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



AFRICAN
WOMEN'S
DEVELOPMENT
FUND



**Women and Law
in Southern Africa
Zimbabwe**

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Contents

List of Acronyms	iv
About WLSA Zimbabwe	v
1. Introduction	1
2. Barriers to Access Prenatal and Maternal Health Services by Pregnant Adolescents and Rural Women	3
2.1 <i>Legal and Policy Related Barriers</i>	3
2.2 <i>Social-Cultural and Economic Barriers</i>	9
3. Conclusion and Recommendations.....	16

List of Acronyms

ABR	Adolescent Birth Rate
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
FGD	Focus Group Discussion
GBV	Gender Based Violence
HTC	HIV Testing and Counseling
IEC	Information Education Communication
KII	Key Informant Interview
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOHC	Ministry of Health and Child Care
MWACSMED	Ministry of Women Affairs, Community, Small and Medium Enterprise Development
NGO	Non Governmental Organisation
NDS	National Development Strategy
PNC	Postnatal Care
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health Rights
TSP	Transitional Stabilisation Programme
UDACIZA	Union for Development of Apostolic and Zionist Churches in Zimbabwe
UNFPA	United Nations Population Fund
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZWLA	Zimbabwe Women Lawyers Association

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's high maternal mortality ratio which in 2017 led to the country being 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. Despite a reduction in the Maternal Mortality Ratio (MMR) per 100,000 live births from 651 in 2015 to 462 in 2019,¹ MMR in Zimbabwe remains high. Benchmarking regionally, East and Southern Africa Region's MMR in 2017 was much lower than that of Zimbabwe at 384. 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%).² There are other factors as well contributing to the high maternal mortality in Zimbabwe that include negative labels attached to health facilities, high costs of services, poor attitudes of health service providers, extended waiting times, and distances to health facilities.

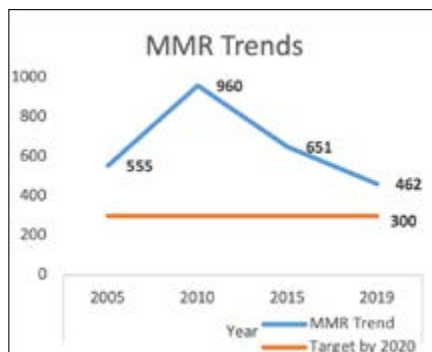


Figure 1: Trends in maternal mortality rate 2005-2019

Adolescent pregnancy remains a major contributor to maternal and child mortality. Zimbabwe's Adolescent Birth Rate (ABR) remains high, at 108 live births per 1000 women against a national target of 99 by 2020 and a global average of 44.³ A downward trend has been observed from 2010 where ABR was 118. Rural ABR of 136 was double that of urban's. Education is the factor most strongly associated with inequalities in ABR.

- 1 Ministry of Health and Child Care Zimbabwe (2020). 2019 Annual Family Health Programme Report.
- 2 Maternal Death Surveillance and Response, 2017 Annual Report.
- 3 Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

With pregnancy and childbirth complications being the leading cause of death among girls aged 15-19 years globally, more needs to be done to further reduce the adolescent birth rate.

The main purpose of this paper is to describe the utilisation of antenatal and maternal services in Zimbabwe by identifying the factors that affect the utilisation of antenatal and maternal services by pregnant adolescents and rural women as well as recommend ways in which these services will become more accessible to pregnant adolescents and rural women. This position paper draws on the findings 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."

2. Barriers to Access Prenatal and Maternal Health Services by Pregnant Adolescents and Rural Women

2.1 *Legal and Policy Related Barriers*

Zimbabwe like other countries ratified several treaties that require State parties to ensure that all everyone including rural women and adolescents have access to sexual and reproductive health services and information, and comprehensive sexuality education, free from barriers and discrimination. Section 76:1 of the Constitution of Zimbabwe states that every citizen has a right to access basic healthcare services. 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. These constitutional, policy and legal provisions are implemented under the leadership of the Ministry of Health and Child Care responsible for health and child care, local authorities, civil society and private

sector health service providers. The Adolescent Sexual and Reproductive Health strategy highlights the need for a multi-sectoral and participatory approach that also recognizes the participation of youth of both sexes at all levels of SRHR programming. The strategy is aimed at ensuring that adolescents have unlimited access to SRHR services both in school and out of school. Key documents include:

- The 2016-2020 National Health Strategy (GoZ, 2016).
- The National ASRH Strategy for 2016-2020: The ASRH Strategy I (2010-2015) had four interconnected streams for service delivery. These were; (i) community-based youth centres offering counselling, recreation, IEC materials and health consumables like condoms. However, this approach failed to achieve the intended purpose because the youth centres were not cost effective and was used for recreational purposes limiting girls' access to ASRH services. (ii) health facility-based, that is onsite youth-friendly corners facility that offer voluntary counselling and testing as well as IEC materials, health consumables and family planning services. This approach had weak referral systems and most young people could not afford to access the centres. (iii) school-based services including life skills training and counselling,

and (iv) the peer education model: Although this was a promising approach, it was affected by lack of resources and limited support. To address these challenges and also improve ASRH services and delivery for young people, the Government of Zimbabwe revised the ASRH strategy in 2015 and now is focusing on (i) increased safe SRH and HIV practices among Adolescents and Young People with emphasis on increasing correct and comprehensive knowledge of HIV/STIs and pregnancies and improving life skills among AYP, (ii) increased uptake of quality youth friendly integrated SRH/HIV services and (iii) strengthening protective environment for adolescent and youth through improving increased community support for ASRH and adolescent HIV programmes and improved parent to child communication on SRH and HIV services. The strategy however still fails to clarify adolescents' rights to access sexual and reproductive health services and information without imposing limitations based on age, marital status and the consent of a third party.

- The National Health Strategic Plan (2016-2020) seeks to strengthen ASRH through improving provisions of integrated youth friendly services using appropriate and evidence based

inclusive models, strengthening school health programme to include Comprehensive Sexuality Education and awareness of ASRH among others.

- Zimbabwe Maternal and Neonatal Health Strategy (2017-2021).
- Section 35 of The Public Health Act of 2018 has been read to provide that children under 18 require parental or adult consent to access medical health services.
- Access by adolescents to contraceptive services is governed by Zimbabwe's National Guidelines on Clinical Adolescent and Youth-Friendly Sexual and Reproductive Health Service Provision, 2016 (Clinical YFSP Guidelines).
- The Termination of Pregnancy Act (No. 29 of 1977) (as amended in 2001), allows abortion when it is necessary to save the life of the woman, to preserve her physical health, when there is foetal impairment and when the conception is the result of rape or incest. Anything outside that is criminalised.
- The Criminal Law Codification Act also set limited conditions under which abortion can be conducted. Any abortion done outside these provisions is an offence.

- The School Re-entry Policy, to 'protect' pregnant learners. The Policy Circular 35, provides that when a girl gets pregnant in school she can go for maternity leave and be re-enrolled at the same school, in the same grade/form in which she was before she took leave.
- The School Health Policy and the amended Education Act which alignment with the constitutional provision on education and international best practice as stipulated in the Convention on the Rights of the Child and the African Charter. The mended Act addresses issues of access to sexual and reproductive health services. Section 3 subsection (1a) provides for the provision of sanitary wear and other menstrual health facilities to girls in all schools to promote menstrual health.
- The National HIV Testing Guidelines of 2014 which states that a child under the age of 16 is unable to consent to HIV Testing and Counselling (HTC).
- The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III, 2015-2018) supports efforts that will consolidate mainstreaming of human rights and gender responsive approaches in AIDS planning and service delivery mechanisms.
- The National Family Planning Strategy and the National Family Planning Costed Implementation Plan. The two goals of the Zimbabwe National Planning Strategy are to increase the contraceptive prevalence rate from 59% to 68% by 2020 and to reduce teenage pregnancy rate from 24% to 12% by 2020.

It is clear that the strategic priorities include improving availability and access to comprehensive family planning services, expansion of other SRHR services, 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. All of these policies emphasize that health care delivery should be appropriate to the age of youth being served.

The shortfalls of these legal and policy provisions are not limited to the following:

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 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 need to amend the law to ensure adolescents can access sexual health services universally.**

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 to align it to the age of consent to marriage. 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 *Social-Cultural and Economic Barriers*

There is a plethora of barriers to accessing prenatal and maternal health services by pregnant adolescents and rural women in Zimbabwe. WILD (2020) summarises the challenges that women in general face in relation to access to health as absence of waiting mothers' shelters, poor road infrastructure, long distances to get to the nearest medical services, lack of medication and qualified health personnel. These barriers have immensely contributed to maternal morbidity and mortality, postpartum depression and obstetric related cases. This section details the barriers.

