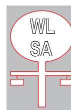
POLICY BRIEF
SEPTEMBER 2022

Towards Improved Utilisation of Prenatal and Maternal Services by Pregnant Adolescents and Women in Zimbabwe



Women and Law in Southern Africa
Zimbabwe

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About WLSA Zimbabwe

Formed in 1989, Women and Law in Southern African Research and Education Trust (WLSA) Zimbabwe is a local Chapter of a sub-regional network - member countries are Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe - seeking to contribute to sustained well-being of women and girl children in Southern Africa through action-oriented research in the socio-legal field and advocating women's rights.

By action-oriented research we mean research which is intended to inform and influence action being taken to improve the socio-legal situation of women and girl children. WLSA work incorporates action into research by questioning and challenging the law, instigating campaigns for changes in law and in policies, educating women about their rights, providing legal advice and gender sensitising communities and leadership during the course of the research.

Vision

A society where justice is equitably accessed claimed and enjoyed by women and girls in all spheres of life.

Mission

WLSA Zimbabwe aims to be a renowned Southern Africa feminist and human rights organisation that coordinates and supports evidence based interventions to promote and protect women and girl's rights through legal and policy reform and changes to discriminatory socio-cultural practices.

Values

WLSA Zimbabwe is guided by the following values:

- Good governance (professionalism, transparency, accountability and integrity)
- Solidarity
- Ownership

1. Introduction

Zimbabwe has a high maternal mortality ratio (MMR). Benchmarking regionally, East and Southern Africa's MMR in 2017 was much lower than that of Zimbabwe at 384. In the same year, Zimbabwe was one of the 15 countries that were considered to be 'very high alert' or 'high alert' with MMRs ranging from 31 to 1150 on the Fragile States Index. In 2019, the MMR per 100,000 live births was 462.[1] The country's Adolescent Birth Rate (ABR) is also high, at 108 live births per 1000 women against a national target of 99 by 2020 and a global average of 44.[2] The major causes of maternal deaths in Zimbabwe include haemorrhage (22%), eclampsia (16%) and infections (14%). Among adolescent and young women aged 15-24 years, the major causes of maternal deaths are puerperal sepsis (16%), eclampsia/PIH (16%) and post-partum haemorrhage (14%).[3] There are a number of factors contributing to the high maternal mortality in Zimbabwe that include policy gaps, negative labels attached to health facilities, high costs of services, poor attitudes of health service providers, prolonged and frequent strikes by health care personnel, extended waiting times, and distances to health facilities. Adolescent pregnancy and child birth complications also contribute significantly to maternal and child mortality. This policy brief discusses some of the key areas that should be addressed to promote utilisation of prenatal and maternal services and reduce maternal deaths in the country. These areas came from a study conducted by WLSA titled, *"The Utilisation of Prenatal and Maternal Services by Pregnant Adolescents and Rural Women in Selected Districts in Zimbabwe: A Qualitative Study of the Pregnant Woman's Experiences".*

1 Ministry of Health and Child Care Zimbabwe (2020). 2019 Annual Family Health Programme Report.

2 Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

3 Maternal Death Surveillance and Response, 2017 Annual Report.

2. Barriers to Access to Prenatal and Martenal Services in Zimbabwe

2.1 Gaps in the legal and policy framework

The Constitution of Zimbabwe provides for the right for all to access basic healthcare services on Section 76:1. This includes sexual and reproductive health services. Section 81:1f affirms children's health rights. The constitutional provisions are given effect through national policies, strategies and programs. For adolescents, the Adolescent Sexual and Reproductive Health strategy aims to ensure that adolescents have unlimited access to SRHR services both in school and out of school. The strategic priorities include improving availability and access to comprehensive family planning services, expansion of other SRHR services including cervical cancer screening and increased safe sexual and reproductive health and HIV prevention amongst adolescents and young people, increasing uptake of quality youth friendly integrated SRH and HIV services and strengthening protective environment for adolescents and young people. The strategy emphasizes that heath care delivery should be appropriate to the age of youth being served. However some existing gaps in the legal and polciy framework affect access to SRHR services that include prenatal and maternal services ultimately lead to maternal mortality in the country. These gaps are discussed below:

i. Zimbabwe's constitution has a strong anti-abortion stance

Terminating an unwanted pregnancy is prohibited and can attract a prison sentence up to five years, as per the Termination of Pregnancy Act of 1977 [Chapter 15:10]. Exceptions are in cases of rape, incest, when the mother's life is at risk, or when the child may be born with serious disabilities. In the latest concluding observations of the Committee on the Rights of the Child on Zimbabwe, the Committee expressed concern over the high rate of sexual violence and pregnancies experienced by adolescent girls and stated that the abortion law in Zimbabwe was restrictive and that the extensive procedures for authorizing an abortion resulted in "illegal and unsafe abortions". **The Committee urged the Government to "ensure children's access to safe abortion and post-abortion care services in law and in practice".**

ii. Zimbabwe does not have a specific law to govern the age at which children may consent to medical procedures, including services related to SRHR

