

**THE IMPLICATIONS OF THE  
CURRENT ECONOMIC CRISIS ON THE RIGHT OF PREGNANT  
WOMEN TO MATERNAL HEALTH IN ZIMBABWE. A CASE  
STUDY OF HARARE HOSPITAL**

**Abstract**

**This dissertation examines the extent to which the current economic meltdown of the Zimbabwean economy has impacted upon the human right of pregnant women to enjoy good health within a large government hospital. The writer utilizes several gender-centred methodologies (especially the Women’s Law, Grounded Theory and Human Rights based Approaches) and complementary data collection methods to gather and analyse relevant written and verbal evidence of the deplorable extent to which the State is breaching its duty to realize its patients’ right to good health. Some breaches are so serious that they even result in death. Having determined the traumatic nature of the ‘lived realities’ of these poor and often ignorant patients, the Women’s Law Approach also looks to these same women for their suggestions about possible solutions to their lamentable predicament. Their answers form the basis of a multitude of recommendations and reforms which, the writer finally suggests, should be implemented by the Government in co-operation with the NGO community and in conformity with its obligations under several binding/persuasive regional and international HR instruments.**

**BY**

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## **Dedication**

*To the men in my life my father Manatsa,  
my brother Dzingai, my son Tadiwanashe  
and my husband Terence.*

*Thank you for being there for me throughout this period and for giving me the courage  
to believe in myself and my capabilities.*

*For my mother Gladys who is the best mother that anyone could wish for. Thank you for  
being the woman that you are and will always be to me. Your love grows stronger with  
age. Thank you*

*To my sisters Primrose, Margaret, Melody, Delight and Phyllis. Let us always be there  
for each other.*

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## **International Instruments**

The International Covenant on Economic, Social and Political Rights

The African Charter on Human and People's Rights

Convention on the Elimination of all Forms of Discrimination against Women

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa

Gender and Development: A Declaration by Heads of State or Government of SADC

## **National Legislation**

Constitution of Zimbabwe

## **Definition of Terms**

**Availability of Care** means that for functioning health system facilities, goods and services as well as programmes should be available in sufficient quantity and these include trained medical personnel, health facilities and materials needed for the functioning of the health sector.

**Accessibility of Care** means that the health facilities should be physically accessible by the availability of ambulances and other forms of conveyance to hospital and the availability of road networks linking the health institutions. It also means that women do not have to travel long distances to get to a hospital or clinic.

**Affordability of Care** means that the services provided by the health providers should not be so expensive that women cannot afford and stay away as a result of the cost.

**Acceptability of Care** means that the care provided must be respectful of medical ethics and culturally appropriate taking into account the needs of women and accepting their differences.

**Midwife** - a specially trained nurse who specializes in maternal health or assisting women in delivering children.

**State Registered Nurse** - a health care professional with basic medical training not specialized training to assist during birth.

# CHAPTER ONE

## 1.1 INTRODUCTION

Zimbabwe has been in the grip of an economic meltdown since 2000 and the situation has been getting steadily worse. In 2000 the government and war veterans embarked on the fast track land reform whereby land was taken from the white minority and given to the black majority to reverse the land grabbing by the whites during the colonial period. The exercise was not condoned by most of the European states especially the British who felt that the rights of the whites were being violated by the manner in which the land was grabbed without compensation and they were given too little time to wrap up their affairs. As a result there was widespread condemnation of the government and the government lost support from the international community and donor support started to dwindle. The economy began to melt down with a lack of productivity in most of the sectors and the quality of life for the average Zimbabwean deteriorated.

There have been attempts to turn around the economy but as a result of the “sanctions” imposed on the country by the west, the economy has not recovered and has continued on a downward spiral which has become quite uncontrollable. The International Monetary Fund and the World Bank have pulled out of the country and no financial help is forthcoming from them. This has resulted in a critical foreign currency shortage that has affected the whole economy as the industries cannot find foreign currency to source raw materials and this also means that there is no money to import drugs for the hospitals and the local producers have no raw materials. Most of the foreign currency in existence is on the parallel market and the rate of exchange goes up on a daily basis. In order for business to survive the owners now quote their products in foreign currency especially the US dollar in order to remain viable. The year 2007 has been termed by many as the most difficult year for the people of Zimbabwe as inflation continued to rise.

The inflation for Zimbabwe reached a maximum of 66 000% in December 2007 from 26 000% in November 2007 and by January 2008 had reached a record 100 000% and



the prices of goods and services rose to unprecedented levels such that most people in Zimbabwe could no longer afford. In an effort to cushion the people from the rising inflation the government introduced price controls on all basic commodities in June 2007. As a result of this measure the stock in the supermarkets was sold out and the supermarkets no longer put anything new on the shelf and were virtually empty. There was the emergence of long queues for all basic commodities and people relied on the black market where they still bought the goods at very high prices.

Most people in the country started to rely on products from outside the country like South Africa and Botswana and if they were sold in the country their prices were not controlled. There was also a cash crisis from November up to the end of December which increased the number of queues that could be seen around the city as people started queuing for money from as early as 3 in the morning in order to get \$5 million (USD\$0.025) which was not enough to buy anything. As a result of all these problems a lot of the professional people in the country, especially those employed by the state, left for greener pastures in neighboring countries as they were not being paid a living wage. The health institutions were not spared the brain drain and most of them were left with skeleton staff.

In the midst of all these problems, the pregnant women in the country could be seen standing in queues like everyone else in order to get something to eat. There was even a shortage of nappies as their prices had been controlled as well. Even though the government had controlled the prices of goods the price of medical care continued to rise and there were stories of people being turned away because of a shortage of doctors and medicine. During this time there was a rise in incidences of water and power cuts around the country with some places going for months without water.

## 1.2 WHY THE TOPIC?

I chose the topic because during the course of the year I had been hearing stories from women who had given birth and they hardly had anything good to say about the hospitals. A woman who had given birth at local clinic, whom I met at church in Glen View, narrated how she had to take 20 liters of water and 3 candles to the clinic to the clinic as there was no water and the candles were in case there was a power cut. This led me to want to find out what the situation is like in the hospitals if they have the same problems of water and power cuts. The economic situation is affecting every facet of life and I wanted to find out how the pregnant women were coping. Women who are pregnant need a special diet and they also need special care in terms of being monitored by doctors or by nurses. There was a rise in the cost of transport so that in order to get the required visits at the clinic women needed a lot of money which most of them could not afford.

Generally the standard of living of the people had deteriorated to such an extent that most of the people were poor and even those who were employed were just a pay check away from poverty as they had no money to make savings therefore lived from hand to mouth.

I also had a personal experience in the hospital when I gave birth to my son in May 2004. I gave birth at a private clinic in Glen View but my son had complications and I had to be referred to Harare Hospital. I arrived at the hospital around 11 in the evening and was only given a bed after 2 am in the morning. My son was only attended to at 12 midnight as that was when the doctor showed up. It was the winter season and it was very cold and my son had a cold for two months as a result of that night. When I heard people say that the situation was bad at the hospital I could relate to that and I developed an interest to find out just how bad the situation had become for women. I wanted to do the research as a contribution to the voices of women who have no power

to change the situation but who are affected by the economic situation much worse than anyone else.

### **1.3 WHY HARARE HOSPITAL AS THE LOCATION OF STUDY?**

When I first started the research I intended to look at 3 government hospitals Harare, Parirenyatwa and Chitungwiza hospitals and also some local clinics especially in Mabvuku/Tafara as that was where the water shortages were most prevalent. Also I felt that if I looked at all of these health institutions it would give me a diverse view of the problem facing health providers in the country. A number of institutions would also give a comparative analysis of the problems faced by women according to location for example women at Parirenyatwa are more affluent than the women likely to be found at Harare Hospital. The government runs the hospitals while the local clinics are mostly run by the city council so that their problems are likely to be different and my research would benefit from that analysis.

When I went to look for permission to go to the hospitals from the Ministry of Health Permanent Secretary I was granted permission to go to Harare and Parirenyatwa Hospitals only and Chitungwiza was not included. I went to the city department of health at Rowan Martin Building and I left my application that was never replied to for the duration of the research. When I left the application the secretary told me that the city was not allowing anyone to do research because there were no nurses at the clinics and it turned out to be true as they did not respond to the application.

I then went to the hospitals and I was told that I had to seek permission again from the hospital administration before I could do the research. I was granted permission to Harare Hospital but was denied access to Parirenyatwa so I ended up having only one hospital to look at. The problem that I had was also with my topic as it dealt with human rights most of the people that I had to seek permission from were wary of the topic as they were not really sure if the government would approve of such a research even if I had the permission of the Ministry of Health.

As a result of the seeking permission at all levels I started the research late as I only managed to gain entry to Harare Hospital on 22 November 2007. This means that my research was limited by time as the research was supposed to be in 4 months but I ended up doing it in less than 2 months.

The fact that I ended up with one hospital also means that I could not do the comparative analysis that I had wanted to do and had to contend with a comparative analysis of the people I interviewed outside Parirenyatwa who gave me the situation in the hospital but I had no information from the staff at the hospital. It also means that I had to change my focus from the Harare area to just Harare Hospital and this limited the research that I wanted to do.

#### **1.4 STATEMENT OF THE PROBLEM**

Giving birth has become a nightmare for women in Zimbabwe especially at government hospitals where the quality of care has deteriorated and is no longer acceptable to most women. The government has an obligation in accordance with human rights instruments to protect the rights of women and to improve their quality of life. The standards that I used to analyze the problem have been set in the international instruments and were aptly summarized in a book titled *Claiming our Rights Surviving Pregnancy and Childbirth in Mali* (Katsive L, Djourte F 2003) and this book gave me a starting point of what the problem is for women and what the government needs to do in order to guarantee the rights of women. The book analyses the concept of availability, accessibility, affordability and quality of health care that is supposed to be made available to pregnant women.

The availability of health care is the provision of health care facilities with all the essential equipment and materials and trained personnel at birth for pregnant women. It showed how the lack of health facilities has resulted in women not having access to

prenatal care as the number of health facilities is inadequate. The book also shows the problem of the shortage of materials especially essential medicines for emergency obstetric care in the health centers available and the impact that the shortage has on the availability of care for pregnant women. With the brain drain of professionals the problem of trained personnel also existed as a problem to be analyzed in the way that it affects pregnant women in Zimbabwe. I then used this to analyze the situation in the country and how this is affecting pregnant women.

Accessibility of health care looks at the fact that services should not be denied on a discriminatory basis and health facilities should be physically accessible and information about those facilities should be easily available (Katsive L, Djourte F D 2003: page 42). In the formulation of the assumptions this was taken into consideration as some of the problems that women in Zimbabwe face in their efforts to access maternal health care from the various health care facilities. The book raises the problem of how women wait to access health facilities until the last minute and this provided with a question as to why women in Zimbabwe also wait to access health facilities and who is to blame for the lack of access of maternal health care.

Acceptability of care is an assessment of whether the women are satisfied with the care provided and if it conforms to the medical ethics and is culturally appropriate and sensitive to gender and life cycle requirements. This is an attempt to look at how the health providers treat the women when they are at the hospital and whether the women accept the treatment by the health providers. This provided a basis of what to look for when I went on the ground to do the research as well as in the formulation of the assumptions.

Quality of care provides that health facilities, good and services must be scientifically and medically appropriate and of good quality. This provides a basis for the evaluation of the care provided by health facilities and the way it is received by the women that are being cared for. Health facilities need constant assessment to find out if the care is still adequate and there is also need for training of health providers and regulation of the

conduct of the health providers so that they act within the parameters of those regulations.

The research is also an assessment of Harare Hospital: the findings point to how acceptable, available and accessible the hospital is to pregnant women in need of maternal health in the light of the economic crisis in the country and how the hospital has reacted to cushion pregnant women against the effects of the crisis, if they have made any effort at all. It is from this premise that the assumptions, objectives and the research questions were formulated.

## **1.5 OBJECTIVES OF THE RESEARCH**

- To find out the impact of the water shortages on the quality of care accorded to pregnant women at public hospitals.
- To find out the impact of the shortages of essential medicines on the quality and availability of care for pregnant women at the hospitals.
- To find out the impact of the shortage of personnel on the quality and availability of care for pregnant women.
- To find out the impact of the shortage of equipment on the quality and availability of care available to pregnant women.
- To find out to what extent the cost and availability of transport has impacted on pregnant women's access to public hospitals.
- To find out the impact of the cost of healthcare in public hospitals on pregnant women's right to access ante-natal care.

- To find out the impact of the food shortages on the quality of care provided by public hospitals.
- To find out the impact of the electricity cuts on the quality and availability of care for pregnant women.

## **1.6 RESEARCH ASSUMPTIONS**

- ❖ The current water shortages have not only affected households but have also affected the public hospitals impacting on the accessibility and quality of care provided by public hospitals and clinics for pregnant women.
- ❖ The cost of primary health care has become prohibitive for many pregnant women so that women's access to public hospitals is limited.
- ❖ The economic crisis has impacted on the quality of care provided by public hospitals as they face food, medicine and staff shortages and these shortages impact on the care provided to pregnant women in these hospitals.
- ❖ Pregnant women's visits to public hospitals are limited by transport costs so that complications are not dealt with in time compromising women's right to health.
- ❖ Public hospitals also face power cuts impacting on the accessibility of the hospitals and clinics by pregnant women.

