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WOMEN'S REPRODUCTIVE RIGHTS IN ZIMBABWE:

A Shadow Report



The Center for Reproductive Law & Policy (CRLP)
Women in Law and Development in Africa (WILDAF),
Zimbabwe

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INTRODUCTION

This report is intended to supplement, or “shadow,” the report of the government of Zimbabwe to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW). It has been compiled and written by the Center for Reproductive Law and Policy (CRLP) and Women in Law and Development in Africa (WiLDAF), Zimbabwe. As has been expressed by CEDAW members, NGOs such as CRLP and WiLDAF can play an essential role in providing credible and reliable independent information to CEDAW regarding the legal status and the real-life situation of women and the efforts made by ratifying governments to comply with the Convention on the Elimination of All Forms of Discrimination against Women (Women’s Convention) provisions. Moreover, if CEDAW’s recommendations can be firmly based in the reality of women’s lives, NGOs can use them to pressure their governments to enact or implement legal and policy changes.

Discrimination against women permeates all societies. Clearly, this discrimination requires urgent action. However, this report is focused particularly on reproductive rights, laws and policies related to such rights, and the realities affecting women’s reproductive rights in Zimbabwe. As such, this report seeks to follow-up on the December 1996 “Roundtable of Human Rights Treaty Bodies on the Human Rights Approaches to Women’s Health with a Focus on Reproductive and Sexual Health Rights” held in Glen Cove, New York by bringing to the attention of treaty monitoring bodies the human rights dimensions of health issues, with a particular focus on women’s reproductive and sexual health. As articulated at the 1994 International Conference on Population and Development in Cairo, as well as the 1995 United Nations Fourth World Conference on Women in Beijing, reproductive rights consist of a number of separate human rights that “are already recognized in national laws, international laws and international human rights documents and other consensus documents,” including the Women’s Convention. We believe that reproductive rights are fundamental to women’s health and equality and that States Parties’ commitment to ensuring them should receive serious attention.

This shadow report links various fundamental reproductive rights issues to the relevant provision(s) of the Women’s Convention. Each issue is divided into two distinct sections. The first, shaded section deals with the laws and policies in Zimbabwe relating to the issues and corresponding provisions of the Women’s Convention under discussion. The information in the first section is mainly obtained from the Zimbabwe chapter of *Women of the World: Laws and*

Policies Affecting Their Reproductive Lives – Anglophone Africa, one of a series of reports in each region of the world being compiled by CRLP in collaboration with national-level NGOs. WiLDAF collaborated with CRLP and the International Federation of Women Lawyers (Kenya Chapter) F.I.D.A.-K on the Zimbabwe chapter. The second section focuses on the implementation and enforcement of those laws and policies -- in other words, the reality of women's lives. WiLDAF has provided most of the information included in this section.

This report was coordinated and edited by Katherine Hall Martinez and Nicolette Moodie for CRLP, and by Gladys Siwela for WiLDAF. The following organizations in Zimbabwe also contributed to the report: the National Shadow Report Meeting working group; Dondolo Mudonzvo Credit Scheme; the Women's Action Group; YWCA of Zimbabwe; the Zimbabwe Nurses' Association; Jekesa Pfungwa/Vulingqondo; the Zimbabwe Women's Bureau; ZimRights; the Zimbabwe Women's Resource Center and Network; and the Zimbabwe Council of Churches.

December 1997

**Laws and Policies Affecting Women’s Reproductive Lives
Implementation, Enforcement, and the Reality of
Women’s Reproductive Lives**

A. RIGHT TO HEALTH CARE, INCLUDING REPRODUCTIVE HEALTH CARE AND FAMILY PLANNING (ARTICLES 12, 14 (2)(B),(C) AND 10(H))

1. Access to health care

Laws & Policies

The government of Zimbabwe has identified health as a human right and prioritized the improvement and extension of health services as “a necessary and primary condition of development.”¹

The Ministry of Health and Child Welfare (“MHCW”) administers the national health policy, which establishes the framework for health services in Zimbabwe. Primary health care is a central component of this policy.² MHCW strategies have focused on integrating the delivery of basic health, as well as informational and educational services, and increasing access to health facilities.³

