# WOMEN AND GIRLS LIVING WITH HIV/AIDS AND THEIR ACCESS TO MEDICAL CARE AND TREATMENT FOR OPPORTUNISTIC INFECTIONS (OIs) IN HARARE, ZIMBABWE

**BY**
**Sandra MAKWECHE**

**Supervisor: Rosalie Katsande**

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

## Abstract

**Zimbabwe is one of the countries in Sub Saharan Africa whose women have not escaped the severe impact of Hiv/Aids, the majority of whose victims die as a result of contracting opportunistic infections (OIs). This dissertation looks at women and girls living with Hiv/Aids (PLWHA) and their access to medical care and treatment for OIs using public health institutions in Harare. It argues that women and girls suffer from OIs (especially certain sexually transmitted infections which are unique to women) which require treatment outside antiretroviral drugs (ARVs) and that the treatment for such OIs, although relatively cheap, remains unaffordable to the majority of them. As a consequence, increasing numbers of Zimbabwe women are unnecessarily dying of these OIs which could be relatively easily and cheaply treated. This silent, untold catastrophe threatens to devastate the population and seriously hinder the development of the country. Adopting several methodologies (including the Human Rights and Grounded Theory Approaches) which are guided overall by the Women's Law Approach, the writer, a magistrate, selects her female (and some male) respondents for the research primarily from two large high density areas of Harare, Zimbabwe's capital, and analyses how they access OI treatment from several key public institutions within and around the city. She collects and analyses data from interviews with them and several key informants including doctors, nurses, policy making government officials and NGO representatives involved in donor funded Aids work in Zimbabwe. She conducts and presents the research within a comprehensive theoretical, policy and legal context from the perspective of PLWHA. The study finds that, although Zimbabwe has a good national Hiv/Aids policy framework (which provides that OI treatment is free), its implementation through an adequate legal framework is failing dismally. The theoretical framework of this research focuses on the intersection between the Hiv/Aids epidemic and the entrenched economic, social and gender inequalities suffered by women. They combine not only to exacerbate their vulnerability to OIs but also to reduce the ability of such women to afford the necessary medical care and treatment when they become infected by them. The study revealed that key barriers which impede women`s access to healthcare include user fees charged by public health facilities, the prohibitive costs of medication and diagnostic tests, drug shortages and transport difficulties which resulted in the majority of women (most of whom live below the poverty datum line) failing to seek appropriate health care when it is needed. As a coping mechanism, some women turn to traditional herbal medicine which is cheap and has sometimes proven successful. The study concludes that there is a huge mismatch between the Hiv/Aids policies on paper and women`s lived realities and experiences when using the public health facilities. In order to remedy this problem, the writer recommends including OI treatment within a suggested Action Plan to achieve a Comprehensive National HIV Prevention, Treatment and Care Programme (co-ordinated between relevant Government Ministries and NGOs) which includes the following: making the right to health care for women a human right within Zimbabwe's Constitution; making relevant international Human Rights Instruments part of Zimbabwean law; increasing the national budget for women and girls living with Aids and improving its management; improving women`s economic empowerment; exploring the possibility of finding a place for traditional herbal medicine alongside formal public health care.**

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**Declaration**

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

Signed……
Date……

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

Signed…….
Date…….

ROSALIE. K. KATSANDE
Lecturer at Southern and Eastern African Regional Centre for Women's Law, University of Zimbabwe

Date…….Signed…….

## *Dedication*

*This work is dedicated to my lovely children Ruvimbo Tania (5 years) and Tinayeishe Ryan (1 year 7 months) for not being there for you when you needed me most. You are so special to me.*

*And in loving memory of my mother, Annah Makweche. I followed in the footsteps of a woman dedicated to making life the very best that it could be for her family.*

**Acknowledgements**

I want to thank the Almighty God, who is Jehovah Ebenezer, for thus far He has taken me throughout my studies at SEARCWL.

I wish to express my deep gratitude and heartfelt thanks to my supervisor, Rosalie K. Katsande for her intellectual contribution and in guiding me throughout my research. Her valuable comments and suggestions helped me to shape this study.

I am especially thankful to Professor Julie Stewart, Dr Amy Tsanga and the entire visiting lecturers for all the knowledge they imparted in me. I have been empowered.

I would like to express my sincere appreciation to NORAD for the financial support through out the programme, this work would have been impossible without the necessary finances.

To the entire staff at SEARCWL, thank you for your support, love and for making the learning environment enjoyable.

I am deeply grateful to my loving husband, Simon Mupindu, for his constant encouragement, companionship and unwavering support and for serving as inspiration to me throughout this journey.

I owe a special note of thanks to my brothers Thomas Makweche and James Saidi for believing in me and always encouraging me to do my very best and for the wisdom to never allow anyone to tell me what I cannot accomplish in life.

SEARCWL class 2011/12, you were the best classmates I could ever wish for and I will certainly miss you. Special thanks to Mary for everything we shared.

I would like to extend a heartfelt thank you to all the women (and men) I interviewed. I am deeply grateful to them for sharing their stories with me. This research is my best effort at respecting your voices and paying tribute to your stories. I also want to acknowledge the useful contributions made by all the interviewees.

A special thanks to my aunt Sarah Manjonjo and my maid Beaula Ndemera for being second moms to Tania and Tinaye as I pursued this masters program.

Finally, to my prayer partners and friends Valeria Shumbamhini and Tendai Mutukwa, thank you for the prayers and words of encouragement throughout the period in which I was committed to my studies. I am humbled by my experiences in this masters program. I thank God for the opportunity to pursue my destiny.

To God be the Glory!

**Acronyms and Abbreviations**

| | |
|---|---|
| Aids | Acquired immune deficiency syndrome |
| ART | Anti-Retroviral Treatment |
| ARVs | Anti-Retroviral drugs |
| CEDAW | Convention on the Elimination of all forms of Discrimination Against Women |
| ESP | Expanded Support Program |
| Hiv | Human immunodeficiency virus |
| JAT | Justice Aids Trust |
| MDGs | Millennium Development Goals |
| NAC | National Aids Council |
| NATF | National Aids Trust Fund |
| NGO | Non Governmental Organisation |
| OI | Opportunistic Infection |
| PCP | Pneumocystis Carinii Pneumonia |
| PLWHA | Person/People Living with Hiv/Aids |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UNAIDS | United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| WLSA | Women and Law in Southern Africa |
| WHO | World Health Organization |
| ZNASP | Zimbabwe National Hiv and Aids Strategic Plan |
| ZNNP+ | Zimbabwe National Network of People living with Hiv |
| ZWLA | Zimbabwe Women Lawyers Association |

**Human Rights Instruments cited**

Abuja Declaration (2001)
Convention on the Elimination of all forms of Discrimination Against Women
Covenant on Economic, Social and Cultural Rights (1966)
Maseru Declaration on Hiv/Aids (2003)
Millennium Development Goals
Protocol to the African Charter on Human and People`s Rights on the Rights of Women in Africa ('The Women`s Protocol')
Universal Declaration on Human Rights (1948)
United Nations General Assembly Special Session on HIV/AIDS (2001)
SADC Protocol on Gender and Development (2000)

**List of Statutes cited**

Constitution of the Republic of Zimbabwe
Indigenisation and Economic Empowerment Act, Chapter 14:33
Indigenisation and Economic Empowerment (General) Regulations, 2010 [Statutory Instrument ('SI') 21/2010]
Public Health Act, Chapter 15:06
Social Welfare Assistance Act, Chapter 17:06

**List of Policies cited**

National Hiv/Aids Policy, 1999
The Patients Charter
Zimbabwe National Strategic Plan (ZNASP) 11, 2011-2015

**Cases cited**

*A Juvenile v The State 1989(2)ZLR61, 72*

## List of Tables

## Executive Summary

Zimbabwe is one of the countries in Sub Saharan Africa that has not escaped the severe impact of Hiv/ Aids in relation to women. As such, this dissertation looks at women and girls living with Hiv/Aids and their access to medical care and treatment for opportunistic infections (OIs) using public health institutions in Harare. The main objectives for conducting the research were to assess the efficacy of Zimbabwe`s national Hiv/Aids policy framework in safeguarding women`s right to health, examining the challenges women and girls encounter in accessing medical care and treatment of OIs and exploring further ways in which government can increase its effectiveness in ensuring that women have equal access with men to treatment of OIs. It argues that women and girls living with Human immunodeficiency virus (Hiv) suffer from OIs which require medical treatment and care outside Antiretroviral drugs (ARVs). It also raises issues that whilst having the national Hiv/Aids policy framework in place is a starting point towards achieving equitable access to medical care and treatment of OIs, it is not an end in itself towards the full realization of women and girls` right to healthcare because legal measures do not mean anything if they are not effectively implemented. It argues that treatment for OIs is unaffordable to the majority of women living with Hiv/Aids resulting in their not always seeking appropriate healthcare when its needed thus becoming even more vulnerable to many other OIs which in turn impact on their right to life guaranteed in section 12 of the Constitution of Zimbabwe.

The methodologies relevant to the study were the women`s law approach, grounded theory approach, the human rights-based approach and the influence of actors and structures. I adopted a qualitative approach in carrying out the research. In embracing the Women`s law approach, Hiv positive women were the central focus of the investigation and inquiry in the study for understanding and examining their actual lived realities and experiences when using the public healthcare system in contrast with the *de jure* system in place. The use of grounded approach also helped me in interrogating what is taking place on the ground as opposed to desk research. As the research focused on access to health care, the human rights approach became relevant in comparing what Zimbabwe is expected to do in terms of the human rights standards pertaining to the right of Hiv positive women to access health care and the reality on the ground. The use of the actors and structures approach was instrumental because it enabled me to start with Hiv positive women`s experience in accessing medical care and treatment of OIs and then look at the actors and structures that impact on their daily lives.

The research was informed by feminist theoretical perspectives. The study relied on what is expressed in relational feminist theory that women`s lives exist in relation to others hence their lives are relational rather than autonomous. This I found to be true during the research because the majority of women when they managed to acquire a little income, they prioritised feeding and educating their children at the expense of seeking treatment for their own OIs. As a result, because of the gender, economic and social inequalities between men and women, there is no equitable access to Hiv treatment and care as provided for in guiding principle 2 of Zimbabwe`s National Strategic Plan (ZNASP)11, 2011-2015.

The study also relied heavily on observations made by Socialist/Marxist theory which attributes the vulnerability of women to Aids to their subservient and unrecognised role within a heavily patriarchal and capitalist society. Women`s educational attainment, work patterns, income levels, access to and control of resources and social roles all have

considerable impact on their right to health care. The research using grounded approach showed that the majority of women were largely responsible for expressive roles such as child rearing, household chores and urban farming which is unpaid work thus supporting the Marxist /Socialist theory. Since most of the women`s work in the home is not paid work, the majority of women had no access to resources, yet ownership of resources is essential for the right to health to be realised. I discovered that women as a result, had less time for income generating activities and this impacted on their capacity to afford medical care and treatment of OIs due to lack of access to and control over resources.

In this study, the data collected using the grounded approach strongly suggested that Hiv positive women and girls in Harare are vulnerable to women-specific OIs which require treatment outside antiretroviral drugs (ARVs). I submit that until women`s vulnerability to infections of their reproductive system (which is unique to women) is acknowledged, more and more women will succumb to them. This will have a devastating impact on Zimbabwe and its development.

The study showed that key barriers women encountered in seeking medical care and treatment of OIs were the user fees charged by public health facilities, prohibitive costs of medication, diagnostic tests, drug shortages and other hidden costs such as transport. These barriers impede Hiv positive women`s access to health care for OIs resulting in the majority of them often failing to seek appropriate health care when its needed. Such financial and organisational barriers have generated poverty and impacted negatively on the quality of life of Hiv positive women in Harare. Despite government`s pledges in the Hiv/Aids policy and strategic framework to make the cost of health care for Hiv/Aids treatment and care more affordable and available, it seems from the research findings in Harare, there is no effective implementation of these policies.

The research also revealed that Hiv positive women also use traditional herbal medicine especially for treatment of sexually transmitted infections (STIs) as these are both economically and physically accessible and available. Although some of the herbal medicine is effective in treating some OIs, these are not a substitute for ARVs which are life sustaining drugs and also there are other OIs which require attention within the formal health care system. I discovered that some of the women living with Hiv believe in spirituality as an ultimate coping strategy whilst others resort to it for treatment of OIs because of drug shortages.

The research concludes that there is a mismatch between the Hiv/Aids policies on paper and the women`s lived realities and experiences when using the public health facilities for OIs. Zimbabwe`s public healthcare falls short of the human rights standards enshrined in both the regional and international instruments to which Zimbabwe is a signatory to and is duty bound to ensure that women and girls access medical care. It recommends that women`s economic empowerment will go a long way in promoting equitable access to treatment and medical care for OIs. The provision of socio-economic rights including the right to healthcare in Zimbabwe`s Constitution will go a long way in making strides in the achievement of women`s health rights. The government as the primary duty bearer should fulfil women`s right to healthcare by domesticating both the regional and international human rights instruments to which Zimbabwe is a signatory to and is duty bound to ensure that women have equitable access to healthcare for OIs with men.

# CHAPTER 1

# 1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

## 1.1 Introduction

Women and girls living with Human immunodeficiency virus (Hiv) suffer from opportunistic infections (OIs) which require medical treatment and care outside Antiretroviral drugs (ARVs). This research has shown how Hiv positive women are vulnerable to women-specific OIs and the challenges they faced in exercising their right to healthcare using public health facilities. The study further explored the coping mechanisms used by women and girls in treating OIs.

This introductory chapter will give a background and justification of the study, the statement of the problem, the objectives of the study, research assumptions and research questions, location of the study and conclude by defining key concepts. The next chapter will discuss the theoretical framework more particularly the theories that informed the study and relevant human rights instruments applicable to the study. The third chapter will explain the methodological framework and methods which I used to collect data on women`s access to medical care and treatment of OIs. The fourth chapter discusses the challenges encountered by women and girls living with Hiv/Aids in accessing formal healthcare. The fifth chapter discusses the coping strategies used by women for treating OIs. The final chapter is on the conclusion on the findings and the recommendations on how to scale up women`s access to healthcare for medical care and treatment of OIs using the public health facilities.

## 1.2 Background to the Study

In spite of my considerable experience on the bench as a magistrate, I chose a dissertation topic in the area of women's health rights. This study was mainly influenced by one of the 'Access to Resources' lectures when we analyzed the barriers which impede women`s access to healthcare. I linked that to my personal experience of taking care of my Hiv positive sister and meeting all her medical bills for treatment of OIs since 2009. I remember vividly the first

time my sister confided in me when she had an OI. She recounted her situation to me as follows:

> "For the past three months I had a severe lower abdominal pain and felt as if there was a fire in my abdomen just below my umbilicus. The doctor at Harare central hospital told me I have an abscess (a severe boil) and I am supposed to undergo an operation for the treatment of the abscess. The doctor explained to me that the abscess was caused by a condition called pelvic inflammatory disease (PID) which occurs more frequently and aggressively in Hiv positive women. I do not have the money required for the operation."

My sister`s story and many other similar stories I came across in the press opened my eyes to women`s vulnerability to Hiv-related OIs and their inability to meet the costs for medical care and treatment of such OIs, which would result in some Hiv positive women not always seeking appropriate heath care when it is needed. I had noticed the various challenges Hiv positive women face in accessing medical care and treatment of OIs, but I did not seriously think about them. When faced with choosing a dissertation topic, I thought this was a good opportunity for me to explore the workings of the Patients Charter, in particular the provision on free treatment for people living with Hiv/Aids (PLWHA) attending OI clinics and other Hiv and Aids services and the Zimbabwe National Strategic Plan (ZNASP) 11, 2010-2015 Guiding Principle 2 on equitable access to treatment of OIs. This resulted in my conducting the grounded research on the actual lived realities and experiences of these Hiv positive women and girls on access to healthcare using public health facilities in Harare. The research was to interrogate on the current government`s Hiv response in addressing women`s specific health needs with the aim of improving women`s access to OI drugs as provided in the Hiv/Aids policies and strategic plans. I concluded that the various challenges Hiv positive women face in accessing the right to medical care and treatment of OIs will impact on whether Hiv positive women will continue to use the formal health care for treatment of OIs.

