own making and the fact that it originated from the English.

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[15] All the dictionaries are available on http://www.thefreedictionary.com/midwife (accessed 09.02.2012).
[16] Ibid.
[17] Ibid.
[18] http://www.thefreedictionary.com/midwife(accessed on 15.02.2012).
[19] Ibid.

## 4.3 Stumbling Blocks

The first assumption concerned the problems women face in exercising their right to maternal health care. Poor service delivery at the clinic, long distances, lack of financial capacity to meet the necessary medical expenses and were the sub assumptions. These sub assumptions are dealt with below in their chronological order.

### *4.3.1 Poor Service Delivery*

Poor service delivery at the clinic scares away women from seeking maternal health care. In an interview one woman narrated how she was treated at the clinic and what she went through after the treatment. She said:

> "Last month I delivered at the clinic and I had a tear. I was sutured and the stitches were undone within three days after delivery, I had to be resutured. When I returned for medication they referred me to Rusape General Hospital where I was resutured at a fee. I went through hell and I will never visit that clinic again. The woman who was using a bed next to mine died just after delivery, due to excessive bleeding, it was terrible".

Due to what she experienced, she vowed never to visit the clinic again. This alone shows that the midwife who attended the delivery is not professionally skilled to be a midwife. This is in contravention of one of the tenets of the right to health which requires services to be of good quality, which is defined to encompass health facilities, services and goods that are medically and scientifically appropriate. Skilled medical personnel, scientifically approved drugs as well as hospital equipment are also some of the necessities. Failure by the clinic to cope with excessive bleeding was because the clinic did not have the essential drugs a fact confirmed by the nurse I interviewed who indicated that at times they fail to discharge their duties effectively due to lack of drugs and the necessary apparatus.

There is a critical shortage of midwives in the country and due to some economic challenges, these are currently being trained but at a lower rate. At Nyamidzi Clinic only one nurse has midwifery skills. This was confirmed by the nurse I interviewed:

> "At times I am scared to assist women with deliveries since I do not have midwifery skills and more often than not I refer them to the Hospital if the other nurse with midwifery skills is not around".

According to Cummings, R, et al (2011), Zimbabwe has a severe shortage of midwives, a problem likely to persist as too few are being trained. She further indicated that remote rural clinics are staffed by nurse with little or no midwifery skills. As if that was not enough, the clinic was manned by only two nurses during the relevant period when I carried out the research, and only one of them had midwifery skills. The fact that it is a male nurse who is qualified to do midwifing in itself also discourages women from delivering at the hospital as they consider it taboo.[20]

However on the day I first visited the clinic there was only one nurse manning the whole clinic. This then impacted on the quality of services offered as the nurse must have been tired. She failed to cope with the work as there were too many patients for her to attend to and I had to return home before being tested for Hiv/Aids.

> "Women do not always access maternal health services because at times there will be other emergency issues to deal with and we will dismiss women who would have come for scaling and registration of pregnancies",

said the nurse said upon being interviewed.

When I interviewed her on my second visit she indicated that three nurses resigned searching for greener pastures and since no replacements had been made, the Clinic had a serious manpower shortage. Despite this situation the Ministry of Health and Child Welfare is in the process of making arrangements for the exportation of qualified nurses. The Deputy Minister, Mr Mombeshora indicated that nurse exportation was necessitated by the fact that the Ministry of Finance froze all government posts although there are still vacancies[21].

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[20] Moderate *Zunza* aged 24 indicated that as long as there is a male midwife, she will not deliver at the clinic. She considers it a foreign thing which she is not comfortable with. For all her three children she was assisted *mbuya nyamukuta*. She prefers visiting the local *mbuya nyamukuta.*

[21] http://www.thestandard.co.zw/local/33737-zim-to-export-jobless-nurses-minister.html (accessed 16.02.2012).

The nurses showed disrespect of the women they are supposed to serve. On the day I first visited the clinic, an expectant woman almost gave birth outside the clinic despite the fact that she arrived well before the labour pains were advanced. She was only attended to after I intervened but the nurse was there and had seen her when she arrived. The negative attitude by the nurse was very unfortunate as it was about to cost the life of either the baby or the mother.