## **1.7 RESEARCH QUESTIONS**

The study had the following questions emanating from the assumptions

- What effect has the water shortages had on the health sector and how has it affected the accessibility and quality of care provided by public hospitals?

- How has the food shortages affected the quality of care provided by public hospitals?
- What impact has the economic crisis had on the availability of medicine at Harare Hospital and how has it affected the quality of care provided by the hospital?
- What impact has the shortage of equipment had on the quality and accessibility of care for pregnant women at Harare Hospital?
- What impact has the brain drain of health personnel had on the accessibility and the quality of care provided to pregnant women at Harare Hospital?
- What impact has the rising cost of healthcare had on the accessibility of Harare Hospital by pregnant women?
- What impact has the transport cost to and from the hospital had on the accessibility of the hospital by pregnant women?
- What impact has the rising incidences of power cuts had on the accessibility of the hospital by pregnant women?

## **1.8 STRUCTURE OF THE DISSERTATION**

The dissertation will be structured as follows:

**Chapter One** deals with the introduction of the topic and the reason the topic was chosen. It also looks at the statement of the problem and the problems faced by women in attaining the right to health.



**Chapter Two** deals with the literature used to further the understanding of my research as well as the arguments advanced by the different authors. The chapter also deals with the human rights instruments and the national frameworks that provide the right to maternal health.

**Chapter Four** deals with the findings as they relate to the initial assumptions that inform the research.

**Chapter Five** deals with the analysis of the findings and how the State is responding to the situation in the hospital. It also looks at the responsibilities of the State according to the international Human Right (HR) instruments and how the instruments are being implemented.

**Chapter Six** is the conclusion and the recommendations that are needed which emerged from the findings.

## **CHAPTER TWO**

### **2.0 LAW AND LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter looks at the human rights framework that informed the study and how they capture the rights of pregnant women to maternal health. It also discusses the national framework that provides women's right to maternal health or the lack thereof.

#### **2.2 HUMAN RIGHTS FRAMEWORK**

The research was premised from a human rights background where I was looking at the right of women to healthcare as provided for in the international and regional instruments. Human rights provide for minimum standards of care that are supposed to be implemented by governments so that the care is acceptable, available, affordable and accessible. It was from this premise that I started the research where I wanted to find out to what extent the government is implementing or violating the rights of pregnant women to healthcare. Women have a right to survive pregnancy and the human rights framework provided me with an opportunity to look at how things are on the ground as compared to what they should be. The framework also helped me to appreciate that states are obliged to undertake steps to the maximum of its available resources with a view of achieving progressively the full realization of the rights recognized in the conventions (Matsheza P, Zulu L 1997: page 13) and this means that the state has the duty to allocate the resources necessary to the best of its ability. This can be used by States as they can always argue that they do not have the resources to fulfill their obligations especially in the context of Zimbabwe, which already is suffering an economic crisis. The human instruments are designed to give an indication of areas of priority areas, such as health services, to which resources should be allocated.

The instruments I referred to were:

The African Charter on Human and People's Rights article 4 which provides that

“human beings are inviolable. Every human being shall be entitled to respect to respect for his life and the integrity of his person.. No one may be arbitrarily deprived of this right.”

This instrument was used in so far as it provides that the lives of women should be respected and held above all else and it follows that women should not lose their lives for no justifiable reason and all measures should be taken to save their lives.

The Convention on the Elimination of All Forms of Discrimination against Women provides a basis for the rights of women as it is the first instrument to expressly guarantee women the right to equality. Zimbabwe is signatory to CEDAW and therefore is bound by the provisions of the convention. Zimbabwe ratified the convention 13<sup>th</sup> May 1991 without reservations thereby agreeing to pursue active measures to eliminate discrimination against women.

Article 12(1) provides that

“States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care.....on a basis of equality with men and women, access to healthcare, including those related to family planning.”

This article provides for equality of access to healthcare between men and women and can be criticized for not taking into consideration the fact that women have special health care needs that men are not ever likely to have.

Article 12(2) provides that:

“notwithstanding the provisions of paragraph 1 of this article states parties shall ensure to women appropriate services in connection with pregnancy,

confinement and the post-natal period , granting free services where necessary , as well as adequate nutrition during pregnancy and lactation.”

The Convention also provides under article 2 that:

“ State parties condemn discrimination against women in all its forms.”

This means that states have an obligation to eliminate discrimination and make sure that women enjoy benefits on a basis of equality with men and also take into consideration the special needs of women that have led to their discrimination in the past.

The article deals specifically with the matter of the cost of health care and provides that the state should provide free services where necessary and I felt that this had an impact on the situation in the country where the cost of health care was going beyond the rights of many. It also shows that the state has the responsibility to grant women the minimum standards set out in the article.

The International Covenant on Economic, Social and Cultural Rights provides under article 12(1):

“the state parties to the present Covenant recognize the right of everyone to the enjoyment of the highest standard of physical and mental health.”

The Covenant provides a framework for identifying if governments are implementing the right to health in the General Comment on the right to the highest attainable standard of health it provides that there are four interrelated and essential elements which are availability, accessibility, acceptability and quality<sup>1</sup>and I used these elements to identify the shortcomings of the health system in Zimbabwe and specifically at Harare hospital.

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<sup>1</sup> ICESCR General comment 14

Article 12 (2) requires that:

- “ the steps to be taken by states .....include
- 1) the provision for the reduction of the still birth and of infant mortality and for the healthy development of the child.....
  - 4) The creation of conditions which would ensure to all medical service and medical attention in the event of sickness”

The covenant grants women the right to the highest standard of physical and mental health and the states parties who are party to this covenant should uphold this. Zimbabwe is party to the covenant.

The Covenant acknowledges that there can be resource constraints but the state still has the obligation to provide the widest possible enjoyment of the relevant rights of food, healthcare, shelter and housing under the prevailing circumstances.<sup>2</sup> This means that the country is not absolved of its duty to provide healthcare for women by the fact that there is an economic crisis in the country or the fact that they claim to face financial constraints.

The Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa provides under article 3 that:

every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights.

This guarantees women the right to be protected and to make sure that their rights are respected and protected by law.

Article 14(2) (b) provides:

State parties shall take measures to..... establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

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<sup>2</sup> ICESCR General Comment No 3

Zimbabwe recently became signatory to the Protocol and is now bound by the terms of its provisions. The Protocol also provides under article 19(f) that states shall take all appropriate measures to:

“...ensure that the negative effects of globalization and any adverse effects of the implementation of trade and economic policies and programmes are reduced to the minimum for women.”

The government of Zimbabwe should take all measures that the economic state of the country's effects is reduced for women in accordance with their obligations according to the protocol.

The Millennium Development Goals 4 and 5 are on the reduction of infant mortality and the reduction of maternal deaths by year 2015. Zimbabwe is signatory to the development goals and is therefore committed to do the minimum requirements so that they can achieve the goals by 2015. At the moment there seems to be not much being done to reduce the incidences on maternal deaths and infant mortality and the current economic situation has made it difficult for the goals to be realized by the set date. In line with the realization of these goals there was the Roadmap for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Zimbabwe that was published in 2007 and shows what actions are to be taken by the government to reduce maternal and neo-natal mortality. More will be discussed in the national framework.

Zimbabwe is also signatory to the Gender and Development: A Declaration by Heads of State or Government of SADC provides the heads of state of the SADC region...

“...As leaders we should spearhead the implementation of these undertakings and ensure the eradication of all gender inequalities in the region...”

They go further to undertake and commit themselves and their respective countries to:

- vi) making quality reproductive and other health services more accessible to women and men
- vii) recognizing, protecting and promoting the reproductive and sexual rights of women and the girl child.

This means that the President is bound by the agreement and should implement the rights of women to reproductive health services so that the country should not be known for just signing agreements that they have no intention of implementing.

Zimbabwe like the rest of the African continent is formally committed to the principles of human rights as provided for in the human rights instruments by virtue of being signatory to these instruments. The country has shown that it is not committed to the instruments in that they have not been reporting on the instruments for a long time and most of the instruments are in arrears on reports due. For CEDAW there was only one report, which was the first report and that was in 1998 and there has not been another report since then. The country is preparing combined second, third and fourth report at the same time and this will be a combined report. The reports are there to measure the compliance of the states to the provisions of the instruments and also to judge their commitment to implementing the provisions. Most of the instruments have reporting procedures

### **2.3 NATIONAL FRAMEWORK.**

There is no right to health provided for in the Constitution or the legislation of Zimbabwe. The Constitution of Zimbabwe is the country's supreme law and any law that is inconsistent with the law is void to the extent of that inconsistency. The Constitution has guaranteed civil and political rights but not economic, social and cultural ones. The Constitution guarantees the right to life for the people of Zimbabwe

and this means that the state should do everything in their power to protect people's right to life and this includes the right of women to life. There is also the provision of freedom from discrimination in the Constitution on the grounds of "race, tribe, place of origin, political opinions, color, creed, or sex". The Constitution has included the right to freedom from discrimination on the basis of sex that affects women more than it does men. It is also consistent with the provisions of CEDAW that guarantees women freedom from discrimination and for my research this guarantees women freedom from discrimination in the field of health. The grounds of discrimination are however not exhaustive as there are other grounds on which women are discriminated against, like pregnancy and marital status.

The Constitution also provides that:

- (a) No law shall make any provision that is discriminatory either of itself or in its effect and,
- (b) no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of public office or any public authority."

When applying the test within this provision to the conduct of the staff at Harare Hospital and the Minister of Health I found it to be discriminatory in that they have formulated a law that women be the cash providers for the entire hospital and that discriminates against women on the basis that they are women and are the only ones who get pregnant. The hospital policy is that women in the maternity wards are to be treated as the money generating part of the hospital and will not be released without paying for the services because the hospital needs the money for its upkeep. The policy operates as a law against the women because they are forced to comply with it and there is no exception to the operation of the policy as women are detained at the hospital for failure to settle their bills and this amounts to discrimination on the part of the women.

The Constitution does not provide for the right to health and this is a weakness that needs urgent attention, as the state has no obligation to provide healthcare for its people,



as it is not a constitutional right. If a person has an issue with the health sector for example of wrongful death in a public hospital the person can only sue the hospital, doctor responsible and the Ministry of Health but not the state even if it is the state which is making the situation not conducive to the provision of health services. Even if the right is provided for in the international instruments the right is not justiciable in the country as international instruments need to be domesticated by an act of Parliament in order to become law according to section 111B (1)(b) of the constitution which states that international instruments:

“shall not form part of the law of Zimbabwe unless it has been incorporated into the law by or under an act of Parliament”

The instruments that are discussed in the human rights framework have been domesticated in part like CEDAW and the African Charter on Human and People’s Rights. This means that it is very difficult for women to have recourse to the law if they feel their rights are being violated, as there is no local law to refer to.

The right to health is contained in the policies from the Ministry of Health that have been put in place. The policy that I found relevant to the research is the Roadmap for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Zimbabwe that was launched by the Minister of health in 2007. The Roadmap shows that maternal mortality is a significant problem in the country and there is need to do something about it in order to fulfill the Millennium Development Goals on maternal neonatal health by 2015. The problem is attributed to shortage of staff, limited availability and utilization of maternal health services, weak referral systems and weak community participation and involvement. The book also shows the estimated amount of money that it will take to revamp the health sector with the help of the international community, and it needs a lot of money especially in the Zimbabwean sense as it is quoted in US dollars. The first phase is from 2007 to 2012 and the second from 2012 up to 2015.

The Roadmap also shows that the recovery of the health sector is not the sole responsibility of Ministry of Health. It is in the interests of all the ministries to contribute to the revival of general health care and in particular the special needs of pregnant women. The Ministries who should take a leading role in this should include the Ministry of Women's Affairs and Gender, Ministry of Information, Ministry of Education, Ministry of Agriculture. NGOs such as relevant United Nations agencies, development partners and the nurse's council should also co-operate. This showed the magnitude of the problem and also that there is a lot of work to be done that will take a long time for the health sector to be fully recovered. The roadmap also gives hope that maybe someday women will have the right to health after the economic crisis is over as it is not a permanent state but something that will pass with time.

## **2.4 LITERATURE REVIEW**

In order to further my understanding of the subject of healthcare I used books and articles that have been used on the subject. The book that I found most useful on the subject is a book titled *Claiming our Rights, Surviving Pregnancy and Childbirth in Mali* (Katsive L and Djourte F. D 2003). This book showed me the dynamics that are involved in the choice that women make to have more children in that it is not their choice alone but they are almost pushed toward pregnancy. There is an illustration of a woman who falls pregnant and dies because she is trying for another boy<sup>3</sup> and dies as a result of pregnancy. The book also helped me to understand that for African states international human rights instruments are ratified but the reality for the African woman is that pregnancy continues to be a life threatening experience and many women are dying from it. It led me to look at the question of maternal mortality even if I had not intended to look at it in my objectives. The book raises the issue of survival for pregnant women showing that it is something that is to be survived and the right of women to life is being violated.

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<sup>3</sup> Page 31

The book also illustrates how the terms accessibility, acceptability, availability and quality of care are used in the health sector by giving examples of how the government of Mali was failing to guarantee the rights of women to maternal health by not guaranteeing these standards set by the CESCRC and also where the government was falling short. This provided the starting point for the research as it provided the issues that I had to raise in order to come up with a conclusive research with a human rights thrust.