### 1.3 Statement of the Problem

Women represent 60% of those infected by Hiv in sub-Saharan Africa (UNAIDS, 2008) and are getting infected at a faster rate than men because of social, economic and cultural vulnerabilities. Like most of the countries in Sub Saharan Africa, Zimbabwe is one of the

countries in the region that is seriously affected by the Hiv pandemic[1]. Since the diagnosis of the first case of Hiv infection in Zimbabwe in 1985, out of the estimated 1 023 038 adults living with Hiv, 608 700 are women[2]. Hiv prevalence in women and girls aged 15-49 is 21.1% significantly higher than prevalence in men aged 15-49 which is 14.5%[3].The rapid spread of Hiv worldwide and the patterns that have been generated by this spread have transformed Aids into a woman`s disease (Lindsey, L. 1997).

It is greatly commendable that the Zimbabwean government has made considerable efforts to put in place policies, mechanisms and strategic plans with regard to scaling up Anti-retroviral treatment (ART) services and the local manufacturing of generic ARVs which have turned Hiv into a more manageable chronic condition. However, the issue of access to medical care and treatment of OIs are a critical concern for many Hiv positive women in Zimbabwe. *Most Hiv-related deaths in Zimbabwe are a result of patients succumbing to OIs* which is evidenced by the fact that from the peak of the epidemic until 2007, over 100 000 people died every year from OIs (Rajaratnam, J.et al., 2009). According to (Walker, A. S., et al 2010), ARVs can reduce the amount of Hiv in a person`s body and restore the immune system but *even where ARVs are available, they do not entirely remove the need for preventing and treating OIs*. PLWHA are vulnerable to OIs because they take advantage of the opportunity offered by a weakened immune system, as such, prevention and treatment of OIs remains essential (Lingappa, J.R et al., 2010).

Notwithstanding the fact that Zimbabwe ratified various regional and international instruments on women`s right to health care, these have not been translated into reality. Failure to access treatment for OIs by Hiv positive women and girls in public health centres consequently result in them taking care of themselves or being taken care of by other women and girls thus reducing their time to engage into productive or income generating work. This I found to be true as far as Hiv positive women and girls in Harare are concerned. The prohibitive cost of medication, diagnostic tests, user fees, drug shortages and equipment to effectively address the challenges of women specific OIs have generated poverty and have affected the quality of women`s lives. I submit that comprehensive access to medical care and

[1] UNAIDS/UNFPA/UNIFEM 2004.

[2] Zimbabwe Agenda for Accelerated Country Action for Women, Girls, Gender Equality and Hiv 2011-2015

[3] Zimbabwe-Know your epidemic, know your response, Women, Girls, Gender Equality and Hiv 2010.

treatment of OIs is essential for women to live qualitative, healthy, fulfilling and productive life and this contributes to economic development of the nation.

Millennium Development Goal (MDG) number 6 is on combating Hiv/Aids, Tuberculosis (TB) and other diseases by 2015. Target 6b is on achieving universal access to treatment for Hiv/Aids for all those who need it by 2010. Zimbabwe despite making a commitment to MDG 6, it is still lagging behind in terms of implementation of target 6b as we are already in 2012 and universal access to treatment for Hiv/Aids has not yet been attained.

### 1.4 Justification of the Study

This study is significant as it seeks to analyse the extent to which the Zimbabwean government is in compliance with both the regional and international instruments which provide for women`s rights to healthcare. Hiv/Aids is a women`s issue because the risks and consequences are different for women (Campbell, C. A 1999) and therefore should be studied using a different feminist perspective. This research seeks to add knowledge to Zimbabwe`s Hiv/Aids discourses on women and girls by incorporating a feminist theoretical framework which examines the factors that hinder women and girls from accessing medical care and treatment for OIs.

In deciding to focus on women and girls living with Hiv/Aids, I recognised the fact that women`s entrenched economic and gender inequality within their relationships with men can constrain their ability to access medication and treatment for OIs. As noted by (Cook, R. J 1994:7), issues on utility of health care systems need to be analysed from the perspective of women because they suffer from diseases or conditions that affect men and women differently, that are unique to women, are more prevalent in women, more serious among women and diseases for which the risk factors are different for women or some groups of women or for which the interventions are different for women.

Whilst in reality, Hiv is a retrovirus that does not discriminate between men and women, there are considerable differences between men living with Hiv and women living with Hiv (Bain, 2001). There are vulnerabilities to Hiv that are unique to women. In the light of women`s vulnerability to women-specific OIs as exemplified by my sister`s story, I felt that

there was a need to explore and interrogate the barriers Hiv positive women encounter in accessing medical care and treatment of OIs using public health institutions and whether they resort to other remedies such as traditional herbal medicine and spirituality as coping strategies. Women`s vulnerability to OIs related to their reproductive system is real and needs to be tackled for any progress to occur in the fight against Hiv/Aids. The female reproductive tract is more susceptible to infection by Hiv related STIs than male and women are four times more vulnerable to acquiring STIs because of their biological make-up[4]. It is my argument that *until women`s vulnerability to Hiv related OIs is acknowledged and fought, more and more women will continue to succumb to OIs and Aids* and Zimbabwe will eventually disintegrate as it will be full of sick people intensifying underdevelopment. Women`s vulnerability to Hiv related illness is an urgent issue that needs immediate and urgent attention in order to ensure that Zimbabwe prospers. It is a fact that a healthy population fosters economic development and stability. Thus the research seeks to enlighten Hiv/Aids discourses about the unique position of women.

This research is also significant because it is aimed at transforming the women`s lives and providing policy makers with a reference point to see where the gaps are in the society that enhances women`s vulnerability to Hiv and OIs, especially Sexually Transmitted Infections (STIs).

As a Masters in Women`s law student working towards the realisation of women`s rights, I felt it was important to explore further ways in which the government of Zimbabwe can increase its effectiveness in ensuring that women have equal access with men to treatment of OIs at public health institutions. It was for that reason that I decided to undertake a study on women`s access to the right to healthcare. Thus this research is premised on the need to scale up and achieve equitable access to treatment of Hiv-related OIs using public health institutions and to critically analyse whether Hiv positive women are enjoying the provisions of the national Hiv policies and strategies. An analysis of the conflict between the policies on paper and Hiv positive women`s lived realities and experiences will also be made. Finally, it is anticipated that this research will be a contribution to the growing literature on Zimbabwean women and Hiv/Aids.

[4] "Hiv Infection in Women". 01 May 2006. US Department of Health and Human Services.31 December 2006.

## 1.5 Objectives of the Research

On embarking on this research, I was guided by the following research objectives namely:

1. To identify the country`s Hiv/Aids laws and policies which deal with access to medical care and treatment of OIs.

2. To assess the efficacy of current national laws and policy framework in safeguarding women`s right to health, in particular, access to medical care and treatment of OIs.

3. To assess the efficacy of the health delivery system in Harare in providing medical care and treatment of OIs for women and girls living with Hiv/Aids.

4. To determine the challenges women and girls living with Hiv/Aids face in accessing medical care and treatment of OIs using public health institutions in Harare.

5. To use the findings of the research to come up with recommendations for law reform and policy change and contribute to the literature and documentation that already exist on Hiv/Aids.

## 1.6 Research Assumptions

To achieve the above mentioned objectives, I was guided by six major assumptions, one of them in sub- assumption as listed below:

1. Women and girls living with Hiv/Aids are vulnerable to OIs which require medical care and treatment outside ARVs.

2. The costs of medical treatment of OIs are prohibitively expensive and beyond the reach of many indigent women and girls living with Hiv/Aids.

2.1 The lack of economic access for treatment of OIs by women and girls living with Hiv/Aids shortens their life span thus compromising their right to life.

3. There is a general shortage of essential drugs and important medical equipment in public health institutions to adequately address challenges of OIs.

4. Women and girls living with Hiv/Aids use traditional herbal medicines and believe in spirituality for treatment of OIs as these are economically accessible and available.

5. The Zimbabwean policies relevant to Hiv/Aids are gender neutral but are gendered in their implementation thereby negatively affecting women and girls living with Hiv/Aids.

6. The plight of women and girls living with Hiv/Aids in accessing medical care and treatment of Hiv-related OIs can be ameliorated if duty bearers implement the National Hiv/Aids Policies and comply with the regional and international human rights instruments by making essential drugs for treatment of OIs available and accessible at all levels of health care delivery system.

## 1.7 Research Questions

The research questions emanating from the above assumptions were as follows:

1. Are women and girls living with Hiv/Aids vulnerable to OIs which require medical care and treatment outside ARVs?

2. Are the costs of medical care and treatment of OIs prohibitively expensive and beyond the reach of many indigent women and girls living with Hiv/Aids?

2.1 Does the lack of economic access to treatment of OIs by women and girls living with Hiv/Aids shorten their life span thereby compromising their right to life?

3. What effect does the shortage of drugs and other medical facilities in health institutions have on addressing the challenges of OIs for women and girls living with Hiv/Aids?

4. Do women and girls living with Hiv/Aids use traditional herbal medicines and believe in spirituality for the treatment of OIs because these are economically accessible and available?

5. Are the Zimbabwean policies relevant to Hiv/Aids gender neutral on paper but gendered in their implementation thereby negatively affecting women and girls living with Hiv/Aids?

6. Can the plight of women and girls living with Hiv/Aids in accessing medical care and treatment of Hiv-related OIs be ameliorated if duty bearers implement the national Hiv/Aids Policies and comply with regional and international human rights instruments by making essential drugs available and accessible at all levels of the health care delivery system?

### 1.8 Location of the Study and Target Population

The field research was conducted in Harare which is the capital city of Zimbabwe and has the highest population. Notably, many ethnic groups from all over the country converge in Harare, thus it provided a mixture of cultural practices as well as good tribal balance. Harare also provided opportunities to interact with the women in all their facets - rich and poor, young and old, educated and uneducated, empowered and disempowered. This provided a balance in discerning how the socio-economic factors play out in relation to accessing medical care and treatment of OIs.

In order to have all the research questions answered and triangulation of data, I targeted different groups of people. I targeted women (and men) who are openly living with Hiv and Aids (mainly from Mabvuku Dandaro Support Group and Mufakose) and other areas of Harare in order to discover their experiences and the challenges they face in using the public health facilities for the treatment of OIs. Aids service organisations` officials were also interviewed in order to get their experiences in dealing with Hiv positive women and girls, the efficacy of their Hiv management and mitigation strategies and the challenges they face in implementing these strategies. The Health Service Board officials were also selected because they are policy makers and implementers of the law. Herbalists were included in the target

population so as to get their views on the prevention and treatment strategies for OIs in their communities. An official from National Aids Council (NAC) was interviewed as NAC is the national body which coordinates donor funds and the National Aids levy. Nurses from different clinics and doctors from Parirenyatwa and Harare Central Hospitals were interviewed to get their views and experiences on the women-specific Hiv-related OIs, accessibility of healthcare, availability of essential drugs and equipment to adequately address OIs. Pastors from churches were interviewed to shed light on their experiences of spirituality as a coping strategy for Hiv positive women and girls suffering from OIs. The target population was selected either through my personal networks or randomly using the grounded approach.

## 1.9 Definition of Key Concepts

***Access*** combines two main concepts:

(i) Availability: geographical access

(ii) Affordability: economic access

*Aids*

**Acquired immune deficiency syndrome** is a way of describing a whole group of symptoms and diseases associated with the damage Hiv does to the immune system. There is no cure for Aids, but there are medications that can dramatically slow the progression of the disease.

NB: The abbreviation **Aids** is no longer written in capital letters as a way to do away with stigmatising the disease and same applies with **Hiv**.

***Anti-retroviral drugs (ARVs)***

These are drugs that act by blocking action of enzymes that are important for the replication and functioning of Hiv. The ultimate purpose of (ARVs) is to reduce the Hiv viral load.

***CD4 count***

This is part of the body`s defence mechanism which fight infections and as such it is a marker of immune system function. Hiv multiplies and attacks the CD4 cells.

***Discordant***

means that one partner in a relationship is Hiv positive whilst the other partner is Hiv negative.

***Hiv***

The **human immunodeficiency virus (Hiv)** is a virus that weakens the immune system and ultimately causes a condition called Acquired immune deficiency syndrome (Aids). Hiv destroys a type of defence cell in the body called a CD4 helper lymphocyte. These lymphocytes are part of the body's immune system, the defence system that fights infections. When Hiv destroys these lymphocytes, the immune system becomes weak and people contract serious infections that they normally would not.

***Immune system***

This is the body`s system for fighting diseases.

***OIs (Opportunistic Infections)***

These are mild to severe infections or diseases caused by micro-organisms such as bacteria, fungi, virus or parasites that normally do not cause serious disease in health people but may occur in individuals whose immune system is impaired or compromised in some way and in this study by Hiv.

***Public health institutions***

These are state aided or municipal health centres. These are a way that government fulfil their duty to provide for the well being of their people. The Zimbabwean government provides funds from the national budget to spend on health. The public health system in Zimbabwe provides care and treatment, user fees are charged and the patient pays all the costs. Services are supported by national policies to control costs and to ensure safe and effective use of treatments. Aids treatment, including treatment for (OIs) and ART is coordinated by the Ministry of Health and Child Welfare (MoHCW).

***Traditional medicine***

Traditional medicine involves the use of traditional medicines and in this study refers to herbal medicine from herbalists.

***Treatment***

Treatment is a key element of care and support for people living with Hiv/Aids. It can be:

- Curative, i.e., curing diseases either temporarily or permanently;
- Preventive, i.e., preventing disease from happening or becoming worse;
- Palliative, i.e., reducing symptoms in order to reduce discomfort and distress.

***Viral load***

The viral load is the amount of Hiv in the blood.

## CHAPTER 2

## 2.0 THEORETICAL, LEGAL AND POLICY FRAMEWORK

In this Chapter, I will discuss the theories that informed the study and review related literature because research is not an end in itself, as it must produce evidence and new knowledge to inform the development of policies and programmes. I will also look at the regional and international provisions on the right of PLWHA to healthcare and compare them with the provisions of the national laws and policies to see whether Zimbabwe complies with the laid down human rights standards.

The first case of Hiv/Aids in Zimbabwe was diagnosed in 1985[5]. According to the NAC official I interviewed, at first there was widespread denial and indifference at national level. However, as it gradually dawned on Zimbabwe and the rest of the world that Hiv and Aids and OIs were a threat to mankind, many strategies were put in place and documenting Hiv/Aids was one of the strategies (UNAIDS,2008). The objective of reviewing literature relevant to this study is to find out what work has already been done locally and in other parts of the world in order to identify gaps and take advantage of lessons learnt at local level as justification and a basis for guiding research.

There is a lot of literature on Hiv/Aids and women`s vulnerability to Hiv. I submit that this research emerged from the need to further literature on women`s vulnerability to Hiv-related OIs in Hiv/Aids discourses. Women have been vulnerable to Hiv/Aids and the related illnesses since the epidemic emerged but it appears as if not much research has been done specifically on Zimbabwean women. Since the beginning of the Hiv epidemic, women were suffering and dying from Aids-related illnesses, yet it seems as if the topic of women and Hiv-related OIs is not thoroughly interrogated. The experience of men dominated Hiv/Aids discourses and defined the symptoms of Aids and course of the illness (Lindsey, L. 1997). The invisibility of women in Aids literature led to a delay in understanding how Hiv affected women (Baylies, C., and Bujura, J. 2000). Women were virtually ignored in the literature as Aids was presented as a homosexual disease and a male disease. The notion that women

[5] Zimbabwe Hiv/Aids Research Priorities 2010-2012.

could not contract Aids led to tragic consequences, because women were not getting tested, studied or included in clinical trials (Squire, C. 1993).