Women are forced to seek accommodation from nearby homesteads so that the following day they will be able to join the queue earlier be given a better number in the hope of being seen, since there is no guarantee that you will be attended to at the Clinic. This was confirmed by the people staying near the clinic. On being asked how they see the issue of expecting women and women with children seeking maternal health services at the clinic asking for overnight accommodation so that they will be served the following day. On being interviewed on this issue one man who stays near the clinic answered:

> "There is nothing they can do as they will be coming from afar. They are no longer allowed to sleep at the clinic queuing to be served the following day".

Others just go back home without being attended to or before they have completed the whole process.

### *4.3.2 Long Distance*

Long distances discourage women from seeking maternal health care. In some instances it is just impossible for expecting women already experiencing labour pains to walk twenty or so kilometres to the nearest clinic. The table below shows the average distances women are expected to walk whilst seeking maternal healthcare.

**Table 2: Showing Distances from the various Romsley Villages to Nyamidzi Clinic**

| VILLAGE | DISTANCE (to be walked in km) |
|---|---|
| One | *Twenty five |
| Two | *Eighteen |
| Three | Twenty one |
| Four | *Seventeen |
| Five | Twenty three |
| Six | *Three |
| Seven | *twenty one |
| Eight | Fifteen |
| Nine | Twenty |
| Ten | Nineteen |
| Eleven | Nine |
| Twelve | Twenty |
| Thirteen | *Twenty four |
| Fourteen | *Twenty one |
| Fifteen | *twenty Three |

*The distances are rough estimates since the areas could not be accessed during the research period.

Despite being a signatory to the ICESCR, Zimbabwe is still lagging behind in the realisation of the right to maternal health. Although it provides in the RHP that there will be a clinic in every 10km radius and in the National Health Strategy (NHS) (2009-2013) that there will be a clinic within 8km radius, the provisions remain on paper. It came out of the various discussion I held that most women in Romsley have to walk long distances to the nearest clinic. The maternal health care facilities and services are not therefore accessible. The intended beneficiaries fail to access the clinic because of distance. As if that is not enough, if referred to Rusape General Hospital, this further prejudices them since it lies some 80km from Nyamidzi clinic. The roads are characterised by big potholes which resemble small pools during the rainy season and bridges are nonexistent. Even if an ambulance is summoned from Rusape, it takes a long time to reach the clinic because of the bad roads.

Neither the clinic nor nearby hospitals are physically accessible. Long distances to the nearest clinic are not only experienced in Romsley but are a feature of almost all rural areas, a fact alluded to in the NHS, section 3.1.1 which reads,

> "...physical access to health facilities is still a challenge as some people have to travel more than 10 kilometres to reach a health facility".

### *4.3.3 Lack of a stable Source of Income*

According to the General Comment number fourteen by the ICESCR committee, a right to maternal health must be economically accessible. This effectively means that women must be able to afford to exercise their right to maternal health. Unfortunately women fail to exercise the right due to economic constraints. Although there are no user fees, the ancillary expenses prove too expensive for women. Because of its failure to make this right affordable, Zimbabwe is in clear breach of it mandate under the ICESCR. In an interview it emerged that if women are transferred from Nyamidzi to Rusape General Hospital (RGH), services are not free and they are expected to pay before they are discharged otherwise they would literally be imprisoned until they paid any outstanding fees. The interviewee indicated that when she was transferred to RGH after she had developed some complications she was advised to settle a bill of US$150 before she could be discharged or risk pseudo-detention. She was discharged after three days after having settled the bill. Although this practice is not legally sanctioned, women are being detained for failure to settle a maternal health care bill.

Most women in Romsley do not have a stable source of income as they rely on subsistence farming and gardening as indicated at a general group discussion with the Anglican *ruwadzano* women. The community is generally poor but women are poorer than their male counter parts and they sometimes cannot even afford to buy two packets of family planning tablets at the clinic for a dollar. In the same group discussion women indicated that they cannot afford the money charged for a packet of family planning tablets. They further indicated that even if they manage to raise the money they would rather channel it to the upkeep of their children, so committed are they to the care of their closest dependents. The clinic usually does not have the required medicines and women are given prescriptions to buy them from pharmacies a condition confirmed by the nurse interviewed who indicated that at

times the clinic is short of drugs. The nearest pharmacies are some 80km away and for them to go there they need five dollars and another five dollars for the return journey. This money is just too much for someone who does not have a stable source of income. The challenges encountered in accessing maternal health care forces women to seek the services of herbalist, healers or midwives who are situated closer to their homes.