The MHCW, local government authorities, church organizations, and the private sector are the major providers of modern health care in Zimbabwe.⁴ Traditional and alternative medical care is provided by traditional practitioners,⁵ midwives, and “natural therapists.”⁶ The MHCW is the largest provider of health care in Zimbabwe, employing 90% of all health personnel and providing financial support to other health care providers.⁷

The MHCW utilizes a four-tiered system of facilities, with a centralized public health administration.⁸ At the primary level, urban primary care clinics and rural health centers are staffed with state-certified nurses and midwives, and rural health centers also have environmental health technicians.⁹ In addition, community-based family planning personnel, “farm health workers” and “village community workers” provide basic treatment and preventive care, and conduct educational activities.¹⁰ The secondary, district level is the planning unit for MHCW programming.¹¹ At the secondary, tertiary, and quaternary levels, hospitals are staffed with doctors and nurses and are equipped for surgical procedures and laboratory tests.¹² An internal referral system facilitates access to specialized services and more sophisticated equipment.¹³

Major initiatives to expand the health services infrastructure have included the Family Health Project, which focused on the integration of maternal and child health (“MCH”) programs and family planning services, the development of rural health facilities, and the training and development of MCH personnel. Currently, the Family Health Project is targeting 16 underserved districts to provide services to an additional 40% of the rural population, many of whom cannot afford health care costs under the economic and structural adjustment reform program.¹⁴ In addition, the MHCW has established multidisciplinary health training schools in four cities, with the goal of establishing one training school in each province.¹⁵ Since 1984, the MHCW has conducted training sessions for traditional birth attendants, who attend 69% of births, in order to increase the availability of ante-natal care.¹⁶

The government has proposed that reductions of public subsidies for health services would be offset by improved financial management of health services, increased provision of care by non-governmental organizations (“NGOs”) and local and municipal authorities, and the establishment or expansion of health insurance programs.¹⁷ In addition, the government has implemented a cost-recovery program through the imposition of fees for health services.¹⁸

Hospital fees were re-introduced in the early 1990s. The MHCW provides free health care, including family planning and MCH services, only to individuals earning less than Zimbabwe (“Z”) \$400 per month (approximately U.S.\$45).¹⁹ The MHCW has implemented measures addressing fee evasion, and MHCW clinics require subsidy applicants to provide proof of their income level or their unemployed status.²⁰ Only patients with documentary proof (for example a pay-slip or social welfare card) that they earn less than Z\$400 per month, are unemployed or are pensioners, qualify for free medical services at government hospitals and public health care centers. All immunization services for children and pregnant women are provided free of charge.²¹

All Zimbabweans have the right of access to health care in times of need, regardless of their ability to pay.²² The right to treatment encompasses rights to confidentiality, privacy, and nondiscrimination, including on the ground of sex.²³ Statutory regulations prohibit the divulgence of confidential patient information by a medical practitioner, except where required by law.²⁴ All major risks of a medical procedure must be disclosed.

Reality

According to the government, 80% of the rural population and 90% of the urban population had access to health care between 1985 and 1991.²⁵ These figures are difficult to verify.²⁶ Moreover, the figures can be misleading due to the unavailability of drugs and qualified medical staff. Statistics show that the national nurse to patient ratio is 1:1,000 and the doctor to patient ratio is 1:10,000.²⁷ Other surveys have shown that in some remote rural areas people have to walk a distance of about five kilometers to get to the nearest health-care center, due to lack of accessible roads and transport.²⁸

Urban hospitals have a limited number of qualified doctors, nurses, pharmacists and other medical service providers. - 90% of doctors are based in urban areas. Rural hospitals are marginally staffed. Some rural hospitals have one resident doctor, while others have a doctor visiting once a week.²⁹ At Kachuta Clinic in Guruve, for example, a doctor makes only occasional visits. In mid-1997 a nurse saved a woman’s life there by performing an unsupervised emergency decapitation of the foetus. No doctor was available at the time, the telephone had not been working for months and there was no ambulance.³⁰

The minimum entry qualification for training as a nurse is 5 good “O” level (10th grade) passes. These have to include English, Mathematics and Science. The majority of nurses in Zimbabwe are women. A degree program in nursing has also been introduced.³¹

The Zimbabwe School of Medicine trains between 80 and 100 doctors every year. Affirmative action at the medical school is expected to increase the intake of female students from the current 10%.