## 2.1 Feminist Perspectives

The nature of this study and its underlying assumptions that women and girls living with Hiv and Aids are vulnerable to OIs which require treatment outside ARVs and that women cannot afford the costs charged for medical care and treatment of OIs by public health institutions, meant that I had to acknowledge the importance of feminist theorizing. Feminist theories enabled me to analyse and theorize about what my data was revealing and not to prove that the theories were right. Furthermore, feminist theories in my research provided an alternative lens in examining women`s vulnerability to OIs by looking at social and cultural conditions and disparities that affect women in Zimbabwe. It is of fundamental importance to note that feminist inquiry joins other 'underclass' approaches in insisting on the importance of women studying women and "studying up" instead of "studying down" (Harding, S. 1987).

### *2.1.1 Relational Feminist Theory*

The study also relied on what is expressed in relational feminist theory. One relational feminist argues that women`s lives exist in relation to others hence women`s lives are relational rather than autonomous (West R. L as cited in Becker, M. et al,.2007 ). She further argues that women most of the time are not there to satisfy their own pleasures as required by the liberals but are out to please and satisfy other people`s desires, what she termed as "the giving self". She attributed this to women`s biology in that they are able to fall pregnant and also because of their training for their role as primary care takers.

The advent of Hiv in a family inevitably impacts women who are usually home makers. It is women who work hard to make ends meet when their sons or husbands fall ill because of Hiv and in the end women suffer ill-health to care for their own health (Chirawu, S.et,.2007).Women assume more family care responsibilities and are more likely to sacrifice their own health care in order to care for their family especially their children. According to

(West R. L as cited in Becker, M. et al,.2007 ), women`s suffering is different from that of men, so is their joy. This is the case with Hiv and OIs as women are disproportionately affected by the Hiv epidemic. This I found to be true in Mabvuku and Mufakose during the study as Hiv positive women because of being relational, prioritised feeding their families and meeting their children`s educational expenses at the expense of seeking medical care and treatment for their own OIs. During the general group discussion in Mufakose, one woman indicated that she had stopped taking her cotrimoxazole (an anti-biotic which prevents OIs) for a week because she had no money for transport and consultation required at Wilkins infectious hospital because she had used the few dollars she realised from vending to buy food for her two minor children. She argued that her children come first as there was nobody else who provided them with food because she is a widow. Another woman in Mabvuku also indicated that she did not buy OI drugs prescribed to her at the local clinic because she had used all the money she had realised from her part time job as a general hand to pay school fees for her children. The majority of women were not able to afford the cost of treatment of OIs because they tend to put other people before themselves as highlighted by the two stories above. The remedy according to (West R. L as cited in Becker, M. et al,.2007) is that, for women`s pain to be felt, they need to be able to describe their gender specific pain to communicate its magnitude.

### *2.1.2 Socialist/Marxist Theory*

The research relied heavily on what is expressed in Socialist/Marxist Feminist Theory which attributes women`s vulnerability to Hiv defining illnesses to the capitalist system and patriarchy endemic in the society. Socialist/Marxist feminism argues that capitalism and patriarchy are major impediments to women acquiring complete independence over their lives which enhance vulnerability to Hiv defining illnesses, in particular STIs. Socialist/ Marxist feminist theory explains the oppression, subjugation and global economically disadvantaged position of women as being based in their under representation in economic, social and political structures.

Furthermore, this theory again argues that the lack of serious recognition and reward of women for their domestic productive roles maintains women in a state of dependency on the largesse of patriarchy and patriarchal structures (Jacquette, J 1982). I paid special attention to

the role of women and girls within the family in Zimbabwe. Women are largely responsible for their roles of cooking, urban farming, childcare, care-giving to sick members in the family including for those living with and affected by Hiv. This is often unpaid work and is based on the assumption that women "naturally" fill this role and this means women are not economically empowered and have to rely on men to meet their financial needs. I found this to be true as the majority of women living with Hiv/Aids in Harare are full-time housewives or are unemployed and as home-makers, they have less time for income generation and productive tasks which impacts on their capacity to afford medical care and treatment of OIs. Women living with Hiv/Aids also face challenges in accessing treatment of OIs due to lack of access to and control over resources since most of their work is not paid yet resources are essential for the right to health to be realized. Men own and control resources because they are employed in the public sphere where work is valued and paid. I also sought to link women`s non-paid productive roles as a factor that determined their economic and social standing in society. This theory helped me to identify the social construction of production as the basis for women`s oppression by focusing on the social relations of gender.

Using the Socialist/Marxist perspective on women`s lives, I was able to interrogate the validity of the roles which have been assigned to both women and men in our society. From the research, I discovered that the majority of Hiv positive women in Harare are not formally employed or have lower incomes than men and some do menial jobs with minimal benefits and as a result they have little economic access to medical care and treatment of OIs and affordable medical insurance. Women in Mabvuku and Mufakose were putting aside attending to their own health due to the lack of money to pay user fees or for transport to public hospitals. A problem faced by more men than women. The failure to access health care was because the women did not have incomes of their own or the male figure in their lives would have refused or neglected to provide financial assistance regardless of the fact that he is gainfully employed in the public sphere. This situation caused some women living with Hiv and Aids to seek medical care and treatment of OIs outside the formal health system and resort to traditional remedies because these are both physically and economically accessible. According to the Marxist feminism, the remedy to this oppression of women is to overthrow the capitalist system and patriarchy which would give women spaces in which they can have some say and control over their lives. The net effect of this is to do away with the economic dependence syndrome of women on men and when women are economically

empowered, they will have the economic independence to make their own decisions about how to use their own money. In this case women will be able to pay for their healthcare.

## 2.2 The Human Rights Framework

The human rights approach is a framework which is premised on perceiving the Hiv and Aids pandemic as a human right challenge. The framework also offers a holistic way of addressing all aspects of the pandemic by promoting and protecting rights. It aims at raising awareness among the people to enable them to demand these rights and take responsibility in contributing towards the prevention and amelioration of the impact of the pandemic. This approach enabled me to engage respondents actively in assessing their understanding of the right to medical care and treatment of OIs. Mechanisms and barriers for asserting the right were also assessed. This framework is premised on the basis of the incorporation of international human rights standards in all programming and furthering the realisation of human rights.

I appreciated from the outset that the rights based approach is not a panacea to all the challenges associated with medical care and treatment of OIs. However, the United Nations General Assembly Special Session on Hiv/Aids (UNGASS) noted that a lack of human rights protection fuels the Hiv epidemic by making people more vulnerable to the infection when their economic, social or cultural rights are not protected.[6] As such the research was premised from a human rights perspective where I was looking at the right of Hiv positive women and girls to access medical care and treatment of OIs using public health institutions. Zimbabwe is a signatory to and has ratified several regional and international instruments that seek to improve the Hiv response towards universal access to comprehensive prevention, treatment and care. Human rights provide for standards of access to legal remedies that is supposed to be implemented by governments so that this right is accessible, available and affordable. The human rights framework provided me with an opportunity to look at what things are like on the ground as compared to what they should be.

[6] Special Session of the General Assembly on Hiv/Aids, Round Table 2: Hiv/Aids and Human Rights. 15 June 2001.

Article 3 of Universal Declaration on Human Rights (UDHR) protects for the right to life. The Declaration, though not legally binding provides minimum standards of care by the state parties for its people. Article 25(1) provides for the right to a standard of living adequate for the health and wellbeing of each person and his family including medical care. Zimbabwe by failing to provide medical care and treatment of OIs for women and girls living with Hiv and Aids is failing to protect the right to health of women thus indirectly failing to protect the right to life for women and girls guaranteed by section 12 of the Constitution.

Zimbabwe signed and ratified the International Covenant on Economic, Social and Cultural rights (ICESCR).[7] Article 3 provides for the equal right of men and women to enjoy economic, social and cultural rights. Zimbabwe as a duty bearer in terms of Article 12(1) is obliged to ensure enjoyment of the highest attainable standard of health to the right holders. (Claude, R.P and Issel, B.W 1998) noted that the rights included in the international human rights instruments on healthcare were framed in such a way that whether health-related rights depend on state or private sponsorship, duty bearers should direct their efforts at raising standards of health by providing medical care.

As noted in the Human Rights Bulletin, Number 41, February 2009, Guideline Number 10 states that resource scarcity does not relieve states of certain minimum obligations in respect of their implementation of economic, social and cultural rights. If Zimbabwe is to argue that it is unable to meet its minimum obligations to enable Hiv positive women and girls to access medical care and treatment for OIs, it should demonstrate that every effort has been made to use all resources at its disposal in an effort to satisfy those obligations. The ICESCR is relevant because it provides for socio-economic rights for women. Although Zimbabwe has ratified this Covenant, it is still a long way from making these rights a reality to the ordinary men and women as the Constitution does not provide for socio-economic rights.

The Protocol to the African Charter on Human and People`s Rights on the Rights of Women in Africa (‘The Women`s Protocol’) specifically addresses women`s rights in relation to Hiv and Aids and identifies protection from Hiv and Aids as a key component of women`s health.

[7] Zimbabwe became a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR) on 13 August 1991.

Article 14 provides that State parties should ensure that the right to health of women is respected and promoted. The Women`s Protocol is therefore a useful tool at regional level that can be utilised at domestic level to promote and protect women`s right to health.

In Article 24 of the Abuja Declaration on Hiv/Aids, Tuberculosis and Other Related Infectious Diseases, States committed themselves to ensuring coordination of all sectors at all levels with a gender perspective and respect for human rights, particularly to ensure equal rights for PLHWA. In terms of Article 26 African States also undertook to allocate at least 15% of their national budgets to improve the health sector.

The United Nations General Assembly Special Session Declaration on Commitment on Hiv/Aids (UNGASS) recognises that Hiv/ Aids is a global crisis that requires global action.[8] UNGASS declaration in June 2006 confirmed in its decree that *"the full realisation of all human rights and fundamental freedoms for all is an essential element in the global response to the Hiv/Aids pandemic"*[9].Guideline 6 provides that States should also take the measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for Hiv/Aids prevention, treatment, care and support, including ARVs and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of Hiv/Aids and related OIs and conditions.

The Maseru Declaration on Hiv and Aids[10] is a reaffirmation of UNGASS and the Abuja Declarations. It recognises that Hiv and Aids are best tackled from multi-sectoral interventions and the upholding of the rights of PLWHA. The priority areas requiring attention are improving care and access to treatment. The declaration also affirmed the Abuja declaration commitment to allocate at least 15% of national budgets to improve the health sector.

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**8** The Declaration emerged from the summit on HIV/ AIDS, TB and Other infectious diseases sponsored by the OAU and hosted by the government of Nigeria`s Ministry of Health, 26-27 April 2001.

9 UN Resolution adopted by the General Assembly, 60/262. Political Declaration on HIV/AIDS, Article 11.

10 The Declaration was signed at Maseru, Lesotho by SADC heads of state and government or authorized representatives on 4 July 2003.

The SADC Protocol on Gender and Development has been developed using a rights-based approach. Hiv and Aids are provided for in Article 10 that calls on member states to ensure universal access to the treatment and care of people infected by Hiv and Aids.

## 2.3 National Legal Framework

### *2.3.1 The Constitution*

The Constitution is the supreme law of the land and any law that is not consistent with it is, to the extent of the inconsistency, void.[11] The 1979 Lancaster House Constitution which is currently used in Zimbabwe is silent on socio-economic rights. The government, despite ratifying the ICESCR, appears reluctant to make socio-economic rights a reality since it has failed to guarantee them in the constitution. The gap is critical in terms of issues relating to health as there is no reference to the right to healthcare or to the rights of PLWHA. This shows a lack of political will on the part of the Zimbabwean government to give the necessary high priority socio-economic rights so urgently require despite the fact that the Constitution has been amended 19 times since 1980. It is a fact that both the regional and international instruments which provide for the right to health care were ratified by Zimbabwe after the promulgation of the Lancaster House Constitution which is in use.

Since the right to health is not justiciable, in the event of its violation many Zimbabwean women and girls living with Hiv are in a predicament. Section 12 of the Constitution guarantees the right to life for every individual. PLWHA have a right to life. This right to life for PLWHA requires that they should be able to access medical care and treatment for OIs to prolong their lives. While one might have the fundamental right to life, surrounding circumstances such as lack of access to medical care and treatment for OIs will definitely prevent that person from enjoying the right to life through low life expectancy. However, the right to life guaranteed in the Constitution is narrowly construed to guarantee the right of an individual not to be arbitrarily deprived of his life at the hands of the state. So far, however, it has not been interpreted to protect life in the face of the Hiv/Aids pandemic to ensure that all people with HIV and AIDS are able to access medical care and treatment for OIs.

[11] Section 3 of the Constitution of Zimbabwe.

The right to life would be meaningless without the recognition of other equally important rights such as the right to health which would make that life qualitative and productive. Zimbabwe is currently under the process of formulating a new people-driven constitution and hopes are high that socio-economic rights will be incorporated in the new constitution as these rights mostly impact on women`s lives. On the regional level, section 27(1) of the South African Constitution and Article 43 Kenyan Constitution provide for the right to health care in the bill of rights. This signifies the importance being accorded to socio-economic rights regionally in observance of the 'indivisibility' principle.

Furthermore, there is no automatic transmission of human rights provided for by international instruments into domestic legislation as clearly stated in the Constitution.[12] Despite this seeming drawback in the Constitution, courts are not precluded under the cloak of judicial activism from incorporating international human rights instruments into judgements.[13]

### *2.3.2 Significance of the Right to Health in the Zimbabwean Constitution*

Government has committed itself to fulfilling the right to health by being party to various regional and international treaties which guarantee the right to health. Guaranteeing the right to health in the constitution will bring Zimbabwe into compliance with the regional and international treaties that it is party to and affirm government's commitment to the health of its citizens. Having the right to health guaranteed by the highest law in the land will empower Zimbabweans to demand protection of the right to health and to ask political leaders to justify policy decisions that they make which negatively impact vulnerable groups and are contrary to the constitution. It will also be possible to challenge such policies and laws that violate the right to health in court.

[12] Section 111B of the Constitution of Zimbabwe provides that International law does not form part of the law of Zimbabwe unless it has been incorporated into the law by or under an Act of Parliament.

[13] In *A Juvenile v The State 1989(2) ZLR 61, 72* the judge held that the courts of this country are free to import into the interpretation of...the Declaration of Rights, interpretations of similar provisions in International and Regional Human Rights Instruments such as among others, the International Bill of Rights, The European Convention for the Protection of Human Rights and Fundamental Freedoms... In this end, international human rights norms will become part of our domestic human rights law. In this way, our domestic human rights jurisdiction is enriched.

### *2.3.3 The Public Health Act*

The Public Health Act [Chapter 15:06] in section 17 describes *'infection'* as *'Any form of or state of infection which a person is suffering from or in the incubation stage of whether the disease was transmitted through sexual intercourse or not.'* The section lists infectious diseases which include TB which is one of the common OIs for people with Hiv and Aids.