### 4.4 Coping Mechanisms

My second assumption was that women in rural areas resort to unsafe means of delivery because of different challenges they face in accessing maternal health. However on the ground I discovered that women do not only turn to unsafe means for delivery but for all their maternal health requirements. During the research, I found out that women at times are forced by their failure to seek maternal health care at the clinic to turn or develop their own coping mechanisms which are unhygienic and life threatening. The only government official (nurse) I managed to interview whilst commenting on the issue said,

> "If mother's fail to get access to formal maternity health care, they turn to alternative means which do not always work as it exposes the children and their own health to life threatening diseases like cervical cancer, for mothers as diarrhoea, navel and stomach infections of the baby and even the deadly HIV/AIDS virus well as tetanus for both of them".

Some of the identified solutions to their problems include seeking the assistance of the available untrained midwives, herbalists and that of Johane Marange followers, even if one is not affiliated to that church and these are dealt with in detail below.

As already indicated, some women enlist the help of untrained midwives usually called "grannies" by the community. During a general discussion with Anglican *ruwadzano* women, they referred to them as grannies and not midwives. Although women considered this an effective way of dealing with the distance problem, it is risky since these people are not professionals in the field. These midwives do not have the necessary equipment for them to perform their work. Women are dying in the hands of these midwives during or just after delivery due to a variety of reasons like excessive bleeding, infections and failure by the midwives to deal with complications. During a general group discussion at the clinic I learnt

that one woman from village three died after giving birth with the assistance of the midwife. A broken piece from a clay pot was used to enlarge the birth canal since it was deemed to be small for the baby to make a safe exit. The woman died whilst giving life to the nation.

Socialisation also plays a big role in pregnant women choosing these women as their midwives; they are supposed to conform to societal expectations. As a result they end up as "giving-selves", even if it is not in their best interests as they strive to "obviate the danger of", (as argued by West, R as cited in: Becker, M et al 2007) not conforming to the societal expectations.

These midwives charge for their services but this does not bar women from seeking their assistance despite the fact that the same and sometimes better services are offered at the clinic. During the *ruwadzano* group discussion I learnt that the payment is made in the form of a goat usually a she goat and if there is no she goat then a he goat and a hen, two kgs of sugar, 750ml cooking oil, two bars of green soap and 750ml of paraffin.

Herbalists also play a very significant role in ameliorating women's plight after they fail to access maternal health care as some women during the discussions indicated that they visit them for maternal health care assistance. Most of them are not midwives and are generally women, although I also saw two male herbalists. Maternal health care at the clinic is free but women choose to seek the assistance of the herbalists who charge a fee for their services and they also buy their herbs. This is convenient for them since they do not have to walk the long and tiring distance to the clinic. There is also more privacy consulting them than there is at the clinic. Women claim that it is convenient for them to visit herbalists unlike their going to the clinic where they will not be sure whether or not they would be attended to. This came out during a discussion with the Anglican *ruwadzano* women.

As already indicated, some women would prefer visiting the Apostolic Sect for their maternal health problems. I learnt during an interview that there are also untrained female midwives in the church and an eighty four year old midwife is one of them. I visited her and observed her performing one delivery. The woman gave birth whilst lying on a piece of black plastic; the midwife wore no protective clothing. Fortunately she had a new razor blade but she tied the child's navel with a twine string. She gave the child some coke and she explained that it was meant to cleanse the baby's stomach. It was alleged by some women interviewed that

apostolic sect midwives anterior fontanelle known as *nhova* in the vernacular. They actually referred to them as experts in the area.

## 4.5 Religion, Tradition and Culture, as Confusion Causes

In its MDG 2010 Report on goal number five, the GoZ indicated that `health services are organised in a manner that fails to address the religious concerns and beliefs of certain faith groups', as a result of which people will shun the services including women in dire need of maternal health services.