Another publication that I found useful is the Briefing Paper (January 2005) called *Surviving Pregnancy and Childbirth. An International Human Right* in which it is stated:

“Women’s reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy but, rather , injustices that societies are able and obligated to remedy”

and goes on to say...

“ holding governments legally accountable for the realization of these rights is a powerful means of overcoming acceptance of death during pregnancy or childbirth as an unavoidable risk of womanhood”<sup>4</sup>

This book showed that even when I was doing my research I should not take things for granted but look at them from a human rights perspective of what should be there and not the reality of what is there. It highlighted the fact that women have accepted the reality that women die and suffer complications as natural as they are not informed of their rights. The government and the international community should be held accountable for the failure to provide healthcare and to implement the right to health for women. The paper also reflects the fact that failure to provide healthcare is also a form of discrimination against women.

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<sup>4</sup> Page 1

The book *Women, Law and Human Rights: An African Perspective* (Banda F 2005) helped me to understand the language of rights and the African continent. The book helped me to understand that there are arguments advanced that rights are the language of the west and that they have been imposed on the continent as a process of othering the African people.<sup>5</sup> This statement helped me to understand the reasons why the people in authority were receiving my research with such suspicion as they felt that I was trying to criticize the government. Even if the international instruments had been the language of the west, the governments of Africa accepted the terms by ratifying the international instruments and that shows a commitment to the language of rights and an agreement to be bound by the provisions. Banda also goes on to explain that Africans have tried to make the conventions more African by having African instruments that reflect the values of the African people by having regional and continental instruments<sup>6</sup> like there is an African Charter for Human and People's Rights and there is the African equivalent of CEDAW in the Protocol on the Rights of Women in Africa. CEDAW had left out issues that were unique to African women and not suffered by western women for example polygyny and widow inheritance and the Protocol on the Rights of Women in Africa included those and also reinforced the rights that were contained in CEDAW so that the African states are still bound. The governments cannot then argue that the values reflected are western as they have embraced the language of rights. This shows that they have acknowledged that they are bound by the language of rights and are therefore bound to implement the provisions of those rights.

I also understood the fact that women in Africa are always taken as victims who need saving in most of the international instruments and I realized that I had also fallen into the trap as the first thing that I had wanted to look at is of women's reproductive roles and their vulnerability as if that is the only role they play in society. I have realized that women during the economic hardships have become quite innovative in ways to survive and some are doing quite well buying and selling commodities. I analyzed again the reason that I had chosen the topic and realized reproduction is not the only role of

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<sup>5</sup> page 44

<sup>6</sup> page 47

women but I am passionate about the subject due to the fact that my giving birth was not very easy and I needed to find out how the situation was affecting others.

The Internet also became a source of information and the articles that I found helped me to understand what has been written by others about the health situation in Zimbabwe and also women's right to health in other countries. I used an article by Grieco M, Turner J entitled Maternal Mortality: Africa's Burden Toolkit on Gender, Transport and Maternal Mortality Vs4- 04-05 which looks at the problem of transport as a contributory factor to the rise in maternal deaths. They state that:

“Reduction of maternal mortality is a matter of organization and part of that organization is the provision of transport facilities and hostel provision for those in need of or likely to need emergency obstetric care.”

This article helped me to understand the relationship between transport availability and the reduction in maternal mortality hence a good transport network is a pre-requisite for pregnant women to enjoy the right to health and the right to life. It related to my research as I was looking at the transport costs and women's access to the hospital as one of my assumptions.

Professor Kasonde of the University of Zimbabwe is quoted and says that:

“In spite of the harsh economic environment prevailing in Africa, the application of appropriate policies by governments would lead to improvement in the outcome of pregnancies irrespective of the economic status of countries.”

And this shows that the economic state of the country has does not mean that the state cannot improve the right of women to health as it is a matter of what policies are in place and what the priority of the government is at that time. This gave me the impression that if the policies of the state had been positive in the provision of health for pregnant women the economic status of the country would not have mattered and there is need for the state to change its policies.

Another article that I found useful is one that appeared in the Mail and Guardian Online on 7 February 2007 and is titled Maternal Deaths become a neglected tragedy in Zimbabwe and featured the story of a woman who had found out that she was carrying dead twins in her womb when she went to the hospital. The article the horror and pain of the woman as a result of that experience. The Minister of Health also comments and says that maternal mortality has been reduced from some 900 cases to 550 and that whoever says to the contrary is ill informed. Another organization provides statistics on the same matter and says that maternal deaths are decreasing from 695 per 100 000 deliveries in 1999 to 555 per 100 000 in 2006 and the decrease is not because of anything has improved but that a lot of women are no longer having children and this means there are fewer babies being born. The article also confirmed what I had found on the ground that a lot of women have simply stopped having children and this may account for the reduction in the maternal mortality rates. The article showed me the disparity of the state information and independent organizations in the information that they provide and the article also highlights the problems for women in Zimbabwe.

An article by the The Standard entitled Child Mortality Rates Shoot up in Zimbabwe<sup>7</sup> quotes Dr Parirenyatwa (the Minister of Health) in a workshop with House of Assembly members on 28 November 2006 in a work shop entitled Every life matters, Every maternal death counts, Save a mother, Save a nation. The Minister was trying to create awareness on maternal and neo- natal morbidity among the members of Parliament and seek their support in finding ways to reduce the death rate. He said that the government considers health a basic human right for all and he also attributes the failure by women to access hospitals to the high medical costs and lobbied the parliamentarians for a free health delivery system so that more women could access the hospitals. The article showed that the minister is aware of the rising cost of healthcare in the public hospitals and is aware of the fact that the costs have led to women not accessing hospitals leading to the rise in maternal deaths. The Minister is the one who is supposed to have given the

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<sup>7</sup> <http://www.google.co.zw/search?hl=en&q=women+right+to+health+in+zimbabwe&btnq=google+search>.

directive that the women who are treated at Harare Hospital be treated as the money generating part of the machine while in this article he sees the need for free services for pregnant women. It showed me the contradictions of politicians who say one thing and do something else.

## **CHAPTER THREE**

### **3.0 METHODS AND METHODOLOGY**

#### **3.1 INTRODUCTION**

Various methods and methodologies were used during the research and they all worked in different ways in shaping the research and the findings that I finally came up with.

#### **METHODOLOGY**

#### **3.2 WOMEN'S LAW APPROACH**

The women's law approach was used as it provides guidelines in capturing women's lived realities and using them as a starting point for the debate on the rights of women to health.

Women's law is a legal discipline which explores the reality of women's lives and from that perspective interrogates and investigates the law. (Weis Bentzon A et al 1998: page 26)

This approach means that women are the starting point so that one has to first listen to what the views of the women are on the particular subject. My starting point had been to assume that women knew they had a right to health and that they had a right to survive pregnancy but I found that women were quite willing to take whatever the hospital was giving them on the basis that they could do nothing about it. I had formulated my assumptions on the basis that there was somewhere where it was provided that women or the people of Zimbabwe had the right to health so that that would be the starting point in the research. There is no law and the constitution does not provide for the right to health so women have no recourse to the law and the basis of the right is international instruments. This meant that in asking women about their rights I had no Zimbabwean law to refer to and they were not aware of the international



instruments so that even if I was referring to rights I was referring to something they were not aware of.

The reality of the women was that they do not know they have a right to survive pregnancy and that what was happening at the hospital was not normal and they had a right to protest. At the same time I was not there as an agitator so the amount of information that I could give to women that they considered important was very limited. The women would be more concerned with finding the money to be discharged than learning that there are instruments that give them the right to affordable healthcare and it became imperative that I find a way connecting with the women and I did that by just letting them talk and guiding them through the issues that I wanted to raise.

The hospital policy and the reality of the women's lives are also far removed in that the hospital assumes that women are better placed to pay their hospital bills and hence they have a policy that the maternity wing was the money generating wing of the hospital. The hospital had not consulted the women themselves about their views if they are able to pay and there was need for them to consult. The women's law approach helped me to find out from the women themselves how the fact that the cost of healthcare was going up and they were required to pay before they were released was affecting them as women. I also was able to realize that policies are made from a male point of view without considering the reality of women who have to live with the policy on the ground. The Ministry of Health had approved increase in the fees without looking at the fact that women in Zimbabwe make up less than 18% of the employment sector and most of them are in the informal sector so that they have no permanent income and there was need for the Ministry to protect them instead of burdening them some more. Although, the informal sector is higher paying than the formal sector these days women who are the bread winners in the family are limited in the amount of work that they can do when they are pregnant so some have no income from their economic activities for example cross borders.

The approach helped me to understand the marginalization of women in the health sector and the discrimination faced by women. The Ministry one might argue is taking advantage of the reproductive capacities of women and wanting to benefit from it by making sure that the funds generated from women is used for the upkeep of the hospital. I felt that it was both discrimination and exploitation because if they had asked the women they would not have volunteered to be the money generating part of the hospital but the voices of women are hardly ever heard and the policy is in place and women have to pay a lot of money to keep the hospital running and retain their health.

Using the women's law approach I was able to formulate questions best suited to the particular woman I was speaking to at that time because I realized the problems of women are not universal and they are different in what they considered a priority. Some women I realized were more concerned about the amount of money that they had to pay but others were concerned about the state of the hospital toilets and the attitude of the staff rather than the money. I was able to accommodate the differences between the women and accept that there are social differences even between the women themselves. This also helped me when I wanted to do individual interviews to understand where the woman was coming from first so that I know what issues to address and to prioritize and also for me to accept the views of those women who were not overly concerned about the issues that I was raising because to them something else was important. I therefore identified problems at personal and individual level and I was able to come up with the views of the majority at the end of the day.

In order to have a holistic approach to the problem faced by women in the hospital I also included men in the research because they were the ones that the hospital assume will face the burden of paying the fees for their wives in hospital. Women are considered to be the money generating part of the hospital because it is assumed that the men will pay for them and therefore ultimately it is not the burden of the women but the burden of the men. As a result it was necessary to include the voice of the men and find out how they felt about the policy. I was then able to determine who bears the burden of the payments and how the hospital policy is affecting both men and women.

### **3.3 GROUNDED THEORY APPROACH**

Grounded theory approach is an approach that requires that the researcher as far as possible start with an open mind and that means that one should be aware of the assumptions of the research and take nothing for granted (Weis Bentzon A et al 1998 page 178-9). I already had my assumptions about how the economic situation was affecting the rights of women to health-care at Harare Hospital and these helped me with a starting point in what I wanted to research. When I was asking for permission to do the research the administrative personnel wanted to know specifically what I wanted to find out and how I was going to go about it. This meant that I had to have specifically defined issues that I wanted to find out and I needed to be able to explain what it was I wanted at any moment and to anyone. The people I was dealing with were professionals in their field so it meant that I had to bow to their superior knowledge on some of the issues as they would answer the questions even when I am in the process of explaining to them. I was ready to believe that I had embarked on a fruitless research because nothing is happening at the hospitals.

When I finally got to the women I had the view that since the professionals had been preparing me for a situation which was not as bad as my assumptions had shown, I was prepared to find that the situation is not as bad as I had thought. The women painted another picture based on the reality that they were facing and I had to disengage myself from the reality painted by the administrative personnel and look at the reality that the women were showing me.

As I was interviewing the women it emerged that most of them were constantly thankful that they are alive and I began to question why. During the interviews I began to ask the women if they had heard of many women dying at the hospital as a result of pregnancy and most of them would relate their stories of how they came to be at the hospital and how lucky they were to be alive. Even if it had not been my initial assumption I realized

that maternal mortality is something that the women are concerned about and therefore I needed to find out more from the women and the hospital personnel.

When I compared the answers I got from the personnel on the ground and those from the administration building I realized that they differed in that the administration personnel understated the problem and considered the problems to be minor even though they do acknowledge that they do have problems in the health sector. The nurses and doctors at the maternity wing were quite vocal about the problems that they face and the fact that the problem is quite urgent. I then realized that the problem depends on whom one speaks to and the reality of the women is what I wanted to find out therefore there is need to engage more with the women. The constant comparative method helped me to compare what the women were saying with what the maternity nurses and doctors were saying so that the information could be verified and I did not make unfounded accusations. However, in issues concerning the conduct of nurses and doctors I found that the nurses and doctors protected each other or absolved each other of blame and in some cases doctors would blame the nurses and the nurses would blame the doctors so that it became quite difficult to find out the truth. An example where this happened is where I was asking about maternal deaths and the nurses would say the doctors come late if they are called and the doctors say the nurses sometimes call them where it is not necessary so sometimes they have to verify that it is a real emergency before they come.

### **3.4 HUMAN RIGHTS APPROACH**

The human rights perspective was relevant as I was looking at women's right to maternal care and the economic crisis in the country. Women are protected and granted the right to maternal health by international and regional human rights instruments while the laws in Zimbabwe do not grant the same right. It was necessary for me to question what the human rights instruments themselves provide and to compare this to what is on the ground for women at the public hospital. The framework that I used of

accessibility, availability, acceptability and quality of care are minimum standards interpreted by the Committee on Economic, Social and Cultural Rights. The minimum standards provided a starting point for me and served as a basis on what I wanted to question the women and also what I had to look for at the hospital. My assumptions and objectives were formulated around these minimum standards that the state had to fulfill in order to grant women the right to health.