### *2.3.4 The National Aids Policy Framework*

A National Hiv/Aids policy framework exists in Zimbabwe. It includes the Health Charter, the National Hiv/Aids policy, 1999 and ZNASP. The Patients Charter provides for free treatment of OIs for all PLWHA. The National Hiv/Aids Policy recognizes that the government should change the underlying social and cultural structures that perpetuate the vulnerability of women to HIV infection and transmission[14]. ZNASP 1 was for the period 2006-2010 and ZNASP 11 is running from 2011-2015. The overall goal of ZNASP 1 was to reduce the spread of Hiv, improve the quality of life of those infected and affected by Hiv, and to mitigate the socio-economic impact of the epidemic in the country. ZNASP II`s guiding principles include, *inter alia* ,ensuring equitable distribution, availability and access to services by all PLWHA and that respect and fulfilment of human rights is a pre-requisite for an efficient and effective Hiv and Aids response. The National Aids Policy and ZNASP 11 underlined the importance of respecting, protecting and fulfilling human rights and gender equality in the context of Hiv epidemic. ZNASP 11 does not comprehensively cover the medical care and treatment of all OIs. There is no effective implementation of either strategy and both financial and human resources are cited as major resource constraints. The government engages resource mobilisation both internally and externally. Internal strategies include the National Aids levy whereby 3% of all taxable individuals and corporate income funds Hiv programmes. However, the Hiv response in Zimbabwe is heavily dependent on availability of donor funding.

[14] Zimbabwe, "National Policy on HIV/AIDS for Zimbabwe," (1999), Section 7.

### *2.3.5 Case Law*

Zimbabwean jurisprudence on Hiv and Aids has not developed substantially. Zimbabwean case law has not dealt with the issue of access to medical care and treatment of OIs by PLHWA. The lack of case law in this area points to the need for strategic litigation to advance the rights of women and girls living with Hiv and Aids to access medical care and treatment of OIs at health institutions.

Possible cases in Zimbabwe could be Constitutional ones based on the rights enshrined in the Declaration of Rights. For instance the right to life provision in section 12 of the Constitution could by used to support a class action claim that PLWHA are entitled to access free medical care and receive treatment for OIs. Litigation has the potential of advancing the rights based approach. Litigation ought not to be limited to the existing laws but also to the international human rights framework. Once an international instrument is referred to in a case, it creates a judicial precedent that can be used to advance women`s human rights.

In conclusion both relational feminism and Marxist/Socialist theories informed the study. Zimbabwe has shown its commitment to promote women`s right to health by ratifying the above mentioned regional and international instruments but these have not been translated into reality. On paper, Zimbabwe has a comprehensive Hiv/Aids policy framework but there is no effective implementation of the policies. The next chapter discusses the various methodologies relevant to the study and the research methods used and their evaluation.

# CHAPTER 3

# 3.0 RESEARCH METHODOLOGIES AND DATA COLLECTION METHODS

## 3.1 Methodological Framework

This Chapter describes the methodologies and data collection methods that enabled me to collect the data I needed and answer the research questions. I adopted a qualitative approach in carrying out the research. Much effort was made to capture the voices of women and to find out their views on access to medical care and treatment of OIs. Although I was focusing on women, men were not excluded in this study. I included men`s voices to have a balanced view as expostulated by (WLSA 2007). (Bentzon, W. et al 1998:79) states that, empirical research is not undertaken in a vacuum but is informed by a variety of factors. The chapter discusses the women`s law approach, grounded theory approach, the human rights approach and actors and structures perspectives as they applied to my research. I also used my own experiential data of taking care of my Hiv positive sister to triangulate the information that I was getting.

### *3.1.1 Women`s Law Approach*

In my endeavour to critically analyse the position of Hiv positive women and girls regarding access to medical care and treatment of OIs using public health institutions in Harare, I had to adopt an appropriate research framework, as such I embraced the Women`s law approach. The Women`s Law approach as expounded by (Dahl, T.S. 1987) is a woman centred approach, which takes women`s actual lived realities and experiences as the starting point for analysing the position of women in law and in society. As such, Hiv positive women were the central focus of investigation and inquiry in this research. The women`s law approach was instrumental in understanding and examining the actual lived realities and experiences of Hiv positive women and girls as they exercised their right to medical care and treatment of OIs using public health centres. I used the approach to formulate my research assumptions and questions to capture women`s lived realities in every aspect that I had sought to have been answered.

The major component of the Women`s law approach facets is to critique the interplay between law and life because the approach is predicated on the need to capture women`s lived realities as a means of interrogating the adequacy of the political, socio-economic and legal mechanisms in place with the aim of redressing any existing gender-specific injustices. Although the right to health is not enshrined in the Constitution, the Patients Charter provides for free treatment of OIs to all PLWHA, whilst the National Aids policy provides for comprehensive, cost-effective and affordable care to PLHWA[15]. ZNASP`s Guiding Principle 2 provides for ensuring equitable distribution, availability and access to services by all people. Whilst a policy framework exists and is gender neutral on paper, the question I asked myself was whether these policies have been translated into reality. I interviewed women living with Hiv in Mabvuku, Mufakose and some parts of Harare to find out their lived realities so as to assess the gap between the laws and policies on paper and the reality on the ground. The women`s law perspective also enabled me to begin the research with what appears problematic from the perspective of women`s experiences. I carefully listened to women as they narrated their experiences in accessing medical care and treatment using public health institutions in Harare. I found out that most women were eager to share their experiences and concerns about how user fees, prohibitive cost of medical care and drug shortages were major hindrances in their bid to access public health centres for treatment of OIs. One woman who tested Hiv positive in 2006 said:

> "I cannot afford the US1 or US$5 consultation fees charged at the local clinic and the hospital respectively. To make matters worse, anti-biotics such as cotrimoxazole which prevent OIs are usually out of stock or unavailable at the local clinic. I have difficulties in getting US$3 to cover transport costs to and from the hospital where I collect my monthly supply of ARVs. As a result of all these challenges, I have always been a sick person who is infected by various OIs".

This bottom-up approach, where I captured the Hiv positive women`s daily experiences at grassroots level was instrumental in collecting empirical data from women because the methodology acknowledges the pluralities of norm-setting institutions in a woman`s life and therefore endeavours to investigate the woman in her actual lived realities as opposed to the former position where other people, mostly men, spoke on behalf of the women (Bentzon et al., 1998). The research assumptions on prohibitive costs of medical care and treatment for

[15] Guiding Principle 12 of the National Aids Policy, 1999.

OIs, drug shortages in public health centres to address the challenges of OIs and that the gender neutral Hiv policies impact negatively on women, were confirmed using the Women`s law approach. The women's law approach shaped the focus of the study and enabled me to contrast the *de facto* (or factual) system Hiv positive women are placed in as a lived reality with the *de jure* (or legal) system in place in so far as access to health care is concerned.

The methodology also involves capturing the voices of women from across the social spectrum to see whether they speak with one voice over the right to medical care and treatment of OIs. My group discussions with the women in Mufakose and Mabvuku informed me that even the uneducated women had knowledge about their rights to healthcare and blamed the government for failure to fulfil and promote this right.

I carried out the research to find out the possible causes of Hiv positive women`s failure to access health care and the corresponding interventions. The approach was instrumental in establishing how marginalisation of women hindered them from getting education which in turn limited employment opportunities thus making it difficult for them to afford drugs and diagnostic tests. A 25 year old woman with two children who tested Hiv positive in 2009 said:

> "I am not formally employed. I failed my "O" level and I am a full time housewife. My husband is Hiv negative and is a cashier in OK supermarket. He does not prioritise giving me money for treatment of OIs. I do not have my own money to pay the costs to get treatment."

I also used the approach to assess the medical services as well as educational programmes that women receive from Newlands clinic, Epworth clinic and Mashambanzou Care Trust[16]. Finally, in formulating recommendations, the women's law approach was useful in establishing whether the realities of women could be addressed through effective implementation of the existing policies and administrative measures. This was the case because the research focus was to respond to women`s explanations of the phenomenon under investigation and to provide suggestions as to what they want. Using the Women`s law approach, the women did not only identify the challenges encountered in accessing healthcare but they also identified the possible solutions.

[16] These are NGO funded clinics which provide medical care and treatment of HIV-related illnesses.

### *3.1.2 Grounded Theory Approach*

The grounded theory as a key component of the women`s law research is a research paradigm in which theory is developed from data. The approach starts from interrogating what is taking place on the ground as opposed to desk research. In grounded theory, the researcher must keep moving through the data to see the incident over and over and constantly be comparing and conceptualizing (Glasser, B. 2002). This was a useful approach which was critical in as far as it allowed me to constantly engage with the data I had collected and determine what data to collect next. In some instances during the research, one interviewee would lead me to the next relevant person in conformity with the 'dung beetle' process whereby data would be accumulated on the ground, analyzed and sifted later.

This methodology was practically used on all the assumptions as listed in Chapter 1 as will be evident in Chapters 4 and 5 on research findings. For example, when the women stated that they suffered from OIs which required treatment outside ARVs, I sought to find out the factors which make women vulnerability to OIs. Questions developed as the study progressed for example, I interrogated what were the women-specific OIs and the next question was where the women sought treatment for the OIs resulting in my interviewing the doctors, nurses and a herbalist.

Grounded theory provided me with valuable insights into some of the factors which prevent Hiv positive women and girls` from accessing medical care and treatment of OIs. The approach helped me to see the situation on the ground, analyse it and identify gaps that exist between the law and the women`s lived realities. It became apparent that user fees currently charged by public health centres and other hidden costs such as transport are stumbling blocks for women and girls living with Hiv in accessing medical care and treatment of OIs. This was a useful method as it uses empirical data to define a problem and the women proposed intervention measures such as their economic empowerment to address their plight.

Finally, the approach enabled the study to be conducted with an open mind in a manner that allowed a constant engagement with the assumptions and research questions to enable me to deal with emerging issues. Before I went into the field, my assumptions were based on the

fact that ARVs were given for free. Using grounded approach, it emerged that ARVs are not given for free at all public health centres in Harare but that an administration fee of US$1 is charged apart from transport costs as ARVs are mainly dispensed at public hospitals where the majority of PLWHA are registered as opposed to local clinics. Another Hiv positive woman in Mabvuku recounted her story:

> "I get my monthly supply of ARVs at Wilkins infectious hospital but I have to pay a consultation fee of US$1 or else I will not get the supply as the nurses insist on seeing the receipt from the Accounts office before giving me the tablets. Besides the US$1, I also need US$3 for transport to and from the hospital. I cannot afford all these costs every month."

### *3.1.3 Human Rights-based Approach*

The human rights based approach is primarily premised on the universality and fundamentality of human rights. It is a conceptual framework normatively based on international human rights standards and operationally directed towards promoting and protecting human rights. It integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development of a country.

As the research focused on access to health care, the human rights approach became relevant in comparing what is Zimbabwe is expected to do in terms of the human rights standards pertaining the right of Hiv positive women to access health care and the reality on the ground. The rights-based approach places the individual as the holder of basic rights and at the core process of development. During research, I investigated the extent to which Hiv positive women in Harare as rights holders under the various regional and international instruments stated earlier on and ratified by Zimbabwe, were accessing the right to health care for OIs. In embracing the human rights-based approach to health care, I focused on the issues of accessibility, affordability and availability medication for OIs.

The human-rights based approach enabled me to engage interviews actively in assessing their understanding of the right to healthcare. The research revealed that Hiv positive women and girls had limited access to health care for OIs using public health centres because of factors such as user fees charged, prohibitive cost of medication and essential drug shortages. These

factors hit indigent women and girls in Harare the hardest. Using the approach, I analysed the predicament of Hiv positive women and girls in as far as their right to healthcare is concerned in light of the human rights standards. Again in terms of MDG 6 on Hiv/Aids target 6b on universal access to treatment by the 2010, our nation is lagging behind in terms of implementation as we are already in 2012 and universal access to treatment has not been attained.

The government of Zimbabwe as the primary duty bearer must take steps to respect, protect and fulfil Hiv positive women`s right to health care for OIs. Using the rights based approach, I also analysed the current domestic legislation and Hiv/Aids policies in light of the international and regional human rights standards to which Zimbabwe is a party to, to assess the State`s compliance whilst making an effort to advance the rights of Hiv positive women in Harare to access healthcare for OIs.

### *3.1.4 Actors and Structures Perspectives*

It was significant for me to use an actors and structures approach because it enabled me to start with Hiv positive women`s experience in accessing medical care and treatment of OIs and then looked at the actors and structures that impact on their daily lives. In my research, I scrutinized the role played by the following actors namely doctors, nurses, NGOs, pastors and herbalists in as far as access to healthcare is concerned as the approach directed me to these key respondents in my research. I also looked at how structures like NAC, MoHCW, the Health Service Board, government and municipal clinics and hospitals impact on Hiv positive women`s access to healthcare of OIs. The approach helped me to interact with these players and analyse the impact of the different actors and structures that Hiv positive women engage with in accessing medical care and treatment of OIs using public health institutions in Harare and using traditional herbal medicine. Using this approach, I discovered from these various actors that women cannot afford the user fees charged by public health institutions and costs associated with drugs, x rays or diagnostic tests and that some women used herbs to treat OIs as these were easily accessible and available. Finally, I also chose to employ this approach to understand the influence these actors have in addressing the challenges women encounter in accessing the right to health.

## 3.2 Data Collection Methods

Data collecting methods are the techniques employed in gathering the desired data (Bentzon et al.1998). In order to get the desired information in my field research, I used the following methods:

### *3.2.1 Key Informant Interviews*

Key informant interviews were conducted. The method involves the collection of data from the perceived "knowers" or experienced about the topic or some people with influence in the community (Chirawu, S. et al,. 2007). The key respondents were as follows:

**Table 1: Showing Key Respondents**

| Interviewees | Female | Male | Total |
|---|---|---|---|
| Medical doctors | 5 | 1 | 6 |
| Nurses | 6 | 1 | 7 |
| NAC Official | 0 | 1 | 1 |
| Health Service Board Member | 1 | 0 | 1 |
| NGO Officials | 2 | 2 | 4 |
| Herbalist | 0 | 1 | 1 |
| Pastors | 0 | 2 | 2 |
| **Total** | **14** | **8** | **22** |

Key respondents were chosen based on their expertise and skills they were perceived to have taking into consideration either their experience in providing medical care and treatment of OIs and engagement with Hiv positive women and girls. This method is a reliable tool for collecting data from strategic sources. The purpose of interviewing official respondents was to get the official position from those actually providing the medical care to Hiv positive women and girls. The research would have been incomplete without the voice of those handling the job in order to verify the information obtained from Hiv positive women. The key objective of the interviews was to obtain information from individuals who are directly and indirectly responsible for the administration of funds to buy OI drugs, provision of medication care and treatment for OIs and providing information on treatment of OIs.

Key informant interviews were helpful and I used unstructured questions. The official respondents had special knowledge about medical care and treatment of OIs and were connected in some way with issues involved and narrated their stories using their own experiences and observation thus providing the desired information. My research questions and assumptions helped me in my line of questioning. This method also provided useful information to the research as the official respondents were already in the system and they verified the information that I got from Hiv positive women about the challenges they encountered in accessing medical care and treatment of OIs at public health institutions in Harare.

### *3.2.2 Individual Interviews*

Individual interviews were conducted with PLWHA.

**Table 2: Showing Individual Interviews conducted with PLWHA**

| **Interviewees** | **Female** | **Male** | **Total** |
|---|---|---|---|
| Mabvuku residents | 12 | 5 | 17 |
| Mufakose residents | 10 | 3 | 13 |
| Other suburbs of Harare | 7 | 3 | 10 |
| **Total** | **29** | **11** | **40** |

A combination of young women, old women and men were interviewed. The interviewees were selected from Dandaro Support group in Mabvuku, randomly in their homes in Mufakose with the assistance of a relative of mine, church mates and clients at my sister`s workplace. I used this method during the research and the women were chosen randomly to present a divergent view on all issues. This method was used as I could deeply question the life situation of the particular woman which I could not do in a group discussion. The advantage of using this method was that I established a relationship with the respondent and I could understand the feelings and opinion of each woman and man about her or his ability to access medical care and treatment of OIs at public health institutions in Harare and the importance of the assistance they got from the NGO clinics in the capital city. All the women were quite willing to talk and I was surprised at the content and quality of information that they would share with me. 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 less structured interview, with open ended questions as opposed to a standardised questionnaire was used as it permitted a more intensive study of attitudes and perceptions. This data collecting method left room for getting information on the economic and social standing of each individual. The advantage of using this method in collecting data was that the responses were spontaneous, specific and self revealing.