The third assumption was that religion, tradition and culture are also obstacles to women's access to maternal care. It came out during the research that not all religions, culture and traditions deny women to access maternal health care. Religion, tradition and culture affect how rural women react to the issue of accessing maternal health facilities. Initially, I thought these were impediments to women's exercising their right to maternal health. Whilst in the field I realised that most of the women do not see them as such but that is what is supposed to be done although from my own perspective they remain impediments. These shall be discussed in the following sequence religion first and then tradition and culture will be dealt with together.

### *4.5.1 Religion*

As far as religion is concerned, the major sect is the Johane Marange sect which is the dominant religion in the area. Followers of this sect are not allowed to seek medical care and women are not spared. In an interview with a Johane Marange midwife, it was indicated that holy water, prayers and fasting are the ways in which the church members are healed and not visiting health institutions. They are told that seeking medical attention is demonic, hence, they shy away from these medical institutions. One Johane Marange follower during a group discussion said that she was suffering from a uterus infection but she could not visit the clinic because of the dictates of the church. Although some church members seek maternal health care she could not as she risked being divorced. She had valued her relationship with her religious institution (as argued by relational feminism) more important than going to the

clinic. They give birth at their places they call *chitsidzo*[22], which consist of small wooden, grass-thatched huts as was indicated by these women in the same group discussion.

During a group discussion with the male leaders of the church known as *sadare* I learnt that in this sect men make up the rules and women are not permitted to question them; in other words, if the men ask the women to jump, they are only permitted to ask: "How high?". In this sect, women are seen as "the other" whose meaning for existence is determined for them by men, as argued by Simone de Beavoiur. The women gate keepers were also interviewed and they seemed very comfortable with the arrangement. In the same discussion with Johane Marange women it came out that although some women are not comfortable with the dictates of their religion, they still feel bound by them as they cannot do anything since they are told to be submissive to their husbands and they entirely depend on them, thus internalising the view that they are inessential. Instead of arguing and fighting for their rights, they are passive. They value relationships for fear of being divorced as expounded by West. It takes courage to defy some of these 'must does' since such defiance will lead to excommunication if discovered. One couple I interviewed is very progressive. Despite being members of this church, they sought medical intervention when the wife was pregnant. The husband commented:

> "I am still bound by the traditional position whereby I would visit medical institutions for medical assistance then repent from the so called evil deed .We decided to ignore the sudden shift of position of church principles without any explanation because of bureaucratic arrangements. We need a Liberalised approach towards the issue of medical attention including the maternal health care. A rigid approach will not solve anything but causes unnecessary loss of lives".

### *4.5.2 Tradition and Culture*

Section 23(3) (b) of Zimbabwe's Constitution provides for the supremacy of culture. This provision lets down women as most cultural beliefs operate to their disadvantage. In this case, some families do not seek maternal health care because of their beliefs in culture and if a woman marries into a family she becomes bound by the family culture or tradition. At times

[22] It can loosely be interpreted as an oath. To them it is a place where women fulfil their oaths of bearing as many children as possible for their husbands as per the word of God which requires them to multiply.

socialisations also have a bearing. For instance, in the case of my sister in law whose mother instructed our family not to take her to any medical institution for her delivery, all her sisters and aunts I know survived their pregnancies without visiting the clinic for services. I later understood that it was their tradition.

## 4.6 Inadequacy of the Legal Framework

My fourth assumption was on whether or not The Public Health Act and The Reproductive Health Policy adequately cater for the needs of rural women before, during and after pregnancy and whether or not they complied with the ratified international instruments. I had to modify this assumption by looking at other legal provisions covering maternal health, thus, instead of limiting myself I later broadened the legal framework. The legal framework governing maternal health care is not adequate. One would expect to find the right to maternal health care covered in the Public Health Act, which is the main act concerned with health care. Its surprising absence from the said Act is a blow to women's right to maternal health care taking into account the fact that maternal health is a matter of life or death. Provisions are made for diseases which are not even life threatening. As if that were not enough, it is provided for in other pieces of legislation, plans and strategies which are by nature not enforceable, thus *"women's suffering for one reason or the other is outside the scope of legal redress"*, (West, R.L. as cited in : Becker, M. Et al 2007). Women are treated as the other (existentialist) as their pain is not felt (relational) hence the omissions of the right to maternal health care from enforceable pieces of legislation. Women have no legal recourse in the event of their right to maternal health care being violated.