The research was on how the economic situation has resulted in the violation of these rights for pregnant women especially at Harare Hospital and what the state needs to do in order to help women realize the right to health. The women I questioned were not aware of their rights so that it was a foreign concept to them, as they had not been informed of the rights. The human rights approach helped me to understand that there is a much higher standard than what I was seeing at the hospital and this situation has been created by the economic situation of the country.

### **3.5 FEMINIST PERSPECTIVE**

I found the views of the existentialist feminist helpful during the research as propounded by Simone de Beauvoir in *The Second Sex* (De Beauvoir S 1997) in which she explains women are the other and are regarded as the inessential and man is the essential. She says that women have gained only what the men have been willing to grant them and have taken nothing but only received. The fact that the hospital in this economic situation where the whole country is suffering can think of making pregnant women the economic backbone of the whole hospital reflected a disregard of women. Women are the only ones who get pregnant and they are not very important so they should pay as they are the other and the decision is made by men who are at the top without consulting the women.

The liberal feminist view that women are socialized to limit themselves to the private sphere while the men advance in the public sphere of work and education helped me to

understand the attitude of women and staff at the hospital. Women acknowledged that the situation was bad and they should not have become pregnant but it is their duty to have children or else their husbands will leave them. One woman said that she had recently married a younger man and needed the child to cement the relationship otherwise he would leave her. They have no job outside the home hence the financial dependents on the husbands who have the income and the need to please them. There is need for equality of the sexes and for women to be empowered financially and psychologically because if the women had been educated and had an independent income they would not be so dependent on their husbands and would be able to enforce their right to health. All the women I interviewed waited for the husband to bring back the money for the hospital and some waited for days before the husband brought the money.

The radical feminists are of the view that:

“If we want to understand why women are subordinate to men we require a biological ,not an economic explanation .....men’s and women’s differing reproductive roles led to the first division of labor at the origins of class...” (Tong R: 72)

and believe that women’s liberation requires a biological revolution. I was persuaded by this view because I believe that women are saddled with the biological roles and their right to biological determination is not respected because men do not go through the same process hence it is trivialized. If men and women played the same roles and women no longer had to give birth then women might be considered important and the problems faced by women to access healthcare will be a thing of the past. Women would not have to risk their life doing a thankless job and can engage in something more productive. This helped during the research when I was feeling helpless and angry at the attitude of the hospital administration and I comforted myself with this rather extreme view.

## **METHODS OF DATA COLLECTION**

The data was collected using various means and they worked in different ways for the research and the findings that I came up with.

### **3.6 INTERVIEWS**

The interview method was primarily used during the research. A brief background of the research and whom I am representing started the interview because I realized after the first interview that some of the women assumed that I was a doctor and would therefore understand what their medical problems were. The interviews took the format of group discussions and individual interviews. The interviews were unstructured in that there was no format to the interview and I proceeded in the direction that the women wanted to go and only asked the questions that had been left out at the end. This helped me to get more information and also to keep the women interested in the discussion as it was not formalized. I listened mostly while they talked and argued among themselves and I only probed the discussion along if it got bogged down on one issue.

#### ***3.6.1 Group Discussions***

Most of the interviews were in the form of group discussions with a group of six women each which is the number of women in the wards. The use of group discussions helped me to gather information in a short space of time and also to gather divergent views on the same issue in the same interview. It also enabled to find out the majority views of most of the women in any one group so that I found out earlier in the research what the issue was for women that I needed to concentrate on and this became the starting point of the discussions. The other advantage was that there is more likelihood of finding someone who is willing to talk in a group interview and this makes the other women open up as well.

The disadvantage was that there are women who tend to be more vocal than others so that they tend to impose their view on others. These women tend to be the ones who are heard and want to have the last word in any argument and it becomes an individual interview of that one woman because she answers all the questions. In other discussions some of the women just echoed the views of others so that it becomes difficult to judge if they are really genuine. The women also tended to focus more on the negative for example on the issue of the cost of healthcare if all the other women are saying they cannot afford it then none of the women would admit that they have the money to pay for fear of appearing out of place. There was a difference between the older women and the younger generation women (less than 30 years of age) in one ward with the older(above 30 years old) imposing their views by saying that they have seen more than the younger women who are weak and are “masalad”<sup>8</sup> so that I should not listen to them.

I realized that I could also be misled in a group interview for example there was a woman in one of the wards who had been in the hospital for two weeks and when I was doing the group interview she did not tell me about it but told me that she had been discharged and was waiting to go home. When I left the ward I heard one of the nurses telling someone about how the woman had been in the hospital for the past two weeks waiting for a plaster because she had a broken leg and there was no plaster at the hospital. I then went back to woman and she confirmed the story and she appealed for assistance with the plaster. As a result of this I realized if I wanted to find out more I had to do individual interviews to establish more connection with the respondents.

### ***3.6.2 Individual interviews***

I also used individual interviews during the research and the women were chosen randomly to present a divergent view on all issues and 10 individual interviews were

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<sup>8</sup> Young people with a westernized view of life who the old people think have a low threshold for pain and who are mainly brought up in the city.



conducted during the course of the research. This method was used so that I could question more deeply the life situation of a particular woman, which I could not do in a group discussion. The individual interview has more privacy and I could interact more personally with the interviewee without fear of the information being repeated by others. I chose those women who were willing to talk in the group discussion and were not given a chance and also those who were quiet to find out how they felt. There was need to find out how women were actually affected by the issue of the amount of money that they have to pay at the hospital. In order to find out there was a need to be specific and to ask women individually how they were personally coping in private.

The advantage of using the individual interview was that I established a relationship with the respondent and I was able to ask personal questions about their lives and explained that this was for me to establish their difficulties and where they were coming from so that we could understand each other better. Most of the women were quite willing to talk and I was surprised at the kind of information that they would share with me. I established that there are differences between the women in that some women although they complained that they had to pay a lot of money did not mind paying because they had the money and those who were really poor would explain that they had not even have the clothes for the baby. I gathered more information that was pertinent to my research and the data was more focused than the information gathered in group interviews as I could relate the data to a particular individual.

The disadvantage that I found was that I spent a lot of time with one respondent because I could not rush them through their story so I had to be very patient. Women relished the attention and the ability to be able to contribute so they wanted to give as much information as they could so I would interview one woman for almost an hour so I found it very time consuming. Some of the women needed a lot of probing before they open up and I gave up on some of the women because they simply refused to talk about their lives and their backgrounds even if I could see that they were poor.

### **3.7 OBSERVATION**

I also used observation as a means of data collection whereby I would observe as the staff and the patients go about their business. Using this means I was able to observe how the nurses and the doctors treat the women at the time they are in hospital. I observed the admissions wing so that I could observe the time that it took for a woman to be attended to and the amount of attention given to one particular woman so that I could judge if it was adequate, and payments office so that I could observe how much women are made to pay and if they actually pay the amounts that are on their bills.

The advantage was that the nurses continued to do what they always do and I was able to judge for myself if the women were treated with respect or not. I was able to observe a woman who was admitted and needed an operation for twins who were in breach. The woman had been brought by a nurse aid from Norton and she was almost overdue for an operation. She had been referred because Norton Hospital apparently had no equipment to use although they had a theatre and the doctor had not told the woman she was expecting twins. The woman, a very young woman having her first children, cried when she was told that she had to have an operation and asked to see her mother who was outside. The doctor and the nurse laughed and said they were concerned with saving her babies and herself and her mother was not a priority at that time but her health. I felt that this gave me an insight into the fact that women are not given information on the procedures that are to be done on them and the nurse and the doctor were quite insensitive where they could have been more accommodating and their attitude actually affected me.

They did not see anything wrong with the fact that they had laughed at the woman's fears and continued to talk to me while they prepared her for an operation. This observation gave me information which if I had asked nobody would have told me because it seems not pertinent. In the payments office most of the people would protest first and negotiate terms of payment and I did not see anyone pay the whole amount while I was there which showed me that people really could not afford the payments.

This served the purpose of helping me make judgments for myself instead of relying on what the people say as people could exaggerate especially on the payments that they had made and I was able to see for myself.

The disadvantage that I found was that I could not understand most of the terminology used as they used technical terms especially in the admissions department and I sometimes did not know what was supposed to be happening so I could get the wrong impression when it is the right procedure as I am not very conversant with medical procedures. As a result of this I limited myself to the observation of attitudes to the patients by the nurses and doctors which I could judge. The other thing is that when they observe the women they are behind closed curtains so I have no idea what goes on behind the curtain and what I could observe was limited to just hearing voices.

### **3.8 DOCUMENTS /POLICY ANALYSIS**

I also used documents especially those which showed the amount of money to be paid by a woman and how it is calculated. The hospital policy of how the money is to be paid seems not to be written down and also that which takes the maternity wing as the money generating part of the hospital. They are policies which are just known by those who are supposed to enforce them while there is no policy document to refer to.

The documents enabled me to appreciate how the costs are arrived at and the amounts of some of the procedures that are supposed to be done. I also perused some of the bills that had been given to women and I realized that women were given a bill with just the money that had to be paid and if they needed the breakdown of how the money was arrived at they had to request for the breakdown from the payments office. The bill did not give the women enough information while it is the right of the women to be informed. I also perused the admissions books which showed the number of women admitted since 2006. The earlier were at the records office and I was not given access to the office.

### **3.9 KEY INFORMANTS**

The administration personnel and the nurses and doctors were interviewed in order to verify the information I was getting from the women about the problems faced by the hospital. These authenticated the allegations by the women about the state of the hospital although the administration tried to underplay the situation and the extent of the problems they were facing. I interviewed 3 doctors, 6 nurses and 4 administration workers. The finance clerks also verified the bills paid by women and the reasons why they had to pay the amounts of money that the hospital was asking them to pay. They even showed me some of the bills that they had previously processed so I could get a sense of the extent to which the bills were being raised.

### **3.10 TABLE OF RESPONDENTS**

<b>RESPONDENTS</b>	<b><u>NUMBER</u></b>
<b>Pregnant women in hospital interviewed as a group</b>	<b>12 wards with 6 women per ward</b>
<b>Nurses.</b>	<b>6</b>
<b>Doctors.</b>	<b>3</b>
<b>Other women</b>	<b>11</b>
<b>Administration personnel</b>	<b>4</b>

## CHAPTER FOUR

### 4.0 FINDINGS

#### 4.1 INTRODUCTION

Harare Hospital is one of the major referral centers in Harare catering for a large number of people and most of the people that are catered for are poor. Some of the people who are attended to the hospital come from as far away as Masvingo(292 km from Harare) , Murehwa (80 km from Harare), Chivhu ( 150 km from Harare) and the surrounding areas in Harare mostly Mbare, Hopely, Norton( 40 km from Harare) and Hatcliffe. Most of the people living in the areas like Hopely and Hatcliffe were resettled after operation Murambatsvina/Restore Order<sup>9</sup> and are very poor and are mainly women and children.

Most of the women that are admitted have complications and need special care especially Caesarean sections or the women have High Blood Pressure which needs to be monitored. As it is a referral center most of the women come to the hospital as a result of being referred from local clinics and other surrounding hospitals. The maternity wing at the hospital is apart from the other buildings at the hospital and has its own theatres in case of operations. There are also doctors who deal specifically with the maternity wing though they are mainly junior doctors.

This chapter deals with what was discovered on the ground and according to the assumptions that I had initially. The findings are grouped according to the assumptions and the objectives that I had and the list is not exhaustive of the problems faced by women at the hospital. These are what I considered important limitations to the

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<sup>9</sup> This was an operation by the Harare City Council and the Zimbabwe Republic Police in which a lot of illegal settlements were demolished in the context of cleaning the city as they argued it had become overcrowded. The operation affected a lot of women who had been living in the outside houses in high density suburbs as they were left with nowhere to stay and most of them went to the rural area or were resettled by the government in the settlements listed above. Most of the people who live in these settlements are very poor and are unemployed with no source of income.

provision of maternal health by Harare Hospital and which violate the right of women to maternal health. The study sought to answer the following questions:

- What effect has the water shortages had on the health sector and how has it affected the accessibility and quality of care provided by public hospitals?
- How has the food shortages affected the quality of care provided by public hospitals?
- What impact has the economic crisis had on the availability of medicine at Harare Hospital and how has it affected the quality of care provided by the hospital?
- What impact has the shortage of equipment had on the quality and accessibility of care for pregnant women at Harare Hospital?
- What impact has the brain drain of health personnel had on the accessibility and the quality of care provided to pregnant women at Harare Hospital?
- What impact has the rising cost of healthcare had on the accessibility of Harare Hospital by pregnant women?
- What impact has the transport cost to and from the hospital had on the accessibility of the hospital by pregnant women?
- What impact has the rising incidences of power cuts had on the accessibility of the hospital by pregnant women?

## 4.2 STAFF

**Objective: To find out the impact of the shortage of personnel on the quality and availability of care for women.**

There is a major problem of brain drain of professional people in the country at the moment and the health sector has not been spared. The shortage of staff means that women do not always access professional when they need it and the staff that remains at the hospitals are not experienced like newly trained nurses who are still under bonding by the state and cannot leave for greener pastures. This problem has affected Harare Hospital and the care that they can provide for pregnant women.