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 but I found it to be time consuming.

### *3.2.3 Focus Group Discussion*

This method involves interviewing a group of people with specific experience and knowledge in the topic (WLSA, 2000). The focus group discussion was held in one of the residential flats for medical doctors at Parirenyatwa central hospital. This method helped me to get information in a short space of time. I acted as a facilitator for the discussion and appreciating that this was grounded research, issues under discussion were put forward and respondents discussed. The focus group deliberated on the following issues among others:

(a) The most common Hiv positive women-specific OIs and women`s vulnerability to them.

(b) Challenges faced by Hiv positive women in accessing public health centres for medical care and treatment of Hiv-related OIs in particular on accessibility, availability and affordability of drugs and health care services.

(c) Gender sensitivity of women`s healthcare needs in Hiv/Aids policies.

The discussion with the medical practitioners was held in the evening which was convenient for them since they had completed their daily shift. It had proved difficult to interview them during the day.

### *3.2.4 General Group Discussions*

A total of two general group discussions were conducted during the research. On average, the age composition of both groups ranged from 18 years to 50 years. Both groups brought together women and men but generally there were more women who attended the meeting. The venue for holding the discussions were Municipality creche grounds in Mabvuku and Mufakose which were manned by municipal police officers. Besides being an appropriate way of targeting the two communities, general group discussions enabled me to collect data on the assumptions informing the research and the goals informing people`s actions, beliefs and values.

Of significance was the openness with which both women and men in both group discussions articulated the issues at stake and some even volunteered to give their personal experience with either the formal or informal health system in accessing medical care and treatment of OIs. The group members were free to express their opinion in the presence of other members of the group. The discussions were quite revealing and the method proved very effective. There was commendable participation from the women in both general discussion groups which is an indication that women are slowly but surely beginning to rise above the intimidation and culture of silence which prevails when they are in the presence of their male counterparts. I think the major reason for that was that I simply played the role of a facilitator.

The information I obtained in both groups was very valuable, with precise and vivid deliberations on issues of women specific OIs, barriers to medical care and treatment of OIs and copying mechanisms. 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. This enabled me to find out the majority views of most of the women in the group. The method helped me to collect data about women`s access to medical care and treatment of OIs at public health institutions in Harare and assess the knowledge the women had on the existing laws and policies on Hiv and OIs and the challenges they encounter when they were utilizing the existing laws and policies. The disadvantage was that there were women who tend to be more vocal than others so they tended to impose their views on others.

### 3.3 Evaluation of Methodologies and Research Methods

The data collection methods used proved very effective. Despite the fact that there were several advantages in researching this topic, the research had its challenges that affected the smooth and uninterrupted data collection and analysis. The first problem was that before some people could be interviewed it was necessary to obtain authority from the relevant offices. Getting such authority was not an easy task. Obtaining authority from the Ministry of Health and Child Welfare (MoHCW) involved a lot of effort. Having been finally granted the authority by the Permanent Secretary for MoHCW, I was not allowed to interview the medical personnel at Parirenyatwa and Harare Central hospitals but I was told to wait for the Health Ethics Board to sit and consider my research proposal and questions on the questionnaire. I made several follow ups and up to now the Health Ethics Board has not sat to approve my request to conduct interviews at their institutions and this was a limitation. I had to manoeuvre my own way and interview the medical practitioners who were my colleagues (and their workmates) at the University of Zimbabwe when I was doing my law degree.

It also was difficult to start the group discussions in the two high density suburbs on agreed time as it was rainy season so the women in most cases cited doing routine household chores and sowing maize in their urban fields as reasons for the delay to attend the meetings as scheduled. I noted that for the women, such activities were a priority over attending the discussion. As a researcher you do not get the feeling that you are disrupting anything too much (Chirawu, S. et al., 2007). As such it was not uncommon to wait for more than an hour before there was a sizeable group to start a discussion. I made use of the waiting time in Mabvuku to tour the garden used by Members of Dandaro Support group to growing a variety of herbs such as rosemary, mint and garlic meant for treating OIs such as skin rashes, colds and stomach pains and also being briefed of the activities of the support group. The major problem was that most of the people who attended the group discussions expected to have all their problems solved. Some of the concerns of the women were not relevant to my research and I had to endure with them pouring their worries and at times it was difficult to stop them. It is in this respect that I found the women`s law approach limiting.

The methodologies and research methods were useful in data collection and provided a useful insight into women's and girls lived experiences in accessing medical care and treatment of OIs using public heath centres. However, notwithstanding the abovementioned challenges, I did my best managed to collect sufficient data to answer the research questions which can be validly used to assess women`s lived realities and the law as will be discussed in the research findings. This was because I was able to get the respondents` lived realities covering the themes of the research and I could triangulate the data I gathered with my experiential data.

## 3.4 Conclusion

In summing up, this Chapter dealt with the methodology and the tools used in data collection. In the next Chapter, the main findings for each assumption will be presented as well as some of the emerging themes that went beyond the assumptions. An analysis of the research findings and linkage with applicable theories and the law and policies relevant to Hiv/Aids will be made.

## CHAPTER 4

# 4.0 THE PREDICAMENT OF HIV POSITIVE WOMEN IN HARARE

This chapter presents the research findings mainly on the challenges Hiv positive women encounter in accessing medical care and treatment of OIs using public health institutions in Harare.

## 4.1 Prohibitive Costs of Medical Care (user fees, drugs, X rays and diagnostic tests)

The second assumption for the research was that the costs of medical treatment for OIs are prohibitively expensive and beyond the reach of many indigent women and girls living with Hiv/Aids. The sub assumption was that the lack of economic access to treatment of OIs by Hiv positive women and girls shortens their life span thus compromising their right life.

This research showed that women have to pay considerable "out-of-pocket' costs that most of them can ill afford for transportation, tests and treatments for OIs at public health institutions in Harare. As a result of such costs, many Hiv positive women end up not seeking appropriate health care when its needed. One Hiv positive woman during the general group discussions in Mufakose had this to say:

> "I had pneumonia after I had been soaked by the rains for several days whilst sowing maize in the field as this is summer season. I didn't get any treatment at Mufakose poly clinic after I was dismissed for failure to pay the consultation fee of US$1. I am a widow with four minor children and I am not gainfully employed. My brother was of no help as he told me that he had many financial obligations. Finally, I just recovered by myself. These user fees should be scrapped."

Another woman in Mabvuku who was is finding it increasingly difficult to access ARVs and OI drugs because of user fees, drug costs and other hidden costs such as cost of transportation to the public health facility had this to say:

> "I find it difficult to access ARVs from Wilkins Infectious Diseases hospital where I get my monthly supply because I cannot afford US$3 needed for transport to and from hospital and US$1 consultation to get the ARVs because I am a full time house wife. At Mabvuku poly clinic which is near, I cannot afford to pay US$1 consultation fee and US$3 to get cotrimoxazole or any other drugs for treating OIs. As a result I have always been a sick person who requires medication for OIs but cannot I afford the costs and consequently I will succumb to OIs and die. It was better if I could get my monthly supply of ARVs at our local clinic."

Interruptions in the taking of ARVs resulting from prohibitive costs for PLWHA can lead to the multiplication and spreading of drug resistant strains of Hiv, a fatal deterioration in health, increased vulnerability to many OIs and the shortening of life expectancy. Failure by majority of women to access ARVs which are life saving drugs because they lack the financial muscle is likely to lead to high Hiv mortality and short life expectancy. As such, the government is violating women`s right to life as enshrined by section 12 of the Constitution. In light of these women`s stories, what it means is that PLWHA who cannot afford the compulsory user fees at particular public health centres are therefore unable to access treatment.

The fifth research assumption was that Zimbabwean Hiv/Aids policies are gender neutral but gendered in their implementation thereby negatively affecting women and girls living with Hiv. Whilst ZNASP`s Guiding Principle 2 is concerned with equitable access to Hiv treatment and medical care, this assumption was confirmed during the research, as I noted that Hiv positive women`s access to treatment of OIs is hampered by their lower social and economic status. The two stories above and many other similar stories during the research pointed to the fact that women`s educational attainment, work patterns, income levels, access to and control of resources and social roles all have a considerable impact on their right to health care. I discovered during in-depth interviews with each woman that most of them did not pass their "O" level exams and are not gainfully employed but spend most of their time doing house work and urban farming which in Zimbabwe is not considered productive and therefore not paid work thus confirming the Marxist/Socialist theory. The few women who are employed do menial jobs and earn very little to sustain them. The majority of the women did not have any income of their own to use to pay for their healthcare and most of them had to rely on income from their husbands or male relatives who are employed in the public sphere where their work is considered productive and is paid work. Unfortunately from the

interviews with the women, the men do not prioritise women`s right to healthcare. Most of the women did not own any resources because most of the housework they do is not paid work yet resources are essential for the right to health to be realized. The results of the research concur with Marxist/Socialist theory that women`s economic inequality and their dependency on men is a major factor in influencing access to health.

Given that few women had money of their own, it was difficult for them to seek health care and treatment of OIs and prioritised putting food on the table for the family, paying rentals and educational expenses for their children. One woman indicated that she had failed to visit the local clinic to get her monthly supply of cotrimoxazole and had used the few dollars she had to by books for her children. She said:

> "I used the US$2 which was all the money I had to by exercise books for my school going children. After that, I had no US$1 to pay consultation and US$3 to get my monthly supply of cotrimoxazole at our local clinic. As a result, I defaulted medication for the whole month."

This story and other similar stories during the research showed that women`s lives are not autonomous but are relational and are giving as opposed to being liberal selves. Most women were prepared to sacrifice their health and prioritise meeting the needs of their children and families because of being relational confirming West`s arguments on relational feminism (West, R. L. as cited in Becker, M. et al,.2007)

According to the Health Service Board member I interviewed, user fees are promoted by the Zimbabwean government as a means for rationalizing health care use and for increasing resources to the health sector. The majority of women reported that they could not afford the US$1 consultation charged by local clinics. I discovered from the doctors at Harare and Parirenyatwa that these two hospitals charge US$5 and US$10 respectively as consultation fees. In addition to paying consultation fees, women reported that most medicines and diagnostic tests are not for free at public health centres and therefore presents a barrier to their accessing treatment and care for OIs.

Patients requiring hospitalisation or more complicated care are referred to central hospitals. One female doctor at Parirenyatwa Central hospital, who preferred anonymity, confirmed that

most Hiv positive women who would have been referred to the institution could not afford the administrative fees, cost of medication and the diagnostic tests required. She related:

> "There is no such thing like free treatment of OIs for PLWHA and being Hiv positive is not a passport for free treatment. Consultation at this hospital for every patient is US$10 and if one does not have it then it means he/she cannot see a doctor. Even TB treatment is not for free as you might think. It`s only the drug that is given for free but investigation to reach conclusion that one has TB is charged such as chest-x ray cost US$25 and US$5 for sputum test. We usually direct women living with Hiv to do viral load tests, pap smear tests or other diagnostic tests at private clinical laboratories but sometimes we wait for them to bring back results in vain. Most of them with low CD4 count as 50 or 100 stay home and die."

The prohibitive costs of medical care and treatment of OIs at public health centres was confirmed by one official from Zimbabwe National Network of People Living with Hiv (ZNNP)+. He stated that government was in a dilemma because health centres argued that they needed the money to stay afloat. He commented as follows:

> "User fees have remained a challenge for PLWHA. Public hospitals and clinics say they need the money to keep running. User fees are only useful in denying access to treatment for PLWHA. They impede access to health care by typically adding the cost of health services to patients resulting in vulnerable population groups not always seeking appropriate health care when it`s needed. People who struggle to afford a decent meal a day are being handed over to debt collectors for failing to pay hospital fees accrued after being hospitalised."
>
> (Emphasis added)

PLHWA are made to pay for their right to health by being asked to pay consultation fees, medication and diagnostic tests at public health centres. Despite the fact that the Patients Health Charter provides that treatment for OI for all PLWHA is for free, this is a policy on paper which is not implemented as the lived reality and experiences of women and girls living with Hiv evidenced by the women`s stories and also confirmed by the medical staff proved otherwise. The essential elements of the right to health in all its forms and at all levels are expounded in General Comment 14 of the Committee on ESCR which states that the right to health must be economically accessible (affordable). This means that health facilities, goods and services must be affordable for all. The research showed that women fail to exercise the right to health because of the user fees, costs of medication and diagnostic

tests which they cannot afford due to economic constrains. By failing to make the right to health affordable, Zimbabwe is in clear breach of its obligation under the ICESCR. Zimbabwe is also in violation of Article 14 of the Women`s Protocol and the Article which requires State Parties to ensure that the right to health of women is respected and promoted because States have specific duties with regard to health services for women to provide adequate, affordable and accessible health services.

Men seemed to be in a better position than women to afford costs associated with treatment of OIs and getting ARVs and usually access private healthcare. This is the case as a greater percentage of men in Zimbabwe have better paying jobs than women because of their better educational qualifications and their employment in the public sphere where their work is valued and paid. One man who is a director of a construction company in Harare was diagnosed Hiv positive in 2005 and is on ARVs not with the government scheme but buys all the drugs prescribed to him by his doctor from the pharmacy. He had this to say during the interview:

> "I always visit my doctor at his surgery every time I am unwell or have an OI. I am on Altin Medical Aid on Mukwa scheme which covers all my medical bills and my company makes the monthly contribution to the medical aid society."

Economic empowerment is the backbone of all the empowerment programmes and without economic independence women cannot access their right to medical care and treatment of OIs. Economic empowerment creates economic freedom and independence. One woman had this to say:

> "Being Hiv positive cannot stop me from working. The problem is not having the means to run a viable income generating project. I did a course in interior decorations but I don't have the capital to kick start the project. Worrying about money and poverty is what will worsen my condition and become susceptible to OIs of which I cannot afford the costs associated with their treatment. I wish I could have financial support from government or NGOs to start an interior decor project so that I take care of my medical expenses and fend for my children. My husband is not interested in financing this project or giving me money for OI treatment as he has been testing negative on more than seven tests. We are a discordant couple."

This research established that the user fees in public health centres were meant to improve the availability of drugs, increase the quality and quantity of care provided to the marginalized population, in fact, they have changed little, resulting in *"a kind of 'sustainable inequality', with fees enabling service provision to continue while concurrently preventing indigent Hiv positive women from using these services."* To sum up, from the research findings, it appears that user fees do not only exclude the economically disadvantaged women from accessing health care for OIs, but are an ineffective tool for raising revenues. A 2004 survey by the civic monitoring program on the socio-economic situation in all ten provinces of Zimbabwe showed that the cost of treatment was the main reason for peoples' inability to use health services. The inability to use health services due to unaffordable user fees has a detrimental effect on PLWHA who require treatment. Despite government `s pledges in the Hiv/Aids policies and strategic framework to make the cost of health care for Hiv/Aids treatment and care more affordable and available, it seems from the research findings in Harare there is no implementation of the policies as user fees, costs medication and diagnostic tests are presenting significant barriers to the ability of PLWHA to access health services.