By omitting the right to maternal health care from the bill of rights, the constitution resembles the racial discrimination and the oppression that was there during the colonial era. As aptly stated by Scott A et al, (2007),

> *"A constitution containing only civil and political rights projects an image of truncated humanity symbolically but still brutally, it excludes those segments of society for whom autonomy means little without necessities of life".*

Maternal health care falls within the category of these omitted rights thus denying women something which is necessary for their life to go on. Recognising maternal health care as a right ensures the realisation of the right.

## 4.7 Will Compliance with International Instruments Change Women's Plight?

The fifth and final assumption was about whether or not rural women's right to maternal health can be achieved if the duty bearers comply with the international instruments by recognising women's right to maternal health as a right, building more resourced clinics and embarking on consciousness raising of the right holders on the importance of accessing maternal health care. The first sub-assumption has already been dealt with extensively and will not be looked at again. The second sub-assumption will be looked at under what needs to be done if rural women are ever going to exercise their right to maternal health in the following chapter. Concerning the last sub-assumption, I realised whilst in the field that it is not only women who needed to be educated on the importance of seeking maternal health care. These women do not live in a vacuum. Men are part and parcel of their lives and they have much influence on women's decisions. It is best that their awareness about the issue is raised so that they may learn to change their perceptions religiously, culturally, or traditionally. It is a fact that as women we cannot run away from our male counterparts in society as long as we are married to them.

## 4.8 The Duty Bearer - Watching and Enjoying the Film?

Although the government is failing women in some respects (e.g., providing them with adequate maternal health care facilities), it is making efforts to try and improve the situation in others, e.g., by engaging in programmes such as the Health Transition Programme (HTP). The government is relying a great deal on donor funding especially in the health sector. This was confirmed by the Parliamentary Committee when it noted that the government was not paying much attention to the health sector and simply leaving it to the donors[23]. The committee further indicated that 98% of the drugs were donor funded and only 2% was

[23]http:// www.financialgazett (accessed03.02.12).

provided by the government. It therefore lacks the resources but this does not absolve it from its obligations.

The government in its efforts to improve the health delivery system set up the Health Transition Fund (HTF) in 2011 with the governments of Canada, UK, Ireland, Sweden and United Nations and European Union partner agencies. It is best described as a multi-donor transitional financial mechanism meant for the revival of health sectors. The HTF is as a result of the National Health Strategy. Under this the government is receiving money from the associates to be channelled towards maternal health. Recently, the European Union granted the government an amount of 4million Euros in support of our failing health sector[24]. The funds are intended to eliminate user fees for women and children. It is expected that this will save more than 30 000 lives of pregnant and infants. Under the HTF, according to the 2012 national budget, the government had already received US$435 in the 2011-2015 phase.

In its 2012 budget, the state through the Minister of Finance allocated 15% of the moneys to health and in compliance with the Abuja Declaration. However a further look at the money reveals that the government contributed 7% with the donors contributing 8%. Ten million is meant for maternal health care. The budget is a very positive step in the improvement of the health delivery system. Clinics and hospitals were allocated some moneys meant for refurbishments and such like. Rusape General Hospital which is a district referral hospital has been allocated an amount of US$2,400,000. It is very unfortunate that although the government is aware that clinics needed some funds, there are no funds set aside in the budget for clinics alone. They are treated together with other health institutions. The government should have given preference to rural clinics which are currently 'empty'. Nyamidzi clinic is literally at 'ground zero'.

It is also receiving money towards the revival of the health sector from the Department for International Development (DFID). For instance the DFID injected an amount of $120m towards child and maternal health in our country[25], courtesy of the government's efforts in improving the maternal service delivery. How that money is going to be distributed is another issue which needs its own research but at least the government is doing something positive.

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[24] Daily News 01.03.2012 and Herald 07.03.2012.
[25] The Standard 19- 25.02.2012.

## 4.9 Conclusion

Zimbabwe is still very far from realising women's right to maternal health care by failing to provide accessible, acceptable, and available and quality health facilities, goods and services. Chapter 5 which is the final chapter will look at the necessary interventions in the form of a detailed action plan.