Internal evaluations by the MHCW have concluded that the specialist referral system functions poorly.³² Rural and urban clinics do not have the facilities to perform caesarian sections or to deal with other complicated births.³³

The Z\$400-per-month income limit for the general health subsidy is below the poverty line in Zimbabwe.³⁴ Moreover, it is often difficult for individuals to prove that they qualify for the health subsidy.³⁵ The time it takes to obtain the required documents has proved to be a hindrance to obtaining free health care.³⁶

2. Access to Comprehensive, Quality Reproductive Health Care Services

Laws & Policies

Although the national health policy does not address reproductive health,³⁷ maternal and child health programs are a major component of the health care system.

The government has associated population issues with development concerns and has given national priority to family planning activities since 1985, implementing two Five Year National Development Plans (“NDPs”). The NDPs focused national family planning activities on the goals of limiting family size and conforming population growth to the pace of infrastructure development.³⁸

The 1985 Zimbabwe National Family Planning Council Act³⁹ nationalized family planning activities through the creation of the Zimbabwe National Family Planning Council (the “ZNFPC”), a parastatal organization under the MHCW.⁴⁰ The ZNFPC is responsible for the provision of reproductive health services, treatment and research⁴¹ and for advising government agencies on population and development issues. From its inception, the ZNFPC has made broad access to services a primary goal. For example, the ZNFPC established its Kubatsirana Project to strengthen women’s role in fertility decisions,⁴² as part of a general governmental initiative to support the participation of women in development.

The ZNFPC is funded by the national Parliament, as well as by fees, loans, and donations from NGOs.⁴³ In 1991, when the government began to pursue a policy of economic reform, the national structural adjustment program contained pledges to continue support for population initiatives and the expansion of family planning services.⁴⁴

Both NDPs identified the equitable distribution of services as a primary objective of family planning programming.⁴⁵ In 1986, the Central Statistical Office established a Population Planning Unit to refine family planning programming and service distribution with improved demographic data.⁴⁶ It advises officials on population issues and promotes studies on the impact of population growth on development.

Reality

Reproductive health services are available through such organizations as the ZNFPC, Population Services and the MHCW. All these organizations have carried out extensive family planning campaigns throughout the country.⁴⁷

According to a 1992 report by the Ministry of Health, the MCH department has improved ante- and postnatal care, the monitoring of births, and child immunization and nutrition programs;⁴⁸ instituted training for health personnel in maternity services; and improved telecommunications and transportation systems in rural areas.⁴⁹ Antenatal and postnatal services are widely available, particularly in areas that have health centers.⁵⁰ Twenty percent of the population in rural areas does not have access to ZNFPC or other MHCW services.⁵¹

In 1991, the ZNFPC conducted an intensive evaluation of national family planning facilities through its Family Planning Service Expansion and Technical Support Project.⁵² The study identified deficiencies in family planning programming, particularly in the areas of staff training and management. Study results indicated that over half of the family planning facilities in Zimbabwe did not keep accurate, long-term records on individual clients, and that 30% of staff had not been formally trained in family planning methods.⁵³ The ZNFPC has since initiated the development of a new service-delivery policy, with additional protocols to ensure accurate record keeping and has revised training procedures for medical personnel, nurses, and midwives.⁵⁴

3. Access to Information on Health including Reproductive Health and Family Planning

Laws and Policies

The ZNFPC maintains that “all individuals in the community have a right to information on the benefits of family planning for themselves and their families. They also have the right to know where and how to obtain more information and services for planning their families.”⁵⁵

The ZNFPC’s Information, Education and Communication Unit consists of MHCW and ZNFPC provincial core groups that identify regional needs and conduct campaigns to promote family planning services.⁵⁶ Until a few years ago, women were the main target group for contraceptive information. Recent campaigns have specifically targeted men and youth in order to promote cooperative decision-making between couples regarding contraception and family size.⁵⁷

A large volume of information in the form of posters and booklets on HIV/AIDS is widely available in English, Shona and Ndebele throughout the country.⁵⁸

Reality

Information on all forms of contraception is widely available and can be obtained on request from health service providers. Injectable contraceptives and implants have been extensively advertised, mainly in urban areas.⁵⁹

Efforts have been made to translate family planning information into local languages such as Shona and Ndebele. Oral transmission of the information is limited to radio in most of the local languages.⁶⁰ Approximately 47% of the urban population and 8% of the rural population had been exposed to family planning messages on television and radio by 1994.⁶¹

4. Contraception

Laws and Policies

There are no specific regulations governing the sale or use of contraceptives.⁶² Any woman over the age of 16 has the right to obtain contraceptives.