### *4.1.1 Lack of Exemptions for User Fees for Vulnerable People*

The government of Zimbabwe established a system of exemptions or waivers for health user fees to assist in equitable access to health care for the poor and vulnerable[17]. However, from the research it seems there is lack of information on the criteria and availability of the exemptions, combined with a failure to have an enforceable and standardized assessment process by which all social welfare officers administer the exemptions, which leads to their subjective and ultimately arbitrary application. This negatively impacts upon indigent PLWHA who urgently need access to healthcare thus leaving them at risk of fatal deterioration in their health. One regional training officer at Hospice and Palliative Care of Zimbabwe (HOSPAZ) commented:

> "Sending people to the Ministry of Labour and Social Welfare is no help at all. It sometimes takes 4 to 5 months for them to get the user fees exemption letter which permits them to receive free treatment but this letter doesn't necessarily mean they will get free treatment for OIs."

[17] This is provided in section 3(6) of the Social Welfare Assistance Act, Chapter 17:06.

A 50 year-old married and unemployed woman living with Hiv since 2004 had suffered from continuous ill health after reacting to cotrimoxazole which made her more vulnerable to OIs. The medical card she showed me indicated that she had visited Harare central hospital several times with various OIs. She had this to say:

> "I reacted to cotrimoxazole and I am always sick from different OIs. I went to the department of Social Welfare in town but I didn't get any help. They told me to come back another time. The last time I went there, I joined a long queue and only to be advised that from their assessment my application did not meet their requirements."

I submit this was an example of arbitrary assessment of applications for user fee exemptions by social welfare officers which although designed to protect indigent Zimbabweans, in practice it fails to protect vulnerable people such as women living with Hiv. The public assistance scheme under the government's Social Welfare Assistance Act is specifically designed to provide assistance to people who, *inter alia*, who suffer continuous ill health or otherwise have need of social welfare assistance. The research showed that government does not provide sufficient information to the public on the criteria for exemptions which also leads to many individuals failing to avail them. As a result, some PLWHA I interviewed who appeared to meet eligibility criteria under the exemption program had not even pursued the option citing that the process was hectic and cumbersome.

The research established that the majority of women living with Hiv are living below the poverty line[18] and failure to obtain assistance from the department of social welfare make them find living with Hiv/Aids and OIs onerous. Transportation fees, consultation fees, medicines and diagnostic tests are well beyond the means of most of the women living with Hiv and without assistance from the department of social welfare, many are unable to access healthcare. This shows that access to health care continues to be a mammoth task for many women and girls living with Hiv/ Aids. The government of Zimbabwe by failing to provide social assistance and information on exemptions for user fees to women living with Hiv is in breach of Article General Comment 14 of the Committee on ESCR which obliges State Parties to promote and fulfil the right to health.

[18] The United Nations Human Development Index states that currently 75% of the Zimbabwean population lives below the poverty datum line of US$2 per day.

### 4.2 NGO Hiv/Aids Clinics in Harare: a Positive Intervention but with limited Capacity

NGO funded clinics in Harare such as Newlands and Epworth clinics are playing a significant role in providing free medical care and treatment of OIs. Both clinics also provide free ARVs and take their patients through empowerment sessions[19]. One woman who resides in Mufakose tested Hiv positive in 2004 and gets her ARVs and all her treatment for OI at Newlands clinic said she was satisfied with the services provided at the clinic. She had this to say:

> "At Newlands clinic, every patient has a right to know his/her viral load and CD4 count. The tests are done for free at the clinic and results are given instantly. There is a bus which carries patients from town to the clinic and back to town at no cost. ARVs are given for free and all OIs are treated free of charge. Patients with low weight are given vouchers to buy food from supermarkets."

I submit that Newlands clinic cannot provide ARVs and OI drugs to all women living with Hiv in Harare because of the rising demand for free health care by PLWHA. Another woman who was diagnosed with TB and then tested Hiv positive in May 2011. After her TB treatment at Parirenyatwa central hospital, she was told to go for a CD4 test to get access to the government ARV program.

> "I tried to go and get a CD4 test at Wilkins Infectious hospital and they wanted US$5 but I had no money. I then went to Newlands clinic but they told me they had enough people and that I should check with them in six months. Right now, I have chronic diarrhoea and persistent fevers. I have tried to get help from the church but they don't have the money to help. I think I am going to die."

Besides the escalating demand for free health care at most NGO Hiv/Aids funded clinics in Harare, another limitation is that a means test[20] is used for one to qualify for health care.

[19] The empowerment session process involves taking the patients through their dietary needs, explaining to the patients about their viral load and CD4 count and the implications on their health and counselling.
[20] For a person to qualify for free health care, his or her monthly income must be lower than US$200.

### 4.3 Women's peculiar Vulnerability to Opportunistic Infections (OIs)

The first assumption was that women and girls living with Hiv are vulnerable to OIs which require treatment outside ARVs. Whilst Hiv impacts anyone who has the disease, whether male or female, I discovered that there are some challenges that are unique to women. One woman who is a single parent with two children who tested Hiv positive in 2002 had lost her Accounting job with City of Harare as a result of continuous illness. She was initiated on ARVs in 2002 and had an OI in May 2011. She explained:

> "I had been experienced a lot of itching and a burning sensation around my private parts. This would be accompanied by a thick white or yellowish discharge from the private parts as well. It was a very uncomfortable situation. The doctor at Harare Central hospital told me it was candidiasis (a yeast common to women who are Hiv positive). The doctor told me that the yeast infection is usually passed on to women if they have unprotected sex. I was given a prescription to buy miconazole cream and metronizadole tablets and I felt relieved after using the medication."

The research showed that women`s vulnerability to most of the STIs is exacerbated by gender inequalities, lack of decision making power in marriage, limited ability to negotiate safer sex with their partners and socio and economic inequalities which also constrain their ability to access medical care and treatment for OIs. The women indicated that their partners would refuse to use condoms when having sex. Both married and single women indicated that their husbands or partners will accuse them of infidelity when they insisted on use of condoms. Another woman who was diagnosed with Hiv in 2005 and is currently on ARVs was also infected by a women-specific OI in March 2010. This was her story:

> "After noticing a lot of small lumps on my private parts, I went to Harare hospital in March 2010. The male doctor who examined me told me that I had genital warts. He explained to me that Hiv positive women tend to get very aggressive warts from a virus which is passed sexually so I had to use condoms to prevent further re-infection. I was advised to buy a special pencil from a chemist that burns off the warts. I only managed to get money to buy the special pencil in July 2010 and I felt relieved."

Hiv positive women may or may not get the same OIs and not all women will experience all of the women specific OIs. Hiv positive women who are infected by women specific OIs are required to keep on taking ARV drugs even if they are on treatment for OIs and even when

all the symptoms of OIs would have disappeared because ARVs are for life. The research from the women`s stories confirmed the assumption that women have to seek treatment for OIs outside ARVs. The research also showed that women usually suffer from OIs related to their reproductive systems which men cannot get as exemplified by the two stories above. As such, treatment of OIs should be part of a comprehensive package for treating Hiv/Aids.

### 4.4 Shortage of essential Drugs and Medical Equipment

The third assumption was that there is general shortage of essential drugs and medical equipment in public health institutions to adequately address the challenges of OIs. Women living with Hiv complained that there were serious drug shortages at both at the local clinics and major government hospitals such as Parirenyatwa and Harare Central hospitals. All the doctors I interviewed also confirmed that there were frequent shortages of drugs in government hospitals. According to the female doctor I interviewed at Parirenyatwa central hospital, the shortage of essential drugs for treating OIs is because all patients, not just Hiv-positive people take medicines for OIs. Her comments were as follows:

> "Take coughing for example, every patient can cough even without Hiv. Medicines supplied to health structures are used also for other patients, as a result, the stock sometimes runs out. We must ensure that the stock intended for PLWHA is really serving them."

The shortage of drugs was also confirmed by a male nurse of 12 years at Mufakose poly clinic. She narrated:

> "Medication for each and every OI is not always available. Currently in our clinic, Acyclovir which is a drug for treating herpes zoster, a common OI for PLWHA has been out of stock for a couple of months. We do not have Miconazole cream, Ketoconazole cream and pessaries tablets for treating vaginal candidiasis which is the common women OI so we prescribe our patients to buy from chemists."

Another 30 years old Hiv positive woman stated that she went to Parirenyatwa Central Hospital in November 2011, with a cervical cancer ailment. After paying consultation fees in the sum of US$10, she writhed for hours on a bed without receiving any treatment. The next day, she was advised by the doctor that she needed to undergo radiotherapy tests. After

making payment of US$25, she was advised that the radiotherapy machine was down and she waited for three weeks before the test was done. The doctors at Parirenyatwa confirmed that they have only one radio therapy machine at their hospital which only works from time to time because it is not regularly serviced.

According to the female doctor at Harare central hospital, Hiv and other treatable OIs such as pneumonia, meningitis, Kaposi sarcoma and cervical cancer are proving fatal resulting in many deaths in the absence of basic drugs. The effect of having drug shortages in public health facilities means that patients are forced to buy them from pharmacies at an increased cost. I have already noted above when referring to Assumption 2.1 (concerning the prohibitive costs of medical care and treatment of OIs), that raising as little as US$1 was difficult for most women since most of them indicated that they survive on an income of less than a dollar a day. The majority of women said they could not afford to buy drugs from chemists as they are expensive and would just decide not to buy them after having obtained prescriptions for them.

The effects of drug shortages are that Hiv patients will develop drug resistance, become more vulnerable to various OIs and in the end succumb to OIs. The government is in breach of its obligation to make available in sufficient quantity, drugs to treat OIs and provide adequate equipment in public health centres as stated in General Comment 14 of the Committee on ESCR. The government has abandoned its obligation to NGOs such as Newlands clinic. Zimbabwe, by failing to provide adequate drugs to treat OIs is failing to fulfil and promote the right to health of women and thus indirectly failing to protect their right to life guaranteed in section 12 of the Constitution.

According to the official from NAC, the shortage of dugs for treatment of OIs is linked to several factors including a lack of funding because major donors have completely withdrawn their support, the economic meltdown and politics. I submit that there is a need for more State funding of heath care as we need local solutions to our local challenges.

### 4.5 Government and Donor Response to Hiv/Aids

According to the NAC official, Zimbabwe has to some extent responded positively in its effort to deal with the Hiv/Aids epidemic since it was the first country in the region to introduce an Aids-related tax in the form of the National Aids Levy Trust Fund (NATF) (Aids levy), an initiative that has been the envy of other countries in the region. He indicated that the country`s response to Hiv/Aids is through domestic and international sources of finance. At the national level, government created NATF also called Aids Levy, which collects 3% of all taxable individual and corporate income and the funds are administered through NAC. This NAC official further indicated that only workers in the formal sector in Zimbabwe earning a net salary of more than US$500 are paying the Aids levy. The current policy states that NAC must set aside 50% of the Aids levy for the procurement of ARV requirements whilst the rest goes to other programmes and administrative support for coordination (Government of Zimbabwe 2009).

NAC official admitted that although funding proposals at all levels are assessed against a gender checklist, there are no guidelines to quantify how women and girls benefit from the disbursement funds. From the interview with NAC official on how the Aids levy is used, it seems there is lack of transparency on how NAC manages the Aids levy and what exactly the figures for procuring ARVs and OIs drugs are.

NAC communications officer indicated that the NATF as it stands today is insufficient to adequately address the health care challenges the country is facing, both as this relates to PLWHA. Therefore, I submit that there is need for more innovative, larger and sustainable options that can complement the Aids levy.

NAC communications officer highlighted that the total allocation of US$345, 7 million to the health vote done by the Minister of Finance for the 2012 national budget is still far below the 15% bench mark agreed national budgetary health allocation in the Abuja Declaration of 2001 to which Zimbabwe is a party to. The allocation for the health sector would reach 15% after combining the government contribution (about 9%) and the US$436 million recently donated by the European Union and its partners through the Health Transitional Fund for various projects with the aim to improve conditions within the health sector and to help revamp the nation`s health sector.

The research has shown that Zimbabwe has in the last decade to date defied the Abuja commitment of 15% government spending on health which excludes external funding, thus allocating the health sector funds below the internationally accepted minimum threshold, unlike Botswana and Gambia which have met the promise. Despite ratifying the ICESCR, Zimbabwe is failing to promote the right to health which also impacts on the right to life guaranteed in section 12 of the Constitution.

From the interview with the NAC official, the Global Fund for Hiv, malaria and TB has been the major donor in Zimbabwe contributing about 76% whilst government is contributing 24% towards Hiv/Aids treatment. These percentages are a clear indication that Zimbabwe is not ready to stand on its own feet on health matters and illustrates the dependency of the national response on external funding. Zimbabwe should envy its neighbour, Botswana which has 75% domestic funding for Hiv/Aids according to the NAC official.

An official from ZNNP+ was concerned about the little funding Zimbabwe got from round 8 of the Global Fund after losing both round 10 and 11. I submit that without increased donor funding and technical assistance, the government of Zimbabwe faces an uphill battle in trying to address the Hiv/Aids pandemic. Ultimately, it will be the marginalized and most vulnerable Zimbabweans especially women who suffer the most from a lack of donor funding and not the government of Zimbabwe.

Be that as it may, I submit that there is a need for local solutions to our local challenges and Zimbabwe has both the human and financial resources to counteract the challenges in access to healthcare encountered by women and girls living with Hiv/Aids. If the health system is funded using the local resources like Botswana, this will go a long way in ameliorating the plight of many women and girls living with Hiv/ Aids. Addressing the burden of Hiv/Aids and OIs should start with adequate national financing of the health care. The Zimbabwean government must ensure that the nation`s own support for its Hiv /Aids programmes does not play a complimentary role to support the programmes they receive from external donors. This has become increasingly important given the cut-back and complete withdrawal of support by a number of major donors including bilateral and multi-lateral funding agencies like Expanded Support Programme (ESP) and the Global Fund. An official from HOSPAZ stated:

> "Zimbabwean government together with the relevant stakeholders must put in place a state-wide policy and implementation plan for the allocation of the nation`s resources towards the support of the country`s public health system. Such resources should include revenue generated from the country`s abundant resources such as the diamonds, gold and silver".

The research showed that the current state of affairs in the health sector has been blamed on corruption and politics as the major contributors to neglect.

## 4.6 Conclusion

In summary, this Chapter dealt with the challenges women and girls living with Hiv encounter in accessing medical care and treatment of OIs using the public health care. The next chapter examines the copying mechanisms available to women outside the formal health care for treating OIs.

# CHAPTER 5

# 5.0 TRADITIONAL AND SPIRITUAL REMEDIES FOR TREATMENT OF OPPORTUNISTIC INFECTIONS (OIs)

## 5.1 Background

According to Kazembe, T. (2007) traditional healing predated the organised modern health care system in Zimbabwe. He argued that before the advent of colonialism, traditional medicine greatly helped in the management of healthcare for many people but the acceptance and subsequent adoption of the modern health care delivery system by the native people championed by the elites, prevented traditional medicine from interacting with or complementing the rest of the health care system. According to him, this subsequently led to the failure of the government (especially before Independence in 1980) to recognise the value of the traditional health care system. The study revealed, however, that traditional medicine is being utilized by a substantial majority of women living with Hiv/Aids.

## 5.2 What is Traditional Medicine?

The WHO 2002 guidelines observed that it is difficult to assign one definition to the broad range of characteristics and elements of traditional medicine, but that a working definition is essential. It thus concluded that traditional medicines include diverse health practices, approaches, knowledge and beliefs incorporating plant, animals and or mineral-based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat themselves, diagnose or prevent illness.[21] Traditional healers are generally divided into two categories – those that serve the role of diviner-diagnostician (or diviner-mediums) and those who are healers (or herbalists).[22] The diviner provides a diagnosis usually through spiritual means, while an herbalist chooses

[21] Traditional Medicine Strategy 2002-2005, World Health Organization, WHO/EDM/TRM/2002.1, Geneva, p.7. The WHO draws a distinction between *'traditional medicines'* and *'complementary and alternative medicines'*.