- **Cultural and Religious Beliefs and Practices**

The health care system in Zimbabwe is characterised as pluralistic because of the co-existence and concurrent use of traditional and biomedical practitioners. Cultural and religious beliefs have a strong effect on the responsiveness of pregnant women towards accessing maternal health. The media was awash with a story of Memory Machaya who died at the Johane Marange religious shrine giving birth. In addition, religious beliefs also affect use of contraceptives especially by women from the Johane Marange.

Cultural and traditional influences on access to maternal health services are also predominant particularly in rural settings. Seeking early maternal care was viewed as not necessary as women are socialised to endure pain. There are adults who are believed to be good at diagnosing pregnancy with eyes and who can also conclude that one is carrying a healthy baby and subsequently discourage the need to visit the antenatal clinic (Dodzo and Mhloyi, 2017).

Gender norms demanding that girls should remain shy and innocent about sexual matters limit their access to information on sexuality, contraception, pregnancy and related services. This also extends to health care personnel who may then stigmatize and disrespect pregnant adolescents. Health-seeking behaviour for these adolescent mothers is therefore mainly affected by norms and values in a particular society. Relatedly, culturally, parents are not expected to talk about use of contraception with school going children. These social norms reduce the use of contraception among the adolescents, contributing to limited access to prenatal and postnatal services among adolescent mothers.

- **Lack of financial resources and shortage of health facilities and services**

One of the major challenges in the rural setup is the shortage of health facilities. Most rural clinics do not have all prenatal and maternal services and in most cases, accessibility remains a challenge due to transport costs as the facilities are located very far. In general, in addition to \$10 registration fee, local clinics demand that one brings their own sanitary pads, bed sheets, a bucket of water, a razor to cut the baby's umbilical cord, gloves for the nurses and candles for lighting which would add up to \$20. If one is transferred to a hospital they would pay at least \$70 more and a blood transfusion if needed would cost \$120/unit (RBF Health 2019). This is a lot of money and beyond the reach of pregnant adolescents and rural women. Although, the Rural Based Financing Program subsidizes health care services for pregnant women and children under five in rural areas, unavailability of some of the services at the facilities hinders women from utilising this facility. Pregnant women have to gamble with their lives by opting for home delivery due to underfunded and under-resourced government hospitals or because they cannot afford the costs of care.

Some women give birth at religious shrines owing to high costs of accessing services at health centres. High exodus of staff and shortage of essential drugs, have also forced many women to seek traditional care. To this end, economic challenges have not only affected households but even the community since some clinics in rural areas are community owned; they are built using locally available resources with the help of local government (Rural District Councils Act, Chapter 29:13). There is therefore shortage of health facilities. Distance to health care facilities therefore becomes a major challenge for remote locations and communities inhibiting access to health care services⁵. The current health facilities profile in Zimbabwe indicate that there are 214 hospitals and 1634 primary health facilities countrywide.

5 Ray, S and Masuka, N (2017) Factors and Barriers to Effective Primary Health Care in Zimbabwe.

Table 1: Health Facilities Profile in Zimbabwe

Hospital	Number	Primary Health Facilities	Number
Central hospitals	6	Clinics	1122
Provincial hospitals	8	Polyclinics	15
District hospitals	44	Mission clinics	25
Mission hospitals	62	City council/ municipal clinics	96
Rural hospitals	62	Rural health centres	307
-	-	Private clinics	69
Total	214		1634

Source: Ministry of Health and Child Care 2016-2020 National Health Strategy for Zimbabwe

There have been initiatives by the government of Zimbabwe to have waiting mothers' shelters in some rural areas to deal with the challenge of distance to health facilities.

Where few clinics exist, they are usually ill-resourced and the conditions of health care staff are considered as poor thereby affecting their discharge of quality services to patients.

Due to financial challenges, rural women are left with home delivery as an option since transport cost can go beyond their financial capacities coupled with poor road networks. Failure to have resources to construct more clinics becomes a challenge and to those who have the facilities, failure to cater for service costs such as caesarean section during delivery and other maternal services becomes a great barrier to accessing medical care.

The challenge for adolescent mothers is compounded by the fact that local clinics are not allowed to attend to them; instead they are referred to general hospitals, where specialised care is available, thereby increasing the costs of accessing services for this category of patients. Owing to the age of the mother, there are risks of perinatal mortality for the child and prolonged labour for the young mother hence the need for them to be attended to at general hospitals.