Harare Hospital needs a compliment of 158 midwives but at the time that I went there were 22 midwives turning up for work. The matron at the hospital who tried to demonstrate that they were overworked revealed this:

*“How can 22 people do the work of 158 people. Most of the midwives that are remaining are also frustrated and thinking of going somewhere else. Those that remain are old like us who are near retirement and have nowhere to go.”*

From what she said it emerges that she is remaining at the hospital because she is too old to look for a job somewhere and not out of commitment to the job. The midwifery post is a specialized job that needs special training over and above that of a state registered nurse and there is need for another certificate in order to be a midwife. They deal specifically with delivering children as compared to the registered nurse who can be posted to any division of the hospital. The midwives are leaving because of the low pay that they are getting as it is hardly enough to make a person survive

*“When I saw my pay-slip for November I actually cried because I knew that the money was low but I did not expect it to be this low. The money is hardly enough to make me come to work the whole month and I am supposed to survive with my family on it.”*

The nurse had been given \$26 000 000 (USD\$ 13) as salary together with her bonus for the whole year. The nurses are also frustrated because of the shortage of equipment at the hospital for them to use. Most of the equipment is broken or outdated so that they have nothing to use,

*“I find that when a woman comes for help, I have to improvise on almost everything even the smallest thing. My job is to save the life of the woman to the best of my ability and I can hardly do that without the appropriate equipment to do so.”*

There are no incentives for the nurses to do their work as there is not even transport to carry them to their places of residence and the matron was saying that she had to scramble for the one bus available with young people and they hardly notice that she is there because even if she is a matron she has no car although her post is supposed to have a vehicle provided. There is also no accommodation available for young nurses at the hospital who are now opting to go and work at mission hospitals where they are provided with accommodation, as accommodation in Harare is now too expensive. The rate of resignation of the nurses is not commensurate with the rate that they are trained so that there will always be a shortage of nurses at the hospitals.

The hospital deals with a large number of women who are admitted from all over the country and it is difficult for them to cope with the staff that they have. The 22 midwives are assisted by 60 registered nurses who also deliver babies, which is in contravention of the human rights instruments, which provide that a trained person shall attend to every birth. The state registered nurses are not trained in midwifery and hence do not qualify as trained personnel for child birth, according to the matron.

There is also a huge shortage of doctors at the hospital so that most of the time nurses attend to the women until it is absolutely necessary for the doctor to be there. The nurses complain that the doctors sometimes take too long to come if they are called for an emergency and sometimes this results in fatalities. The doctors go on strike and do not announce their intention to go on strike and they only announce that they are on



strike after they are called for a patient. They are always complaining about their salaries and they are leaving the country so that there are only junior doctors remaining at the hospital.

The experienced doctors operate surgeries so that they would rather operate at the surgery where it is more profitable than working at the hospital. Junior doctors who are supposed to be assisted by a senior doctor when they operate on a patient are doing the operations on their own as the senior doctors do not show up. The fact that they operate on their own also means that there is lack of real supervision for the junior doctors in case there is a mistake due to the inexperience of the doctor thus putting the lives of women at risk.

The doctors also complain that they have no equipment to work with and this affects the quality of their work as they have to make do with what is available and sometimes it is not the best.

### **4.3 WATER CUTS**

**Objective: To find out the impact of the water shortages on the quality of care accorded to pregnant women at public hospitals.**

Zimbabwe experienced water shortages during 2007 and this was attributed to the shortage of treatment chemicals needed in the purification of water. There was the takeover of water provision by the Zimbabwe National Water Authority in from the local authorities but water provision did not improve. From the beginning of the year there were water cuts lasting for days in some areas and even months in areas like Mabvuku/Tafara where the crisis was worse. Clinics were not spared the water cuts leading to women being referred somewhere else if there was no water at the clinic and according to my findings Harare Hospital was not spared either.

The water crisis also affected the hospitals as emerged at Harare Hospital. When there was a water cut at Harare Hospital there was a bowser that was brought to the front of

the wing and the water had to be carried inside the hospital by the staff for use by the whole wing which made a lot of work for the aids. The women who were at the hospital also had no buckets to carry the water inside and had to wait for the few buckets in order to carry water for their sanitary needs. Most of the women at the hospital are those with operations who find it difficult to carry the water inside if they need to bath and have to wait for relatives to carry it for them when they visit at lunch time if they have visitors coming as the staff cannot cater for all the women admitted.

The water cuts were not an everyday occurrence though but it was bad when there was no water for those women admitted. Most of the women I interviewed had not had problems with water while at the hospital and some of them had had problems at the clinics where they had originally booked and been transferred to the hospital as a result of the water shortage at the clinic but had not had problems at the hospital itself. The interviews with these women showed that the problems of water were widespread in most of the health institutions and it was affecting health delivery.

Some of the women complained about the fact that the water even if it was there had no pressure and most of the sinks had no water so that they still have to ask the aids for water if they are thirsty,

*“ I have been asking for water since morning and I still have not been brought the water and I have no container so that I would have fetched it for myself. The sink here has no water and we have to get from the toilet.”*

The woman asked for water while I was there because there was no running water in the ward and the water was still not brought to her as the aid said she was too busy and showed disregard for the welfare of the people she is supposed to take care of. This impacts on the quality of care that the women get at the hospital as a result of the water crisis. Due to the fact that the water has no pressure the toilets are also affected as most of them are dirty as they are used by so many women who are bleeding and need a lot of water.

#### **4.4 COST OF HEALTH CARE**

**Objective: To find out the to what extent the cost of healthcare in public hospitals on pregnant women's right to access antenatal care.**

The cost of health care has gone up in the past year as a result of inflation, which was 66 000% in November and is now pegged at 100 00 %, is at the point where most women can no longer afford to access health care. The unemployment rate in the country is upwards of 80% and the majority of the unemployed are women. In any case the ratio of the rise in prices and the salaries to those that are employed is not proportionate so that even those that are employed cannot afford.

The maternity fees for Harare Hospital were raised with the concurrence of the Minister of Health so that the hospital can raise money for the upkeep of the hospital before the budgetary allocation for the hospital becomes due. Under the Hospital Services Board that is responsible for the day-to-day upkeep of the hospital the maternity wing is supposed to be the money generating arm of the hospital. There are a lot of women admitted and being discharged at one given time and hence if they all pay before they are released it means that the hospital has the money to buy smaller items for its immediate upkeep. As a result of this need there is a hospital policy that women will not be released until they have paid at least half of their bill and failure to pay half at least something toward their upkeep. This has led to women being detained for failure to raise the money and they have to raise the money in exchange for their liberty. An association of medical aid providers determines the bills for the drugs and treatment even if most of the women are cash paying and not on medical aid so the accounting department only has a schedule to implement the costs of the drugs. The bills have no breakdown so that women are not aware of how the figure is arrived at. The hospital raised the bill from almost a \$1000 (USD0.03) to amounts that are not affordable by most women and most women can no longer afford to pay.

The cost of the hospital was the major issue for the majority of the women whom I interviewed and this affected the affordability of health care for pregnant women. It was a major issue such that it was the first issue raised by the women I interviewed and their views and backgrounds were diverse. The cost of the hospital is such that most of the women could not afford to pay as most of them were non-working women from very poor backgrounds and they were expected to pay huge bills. The bills they had to pay ranged from \$19(USD \$8) - \$562 million (USD\$ 250 in December) and the figures rose significantly in January 2008. The salaries that were paid to the people in the country at this time did reflect the reality of the money that they were expected to pay. One man said:

*“ Where do you expect me to get the money that you want me to pay. My pay-slip has \$19 million and you want me to raise half of \$164 million where do I get it from.”*

The man had to raise the money so that his wife could be released after she had been detained at the hospital for 3 days. He ended up raising \$50 million(USD \$20) and his wife was released. Another woman who had been transferred from Mrehwa said

*“They can keep me here but that does not mean I will find the money. My husband is staying in Chitungwiza and cannot find the money to come and visit and they expect him to find \$190 million(USD \$90).”*

The woman had been registered at a clinic in the rural area of Mrehwa, from where she was transferred to Marondera (60 km from Harare Hospital), then to Chitungwiza (40 km from the city) and then to Harare Hospital. All the other hospitals that she went to had no doctors or had no materials for the operation that she needed. She had been in labor for more than three days before she was operated on and the baby almost died from exhaustion. The husband was not working and they depended on a small garden in the rural area for their livelihood and the husband did some odd jobs for people in the village which did not give him a lot of money. She knew they would never find the money and had already been detained for four days. The husband had said he could only

raise \$10 million (USD\$5) from the relatives and from that money they needed \$5 million for the transport back home.

The situation was compounded by the fact there was a cash crisis at the banks from November to the end of December 2007 which saw a lot of people failing to access their money at the bank even if they had the money

*“I have been going to the bank for the past two days and I have not been able to get any money. The hospital needs something for my wife to be released. If I pay using RTGS<sup>10</sup> they wait for it to be cleared before they can release her and that’s takes another 3 days.”*

The money had to raise \$89 million(USD \$48) and the hospital needed half of the money before the wife could be released. Another man said

*“ Even if you have the money the banks will only give \$5 million (USD \$2) and that means that I have to queue for 10 days in order to get the \$50 million(USD \$25) that they want me to pay.”*

As a result of the cash shortage even those who could raise the money were detained at the hospital while their spouses looked for the cash, as the hospital will not release patient unless they have paid something.

Most of the women that I interviewed had no medical aid and this means that they had to raise the cash for the payments. The payments clerk said that

*“ Most of these women are too poor to afford the medical aid. We do look at the situation of the woman before we accept the part payment that the woman can raise.”*

Women who have addresses in Harare are expected to raise more money than those who come from the rural area as they take into consideration they might not have relatives in the city. A woman from the rural area or from the Murambatsvina settlement of Hopely

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<sup>10</sup> RTGS- Real Time Gross Transfer

can raise \$5 million (USD\$2.50) on a bill of more than \$100 million(USD\$50) and can be released. They consider that these women might not have a source of money but they still have to pay for the materials that have been used on them.

Even if the hospital accepts part payments it does not mean that the money is forgotten the rest of the money has to be paid in three months and the women are released on condition that they leave a physical address where they can be followed if the money is not paid as well as the addresses of two other relatives who can act as guarantors. If the money is not paid in three months the debt is taken over by debt collectors who will hound the woman until the money is paid. The payment clerk said that

*“ Once the debt is in the hands of debt collectors we have nothing to do with it. As you know they are people who have been contracted for that job and they have to be seen to be doing their job so we are not responsible for the way that they make people pay as long as they pay. We encourage people to pay within the three months though”*

The money will continue to be a debt for the women to pay even they are released from the hospital after paying a little amount. One woman from Norton said

*“My husband has gone to sell a cow in the rural area so that we can pay the bill of \$82 million. Even if we pay the little amount that we can raise today the money will still have to be paid so the best is to just pay the whole amount.”*

The husband brought the money while I was still talking to her and paid the bill. The woman and her husband work for the Norton Council and she was saying that both their salaries put together are not enough to raise half the money for her bill and if she leaves the hospital the baby needs a lot of things so that the money will never be enough to say she will raise the rest of the money needed by the hospital. She opted to sell her asset to pay the whole amount but this also means that she will never be able to replace the cow that she sold to pay the hospital bill:

*“At least the baby is a girl after she gets married I will get back my cow because at the rate the inflation is going I will never buy it on my own.”*

The social welfare department does not assist women who cannot afford to pay the cost of their hospital fees like they do those with other illnesses. When I went to the finance department there was a man who came with a bill of \$35 million(USD\$17) for his wife and could not pay as he was not working. He was advised to go to the social welfare department so that they can write a letter for him and then he can be treated for free. Women were not given the option as pregnancy is considered voluntary and is not an illness therefore women have to be prepared to pay the costs as indicated by the accountant

*“Women prepare for the birth of the baby by buying everything that is needed in the knowledge that they are going to have a baby so why should they not be prepared to pay the costs. Besides if social welfare starts paying for maternity too many women will get pregnant as they know they do not pay anything. Babies are not the responsibility of the government but of the man responsible”*

This was said by the accountant who is of the view that women plan to get pregnant and therefore have to make a plan for the payment of the things that have been use on them. Some of the women that I interviewed had no one claiming responsibility for the baby and there were no relatives who were forthcoming to help her raise the money. This means that the poor are being given the choice of either stopping having children or raising the money needed for the maternity fees which is hardly a choice a woman can make.

As a result of the cost of the hospital the admissions at the hospital have decreased. The matron attributes the decrease to operation Murambatsvina which led a lot of women leaving the city and also to the fact that the cost of the hospital have been increasing and they were increased to an extent that most women cannot afford in September 2007. In the previous years women used to refer themselves to the hospital because it used to be much cheaper than the clinics run by the city council. The administration increased the

fees so that the numbers of women who are admitted are reduced and the hospital can act as a referral center, which is its role, and not as the first port of call for the women. The following are the tables for the admissions for 2006 and 2007. The tables also show the amount of work that is supposed to be done by the 22 midwives that are available at the hospital, as they have to deliver a high number of babies.