The national government supports more than half the cost of national family planning programming.⁶³ The government subsidizes up to 90% of the cost of contraceptives, and contraceptives are free of charge to low income families.⁶⁴ Following the introduction of the government cost-recovery program in 1991, fees for all health services were increased and condom distribution declined by 43%.⁶⁵

The ZNFPC is a major provider of contraceptives in Zimbabwe, supplying over 1,000 public hospitals and clinics.⁶⁶ Public health facilities distribute pills, condoms, chemical barriers, and injectable contraceptives.⁶⁷ In addition, some facilities are equipped to perform intrauterine device (“IUD”) insertion and sterilizations.⁶⁸ In 1993, the ZNFPC announced its intention to increase the range of methods available, focusing on long-term and permanent methods of contraception.⁶⁹ The ZNFPC directly operates 34 clinics, including two facilities (in Harare and Bulawayo) where female and male sterilizations are available, and facilities within the three central hospitals, where NORPLANT® has been available since 1992.⁷⁰ In 1992, the government reintroduced injectables, which had been restricted in Zimbabwe since 1980.⁷¹ The ZNFPC has introduced sterilization training at district and provincial hospitals.⁷² In addition, the ZNFPC has proposed a new training protocol that provides for staff instruction on IUDs and for the integration of STD prevention education into family planning programming.⁷³

Reality

Although contraceptive prevalence rates in Zimbabwe are among the highest in sub-Saharan Africa, these rates vary by region.⁷⁴ In 1995, contraceptive prevalence was estimated by the government to be 43%.⁷⁵ In 1994, 35.1% of women reported use of a contraceptive method, compared with 41.4% for men.⁷⁶ The most common method of contraception currently in use among women is the pill, which has a prevalence rate of 23.6%.⁷⁷ 14% of men report using condoms.⁷⁸ There is no record of “incentives” or “disincentives” being offered to service providers to promote or discourage certain forms of contraception.

A 1991 study of family planning facilities found that although over 90% of clinics offered both combined and progestin-only pills and condoms, fewer than one quarter made available spermicides and IUDs and only two percent of facilities were equipped to perform female sterilization.⁷⁹ Injectable contraceptives are reported to be available at all health care centers which offer family planning services.⁸⁰ Most gynecologists in Zimbabwe have now been trained to insert and remove NORPLANT®. But many women see general practitioners rather than gynecologists. Fewer than ten such practitioners are trained to do so in Harare. Oral testimonies suggest that it takes an average of four weeks to have NORPLANT® removed.⁸¹ The MHCW has been actively involved in promoting the female condom, even though the general feeling is that it is not affordable, particularly not for those with low incomes.⁸²

The ZNFPC’s community-based contraceptive delivery system reaches an estimated 29% of the rural population.⁸³

5. Abortion

Laws and Policies

Abortion is legally permissible in limited circumstances in Zimbabwe.⁸⁴ Any abortion, irrespective of the duration of pregnancy, must be performed in accordance with the provisions of the 1977 Termination of Pregnancy Act (the “1977 Act”).⁸⁵ Pursuant to the 1977 Act, an abortion may be legally performed when:

- the pregnancy represents a serious threat to the woman’s physical health;
- there is a severe risk that the child would suffer from a permanent, serious physical or mental handicap; or
- the pregnancy was the probable result of rape,⁸⁶ incest, or intercourse with a mentally handicapped woman or girl.⁸⁷ (Other sexual offenses, such as statutory rape, are not permissible grounds for an abortion under the 1977 Act.⁸⁸)