There are serious gaps affecting quality of health care especially. The following key indicators clearly portray the situation:

- Health facility density, an indicator of outpatient service access was 1.1 facilities per 10,000 population, below the Service Readiness and Availability Assessment (SARA) benchmark of 2 facilities per 10,000 population. Across all provinces, facility densities

ranged from less than 1 health facility per 10,000 population to 1.7 per 10,000 population;

- Zimbabwe's national in-patient bed density is 18 in-patient beds per 10,000 against SARA target of 25 in-patient beds per 10,000 population;
- National maternity bed density is 8 per 1000 pregnant women against the SARA target of 10 maternity beds per 1000 pregnant women;
- The overall health infrastructure index score (average of health facility density, in-patient bed density and maternity bed density) is 69% of the respective target values.
- Zimbabwe's overall density of core health care workers per 10,000 population is 8, about a third of the recommended target of 23 per 10,000 population by the World Health Organisation (WHO).
- The national general service availability score is 42%.⁶

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 negligent, unfriendly attitudes of health service providers, inadequate facilities and

supply of drugs, inadequate health service providers and long waiting time.

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. 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.

6 Ministry of Health 2015 Zimbabwe Service Availability and Readiness Assessment Survey.

- **Attitudes of Health Care Providers towards Patients**

Types of attitudes and behaviours such as neglect, disrespect, verbal and physical abuse often take place at health facilities. This is despite the Patient's Charter that states that 'patients shall be interviewed, examined and treated in surroundings designed to ensure reasonable privacy and shall have the right to be accompanied during any physical examination or treatment if they so wish. A client has the right to have the full details of patient's care (including the use of new technology) prognosis and all communication and other records relating to the patients care to be treated as confidential unless the release of such information is authorized in writing by the patient.' The Valerie Chibaya case is a typical example. In 2020 Valerie Chibaya, with WLSA's assistance sued the Vice President of Zimbabwe Constantino Chiwenga in his capacity as the Minister of Health and Child Care for neglecting to treat her as a medical emergency. Chibaya went to Sally Mugabe Central Hospital when she was 23 weeks pregnant after experiencing unusual abdominal pains. Upon arrival, the doctors and nurses did not take her temperature, blood pressure or sugar level nor a routine check. They instead insisted that she gets a scan first before they could treat her. Chibaya began to

bleed without any treatment and went into premature labour and lost her baby without receiving any emergency medical care from the staff at the hospital. Chibaya then filed a lawsuit demanding \$1,5 million for pain, suffering and contumelia damages after she lost her unborn baby. She won the law suit and the Minister of Health and Child Care was ordered to pay \$900,000 in damages.

Staff disrespect towards pregnant women have been associated with an increase in home deliveries and a subsequent increase in maternal and neonatal morbidity and mortality as observed by Mannava, Durrant, Fisher, Chersich and Luchters (2015).

- **Lack of family support**

Pregnant adolescents and rural women face immense challenges in accessing prenatal and maternal health services because of lack of family support. Lack of acceptance of a pregnant adolescent by her in-laws can be a cause for reluctance to advise the adolescent to seek prenatal and maternal health services. Even the biological parents of the pregnant adolescent out of disappointment may fail to give support to the pregnant girl for her to seek maternal services and resultantly making lack of family support a barrier to accessing prenatal and

maternal health. In addition, rural women are personified as strong and any complain of ill health is seen as laziness. This prompts both pregnant adolescent and rural women to desist from accessing medical care not on voluntary basis but because of no support from the family (Dodzo and Mhloyi, 2017).

- **Disasters and Emergencies**

Disasters generally disrupt access to services. In recent years Zimbabwe has experienced an increase in short term shocks or disasters that have had an impact on access to sexual and reproductive health services in general. In the study districts,

participants cited COVID-19 as having had the greatest impact on access to prenatal and postnatal services. It was reported that measures taken by the government to contain and reduce the spread of coronavirus affected access to these services. The national lockdown resulted in the disruption of access to the full scope of health services as health facilities concentrated on emergency cases, with most of the cases being referred to provincial hospitals due to limited or no capacity to handle COVID-19 related cases. At these hospitals, women reported that they were being made to wait outside the health centres and were called in batches of a maximum of 5 people which was frustrating and discouraging.