**TABLE 1**

<b>MONTH 2007</b>	<b>ADMISSIONS</b>	<b>BBA</b>
JANUARY	780	4
FEBRUARY	703	3
MARCH	645	7
APRIL	806	10
MAY	652	4
JUNE	670	4
JULY	1044	18
AUGUST	865	8
SEPTEMBER	Not available	
OCTOBER	Not available	
NOVEMBER	Not available	
DECEMBER	Not available	

**BBA - Born Before Arrival**

The table shows the number of women admitted in 2007. The BBA shows the number of babies born before their arrival at the hospital due to a variety of reasons that will be explained later. Even if the nurse explained that the numbers have decreased they are still not commensurate with the number of midwives available. Most of the women who are admitted need Caesaraen sections and they need special care by the midwives as they are the ones who go into theatre with the doctors for assistance. The numbers for the rest of the year had not been compiled so I could not access them. I had needed the



statistics for the previous years but these were not available as they were already at the hospital archive.

**TABLE 2**

<b>2006</b>	<b>ADMISSIONS</b>	<b>BBA</b>
JANUARY	602	9
FEBRUARY	538	14
MARCH	649	17
APRIL	539	4
MAY	668	12
JUNE	371	14
JULY	340	8
AUGUST	539	21
SEPTEMBER	485	17
OCTOBER	875	6
NOVEMBER	869	6
DECEMBER	596	11

Women are supposed to pay for the items listed below if they have an operation at the hospital. The cost is as at November 2007 and it has increased significantly since then. Generally all of the items listed below are used during an operation. The cost increases if the woman needed special care like if the woman had to go through the intensive care unit which happened to some of the women. The charges in intensive care are charged per hour and the figure of \$562 000 000 (USD\$250) that I used is for a woman who had been in intensive care and had almost lost her life because she had arrived at the hospital late.

The items include:

**Charges for Caesarian sections as at November 2007**

Food and bed	\$1330 (USD\$0.025) (raised to \$4 300 000 (USD\$2.50) in January 2008)
Needles	\$3 336 000 each (USD \$2)
Sundries	
Gloves	\$9 000 000 (USD\$4.50) per pack (a woman needs a pack for an operation sometimes more)
Sutures	\$21 100 000 (USD\$11)
Name band	
Sterile gloves	
Latex gloves	\$15 000 000 (USD \$7.50)
Bandages	
Disposable needles	
Cotton wool	
Gauze	
Betadine	
Normal saline	
Blood	\$37 million per pint (USD\$17.50)
Caesarian section	\$28 million (USD \$14)

**Charges for normal delivery as at November 2007 are as follows**

Delivery	\$4 267 000 (USD\$2.20)
Stitches	\$3 000 000 (USD\$1.50)
Card cost	\$1000 (USD\$0.020) (increased to \$10 million (USD\$5) in January 2008)
Bed and food	\$1330 (USD\$0.025) (increased to \$4 300 000 (USD\$2.10) in January 2008)
Gloves	\$4 500 000 for 50 (USD\$ 2.25)
Name band	

The local clinics during this period cost \$5 000 000 (USD\$2.50) for booking which was increased to \$50 000 000 (USD\$25) in January 2008. Most of the women come to the hospital as referrals which means they had already paid the booking fee at the clinic and

were now expected to pay fees at the hospital which were more than they had planned for. The fact that they had paid at the clinic is not taken into consideration and this results in double payments on the part of the women for the same procedure. Some of the women are referred even if they have no complications:

*“ Some of the women are referred from the clinics for being difficult by the nurses. If they cry and cannot cope with the pain then they are referred and still deliver normally”*

The women deliver but still have to cope with the payments of the fees of the hospital. One woman had to be referred because the clinic where she had booked had no water and was transferred to the hospital showing that women are sometimes referred even if there are administrative complications.

*“ I am not going to have a baby until I feel that things have improved and I can cope. I have to pay for my brother’s wife’s stay in the hospital and both me and my brother cannot afford it . I don’t need the hassle I will stay with the two children I have.”*

This was said by one woman who had to assist her brother in paying for her sister in law’s stay at the hospital. I interviewed some professional women who are also concerned about the money that has to be paid:

*Medical aid these days does not pay a lot and I will still have to pay the shortfalls. The convenience is that I don’t have to raise the money at the time I am discharged from the hospital bit I still have to pay it at some point. Things are not well for us women and something really needs to be done in order to protect us after all we are giving birth to future leaders.*

A woman who had come to visit her relative at the hospital said this. Her relative had no medical aid and had to pay cash.

#### 4.5 EQUIPMENT

**Objective: To find out the impact of the shortage of equipment on the quality and availability of care available to pregnant women.**

There is a shortage of equipment at the hospital as most of the equipment comes from outside the country and there is no foreign currency to buy the equipment. There are also no parts to repair the broken down machines and this means that the equipment available is in need of repair and there are no new machines being imported.

I found that the equipment at the hospital is outdated and most of it is in a state of disrepair. The nurses revealed that the most of the incubators in the nursery do not work and there is need to buy new ones but there is no money for the hospital to buy the new ones. Children that need incubators are removed from the incubator if a more critical child is brought to the hospital. This has led to some of the children dying from the lack of proper care due to the shortage of equipment.

When I went to the hospital the washing machine had been broken for more than a month and the linen had to be washed at the dry cleaners but only the essential linen. Sheets and gowns were not considered as essential as most of the women had dirty gowns and some of them were wrapped in sheets instead of wearing gowns because there were no clean gowns for them to wear. There was only one car to take the dirty linen to the dry cleaners and the matron said

*Last week there was an incident where there was laundry that needed to be collected and there was a student who was critical who needed to be collected from Marondera . There was a critical shortage of linen but the choice was between the life of a staff member and the linen. We don't have to make that choice and a big hospital like this cannot function with one car."*

The laundry was not collected on that occasion and after a week it had not been collected as the car now had no fuel to make the collection. The women were suffering after being made to wear dirty gowns:

*“ They gave me a gown which had blood spots on it which were quite visible so that it was quite clear it was dirty. I refused to wear it and they gave me another which was cleaner but not clean either. They will make us transmit diseases to each other”*

As a result of the washing machine not working there are no baby wrappers to use to change children and the changing times are limited:

*I wish they would just allow us to dress the children in their own clothes that we bring. I went to breastfeed the baby and he was soaked through and there was a cold wind coming through the open window so I am sure he was cold. There was no wrapper so I just wrapped the dry parts around him*

The breakdown of the equipment was also affecting the rights of the child to proper care.

The nurses also had to improvise in order to provide the proper care that is needed by women but there is an extent to which they can improvise as sometimes there is just need to have new equipment.

*We cannot say that women should be treated for free because the little money that is raised helps repair some of the equipment that we urgently need to use. The hospital has no money most of the time to do anything so we have to be grateful for the little that is there.*

There is need for a major capital injection so that the equipment at the hospital can be updated and repaired in order for the care available to women to improve.

#### **4.6 MEDICINE**

**Objective: To find out the impact of the shortage of essential medicines on the quality and availability of care for pregnant women at the hospital.**

In the past year the shortage of foreign currency has ground everything to a halt and imports are limited by the availability of foreign. Importation of drugs and medicines is

one of the essential areas that have been affected. This has resulted in the shortage of essential medicines and this has mostly affected public hospitals which depend on the government for medicines and this was confirmed on the ground at Harare Hospital. The shortages affect the availability of care for pregnant women as the hospitals lack essential medicines and women have to buy for themselves.

There is a huge shortage of drugs at the hospital and most of the time the women have to be given prescriptions especially for anti-biotics. Some of the drugs are donated and they come when they are near expiry so that they can only be used for a short time. Most women cannot afford to buy the drugs:

*“One woman was given a prescription after she had a miscarriage and developed an infection. She did not buy the anti-biotic and went home. She came back after two weeks and the infection was worse and she was given the same prescription. She did not buy the medicine and she came back the third time and was told that they would have to remove her womb if she did not buy the medicine. That was when she bought the anti-biotic and by that time the price had increased two fold.”*

The woman had sacrificed the pain that she was in as she did not have the money to pay for the medicine. The problem might also be the fact that women do not consider their health as important and it was when she was told that she could lose her womb that she saw the urgency of the matter. The hospital used to sell cheaper drugs but now the pharmacy resembles a “tuck-shop” according to one nurse as there is nothing for people to buy so they have to buy from the other pharmacies which are more expensive.

#### **4.7 FOOD**

**Objective: To find out the impact of the food shortages on the quality of care provided by public hospitals.**

As explained in the introduction there were price controls which resulted in the shortage of basic commodities especially food. At the time the research was done food was still

in short supply and this seemed to have affected the hospital as well according to what I found on the ground.

There was a shortage of food at the hospital as a result of the fact that after the price controls there was little food available at the shops. There was a shortage of beef and bread and the other basic foodstuffs. The hospital had not recovered November as they were still serving sadza<sup>11</sup> and Soya chunks<sup>12</sup> for lunch and supper with no variety. There was cabbage for women with high blood pressure and that was the only variation. The diet was as follows:

Breakfast 07:00 am	cup of tea with two slices of bread (sometimes there is an egg.)
Lunch 12:30 pm	sadza and Soya chunks or beans
Supper 17:00 pm	sadza and Soya chunks or beans

There is no fruit as part of the diet and the amount that is given to the women is not adequate to satisfy their hunger.

*They give me the same amount of food that I give to my young son.  
Its hardly enough to satisfy my son and its expected to be for a  
grown woman with a huge space in her stomach.*

The women have to get supplementary food from relatives and friends in order to get a balanced meal. Some of the women have no one coming to visit them and rely on the food that is provided by the hospital for their sustenance which is not adequate.

The state of the food makes most of the women just want to leave the hospital so that most of those interviewed could not wait to be discharged and go home

*A hospital is never a pleasant environment but this is too much. I  
cant wait to be able to go home because I can no longer stand the food.*

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<sup>11</sup> Sadza is the staple food of Zimbabwe which is made from maize meal.

<sup>12</sup> This is a form of relish made from ground soya into a palp. Most people do not eat it and it can be said to be for the poor people in the community. It resembles mince meat but does not taste like mince.

This has led women into taking the hospital as one more thing that they have to endure because they cannot help it, they would rather just give birth and go back home.

#### **4.8 TRANSPORT**

**Objective: To find out to what extent the cost and availability of transport has impacted on pregnant women's access to public hospitals**

Harare hospital is located such that most of the people who have to be treated there have to access the hospital using transport of some sort. The right of women to access the hospital has been hampered by the cost of transport and also the lack of the transport in some cases. The majority of women use the commuter omnibuses that ply the route and find that they cannot control the fares that they have to pay. The transport providers determine the price and in the hyper-inflationary environment of Zimbabwe, the price goes up on a weekly basis. As a result of this it becomes expensive for most women to visit the hospital as regularly as they are supposed to. A woman is supposed to have at least more than 5 visits with a service provider when she is pregnant. There are women who deliver using Caesar exclusively and these are allowed to book at the hospital and these women have to visit the hospital regularly for consultation. Most of these women just make the visit if its necessary and most of them had made only two visits prior to delivery.

*“I live in Kuwadzana and I need two commuters to get to the hospital. The commuters are \$500 000 per trip(USD\$0.25) and this means I need \$ 2000 000 per trip(USD\$1). I cannot afford to go there each week as I had been required to do as they need to monitor my blood pressure. The transport cost are too expensive for me.”*

She had only made two visits even if it was for her good that she be monitored for her blood pressure. The transport costs have restricted the access of a lot of women to the hospital.



Women who are referred to the hospital need an ambulance to get to the hospital and the ambulance costs were \$ 3 000 000 (USD\$1.50) per trip in November 2007. The money had to be paid before the trip was paid. City of Harare provides ambulance services and the woman can be carried on credit on condition she provides an address so that if the money is not paid they can cut off the water supply to the house in question. The Council no longer provides the water in the city so now the fees will be incorporated in the rates charges for that house so that the money is paid. The council ambulance at least gives women the leeway to find the money after they have been transported to get care. The other providers require cash upfront or a valid medical aid card before the woman can be transported to the hospital. Emergencies occur when people have no money and women have to find alternative sources of transport which might take too long as revealed by one nurse who said:

*“ One young woman was having her first baby and called for a taxi after the ambulance took to long. She delivered the baby assisted by the taxi driver after the husband had rushed to find assistance from neighboring houses. Luckily there was no complication for her”*

The young woman had given birth normally and arrived at the hospital with her baby. There is an increase in the cases of children being born before arriving at the hospital as shown in the tables above and this is a result of the transport difficulties that women face in getting to the hospital as well as the costs of the hospital.

Ambulance service providers also face the problem of fuel shortages so that sometimes they have no fuel to ferry patients to hospital. One woman revealed

*I had to call all the providers before I could get an ambulance to hospital. They were all saying they had no fuel. It was a crisis.*

The transport costs are also as a result of the rise in the cost of fuel which is unavailable at most service stations and is only available on the black market and at exorbitant prices.

Women who come from out of Harare have the most difficulty getting transport as they come long distances. One woman narrated that she had to find her own transport even though she was in labor:

*I had to find the transport because the clinic ambulance was out of fuel and it would take too long to phone for an ambulance from other clinics. It was better for me to get my own transport. I was accompanied by my mother and my husband and no nurse as there was only one nurse on duty.*

The woman's baby was in breach and she needed an operation. Another woman was transferred from Norton Hospital with an aid who did not even know the name of the patient that she had brought to the hospital. It made me realize that even the health attendants no longer cared for their patients and are no longer committed to their jobs.