In general, an abortion may only be performed by a “registered medical practitioner”⁸⁹ in an institution designated by the MHCW⁹⁰ with written permission from the institution’s superintendent or designated administrator.⁹¹ Contravention of any of the 1977 Act’s provisions carries a penalty of imprisonment up to five years and/or a fine of Z\$5,000 (approximately U.S.\$563).⁹²

Abortion services are provided by the MHCW, and are free to low-income or unemployed women, as part of the fee exemption program.⁹³ Fees for all services involved in the provision of abortions are set by the state.⁹⁴

Reality

In 1994, induced abortions, mostly illegally performed, were estimated by the government to occur at an annual rate of 80,000.⁹⁵ Only 66 abortion related deaths were reported in 1993 at central hospitals in Zimbabwe.⁹⁶ Illegal, but safe abortions are available to wealthy women through physicians in private practice. These can cost up to Z\$4,500 (approximately US\$507).⁹⁷

Although information on legal termination of pregnancy is available, there is a need for administrative and legal reform, according to WiLDAF. The current procedure for obtaining a legal abortion is lengthy, restrictive and cumbersome. They cite an example of a woman who became pregnant as a result of rape. The rape case went to court and dragged on for months. Permission for a legal abortion was given a month after the woman had given birth.⁹⁸

6. Sterilization**Laws and Policies**

No legislation in Zimbabwe directly addresses sterilization.⁹⁹ However, sterilization for health purposes is legally permissible, provided that the operation is performed by a registered medical practitioner who has obtained the consent of his or her patient.¹⁰⁰

The legality of non-therapeutic sterilization, usually for contraceptive purposes, is implicit in Zimbabwe’s family planning legislation. Non-therapeutic sterilizations must be

performed with the free and informed consent of the patient, and ZNFPC practices include the counseling of all clients considering sterilization.¹⁰¹

Sterilization is available at private clinics and MHCW institutions. The ZNFPC operates a referral system with MHCW facilities equipped for sterilization procedures.¹⁰² Government facilities perform female and male sterilizations for a fee of Z\$32.50 (approximately U.S.\$3.65).¹⁰³

Reality

Sterilization is not widely used in Zimbabwe as a contraceptive method. Of late, organizations such as the ZNFPC have been encouraging men to use and support the use of contraceptives. Sterilization has been extensively publicized in this regard. Pre- and post-sterilization counseling is offered at sterilization centers.¹⁰⁴

7. HIV/AIDS and STDs and Women

Laws and Policies

Although the first AIDS cases were reported in Zimbabwe in 1985,¹⁰⁵ the government did not begin to address AIDS as a critical public health problem until the early 1990s.¹⁰⁶ The MHCW established a National AIDS Coordination Unit and a National AIDS Advisory Committee to institute programs providing for the care of AIDS patients, as well as for the prevention and control of HIV transmission. It also established programs for monitoring infection levels and screening blood products in an attempt to control or reduce infection levels of HIV/AIDS.¹⁰⁷ MHCW programs have also focused on the provision of pre- and post-diagnosis counseling services and the training of health workers in the public and private sector.¹⁰⁸

Education and awareness campaigns target patterns of sexuality and contraceptive use in order to encourage self-protective behavior. A major component of these campaigns has been the promotion of condom use. Condoms are distributed free at government and municipal health centers.¹⁰⁹ The Zimbabwe Traditional Healers Association has joined in the campaign to promote safer sex practices and has advocated modification of certain cultural practices, such as the encouragement of safe sex in polygamous marriages and in widow inheritance.¹¹⁰

Pursuant to the Public Health Act, the Minister of Health and Child Welfare may declare an infectious disease to be “notifiable,” requiring infected persons to be immediately reported to the local authorities and imposing a fine or period of imprisonment for noncompliance.¹¹¹ HIV/AIDS has not been made a notifiable disease.¹¹² The Public Health Act also criminalizes the transmission of certain STDs. HIV/AIDS has not been added to the list of STDs that are regulated pursuant to the Public Health Act.¹¹³ The government has proposed legislation specifically criminalizing infection of another person with HIV, except where this occurs within marriage.¹¹⁴