[22] F. Jolles and S. Jolles 'Zulu Ritual Immunisation in Perspective' in Africa 70 (2), 2000, p.230 and M. Steinglass "It takes a village healer – Anthropologists believe traditional medicines can remedy Africa's AIDS crisis. Are they right?" Lincua Franca April 2002, p.32.

and applies relevant remedies.[23] In this research, the use of the term *'traditional healers'* refers to *'herbalists'*. Notably, increasing efforts have been made regionally and internationally to include traditional healers in primary health care, as well as in Hiv/Aids care and prevention. The WHO estimates that up to 80% of the population in Africa makes use of traditional medicine[24]. In Sub-Saharan Africa, the ratio of traditional healers to the population is approximately 1:500, while medical doctors have a 1:40 000 ratio to the rest of the population.[25] It is thus clear that traditional healers play an influential role in the lives of African people and have the potential to serve as crucial components of a comprehensive health care strategy.

### 5.3 The Use of Traditional Herbal Medicine in the Treatment of Hiv related OIs

The fourth assumption for the research was that women and girls living with Hiv use traditional herbal medicines and believe in spirituality for treatment of OIs as these are economically accessible and available. During the study, I discovered that for both palliative care and pragmatic treatment of OIs, women turn to the traditional system of health and healing not only as a substitute for the formal healthcare but as an alternative explanatory model for the diagnosis and management of illness. Some of the women admitted that they consulted herbalists especially for STIs and menstrual problems. Some women indicated that they felt that herbalists actually treated the condition complained of, while in hospitals and clinics some complaints were often not considered a serious problem or at times dismissed. A single lady aged 25 who stays in Mufakose and tested Hiv positive in 2008 had this to say:

> "After I was diagnosed to be Hiv positive, my menstrual pattern changed. I started missing periods though I was not pregnant. The nurse at our local clinic told me that the virus might have affected my hormones that are responsible for regular menstruation and was told to just go home. When I consulted the herbalist who stays in Marimba Park, I was given some leaves of a certain plant to mix with my tea and I was healed. My menstrual cycle is now normal as before and I did not pay."

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[23] *Ibid.*

[24] Traditional Medicine Strategy 2002-2005, p.1.

[25] Abdool Karim SS, Ziqubu-Page TT, Arendse R., *'Bridging the Gap: Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa'* (supplement) SAMJ 1994; 84 s1-s16 as quoted by Colvin et. al. in *'Integrating traditional healers into a tuberculosis control programme in Hlabisa, South Africa'* AIDS Bulletin, March 2002, p.29.

Traditional healers are culturally close to clients, which facilitates communication about disease and related social issues. This is especially important in the case of STIs.[26] One herbalist I interviewed in Marlborough medium density suburb in Harare is commonly known in the community as *chiremba* (meaning 'doctor' in the local *Shona* dialect). He said that as a young boy he used to see his late father who was also an herbalist treating people with different ailments. Sometimes he would accompany his late father to the mountains and forests searching for herbs. According to him, he inherited his expertise as an herbalist from his late father since 1970. He indicated that the use of herbs as medicines proves effective and that all his diagnoses and treatments with herbs have worked. He explained:

> "It is because in plants, there is power to heal. Many people including those infected with Hiv visit me with different illnesses such as cancer, STIs, diarrhoea, throat infections and mouth sores and are healed by the herbs I administer to them. Nobody has returned to me complaining of side effects of my herbs."

The herbalist is making impact in his area of residence because as I was interviewing him, two women came one after the other to get herbs from him and he indicated that they were Hiv positive and were his clients for a long time. When I arrived at his place of residence, he was tending his herbal garden. He showed me various herbs which he grows in his garden which he said most of them were also used to treat people with Hiv related illnesses. The herbs included, *inter alia*, aloe, moringa, onion grass, calendula, garlic, lemon grass, ginger, mint, and pepper mint. He explained to me the benefit and use of the herbs which are used mainly to make tea from the leaves or flowers, eaten raw or added to food during cooking. This herbalist indicated that he also spend hours in the bushes and forests searching for herbs and sometimes going as far as the Great Dyke in Mapinga. He uses the taste of the leaves, barks and roots of plants to determine what the herb can treat. When I asked him how much he charged for the herbs he administered to his clients, he said:

> "I do not earn a living from being a herbalist as I do not charge my clients. I am gifted to be a herbalist and I am there to treat people so that they recover from their sicknesses. I was an engineer but I retired because of my age so I am a pensioner and now I have all the time to serve my community. However, some people when they get healed

[26] *'Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: A Literature review'*, UNAIDS Best Practice Collection September 2000, p.10

> will come back and give me cash or whatever they have to show their appreciation."

One 48 years old widower in Mufakose employed as general hand by City of Harare tested Hiv positive in 2005. He admitted that he visited a herbalist in Kuwadzana when his 7 year old daughter who is also Hiv positive had (*nhuta*) Kaposi sarcoma which is cancer of the skin. According to him, the herbalist attended to his daughter and in a few days the disease disappeared. He said:

> "At first, I was afraid and was not sure whether or not the herbs I was given were going to work because I had been suspicious of people who dabble with herbal medicines. The herbalist told me to smear some herbs on my daughter`s wound which was on her left arm. After a few days, it started drying and now she has been completely healed."

This story seems to suggest that the health care delivery system is incomplete when mention is not made of the traditional medicine especially in Zimbabwe. Although at first this man wavered in his faith in the herbalist, he said he eventually believed in his healing powers after witnessing the recovery of his daughter's ailment and voluntarily paid US$5 to the herbalist a few months later as a sign of appreciation although the herbalist had rendered his services for free. He said:

> "The US$5 I gave the herbalist is far less than the money I would have spent if I had tried the hospital."

Women living with Hiv reported to have been actively participating in the preparation of herbal medicine as part of the treatment regime for Hiv associated OIs. The current 15 members of Dandaro Support group in Mabvuku believe in the use of herbal medicine in treating HIV-related illness. This is evidenced by growing a variety of herbs in their garden meant to treat various OIs. The Chairperson of the support group said:

> "We were trained by NGO officials from Mashambanzou Care Trust on the use of herbs in treating OIs. After the empowerment sessions, we started growing various herbs in our garden. We have peppermint which helps to control diarrhoea and stop vomiting, ginger which is used for treating common colds, flue and nausea and rosemary for skin rashes and other herbs which we showed you."

The research showed that herbalists are more readily accessible, acceptable and affordable to PLWHA than trained medical practitioners. The majority of the women who admitted that they visited the herbalists for OI treatment were not formally employed but spend their time doing house work which is not paid work confirming the Marxist theory. In most cases no transport costs were incurred by people who visited herbalists as these are found in the communities where the people live and in most cases there is no up front cash payment for the traditional medicine. Some women, because of their relational as opposed to autonomous tendencies, argued that they saw it fit to use the little income they got either from vending or doing general work to buy food and pay school fees for their children and use the herbs which they get for free to treat OIs. The high cost and scarcity of essential drugs especially for STIs, cancer and ARVs and the user frees incurred by PLWHA signifies the need to seek alternatives such as the use of traditional herbal medicine.

I agree with the optimistic school of thought that people as well as the society as a whole have benefited from the traditional medicine (Erinosho, O. A. 1998). The findings of the research based on the stories of the respondents suggest that herbalists have a crucial role to play in building the health system in Zimbabwe, strengthening and supporting the national response to Hiv/Aids epidemic. I submit that although the adoption of the modern health care system seemed to overshadow the practice of traditional medicine, this traditional practice has apparently benefited Zimbabwe's citizens. It has been found to play a prominent role in the health of PLWHA some of whom have great faith in it because they have witnessed its positive results. Government officials, however, do not, encourage the use of traditional medicine to treat PLWHA (see next section).

I also submit that there is potential for traditional herbalists to play an important role in responding to the challenges of Hiv associated OIs. Although most of the herbs used have not been scientifically tested, there can be little doubt that some of the remedies given by herbalists are effective in treating OIs. I submit that traditional healers can play a significant role of collaborating with the modern medicine in the search for Hiv-related OIs drugs.

### 5.4 Possible positive Co-operation between Traditional and Western Medicine

I noted that there is friction between 'western' medicines or biomedicines that look at 'material causation' to understand and treat an illness and traditional medicine which is said to lack the standard dosage and has not been subjected to scientific verifications. The medical personnel during interviews admitted that they discouraged their patients from using traditional medicine citing that traditional medicines are not scientifically proven. One of the female doctors at Parirenyatwa said:

> "We do not advise our patients to take herbal medicine as a compliment to the drugs we give them because traditional healers lack the skills needed to proffer correct diagnosis on very serious disorders like Hiv/Aids and more importantly traditional medicine will not have been subjected to scientific verifications. However, our patients use traditional medicine and Chinese herbal medicine commonly known as Tianchi when they have OIs and we learn this when they default taking the drugs we prescribe to them."

The medical practitioners argued that whilst traditional medicine in some cases proves to be effective in treating OIs, these cannot be a substitute for ARVs as these drugs are for life and ARVs are the cornerstone of the overall strategy to reduce morbidity attributed to Hiv-related infections. What this means is that, although herbs are economically accessible to women for OI treatments, some of the women default taking ARVs or anti-biotics which prevent OIs, resulting in their bodies developing drug resistance, a weakened immune system and they become even more vulnerable to many OIs. The net effect is that their right to life guaranteed in section 12 of the Constitution will be threatened.

In Zimbabwe there has been an array of media reports of traditional healers claiming to have a cure for Aids and cancer or submitting their patients to dangerous or ineffective treatments since the herbs which they use are not scientifically tested. I submit that if women fall in the hands of such traditional healers, their right to life provided in Section 12 of the constitution will be at stake. Be that as it may, from the research findings, it seems medical doctors in Zimbabwe should suspend their cynicism and disparagement about traditional healing, so that a common ground for collaboration and support will open up. This partnership could play a significant and deeply influential role in Zimbabwe's response to Hiv/Aids and OIs. I submit that traditional healers also make a unique contribution that is complementary to the formal health care system. I discovered that herbalists often have high credibility and deep respect

among the population they serve and are knowledgeable about local treatment options as well as the physical lives of the people and are able to influence behaviour. As such, it is imperative and practical to consider traditional healers as partners in the expanded response to Hiv/Aids and to maximize the potential contribution that can be made towards meeting the magnitude of needs for care, support and prevention.

## 5.5 Spirituality

The research also showed that spiritual involvement plays a significant role in the lives of many PLWHA. Hiv diagnosis is often an impetus to renew or strengthen spiritual and religious ties. The respondents who have been living with Hiv for several years admitted that they sought spiritual guidance as an ultimate coping strategy. The interviews with the women revealed that some women seek spiritual help before and after visiting the clinic or hospital.

I did role playing at the Apostolic Ejewel Jekenishen church in Mbare high density suburb. I feigned illness and told the prophet who attended to me that I was Hiv positive and had pneumonia. I was prayed for and given holy water to drink and to bathe with so that I could be healed and was advised not to seek formal healthcare. I noted that the elders at the church have a strong faith in divine healing and they do not believe in formal medical treatments. I discovered that members of the apostolic faith believe in divine healing for all forms of sicknesses and diseases and women living with Hiv/Aids who are church members are not an exception. Hiv positive women who are members of the Apostolic sect rely on the holy water *(muteuro)* and prayers from the church elders to cure illnesses and diseases. When illness or disease befalls members of the sect, it is often regarded as an evil omen which can only be addressed through spiritual means. In accordance with this belief system, members of the church are taught to seek healing only from God, and not from institutions of modern medical practice or health-care.

To me, the findings from role play raised the question as to whether the apostolic sects should not start embracing contemporary medical and health-care solutions. In-spite of the devastating effects that diseases such as Aids and OIs have had on its members, a number of sects of the Apostolic faith have remained largely resistant to embracing contemporary

medical and health-care solutions, preferring instead to seek remedies through their faith and religious practices.

The research also revealed that the collapse of Zimbabwe's health-care particularly drug shortages have also led other people who are not members of the Apostolic sect to resort to spirituality for OI treatments. Recently, in March 2012, my neighbour`s six year old daughter who was Hiv positive was very ill and was taken to Parirenyatwa central hospital where the doctor indicated that she had pneumonia. My neighbour was given a prescription to buy ceftriaxone tablets but she did not go to the pharmacy to buy the drug. Despite being my fellow church mate at the Apostolic Faith Mission In Zimbabwe, my neighbour together with her relatives, filled with a high degree of self-conviction and belief, took the girl to one prophet who is a member of the apostolic sect in Kuwadzana high density suburb in Harare. The prophet offered prayers and prescribed solutions using holy water and eggs for healing to happen but unfortunately she passed away a few days later. Resorting to spiritual remedy in this case was a coping mechanism resulting from drug shortages. The government should discharge its obligation in terms of General Comment 14 of the Committee on ESCR to make provide adequate quantities of drugs in public hospitals. Some women succumb to OIs because of drug shortages and government is violating the right to life of women living with Hiv as guaranteed in section 12 of the Constitution.

# CHAPTER SIX

# 6.0 CONCLUSION AND RECOMMENDATIONS

## 6.1 Conclusion

The findings reveal that medical care in Zimbabwe falls short of the human standards enshrined in both the regional and international instruments to which Zimbabwe is a signatory and is duty bound to ensure that women and girls have access to healthcare. The research showed that treatment for OIs is unaffordable to the majority of women and girls living with Hiv. Hiv positive women who try to utilise the public health centres face various obstacles ranging from consultation fees, costs of medication, diagnostic tests, hospital fees, transport costs, shortage of drugs and equipment. Other sundries and the collapse of the system of social welfare exemptions of health fees have resulted in many PLWHA being turned away from the health care that they are entitled to and that the government of Zimbabwe has committed itself to provide. Prohibitive costs of medical care and treatment of OIs impede access to health care by adding the cost of health services to patients resulting in vulnerable population groups such as women and girls living with Hiv and Aids not always seeking appropriate health care when its needed thereby shortening their life span and compromising their right to life enshrined in section 12 of the constitution. These factors are mainly to do with under funding thus showing failure by the state to provide for women`s specific health needs. There is a need for more state funding for Hiv/Aids as the data illustrates the dependency of the national response to Hiv/Aids on external funding.

The findings have also shown that women and girls living with Hiv/Aids suffer from Hiv OIs and in particular those related to their reproductive systems which men cannot get which require treatment and medical care which go beyond simply providing ARVs. This research also showed that women face disproportionately more barriers than men in seeking and accessing medical care and treatment of OIs in public health centres because of their low levels of educational attainment, work patterns, low income levels, lack of access to and control of resources and social roles as most of women`s work such as rearing children and home-making is not paid work.

There is also a significant gap between what the national Hiv/Aids policies provide and women`s lived realities and experiences with the public health facilities in accessing medical care and treatment of OIs. Whilst the Patients Charter provides for free treatment to all Hiv infected people, in reality there is no such thing as free treatment for PLWHA. On the other hand, whilst ZNASP 11`s guiding principle 2 provides for equitable access to Hiv treatment and care, though gender neutral, the lived realities and experiences of women have shown that this has not been attained considering women`s economic and social inequalities with men in our society. There is therefore an urgent need to mobilize support and resources to enable women to achieve real equality to accessing medical care and treatment of OIs. The plight of PLWHA has been worsened by the deterioration of the political and economic situation in Zimbabwe.

The research also showed that women infected with Hiv also use traditional herbal medicines for treatment of Hiv associated OIs. Although traditional medicine is still criticised on the basis of scientific methodology, the women`s (and men's) stories proved the efficacy and efficiency of traditional medicine in the management of some OIs that have continued to threaten human existence. However, traditional medicine despite being easily accessible is not a substitute for ARVs. Many women who take herbal medicine default taking ARVs thus putting their lives in danger. The government as the primary duty bearer has an obligation to fulfil and promote women`s right to life guaranteed in section 12 of the Constitution by providing adequate and affordable ARVs in all public health facilities.