#### **4.9 POWER CUTS**

**Objective: To find out the impact of the electricity cuts on the quality and availability of care for pregnant women.**

The problem of power cuts have resulted in women having more work in the home as they have to get firewood in order to prepare meals for the family. In some areas electricity supply takes more than a month to be restored as the power company fails to get foreign currency to effect the necessary repairs. Most of the hospitals and clinics are located in the suburbs where the power cuts occur and I went to Harare Hospital to find out if the power cuts affect its operations if they have the power cuts. The occurrence of power cuts at the hospital would violate the availability of care for pregnant women who would have to be referred somewhere else and also the quality of care provided by the hospital.

The hospital experiences power cuts but they are not as prevalent as they are in other places. There is a generator that is used in case of a power cut so that none of the services provided for women are hampered. Women hardly notice if there is a power cut as they

go on about their business like before. The time that I went to the hospital and there was a power cut was when there was a blackout in the whole country and still the generator was functional:

*“We get fuel for the generator and there is always some in reserve in case there is a sudden power cut. We have to have the fuel because at any one time there is a woman in surgery so we have to be prepared for the eventuality that the electricity will be turned off and the lives of people are not at risk.”*

The accessibility of the hospital is not affected by power cuts because the hospital has put measures in place to make sure that power cuts do not hamper the running of the hospital. The hospital had three generators donated to them after they had complained that the generators they had were not enough for all the essential areas of the hospital.

The clinics are the worst hit by the power cuts as they have no generators and some women have been referred to the hospital because the clinics where they registered had no electricity.

*“ I was asked to bring 10 litres of water and three candles. The nurses want to see those items before they can attend to you because electricity is unpredictable. When I was referred here I left my candles at the clinic because they had already collected them. Can one person use three candles in one night.”*

The candles have become an added expense that the women have to bear in their bid to have children.

#### **4.10 MATERNAL DEATHS**

##### **Overall impact**

The result of all these problems faced by the hospital is an increase in the incidences of maternal deaths. Maternal death is if a woman dies as a result of the complications of

pregnancy from the time the baby is conceived to 6 weeks after the baby is born. According to the nurses there are three main delays that result in maternal mortality and these are:

- ✓ Delaying to seek medical treatment (women booking too late or not booking at all so that they are not monitored in time to save them)
- ✓ Delay getting to the health center as a result of transport, terrain (if the clinic is located too far away from the road and there is no road for an ambulance to pass through) or natural factors like floods.
- ✓ Delay in getting attention at the hospital (no midwife, no doctor, no surgeon or anesthetist, needed blood but there was none available, needed antibiotics but there were none available, needed a ventilator but there was no free ventilator)

Most of the deaths occur as a result of the first delay where women delay to seek help from the hospital. There are so many intervening factors that make women delay in seeking treatment, which are mainly the cost of the treatment and transport that are beyond the control of women and are determined by the providers. Women are then blamed for the fact that they come to the hospital when it is already too late to do anything for them but there is no attempt to address the reasons why they seek treatment too late. From what I found the third delay is also prevalent at the hospital as there is an acute shortage of staff and the nurses themselves were saying that the doctors take too long to come if they are called for an emergency:

*“There was a woman the other day who came with a breach baby. She was already in acute and needed immediate attention. I called the doctor and he gave me instructions on what to do but she needed to be operated on. The doctor came after 2 hours and operated and the woman died. The baby was already dead by the time the doctor came. Instead of blaming himself he was blaming us for not saving the woman.”*

The nurses and the doctors no longer take the lives of women seriously and are no longer committed to the job as they are themselves frustrated. Unfortunately the nurse did not divulge the name of the doctor so that I could interview him to get his side of the story and make the story balanced.

The women in the hospital seemed not to be overly concerned about the state of the hospital and the other things that I wanted to find out but were grateful of the fact that at least they were alive.

*Some of these things are not important because after all we are here for a few days and we go back to our houses. At least the hospital has managed to give us our children and we are alive so we have a lot to be grateful for.*

This woman was adamant that we want to problematise things that are not important instead of commending the nurses and the doctors for being able to save them under such difficult conditions:

*I know a woman who died at this very hospital and I myself almost died but the doctor did his best for me and I am alive. Wait until you almost die and see if you will be concerned about minor issues like dirty toilets. The money I am paying is going for something because I am buying my life back. I will not have another baby because this time I will really die.*

To her the most important right that she was concerned about was the right to life and she was not concerned about the reason why she had to be concerned about that right. I realized the fact that women are not informed of their rights as far as health-care is concerned and are not aware of the fact that they do not even need to be concerned about their right to life when they are pregnant because it should automatically be guaranteed. The fact that the women are concerned about it shows that the situation at the hospital is not normal and something should be done.

The numbers of women who had died at the hospital are as follows:

<b>2006</b>	<b>52</b> women died out of <b>7071</b> admitted women
<b>2007</b>	January to June <b>14</b> women died out of <b>4256</b> admitted July <b>11</b> women died out of <b>1044</b> admitted women

I found it quite alarming that for the month of July 2007 there were 11 women who died. I found the figure quite high for one hospital as it led me to think of those women who are unrecorded because they die at home and those who die at other hospitals and clinics. I thought that the woman who had been grateful for her life was really justified to be grateful because the incidences are really alarming. In order to further my knowledge on maternal mortality and its significance to my study I looked on the internet and in newspapers about what the ministry of health was saying about maternal mortality. The Minister of Health was quoted as saying that maternal deaths had increased <sup>13</sup> at a conference for legislative members he said that the maternal mortality was 283 per 100 000 live births in 1994 and 695 per 100 000 live births in 1999 and there are indications that it has increased tremendously since then.

The Minister was advocating for free services where necessary and making sure that everything is done to save the lives of women because the figures that were coming out were alarming. He was also sure on this occasion that Zimbabwe would not meet the Millennium Development Goals on the reduction of maternal deaths and child mortality. On a different occasion reported by the same newspaper<sup>14</sup> the Minister of Health was now saying that there has been a tremendous reduction in maternal mortality from 900 cases to 550 cases and the situation had improved despite the economic situation in the country.

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<sup>13</sup> The Mail and Guardian 27 November 2007

<sup>14</sup> Mail and Guardian online 7 February 2008

#### **4.11 SUMMARY**

The findings show a disregard for the right of women to maternal health in the sense that the hospital environment is no longer friendly and women are staying away. The hospital and other service providers are increasing the cost of health care to such an extent that women can no longer afford it and are preferring to give birth at home and going to traditional birth attendants. The USD equivalent used in the findings is as at November 2007 when the parallel market was at USD\$1 to \$2 000 000 and now the rate at the parallel market is USD\$1 to \$40 000 000 which is showing the rate at which the Zimbabwean dollar is losing in light of stronger currencies. Prices of goods and services have continued to rise in light of the rate of inflation and this has resulted in further increases in the cost of maternal health for women. The rights of Zimbabwean pregnant women will continue to be violated if the economy continues to deteriorate as service providers fail to cope with the demands for service.

## **CHAPTER FIVE**

### **5.0 ANALYSIS**

#### **5.1 HUMAN RIGHTS AND THE STATE**

Human rights are understood as being those rights that are inherent to all human beings by virtue of being human and are founded on the respect for the dignity and worth of the person. Human rights are universal rights that are supposed to be applied equally and without discrimination to all people and they are inalienable, indivisible, interrelated and interdependent meaning that it is not enough to respect some of the rights and have no respect for others. All human rights are of equal importance and no human right should be seen as being more important than the other as they are all important for the dignity of the person. Human rights must be promoted and protected by national laws and constitutions so that they are guaranteed for the people by the state.

Human rights were used as the starting point for this research because the state has obligations to the world and to its people to make sure that the rights of its people are guaranteed. The government is signatory to the human rights instruments related to health meaning that they are committed to implement the provisions of those instruments. The state must therefore be held accountable and since there is no right to health in the legislation of Zimbabwe the only way they can be held accountable is through their obligation in the international instruments and this is why I used the international framework. The human rights framework imposes rights and duties on the state and also means that the state is accountable to its people if it fails to guarantee the rights imposed by the human rights instruments.

Women's right to health is guaranteed by the conventions and protocols listed in Chapter 2 and should be respected and promoted by the state as it has the obligation to provide public health for its people. The state has the obligation to respect the rights of women and the state should not restrict the right of women to access healthcare and should create conditions that are conducive for the attainment of the highest standard of healthcare.



“Government’s failure to ensure these conditions constitutes a deprivation of fundamental human rights guarantees to which all women are entitled under international law.”(Centre for Reproductive Rights January 2005: page 2)

The state is failing to deliver on the conditions necessary for the women to access healthcare as there are no drugs at the hospital and most of the hospital staff are leaving due to conditions of work. As I am writing the nurses and doctors are on strike and they have been for the past two weeks complaining about their pay and the state as the employer has not done anything to abate the strike. If the nurses and the doctors are on strike it means that women cannot access the hospital as they will not be attended to and yet the state has let the strike drag on without addressing the grievances of the nurses and doctors. It is the duty of the state to make sure that the hospital personnel are paid satisfactorily and they have a duty to make sure that they address the needs of their employees so that women can access the hospital and this does not lead to the unnecessary suffering of women.

The implementation of human rights is subject to available resources, according to the ICESCR article 2, and states are bound to the progressive realization of the rights so that they can argue that they do not have the means at that time to implement the rights. The article does particularly refer to the adoption of legislative measures and for the state of Zimbabwe this does not involve too many resources so that the right to health is guaranteed in the legislation of the country as this will make the right justiciable and government can be accountable for failure to provide health care. The state can also guarantee that women who need emergency care have the transport for example by providing the ambulance providers with fuel so that they are available for women. The resources that are needed are not always in financial terms but in having the interests of women at heart and showing to the best of their limited resources that they are implementing the right to health. The government in my research I felt was not doing enough as they always argue financial constraints and even for the things within their means they are reluctant to implement.

The government could also ensure that the right of women is realized by making sure that adequate resources are allocated towards the health sector and making the health of women a priority.

“ The gender approach is equally important in promoting women’s enjoyment of their human rights as it allows for explicit attention to gender-based factors in the conceptualization of rights and in their full and equal enjoyment by women.”( Wolfgang B 1988:page 26)

This means that the state in the budget to the best of its resources should make sure that the interests of women are taken into consideration so that women can enjoy their rights. For example the maternity wing at Harare probably has the highest number of operations on a daily basis and this should be taken into consideration when the budget is allocated. There is an increase in maternal deaths and the budget should take into consideration measures in the Roadmap to ensure that women’s right to survive pregnancy is guaranteed.

Pregnant women are not empowered to protect their right to health because they are not informed of these rights and there is need for the voluntary organizations and the international community to make sure that women are made aware of these rights. The treaty monitoring bodies themselves have not enough to protect women, as they have not made sure that the country reports on the implementation of the conventions. Zimbabwe last reported to CEDAW committee in 1998 and has not made an attempt to report since then. The committee should have mechanisms in place to make sure that the state is forced to report because they cannot monitor the implementation of the convention if the country is not reporting. The failure to report also shows that the country is not committed to the international instruments and is not willing to be held accountable for its failure to implement the provisions of the international provisions.

The weakness with a human rights oriented study is that the obligation and duties are with the state and it is mostly what the state can do and not what individuals can do. As they are state obligations it means that individuals cannot do much to make sure that their

rights are protected except agitate for their rights but the duty is on the state to enforce them. If the state shows unwillingness or a reluctance to implement the rights, for example, right to health the international community will only urge the state to respect its international obligations and impose sanctions if there is a blatant disregard of rights. The international community gives rights to the people but do not give them the means to implement those rights. Women have the right to health but the right needs to be implemented by the state and if the state has no means then the rights will not be respected.

## **5.2 WOMEN AND THE RIGHT TO HEALTH**

International law as currently constructed is men's law especially in its application and the way it affects women. This is because human rights language concentrates on violations by the state and its organs and these occur in the public sphere while the lives of women are in the private sphere and this leads to their exclusion (Banda F: page 13). The author argues that human rights also concentrate on political rights and less on the economic, social and cultural rights where the rights of women are largely found and this has led to states not giving them as much attention as they should as can be seen in the way women's health issues have been affected in Zimbabwe. The concentration of the world has been on the politics of the country while the suffering of women has been a secondary issue and a result of the failed politics in the country and there is no attempt to address the right to health as being paramount for women.

Women have a right to control their fertility and to decide on the number and spacing of their children<sup>15</sup> but my research has shown that the economic situation has interfered with this right so that women can no longer decide when they want to have children due to the cost of having children in the country. From the interviews conducted I felt that the state's economic policy has even interfered with this right as women told me that they do not intend to get pregnant until they can feel safe and also until they can afford to have

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<sup>15</sup> African Protocol Article 14 (a) and (b)

the children. Women are being forced to space their children and limit their right to reproductive health by the situation in the country.

There is a shortage of personnel at the hospital so that pregnancy has become a risky business for women in Zimbabwe as they are also not sure that the few medical personnel available will not be on strike when they are admitted. There were two strikes during the course of the dissertation from October 2007 to the time of writing this dissertation in March 2008. The nurses went on strike from December 05 to the beginning of January 2008 and they have gone back on strike in March 2008 and the government has not yet addressed their grievances which means that women will continue not accessing health care for a while longer. The commitment of the health personnel themselves to saving the lives of women is now questionable as they are frustrated by their working conditions. Human rights provide that women have a right to trained attendants at birth and these are no longer guaranteed at Harare Hospital and even when they are there they are not committed to the job so that women's access to health services are still violated.