Reality

Since 1987 over 48,000 AIDS cases have been reported.¹¹⁵ Recent reports put the figure at 100,000.¹¹⁶ The official estimate is that 500 people a week are dying of AIDS.¹¹⁷ It is estimated that two thirds of all AIDS cases in Zimbabwe remain unreported.¹¹⁸ Government estimates place HIV infection at 10% of the general population and at up to 25% of sexually active adults aged 15-49.¹¹⁹ Women account for 43% of all AIDS cases.¹²⁰

A recent survey by the Joint U.N. Aids Programme (UNAIDS) and the World Health Organization (WHO), put the rate of infection with HIV/AIDS in 1996 at one in five adults.¹²¹ In one town with a large population of migrant workers, seven in ten pregnant women tested HIV positive in 1996.¹²² In Beit Bridge, a large border town, the percentage of pregnant women infected with HIV increased from 32% in 1995 to 59% in 1996.¹²³

HIV is mainly transmitted through heterosexual contact in Zimbabwe. The MHCW has reported that the incidence of HIV infection among women is rising.¹²⁴ The highest incidence rates of AIDS and AIDS-related deaths among women occurs in the 20-29 age group, and women between the ages of 15 and 29 have a higher incidence of HIV infection than their male counterparts.¹²⁵ Teenage girls comprise 80% of AIDS cases in their age group.¹²⁶

The government estimates that 25-30% of babies born to HIV positive mothers will be infected at birth. Of those who escape infection at birth, 25-50% will be infected through breastmilk.¹²⁷ 25% more infants are estimated to be dying than would have been the case if there were no HIV. It is estimated that, because of AIDS, Zimbabwe's infant mortality rate will rise by 138% and its under five mortality rate will rise by 109% by the year 2010.¹²⁸ It is estimated that Zimbabwe's population will remain stagnant or even decline over the next 20 years as a result of AIDS.¹²⁹

The rapid increase in infection rates is linked to the prevalence of STDs. Over one million cases of STDs were reported in 1991.¹³⁰ Since then, the number of reported incidents has declined.¹³¹ A 1993 survey within rural and urban clinics found that 50% to 60% of patients receiving STD treatment had been infected with HIV.¹³²

The increase in health service fees introduced by the 1991 economic reform program has caused a decline in the use of hospital-based care by those infected with HIV.¹³³

Different situations give rise to discrimination against people with HIV/AIDS. An HIV test is required by the insurance industry before one can obtain a policy of over Zimbabwe \$100,000 (approximately US\$11,260.00).¹³⁴ Some private national and international companies require an HIV test before employing someone.¹³⁵ Treatment options for people with HIV/AIDS who have low incomes may be limited.¹³⁶ This is because one's income determines the type of medical aid (health insurance) scheme one is able to join and the monthly contribution one is able to make, which in turn determine the level of benefits received. The more advanced the stage of illness of an individual, the more severe discrimination becomes.

8. Adolescent Reproductive Health**Laws and Policies**

The Youth Advisory Services of the ZNFPC is responsible for focusing ZNFPC programming on the sexuality and reproductive health issues of adolescents.¹³⁷ The ZNFPC has

attempted to modify its facilities to serve youth populations and to work cooperatively with community youth organizations.¹³⁸

Although minors require parental consent to obtain medical treatment, the provision of many health and family planning services, including provision of contraceptives, to adolescents is not restricted under the law.¹³⁹ For example, a minor may receive treatment for a sexually transmitted disease without parental consent or knowledge.¹⁴⁰

Reality

Approximately 45% of the Zimbabwean population is under the age of 15.¹⁴¹

In 1993, 14% of all births were to women under the age of 20.¹⁴² In 1994, the median age for giving birth for the first time was 20, while 37% of 19 year old women had at least one child.¹⁴³

In practice, adolescents' access to contraceptives may be limited through informal policies of private family planning providers and government clinics.¹⁴⁴ Parental consent for contraceptive use is often practically imposed, and in ZNFPC and government clinics, contraceptives are not dispensed to youth under the age of 16.¹⁴⁵

B. FAMILY RELATIONS (ARTICLE 16)

1. Marriage and Customary Marriage

Laws and Policies

There are two types of marriage — customary and civil — in Zimbabwe. Women's legal status depends largely on the rights accorded to women under customary law and the enactment of remedial legislation.¹⁴⁶ Protection from discrimination, including discrimination on the ground of gender, is guaranteed in Section 23 of the Declaration of Rights.¹⁴⁷ However, Section 23 specifically exempts from its coverage laws which give effect to customary law or constitutional provisions, or which take "due account of physiological differences between persons of different gender."¹⁴⁸