# CHAPTER FIVE

# 5.0 CONCLUSIONS AND THE WAY FORWARD - *GETTING FROM HERE TO THERE*

## 5.1 Introduction

The study shows that most women are aware that they should seek maternal health care from professional health carers but they face different challenges attempting to do so. The State has failed to provide a conducive environment for the exercise of the right to maternal health care. This chapter gives the possible interventions that are required so that the right to maternal health care becomes real to the women in Romsley.

## 5.2 Conclusions

The first assumption was that women in rural areas face challenges in accessing maternal health care. These included walking long distances to the nearest health institution. In Romsley most women have to walk long distances; for instance those who stay in Village One have to walk up to 25km to Nyamidzi Clinic.  This is not easy for pregnant women. once at the Clinic, the women spent many hours if not days at the clinic waiting to be served and they are sometimes forced to seek overnight accommodation at houses near the clinic. As if that is not enough most women are not financially stable to meet ancillary expenses since they do not have any reliable source of income. Taking all these costs into account it cannot be said that maternal health care is really free.

The second assumption was that women in rural areas resort to unsafe methods of delivery because of the challenges they encounter in accessing maternal health care. In Romsley, it had been shown that women would seek the assistance of untrained midwives, herbalists and the prophets. These coping mechanisms are not always safe for them. During a discussion it emerged that one woman died just after delivery because the untrained midwife who assisted her failed to cope with the complications of the delivery since she had no expertise nor the necessary apparatus.

In making their decisions on whether or not to seek maternal health care, religion, tradition and culture also play a significant role. This was the third assumption which stated that religion, tradition and culture also constitute obstacles to women's access to maternal health care. Most women do not seek maternal health care because of their cultural, traditional and religious beliefs. For example women who are followers of the Johane Marange sect in Romsley do not seek maternal health care because to them it is demonic.

The fourth assumption was that the PHA and the RHP do not adequately cater for the needs of rural women before, during and after pregnancy and does not comply with the ratified International Instruments. The PHA, despite being the main act dealing with the public's health, is silent on the right to maternal health which is extensively provided for in the RHP. Therefore the PHA does not comply with the ratified International Instruments whilst the RHP is in compliance, the only challenge being that RHP is not enforceable. The final assumption was that rural women's right to maternal health can be achieved if the duty bearers comply with the ratified Instruments. More on this will be discussed under recommendations.

## 5.3 The Way Forward: "Getting from here to there"

The recommendations will be given below in the form of an action plan.

**Goal:**
Making the right to maternal health care a reality for rural women.

**Objective:**
To increase or improve access to skilled delivery care. Complications might occur during delivery and it is necessary to have a skilled midwife or doctor available to avoid the unnecessary loss of lives. Women in Romsley live far from obstetric care and other emergency treatment. In Romsley the nearest hospital is 80km away which is inconvenient for women.

**Targets:**
Untrained midwives, Ministry of Health and the Ministry of Finance and the community.

**Activities:**

Untrained women who are already assisting pregnant women should be properly trained and become equipped with midwifery skills. They should also be given a salary. The government should unfreeze the medical posts. There is a need to mobilize the community to increase the demand for the use of maternal and neonatal services through mass media and group discussions.

**Anticipated Challenges:**

This is not an easy task as there might be resistance from the untrained midwives since it is their immediate source of income. Training them can also be problematic because of their advanced age and they might not be able to acquire a working knowledge of all the technical principles involved in advanced midwifery. In addition these people survive on subsistence farming and gardening and they might not see it worthwhile to give up their present daily activities for the training in a skill from whose practice they might not be able to secure them a regular income. The targeted ministries might have no funds for such activities.

**Evaluation:**

Educational refresher courses on midwifery skills and seminars should be held to discuss suggestions on how to overcome challenges encountered. Presentations will also assist.

**Objective:**

To give the right to maternal health care the status of a Constitutionally-protected human right through legal reform, i.e., by amending the Constitution. In other words the right should be enshrined as a human right in the Constitution so that it becomes justiciable and be capable of protection in a court of law. This has worked in other jurisdictions and it might also work for the Zimbabwean rural women. The available RHP must be implemented.

**Targets:**

Parliament, Women's Caucus, Political parties, the community, MOHCW, NGOs, the Judiciary.

**Activities:**

This objective will be accomplished by lobbying for the constitutionalisation of the right to maternal health care and/or its incorporation in the PHA. Members of the judiciary should receive training in order to be more liberal and gender sensitive.