Zimbabwe does not have an expressed age for seeking medical procedure including accessing sexual and reproductive health services, such as seeking contraception or termination of pregnancy. The Public Health Act of 2018 [Chapter 15:17] defines a child as anyone under the age of 18 years, and states that "informed consent" can only be given by a person who has legal capacity to do so. The Act is silent on sexual and reproductive health services, which leaves the provision of such services to children unclear and up to the health care worker to interpret whether or not a child can receive such services without a guardian present. In such a legal environment, medical providers base decisions on personal opinions around the appropriate age, rather than following a stipulated framework. **There is therefore need to amend the Public Health Act to ensure adolescents'universal access to sexual health services.**

iii. The age of consent to sex

The Age of consent to sexual activity has been raised to 18 from 16 under the Kawenda v Minister of Justice Legal and Parliamentary Affairs constitutional ruling of 2022. However, even though children need to be protected from sexual abuse and exploitation, it needs to be acknowledged that adolescents start exploring their sexuality and engage in consensual sexual activity with their peers before they turn 18. This was clear during the Covid-19 lockdown period where just between January and 5 February 2021, the country recorded 4959 teenage pregnancies and 1774 child marriages (Parliament of Zimbabwe Hansard, 2021). The age of consent creates barriers in accessing sexual and reproductive health services, leading to higher levels of unsafe abortions, sexually transmitted infections and unwanted pregnancies. In addition, research shows that promoting sexual abstinence, as is often the case in jurisdictions with high ages of consent to sexual activity, does not actually lead to a delayed sexual debut. It rather gives adolescents the option to make safe decisions about their health. The higher the age of sexual consent, the more barriers exist in accessing sexual health services before that age.

The age at which a person is considered mature enough to consent to receiving health services related to sex and reproduction without a guardian is in many countries tied to the age of sexual consent. Having to obtain consent from a guardian or a parent to access services related

to sexual health is a hurdle many adolescents will choose to avoid. Research shows that the better access adolescents have to sexual health services, the more likely they are to be empowered to express full, free and informed consent to sex. This increases overall health and wellbeing. In this regard, the Committee on the Rights of the Child has encouraged States to recognize a "presumption of capacity" for adolescents to access sexual and reproductive health services.

iv. Lack of translation of constitutional and legal provisions into rights that people enjoy

The other challenge in Zimbabwe is translation of constitutional and legal provisions into rights that people actually enjoy due to a number of factors including lack of understanding and knowledge of rights by the rights holders, inadequate alignment and implementation of the existing legal and policy framework on gender equality and women's rights law, and persistence of patriarchal norms. Women and girls remain second class citizens due to patriarchy which is often perpetuated under the guise of culture and religion. The dual legal system in the country complicates matters for women and girls. For example, the Roman Dutch law and Customary Law define the child differently and hence the expectations of children also differ.[4] Women and girls thus find themselves subject to overlapping and potentially contradictory obligations, emanating from different systems of law. The CEDAW Committee at the 2012 review meeting recognised the important progress Zimbabwe has made in adopting a series of legislative and policy measures but however lamented the lack of implementation of the same. In February 2020, Zimbabwe underwent another review before the CEDAW Committee and the committee called on Zimbabwe to ensure effective implementation of its laws on gender equality and women empowerment and the elimination of all forms of discrimination and to take measures to enhance the implementation of gender equality laws and policies through effective enforcement mechanisms. The enactment of the gender equality law is critical for the delivery of gender equality provisions in the constitution. The gender equality law includes sanctions for non-compliance.

4 For instance, the definition of a child in most cultures in the Southern African region are linked to the child's ability to carry out certain tasks, attainment of marital status, on puberty, on procreation or on circumcision. In terms of civil law a child is defined according to biological age.