In 1982, Parliament enacted the Legal Age of Majority Act,¹⁴⁹ which grants full legal capacity and majority status to all Zimbabweans over the age of 18.¹⁵⁰ Zimbabwean women also obtain legal majority when they marry.¹⁵¹ The Legal Age of Majority Act provides that the attainment of legal majority "shall apply for the purpose of any law including customary law."¹⁵²

Customary marriage is exclusively available to Africans.¹⁵³ If registered under the Customary Marriages Act,¹⁵⁴ a marriage is legally valid for all purposes. An unregistered customary union, the most common form of marriage in Zimbabwe, is legally recognizable only with respect to spousal claims of maintenance and the status, guardianship, custody, and rights of succession of children from the union.¹⁵⁵ A man may enter into more than one registered customary marriage, provided that he discloses the existence of prior marriages.¹⁵⁶ Families contract marriages between their children, giving their consent and arranging for marriage

consideration or bridewealth¹⁵⁷ to be paid to the woman's family.¹⁵⁸ The bridewealth agreement for a registered marriage is legally enforceable.¹⁵⁹ However, a woman cannot be forced to enter into any form of marriage against her will.¹⁶⁰

Civil marriages must be registered in accordance with the provisions of the Marriage Act.¹⁶¹ Civil marriages in Zimbabwe are monogamous and require the consent of both the man and the woman.¹⁶² The civil law governs spousal rights and obligations.¹⁶³ Zimbabweans wishing to enter into a civil marriage must satisfy the conditions set forth in the Marriage Act, as well as the common law requirement of "competency".¹⁶⁴ A woman who at the time of her marriage is pregnant with another man's child fails the "competency" requirement.¹⁶⁵

In any civil or customary marriage, the spouses have a reciprocal duty of maintenance and the obligation to maintain their children.¹⁶⁶ Responsibility for maintenance depends on the financial situation of the parties, as well as their ability to work.¹⁶⁷ Should the responsible party fail to pay adequate maintenance, the aggrieved spouse may apply to a magistrates court for an order directing payment.¹⁶⁸ Adultery by the applicant may result in the court's refusal to grant a maintenance order or the revocation of a previously granted order.¹⁶⁹

Reality

The marriages of 19% of married Zimbabwean women are polygamous.¹⁷⁰ Polygamy is more common among older women and women living in rural areas than among young, urban women.¹⁷¹ There is an inverse relationship between the incidence of polygamy and levels of education.¹⁷²

Although, the Legal Age of Majority Act has empowered women, their decision making capacity may be limited by economic dependence on their spouses. The practice of paying bridewealth to a woman's parents also undermines her independence. Women do not participate in the process of negotiating for bridewealth.¹⁷³

2. Divorce and Child Custody

Laws and Policies

The dissolution of valid, registered civil or customary marriages are governed by the Matrimonial Causes Act.¹⁷⁴ There is no legal action available for the dissolution of an unregistered customary marriage.¹⁷⁵ There are two possible grounds for divorce in terms of the Matrimonial Causes Act: incurable mental illness or unconsciousness of a spouse and the "irretrievable break-down of the marriage."¹⁷⁶ Proof of adultery may establish an irretrievable breakdown.¹⁷⁷

The Matrimonial Causes Act empowers courts to determine an equitable division of assets for registered marriages, as well as to provide for the maintenance of spouses and children.¹⁷⁸ However, property that has been inherited or acquired according to custom may only be distributed for the provision of maintenance.¹⁷⁹ Depending upon the attribution of blame for the breakdown of the marriage, its dissolution may entitle the man and his family to a return of part of the paid bridewealth.¹⁸⁰ However, in dividing assets, courts generally seek to ensure that the financial position of neither spouse substantially changes with the dissolution of the marriage.¹⁸¹

Pursuant to the Guardianship of Minors Act, courts will award custody of a child to the mother upon separation.¹⁸² However, the father always remains the natural guardian of his legitimate children.¹⁸³ Custody decisions are based on what is deemed to be in the best interests of the child.¹⁸⁴