During COVID-19 lockdown, due to mobility restrictions, access health services was limited by a number of factors, namely, the unavailability of transport services, the closure of some health facilities to other cases except COVID related cases as well as the fear by health care workers to contract COVID-19 from people that were walking in from communities. In some cases clinics and hospitals were demanding COVID results for one to access health services, and PCR tests were being charged US\$65, which was beyond the reach of many adolescent girls and rural women. The other challenges were staff shortages as a result of a strike by health personnel and unavailability of essential drugs from clinics and hospitals which meant that women were supposed to procure these from pharmacies which had stipulated opening hours (8am-3pm). Pharmacies ended up charging exorbitant prices for drugs.

Due to mobility restrictions there was low turn-out for routine services such as immunisations, antenatal care, family planning services and HIV treatment and care services. OCHA reports that as of 3 December 2020, access and utilisation of essential services including preventive, curative and rehabilitation services declined in the period April to October 2020, compared to the same period in 2019. Outpatient consultation declined by 49% and attendance of pregnant women at the fourth antenatal care visit declined by 55% and this resulted in an increase in unsafe home deliveries in a country that had witnessed progress in reduction of mortality ratios from 651 in 2015 (2015 ZDHS) to 462 in 2019 (2019 MICS). The number of live births in health facilities fell by 21% while new clients on combined birth control dropped by 90%. There were reports of women being turned away from health institutions as priority shifted to the fight against COVID-19 as well as limited access to family planning services and to modern contraceptives, leading to a rise in unwanted pregnancies. Currently, the unmet need for contraceptives in Zimbabwe is 8.6%.⁷

In the studied districts, women and girls reported that they had limited access to information due to limited access to public spaces, group gatherings and outreach activities.

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

3. Conclusion and Recommendations

From the foregoing, it is evident that pregnant adolescent mothers and rural women face a number of challenges regarding access to prenatal and maternal services. This calls for multi-pronged and sustained engagement with multiple stakeholders, including addressing underlying risk factors such as social norms regarding marriage, women's economic empowerment and policy gaps, alignment and implementation of existing progressive legal instruments. It also calls for economic empowerment interventions, awareness of women's rights as well as adolescent sexual and reproductive health rights, interventions that address religious and cultural practices that perpetuate sexual violations as well as engagement of relevant stakeholders to ensure enforcement of the laws. The following recommendations are proffered:

a. Legislative review

- Review of the 1977 Termination of Pregnancy Act 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.
- 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 to advocate for a review of the Public Health Act of 2018 [Chapter 15:17] to incorporate this.

b. The need for Gender equality law

Gender equality legislation is the missing link on implementation of progressive constitutional provisions. This calls for CSOs to push for the gender equality law which would penalise institutions for lack of implementation the progressive constitutional provisions.

c. Adequate funding for the health sector in line with the provisions of the Abuja Declaration

There is need to advocate 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.

d. Strengthen capacity of independent commissions

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.

e. Intensification of mobile and digital services during emergencies

To ensure wider access to services including during emergencies, there is need to roll out of mobile clinics in communities for basic health services that remained a concern in communities. There is further need for community engagement to improve health information and access to essential services. These could be complimented by toll free and hotline services. The hotlines should use all local mobile networks to enable everyone including those in remote areas to call for services.

f. Strengthen women and girls' agency

Social norms and values influence access to prenatal and postnatal services. Owing to this background, interventions that are aimed at strengthening rural women and adolescent mothers' agency are critical. Supporting adolescent mothers and rural women's business development, including through business and life skills training and financial inclusion is critical for the promotion of access to prenatal and postnatal services. Development of entrepreneurship skills for women and adolescent mothers as well as increasing their access to finance addresses idiosyncratic barriers to economic progress and in turn can address economic barriers to access to services. Economic empowerment of women and adolescent mothers is likely to improve their agency.


g. Creation of Accountability Platforms

Adolescent mothers' agency and voice appears to be undermined by all-inclusive community platforms. There is need for accountability platforms bringing together duty bearers and adolescent mothers and rural women. These could be complimented by development of social accountability tools such as scorecards to enhance adolescent mothers and rural women's participation as well as measure prenatal and maternal service delivery.

h. Partner with UDACIZA and other relevant religious umbrella bodies

To meaningfully tackle the religious factors contributing to limited access to prenatal and postnatal services, especially within the Apostolic sects, strategic partnership with UDACIZA at national level to influence change is critical.

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