On paper, Zimbabwe has progressive Hiv/Aids policies to achieve equitable access to treatment and care but the problem is lack of implementation. The government's response to Hiv/Aids has also been compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of national policies on Hiv/Aids. Nearly 30 years into the epidemic as the diagnosis of the first case of Hiv infection was done in 1985, Hiv programmes and policies are gender neutral and do not sufficiently address the specific realities and needs of women and girls and fail to respect and protect their right to Hiv and OI treatment. While the various policies on Hiv/Aids are in place, their responsiveness to gender, if there is any at all, has remained limited and little genuine transformation in the daily lives of women has occurred. On the ground, the national response to Hiv/Aids does not react a systematic approach to addressing gender specific vulnerability despite acknowledging its critical role in fuelling the epidemic. As such we are lagging

behind as far as implementation of both regional and international obligations on the right to health of PLWHA is concerned. The plight of women and girls living with Hiv/Aids in accessing medical care and treatment for OIs can only be ameliorated if the government as the primary duty bearer honours its promise under both regional and international human rights instruments by promoting equitable access to treatment which can only be realised if medical care and treatment for OIs in public health centres is accessible and affordable.

## 6.2 Recommendations for an Action Plan to achieve a Comprehensive National HIV Prevention, Treatment and Care Programme

***Overall purpose***

To achieve equitable access to medical care and treatment of OIs.

***Target***

ARVs, OI drugs and medical services.

***Objectives***

All the relevant stakeholders should be able to:

- Improve access to comprehensive Hiv prevention, treatment and care to women and girls.
- Recognize the vulnerability of women and girls to OIs related to their reproductive system.
- Appreciate the social and economic realities of women in so far as access to healthcare is concerned.
- Appreciate the effectiveness of traditional herbal medicines in treating some OIs.

***National Indicator***

Percentage reduction in the number of new OIs infections among women and girls.

***Activities and Implementing Partners***

1. **The Government of Zimbabwe** as the primary duty bearer to fulfil the right to healthcare should:

- Prioritise and ring fence the national budgetary allocation of the health sector. Zimbabwe`s budgetary allocation should endeavour to improve health delivery system to deliver results through provision of affordable drugs for treatment of OIs and provision of relevant equipment to test for Hiv related illnesses. Government should allocate at least 15% of the national budget to the health sector in compliance with the Abuja and Maseru Declarations.

- Urgently put in place a state-wide policy and implementation plan for the allocation of the nation`s resources towards the support of the country`s Hiv response. Such resources should include revenue generated from the country`s abundant natural resources such as diamonds, gold and platinum in accordance with the Indigenisation and Economic Empowerment (General) Regulations, 2010, S.I. 21/2010 as read with the Indigenisation and Empowerment Act chapter 14:33. In other words, growing our own economy will be more sustainable.

- Increase the percentage of revenue remitted to it by the Ministry of Home Affairs and Judicial Service Commission (JSC). Growing our own economy will be more sustainable. This will increase the national funding towards Hiv/Aids and that specific increment should be channelled towards procuring ARVs, OI drugs and medical equipment. The problem likely to be encountered in increasing national funding for Hiv/Aids is lack of political will because improving the quality of women`s lives requires seriousness of purpose and steadfast political will.

- (In order to widen the Aids levy net), urgently gazette a statutory instrument (S.I.) which requires that all workers in both the formal and informal sector to contribute 3% of their monthly earnings/income as Aids levy. The Aids levy has to be compulsory and there must be punitive fines for defaulters and NAC should be mandated to implement this S.I. NAC should engage a consultant who is an expert to

give strategies on implementing the S.I especially on collecting Aids levy from the informal sector.

- Domesticate the ratified regional and international human rights instruments which provide for women`s right to healthcare or incorporate them in existing legislation.

**2. The National Aids Council (NAC)**

- Must be efficient and transparent in its use of the national Aids levy funds.

- Should quantify how women and girls benefit from the disbursement funds.

- Should reduce the number of workshops held in expensive hotels and concentrate more on procuring ARVS, OI drugs and medical equipment.

**3. The Ministry of Health and Child Welfare (MoHCW) and the Health Service Board**

- The Ministry must urgently move a motion for the right to health to be guaranteed in the Constitution taking advantage of the constitution making process which is underway. Whilst hailing the government efforts in making commitments at the highest levels for instance the Abuja and Maseru Declarations and CEDAW, there is need for political commitment by the government by ensuring that these commitments are translated into reality. Socio-economic rights are vital in the fight against Hiv and Aids and related illnesses. The problem which might be encountered is that guaranteeing the right to health may not be seen as critical part of political agendas or there might be postponements and delays in guaranteeing this right in the constitution.

- The Ministry has to strengthen procurement and supply management systems of ARVs and OI drugs through service provider training and development of guidelines verifiable by training reports.

- The Ministry has to decentralise availability of ARVs to the lowest health facility and train health personnel in administration of ARVs. The Verifiable indicator will be the number of health facilities offering ARVs and the means of verification will be the health facility records.

- The Ministry should investigate in the possible inclusion of traditional herbal medicine in the national health policy as collaboration between traditional herbalists and medical doctors might have the potential to improve the national response to Hiv/Aids pandemic. The training of herbalists will be crucial as it can assist them in identifying illnesses beyond their capacity and hastening referral to clinic or hospital when necessary.

- The Ministry and the board have to strengthen and implement laws and policies related to Hiv. This will go a long way in preventing Hiv related OIs and mitigating the impact of Hiv and Aids on women.

4. **The Ministry of Women Affairs, Gender and Community Development** should:

- Ensure that Hiv/Aids programmes should collect and use sex and age disaggregated data: to monitor and evaluate the impact of programmes on different populations; build the capacity of key stakeholders to address gender inequalities; facilitate the meaningful participation of women`s working groups and PLWHA and allocate resources for programme elements that address gender inequalities.

- Increase resources and support for home-based care in order to lighten the burden on women and girls.

- Support advocacy work to break the misconception that caring for the ill and orphaned is women`s work.

- Conduct empowerment programmes for Hiv positive women and girls on their health issues so that they make diligent choices in the event of illness; this will be verifiable by the number of empowerment programmes held.

- Advocate for the participation of Hiv positive women in all relevant policy making bodies and in the implementation of Hiv health policies and programmes both of which are essential to an adequate response to Hiv/Aids epidemic. As noted by Smyke (1995), women have to express their own ideas about their needs and decide the best ways to meet them. This will be verifiable by the number of advocacy activities carried out.

- Conduct health education for Hiv positive women and girls in a way that encourages them to express their own beliefs and attitudes about their own health. This is verifiable by the number of women and girls reached through community outreach programs promoting OI treatment and care.

**5. The Department of Social Services under the Ministry of Public Service, Labour and Social Welfare**

Social welfare officers should go in all communities and register all the needy people who are Hiv positive using the eligibility criteria provided in the Social Welfare Assistance Act, Chapter 17:06 and this data should be computerized. This data base should be made available to all state aided clinics and hospitals so that there will not be any need to visit Social Welfare offices when sick. This will be verifiable by outreach reports and clinic and hospital records.

**6. The Ministry of Transport** should:

- Improve urban public transport.
- Ensure that at least public health centres have ambulances of their own and that these ambulances are well serviced and supplied with fuel.

7. **Non Governmental Organisations** (especially those which advocate for women and girls human rights, namely, ZNNP+, JAT, ZWLA and WLSA) should:

- Conduct test case litigation on the violation of the right to life (in terms of Section 12 of the Constitution) based on the Government's failure (through its public health institutions) to provide women living with Aids access to medical care and treatment of OIs. It only takes one good test case to establish a landmark judicial precedent which is likely to have a very positive influence on public opinion and, in turn, political will.

- Conduct shadow reporting on Zimbabwe`s compliance with regional and international instruments on women`s health rights.

- Lobby and advocate for necessary laws and policies that advance Hiv positive women and girls` access to health for example recognition of care work for purposes of remuneration. As suggested by Yamin (2006), advocacy must be combined with consciousness raising to transform legal victories into social and cultural realities. This is verifiable by number of advocacy activities carried out.

- Take up cases to the SADC Tribunal in the event of Zimbabwe`s failure to comply.[27]

- Invest in capacity building which constitutes an important component of this action plan. There should be use of the grass root approach through funding viable income generating activities for women in support groups which will enable them to have income to pay for transport and medication and reduce their dependence on males thus strengthening their capabilities to use public health facilities.

- Empower Hiv positive women and girls economically by providing them with access to credit and business entrepreneurship and marketing skills.

[27] As noted by Yamin, (2006), at the International level, unlike the ICCPR, none of the major treaties that enshrine the right to health historically provided for individual complaints regarding discrimination against women in healthcare.

***Monitoring and Evaluation***

Effective monitoring and evaluation will be a key component of this Action Plan to ensure accountability and to measure the impact of the programme. To implement the action plan, there will be need for concerted efforts to mobilise resources from various sources such as government, bilateral donors, UN agencies, UN Women, the private sector and NAC. Finally, the government and all the relevant stakeholders should seriously consider the adoption of the above recommendations and build a meaningful timeframe within which to implement the action plan.

## Bibliography


Abel, E., & Chambers, K. B. (2004). Factors that influence vulnerability to STDS and HIV/AIDS among Hispanic women. *Health Care for Women International, 25*, 761-780.

Bain, B. (2001). Hiv/Aids-Challenging a monster. Journal of HIV/AIDS Prevention and Education for Adolescents and Children, 4, 3-21.

Baylies, C., & Bujura, J. (2000). AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia. New York: Routledge.

Becker, M. et al. (2007). *Feminist jurisprudence: taking women seriously: cases and materials*. St Paul, MN, Thomson West. Excerpts presented in SEARCWL: Theories and perspectives in women`s law: reading materials for weeks 2, 3, 4 and 7, 2011.

Bentzon, A. W. et al. (1998). Pursuing Grounded Theory in Law: South-North Experiences in Developing Women`s Law. Harare: Mond Books; Oslo, Tano-Aschenoug.

Caldwell, J. C. (2000). Rethinking the African Aids epidemic. *Population and Development Review, 26,* 117-135.

Chirawu, S. et al,.(2007). Challenging the status quo: Gender, HIV/AIDS and the Law in Zimbabwe: A Rights-based Approach. Harare, WLSA.

Claude, R.P and Issel, B.W (1998). "Health, Medicine and Science in the Universal Declaration of Human Rights Thematic Analysis", In *Health and Human Rights: An International Journal* Volume 3 Number 2.

Cook, R. J. (ed), (1994). Human rights of women-national and international perspectives, University of Pennsylvania.

Dahl, T.S. (1987). *Women`s law: an introduction to feminist jurisprudence*. Oslo: Norwegian University Press.

Duffy, S. (2005). Culture and context of HIV prevention in rural Zimbabwe: The influence of gender inequality. *Journal of Transcultural Nursing, 16*, 23-31

Erinosho, O. A. (1998). Health Sociology for Universities. Colleges and Health Related Institutions Ibadan; Sam Bookman

Farmer, P. E. (1999). *Infections and inequalities: The modern plagues*. Berkeley, CA: University of California Press.

Kazembe, T. (2007). "*Traditional Medicine in Zimbabwe*." Rose Croix Journal 4: 56. http://www.rosecroixjournal.org/home.html (retrieved February 16, 2012).

Milan, Felise B., et al (2008). "Use of Complementary and Alternative Medicine in Inner-City Persons with or at Risk for Hiv infection" *In: Aids Patient Care and STDs,* Volume 22, Number 10 p 811-816

Fleischman, J. (2003). Fatal vulnerabilities: Reducing the acute risk of HIV/AIDS among women and girls. A Report of the Working Group on Women and Girls. Washington, DC: Center for Strategic and International Studies Press.

Glaser, B. (2002). Conceptualization: On theory and theorizing using grounded theory.

International Journal of Qualitative Methods, 1 (2). Article 3. Retrieved on 30 March 2012 from http://www.ualberta.ca/~ijqm/

Gupta, R. (2000). *Gender, sexuality, and HIV/AIDS: The what, the why, and the how.* Washington, DC: International Center for Research on Women.

Harding, S. (1987) "Introduction: Is there a feminist method?" in Sandra Harding (ed.), *Feminism and Methodology*, Indiana Press, Indiana.

Jacquette, J S.,(1982) "Women and modernisation theory: a decade of feminist criticism", in *World Politics* Vol 34, No 2: 267-284, 1982.

Kalipeni, S. (2000). "Health and disease in Southern Africa: A comparative and vulnerability perspective". *Social Science & Medicine, 50, 965-983.*

Lingappa, J R et al ( 2010) Daily acyclovir for Hiv-1disease progression in people dually infected with Hiv-1 and herpes simplex virus type 2: a randomised placebo-controlled trial" The Lancet, published online February 15.

Lindsey, L. (1997). *Gender roles: A sociological perspective*. Upper Saddle River, NJ: Prentice Hall.

Meursing, K. (1997). A world of silence: Living with HIV in Matebeleland, Zimbabwe. Amsterdam: Royal Tropical Institute.

Nyantor, F. and Kutzin, J. "Health for Some?. The Effects of User Fees in Volta Region of Ghana," *Health Policy and Planning*, 1999, 14(4) pp. 329-341.

Oakley, A, 'Women and health policy", in Jane Lewis (ed.), *Women`s welfare, women`s rights*, Croom Helm, London and Sydney, 1983.

Otto, D. (1995). "Linking Health and Human Rights: A critical legal perspective" In *Health and Human Rights: an International Journal*, Volume 3 number 2.

Paterson, G. (1996). Women in the time of AIDS: Women, health and the challenge of HIV. New York: Orbis Books

Rajaratnam, J. et al., (2009). *Worldwide mortality in men and women aged 15-59 years from 1970-2010*: a systematic analysis. The Lancet 2010; 375: 1704-20

Sesay, W. (2010). Female bodies: Gender inequalities, vulnerability, HIV and AIDS in Kenya. *Advancing Women in Leadership Journal, 30* (17).

Schuler, M. and S. Kadigamar- Rajasingham., eds, (1992) Legal Literacy: *A Tool for Women`s Empowerment* New York: UNIFEM, 1992.

Stewart, J. et al., (2000). In the shadow of the law; women and justice delivery in Zimbabwe, WLSA Zimbabwe, Harare.

Smyke, P. (1995), *Women and Health*, London, Zed Books

Squire, C. (1993). *Women and AIDS: Psychological perspectives*. Newbury Park, CA: Sage.

Tong, R. (1994). Feminist Thought. A Comprehensive Introduction. London: Routledge.

UNAIDS (2004) *Facing the Future Together*. Zimbabwe Country Report of the United Nations Secretary-General`s Task Force on Women, Girls and Hiv/Aids in Southern Africa. Harare: UNICEF.

UNAIDS (2006). *Report on the global AIDS epidemic*. Geneva, Switzerland: Author

UNAIDS (2008). Addressing the vulnerability of young women and girls to stop the HIV epidemic in Southern Africa.

United Nations, *Women 2000-women and health*, pamphlet, 2000.

Walker, A. S et al (2010). "Daily co-trimoxazole prophylaxis in severely immunosuppressed Hiv-infected adults in adults in Africa started on combination antiretroviral therapy: an observational analysis of the DART cohort" The lancet, published online March 29

Wilkinson, S., & Kitzinger, C. (1994). *Women and health: Feminist perspectives*. London: Taylor & Francis.

WLSA (1997). Paving a Way Forward: A Review and Research Primer of WLSA Research Methodologies. Harare: WLSA

Yamin, A. E. (2006). "Protecting and Promoting the Right to Health in Latin America: Selected Experiences from the Field" In *Health and Human Rights: An International Journal* Volume 5 Number 1.