2.2 *Lack of financial resources and shortage of health staff, facilities and services*

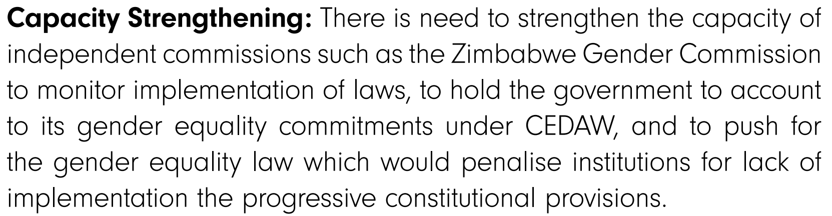
The lack of policy implementation and enforcement in the country is furthered by lack of adequate allocation of resources to advance the laws and policies in place. The health care sector in Zimbabwe is currently struggling to provide good health services (Mafukidze, 2018). Quality service delivery in Zimbabwe is being impeded by a number of factors including linked to inadequate budget allocation to the Ministry of Health and Child Care. These include prolonged and frequent strikes by health personnel, negligent, unfriendly attitudes of health service providers, inadequate health facilities and supply of drugs, inadequate health service providers, and long waiting time. In most cases, student interns are the ones who are being found on sight at clinics/hospitals even during emergencies with no assistance from the qualified health personnel as qualified personnel opt to offer private services which give them more money. Zimbabwe continues to lose qualified health personnel due to brain drain. The exodus of most nurses and doctors to the UK continues every year. Approximately 4780 health personnel have left Zimbabwe to the UK as reported by the UK NHS staff from overseas report of March 2021 (Baker, 2021). The shortage has not gone unnoticed by people and women have tended to socialise themselves to conduct home deliveries using local natural means.

A study conducted by Mutowo et al (2021) in Mashonaland West revealed that shortages of resources such as skilled staff, drugs and essential equipment were some of the reasons why pregnant women did not see the need to seek health care services. Quality service delivery is crucial and if the service offered is poor, it can become a barrier to accessing prenatal and maternal health. Lack of sufficient support to the health sector remains a critical challenge affecting health service delivery in the country. The health sector budget allocation from treasury always falls short of the Abuja Declaration which requires 15% of the total budget to go towards health. The 2022 national budget allocated 12.7% of the budget to the health sector.

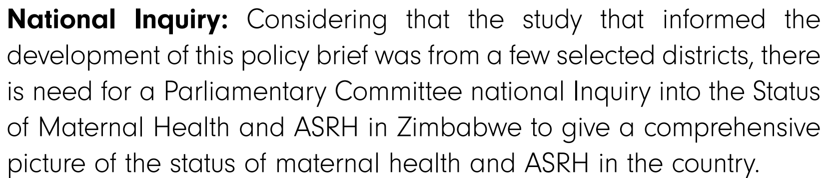
3. Conclusion and Recommendations

It is evident that pregnant adolescent mothers and women face a number of challenges regarding access to prenatal and maternal services in the country. This calls for addressing policy gaps, awareness of progressive women's rights and adolescent sexual and reproductive health rights, as well as engagement of relevant stakeholders to ensure enforcement of the laws. The following recommendations are proffered:

- **Legislative review:** For improved access to prenatal and maternal services by pregnant adolescents and women, some unprogressive laws have to be reviewed:
  - Considering that Zimbabwe does not have an expressed age for seeking medical procedure including accessing sexual and reproductive health services, such as seeking contraception there is need for a review of the Public Health Act of 2018 [Chapter 15:17] to incorporate this.
  - The 1977 Termination of Pregnancy Act should be reviewed to expand conditions under which termination of pregnancy is allowed to include pregnancy of minors. This will ensure children's access to safe abortion and post-abortion care services in law and in practice.
- **Implementation of existing laws:** There is need for adequate financing of the health sector by the government in line with the Abuja Declaration. This will ensure improved conditions of service for health care professionals as well as construction of more health facilities and better equipping of the same.
- **Gender equality law:** In addition, gender equality legislation is the missing link on implementation of progressive constitutional provisions on gender equality and women empowerment. There is therefore need for a gender equality law which would penalise institutions for lack of implementation the progressive constitutional provisions.



- **Capacity Strengthening:** There is need to strengthen the capacity of independent commissions such as the Zimbabwe Gender Commission to monitor implementation of laws, to hold the government to account to its gender equality commitments under CEDAW, and to push for the gender equality law which would penalise institutions for lack of implementation the progressive constitutional provisions.



- **National Inquiry:** Considering that the study that informed the development of this policy brief was from a few selected districts, there is need for a Parliamentary Committee national Inquiry into the Status of Maternal Health and ASRH in Zimbabwe to give a comprehensive picture of the status of maternal health and ASRH in the country.

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