**Anticipated Challenges:**

Although legal reform is expensive, the constitution-making process which is underway has already received funding of between US$38 and US$42 million. The issue here is not about the lack of finance but rather the lack of political will. In view of the fact that men still outnumber women in the judiciary, the institution might be reluctant to enforce the right.

**Evaluation:**

Checking the number and progress of cases involving the right to maternal health care through the legal system. Visiting the rural community and inquiring whether or not the law is being implemented.

**Objective:**

Improving the physical and economic accessibility of the clinic.
Rural women fail to access the clinic mainly because of the distance they have to walk to reach it.

**Targets:**

The MOHCW, Ministry of Transport and Ministry of Finance should work hand in hand for these objectives to be achieved.

**Activities:**

The MOHCW should construct a well-resourced clinic/s no further than 8km from the community/ies it is/they are required to serve (in accordance with the Health Strategy). It should buy more ambulances to cater for emergencies and allocate Nyamidzi clinic a station ambulance. It would assist women a great deal if their clinic/s are within a reasonable walking distance from their homes. The Ministry of Transport should properly maintain all roads within the area and to and from the clinic/s and referral hospital so that women are able to travel to and from it/them quickly and safely. There is a need to improve the road network

generally so that more transport operators are encouraged to serve the area. Healthy competition between them is likely to keep the cost of fares affordable for women who use them to and from the clinic/referral hospital. A good road network will also help to eliminate life-threatening delays encountered during emergency trips to or between health facilities.

**Challenges:**

Lack of funds. It could be argued that finances are available but should be re-allocated to the realisation of this crucial human right. Also controls should be improved to prevent the misappropriation of funds. Funds could also be raised by the Ministry of Transport from its tollgate revenue. In addition, assets lying idle at health and transport ministries could be sold to raise revenue for the said activities.

**Evaluation:**

A follow up should be made by independent NGOs or an independent committee to which the two ministries are accountable. They should be subjected to effective punitive measures for failing to perform their mandate.

**Objective: Consciousness-raising and women's empowerment**

There are other cultural, traditional and religious practices which need critical transformation if women are to be seen as maternal health care right holders. Both men and women should be educated on the dangers of not seeking maternal health care. Women also need to be empowered. A conscientisation approach that emphasizes solidarity and purpose among women with similar problems …..in order for women to give each other strength and courage ( Tsanga A.S:2003 p112), is a necessity.

**Targets:**

This should be done by NGOs, MOHCW and other individuals who are enlightened on the issue.

**Activities:**

Increasing public awareness of and men's participation in safe motherhood programmes. This can be done through mass media, posters, seminars, popular theatre, and discussions especially at the clinic, and cartoons, songs, pamphlets in the vernacular as well. Same sex

group discussions should be done since I found out during the research that women open up if they are on their own. The same organisations and ministries can source money for these women so that they can embark on income generating projects in order to encourage them to become economically dependent. This will enable them to meet the ancillary medical expenses required when they seek maternal health care.

**Challenges:**

There might be resistance by the community. It is difficult to convince someone about the dangers of not seeking maternal care because of different religious, traditional and cultural beliefs. The NGOs, and the MOHCW might fail to source money for the women.

**Follow up:** There should be a team which oversees the projects these women will be doing and how the proceeds are being utilised. This can be done by an effective system of recording all the transactions. Continuous sensitisation through drama, workshops or discussions.

**Objective:**

Improving access to quality antenatal and postpartum care.

Quality antenatal care provides for the screening and treatment of diseases like anaemia and the detection of hypertension whilst quality postpartum care involves quick detection and the management of complications that may occur after delivery.

**Target:**

MOHCW as the main duty bearer and women.

**Activities:**

Women should be told to where to seek assistance during the antenatal period and should be given information about healthy practices. After delivery, they should be counselled to ensure that they will be able to manage their health and that of their babies. It is also at this stage where a mother should be taught about the dangers of not breastfeeding her child, not taking them children for immunization treatment and the importance of family planning. Resuscitation of Community Based Distribution systems and construction of more waiting shelters are some of the activities that might be carried out to achieve this goal.

**Challenge:**

Some women do not visit the clinic and it will be very difficult to counsel them since, because of their religious, political and traditional beliefs, they might be unco-operative.

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