Women are transferred from long distances to be treated at the referral centers which are still functional and this involves a lot of travelling for example the woman from Mrehwa who was transferred to Marondera then to Chitungwiza and then finally to Harare Hospital where she finally gave birth. The health system has collapsed to such an extent that most of the hospitals that have facilities for Caesarian sections are not performing them as a result of the shortage of equipment and the state as the duty bearer on the provision of health services in public hospitals is not doing enough to improve the situation for women. Most of the women who need public services are poor women who are mostly unemployed as more than 70% of the population is unemployed and this leads to the disparity as the more affluent women have access to health services at private hospitals while the poor in the community cannot afford the private hospital and have to rely on public hospitals.

The government from 1980 introduced free health services but was discontinued as a result of the Economic Structural Adjustment Programme and one author has written:

“Government commitment to maintaining mass access to health services in Zimbabwe was beyond question in the 1980’s. This policy of consistent real increases in public financing of health services could not be sustained by ESAP.” (Bijlmakers L.A page 13).

This made me realize that women right to health has always suffered as a result of the economic policies in the country and whenever government cuts on spending and prioritizes other areas of government. The collection of user fees for health services started in 1985 but low-income earners were exempted from paying user fees. In my research none of the women are exempted from paying user fees even if they have no source of income and are obviously poor and these user fees have become unaffordable by many of the women.

The women were not speaking with one voice in the responses they gave me on their right to health and seemed to accept the situation as beyond their control. Women need strategies that will put equal emphasis on their psychological empowerment (Tsanga A.S page 112) so that they learn to put their right to health as being paramount and as a right that the state needs to implement for them. I felt when I talked to the women that they are not really concerned because the situation is affecting the whole country and has affected all service delivery and they did not see themselves as the exception. Even if the situation has affected all service delivery it does not make it normal and measures should be put in place to make sure the rights of pregnant women are not unduly violated and the women themselves should advocate for their rights. There is need for a:

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: page 112)

The women had no solidarity in their problems and although I accept that women are not universal and do not have similar problems there is also need for them to accept that they are fighting for the same goal especially at the hospital. The women at the hospital did not protest even if they all had the same problem, for example, the food. They all accepted that the food was bad but all the time I was there not even one woman raised her

voice to say the food is bad to the authorities or the women who bring the food. This lack of initiative on the part of the women mean that their right will continue to be trampled upon because they wait for someone else to advocate for their rights instead of doing it as a group of women who want to achieve the same goal. If the women had all refused to eat the food, the hospital would have made efforts to improve on the quality of food provided to the women.

There was also an assumption that the women were not bothered about the payments made to the hospital because they did not make the payments themselves but they were made by their husbands. Women were portrayed as economically dependent on their spouses and even the assumption that if a woman is having a baby it means that she is married. I felt that it is negative stereotyping that reinforces women as helpless creatures in need of masculine attention and I also the fact that we are a long way from achieving gender equality because all the women at the hospital were waiting for their husbands to come and pay for them before they could be released and none had an independent income. The example by the matron of a woman who had an infection and did not access healthcare until she was told that she could lose her womb touched me. The woman probably was waiting for her husband to give her the money for treatment and he did not take her health as a priority so did not buy the medication for her. I felt that the problems that we have with the accessibility of the health sector is also because women are not financially empowered to make independent decisions on their health and there is need to promote the financial empowerment of women in order to make sure that their right to health is respected and that they respect the right themselves.

### **5.3 HEALTH AND THE STATE**

The state has the obligation to make sure that the public health system continues to function and this involves providing the necessary environment for the efficient running of the hospital. The hospital personnel are paid by the state and it is the duty of the state to make sure that they are given incentives so that they can stay committed to their job.

The state also has relegated the provision of quality healthcare to private hospitals whereas it is their duty to provide healthcare for the people and conform to the provisions of international and regional instruments which it is signatory to. The state has shown a willingness to be bound by international instruments on the right to health and there is need for it to deliver on its responsibilities to women.

The claw back measure in the Constitution of Zimbabwe where international instruments will only take effect if the Parliament has domesticated it means that the country can sign instruments with relative impunity as they do not have to implement the provisions immediately and the implementation is also subject to the availability of resources. There is no right to health in the constitution but by virtue of having a Ministry of Health the state has acknowledged that they have a duty to provide healthcare for the people of Zimbabwe and hence have to provide quality service for pregnant women. There can be the addressing of nurses and doctors strikes in time so that there is resumption of services as quickly as possible which one can argue is within their means if they prioritize the needs of women.

## CHAPTER SIX

### 6.0 CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 CONCLUSION

In conclusion the economic situation in the country has affected the right of pregnant women to access health care. Women find the transport to and from hospital unaffordable and there is no solution to the problem as yet. In fact the prices of commuters are going up on a daily basis and commuters which were \$500 000 in December 2007 are now \$10 000 000 which is an increase of more than 2000% in three months. This is to give an indication of the extent to which women have to adapt to new prices on a daily basis and one wonders if they could not afford the \$500 000 in December how are they coping with the \$10 000 000. The indication was that pregnant women were not visiting the hospital and risking their lives because they could not afford to make the required visits and as the price keeps going up more women cannot afford the visits and continue forfeiting their right to health. The government has not done much to cushion the women and improve their access to healthcare even if the hospital is aware of the decreasing numbers of women visiting the hospital. Attempts by the Ministry of Health to decrease the rates of maternal and neonatal morbidity have to take into consideration the transport crisis in the country and make sure that women can get to the hospital in time and make the required visits during the course of the pregnancy and like one author has stated:

Reduction of maternal mortality is a matter of organization and part of that organization is the provision of transport facilities and hostel provision for those in need of or likely to need emergency obstetric care. There does seem to be a relationship between poor transport organization and high levels of maternal mortality (Grieco M, Turner J 2003)

The organization of transport is paramount and there is need to take emergency action before more women lose their lives. Pregnant women need to be highly mobile in order to get services because they need to visit the hospital as the hospital cannot go to them hence the need for good transport organization by the state.



The cost of hospital care has also become highly prohibitive for the pregnant women in the country even those who are more affluent than the women at Harare Hospital. One of my classmates who was pregnant and registered at a private hospital had to change from the hospital after she was told that she had to pay \$7, 9 billion (USD\$1000 in February 2008 when she was given the quotation) for a Caesarian section. She could not afford it and had to change to another clinic. This is to illustrate that the price of health care for pregnant women has become unaffordable by all women even those who are employed and who otherwise would have afforded it. Health care has become a luxury that few can afford and women who are at their most vulnerable when they are pregnant are giving up the right to health in the hope that they will not develop complications. The matron at Harare Hospital indicated that women give birth at home and only come to the hospital if they or the baby has complications otherwise the hospital will not even get to hear of the birth. The children will only be registered at local clinics in order to collect birth records for birth certificates but she was quite sure that there are a lot of children being born at home. The cost of health care has continued to increase even when the Minister of Health is advocating for free services for pregnant women and indications are that women are now paying more than \$1 billion at a time when the majority of the employed are earning less than \$500 million. The situation of pregnant women's access to health care is continuing to deteriorate and more women will not access hospital care.

The wage wars have continued between the hospital personnel and the state and the nurses are on strike for more pay as I am writing and the government seems reluctant to address their demands. The nurses and doctors are already not committed to work as they look for activities that will give them more money to supplement their doctors. At the hospital the nurses sell cotton wool to those women who would not have brought it from home and they sell it at a higher price than the shops and the women who are desperate have to buy. When I went to the hospital the in December 2007 there were 22 midwives and when I went back to in January 2008 there were 17 remaining so that if they continue to leave at that rate there will be no midwives at the hospital by April. This unacceptable

situation has made pregnant women direct victims of the brain drain and government's lack of commitment to paying professionals.

The quality of life for the people of Zimbabwe has continued to deteriorate and pregnant women are not spared the shortages of basic commodities which affect the people of Zimbabwe. Women's access to acceptable, affordable, accessible and quality healthcare will continue to be limited as the state continues to argue that they have no resources and prioritize other areas of the economy. The State has not shown commitment to the health sector and women's right to health has continued to be violated because they have no way of enforcing their right to health. The international community has also not done enough to protect the rights of pregnant women and enforce their right to health.

## **6.2 RECOMMENDATIONS**

In order for the health sector to recover there is a need for a concerted effort from all stakeholders in the government and the international community.

**Actions recommended to be taken by the state, its ministries and other organisations:**

### **6.2.1 Ministry of Health**

- Take overall responsibility and show commitment to improving maternal and neonatal health towards the achievement of Millennium Development Goals Number 4 and 5
- Advocate for the highest priority to be given towards the reduction of maternal and neo-natal mortality in the distribution of financial resources and mobilize adequate resources for the implementation of the Roadmap for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Zimbabwe.

- Ensure the availability of adequate numbers of skilled health workers and where necessary train more midwives so that the hospital can be fully staffed.
- Make sure the working conditions of the health personnel are addressed and provide incentives like housing and free transport to and from work so that the hospital can retain personnel.
- Disseminate relevant health policies and guidelines widely so that women know what to expect from the Ministry.
- Advocate for free services so that women can access quality health services.
- Provide more referral centers which are fully equipped with all the equipment for emergency obstetric care so that women do not have to travel long distances to referral centers.

### **6.2.2 Ministry of Finance**

- Allocate adequate resources with a view to revamping the health sector especially towards buying new equipment like incubators and essential medicines.
- Prioritize the health sector in the allocation of resources and budget according to the needs of women.
- Address the salary grievances of health workers timeously and also provide an attractive package with a view to retaining personnel.
- Provide funds for the training of more nurses and doctors to replace the ones that have left for the Diaspora so that the hospital is fully staffed.
- Provide funds to ZESA so that there can be better provision of power services so there are no interruptions at the hospital which often needs to perform vital procedures without interruptions of power.
- Provide the Zimbabwe National Water Authority with funds to meet the water demands of the city to prevent further water cuts as these have unduly affected the rights of women.
- Provide Harare Hospital with more operational funds to stop the exploitation of women as the financial stopgap measure for the hospital.

- Work with other stakeholders towards the turn around of the economy including the international community.

### **6.2.3 Ministry of Justice, Legal and Parliamentary Affairs**

- Advocate for the amendment of the Constitution on the operation of international instruments so that international instruments can be legally binding even without domestication.
- Amend the Constitution so that it protects economic, social and cultural rights and not just political and civil rights.
- Make women aware of the Protocols and Conventions that Zimbabwe is signatory to and their implications on the rights of women so that they are empowered and can demand their rights.

### **6.2.4 Ministry of Transport**

- Provide cheap fuel for ambulance providers so that they do not run out of fuel and are able to provide ease of and cheap access to medical services for women.
- Provide a fleet of ambulances operated by the Ministry, maybe under the CMED, so that they can provide affordable transport for women in need of emergency obstetric care.
- Provide the transport operators with fuel so that they can charge affordable fares affordable to women traveling to and from medical health facilities.

### **6.2.5 Ministry of Foreign Affairs**

- Advocate for healthier relations with the international community so that the country can get foreign currency to finance the health sector.

### **6.2.6 Ministry of Women's Affairs, Gender and Community Development**

- Support the empowerment of women so that they can make informed decisions on their sexual and reproductive health issues including accessing antenatal care and family planning services.
- Support and promote initiatives by other ministries and by the international community to reduce maternal and neo-natal mortality.
- Mobilize women's groups to lobby relevant authorities to enforce necessary legislation on women's right to health.
- Make women aware of their right to health under international instruments and advocate for the implementation of those rights by the relevant authorities.
- Protect women's freedom from discrimination at all levels of their life.

### **6.2.7 Ministry of Labour and Social Welfare**

- Promote the right of women to free maternity services paid for by the State if they have no proven source of funds.

### **6.2.8 United Nations Organizations**

- Support government initiatives in the implementation of policies and strategies to bring about the necessary changes and improve health and quality of life for pregnant women in Zimbabwe.
- Support and provide technical and financial assistance to the Ministry of Health in areas relevant to the attainment of the highest standard of physical and mental health for pregnant women in Zimbabwe.

- Provide financial support to the Ministry of Health for the training of midwives and birth attendants so that women have trained birth attendants at birth.

### **6.2.9 Non- Governmental Organizations**

- Hold the State responsible to its obligations to the international community by providing shadow reports on the State's failure to implement the provisions of international and regional instruments.
- Organize money-generating activities for the empowerment of women so that they can generate incomes that can enable women to pay for health services if they are required to do so.

### **6.2.10 Harare Hospital**

- Promote the operation of a clean environment at the maternity wing so that women's health is not compromised.
- Monitor and evaluate the services of midwives, nurses and doctors to ensure adherence to acceptable standards of practice.
- Ensure the proper preparation of food and the maintenance of an adequate diet for pregnant women.
- Prioritize the needs of pregnant women at budgetary allocations.
- Work with the international organizations and the Ministry of Health in promoting the right of pregnant women to adequate health care and in the reduction of maternal and neonatal mortality in accordance with the Roadmap.

### **6.2.11 Zimbabwe Electricity Distribution Authority**

- Ensure that there are no power cuts at health facilities so that pregnant women's access to health is not hindered.

### **6.2.12 Zimbabwe National Water Authority**

- ensure that there are no interruptions to the provision of clean water to health facilities.
- ensure the availability of alternative sources of water at health institutions like the provision of boreholes.

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