Reality

One in three households in Zimbabwe are headed by women.¹⁸⁵ There are more female-headed households in rural areas than in urban areas.¹⁸⁶ In 1994, 7.8% of women aged 15-49 were divorced, 3.5% were widowed, and 26.9% had never been married.¹⁸⁷

There are very few cases of men who have gone to court to claim maintenance from women. The most common maintenance cases are of women claiming maintenance for their minor children. The procedure for claiming maintenance is long and cumbersome. It is often difficult for women to obtain the information required to process a claim, such as proof of the man's salary, the name of his employer or his residential address. This results in many women preferring to settle claims out of court or in their abandoning the attempt to claim maintenance completely.¹⁸⁸

3. Early Marriage

Laws and Policies

Girls under the age of 16 and boys under the age of 18 may not enter into a civil marriage without either the consent of their legal guardians or a judge, or the written permission of the Minister of Justice, Legal and Parliamentary Affairs.¹⁸⁹

Under customary law, there is no minimum age for marriage.¹⁹⁰ The Customary Marriages Act criminalizes forced marriages and the pledging of girls or women in marriage.¹⁹¹ However, the laws governing marriage in Zimbabwe entrench the institution of bridewealth in all marriages of African girls under the age of 18.¹⁹²

Reality

In 1994, 62% of Zimbabwean women aged 25-49 had been married by the age of 20.¹⁹³ The median age for women at first marriage is 19.¹⁹⁴ There is a direct correlation between educational levels and early marriage: the median age at first marriage for women with no formal education is 17.5 years, while it is 20.8 years for women with secondary education.¹⁹⁵

4. Right to access Family Planning, including Abortion and Sterilization, without Spousal Consent

Laws and Policies

An individual is not legally required to obtain spousal consent for medical treatment, including for contraception, abortion or sterilization.¹⁹⁶

Under customary law, a woman used to be required to obtain her husband's consent for all medical treatment, including the use of contraceptives. As a result of the Legal Age of Majority Act this should no longer be the case.¹⁹⁷

Reality

Medical practitioners may be reluctant to perform a sterilization operation without spousal consent because of its nature and seriousness.¹⁹⁸ Because infertility may be a ground for annulment of a marriage,¹⁹⁹ it is possible that a doctor performing a sterilization operation without spousal consent may incur third party liability for any injury resulting from the loss of reproductive ability.²⁰⁰

C. SEXUAL VIOLENCE AGAINST WOMEN (ARTICLES 5, 6 AND 16)

1. Rape and Sexual Crimes

Laws and Policies

Rape in Zimbabwe is a common law crime.²⁰¹ Evidence of violent threats or fraud, or the use of drugs or alcohol, vitiates the element of consent.²⁰² Zimbabwean criminal law does not recognize marital rape as a crime.²⁰³ Corroboration of a rape charge is not required,²⁰⁴ but evidence of the complainant's prior sexual behavior may be admitted as relevant to the issue of consent.²⁰⁵

Sexual offenses may be prosecuted under the laws prohibiting assault, indecent assault, or attempted rape.²⁰⁶ There are no sentencing guidelines for rape convictions. Typically a rape conviction is punishable with a fine or imprisonment.²⁰⁷

The 1901 Criminal Law Amendment Act (the "1901 Act") criminalizes the unlawful carnal knowledge of or the commission of any immoral or indecent act with a girl under the age of 16.²⁰⁸ However, a "reasonable" mistake about age is a sufficient defense and men who solicit child prostitutes cannot be prosecuted under the 1901 Act.²⁰⁹ A charge of indecent assault on a person under the age of 16 may be prosecuted regardless of whether the act was consensual.²¹⁰ Sexual intercourse with a girl under the age of 12 constitutes both rape and statutory rape.²¹¹

Public service regulations prohibit sexual harassment of government employees in the workplace.²¹² No laws in Zimbabwe address sexual harassment in the private sector.²¹³

Reality

In 1993, there were 2,315 reported cases of rape and 274 reported cases of attempted rape in Zimbabwe.²¹⁴ Although the majority of reported rape cases involve victims under the age of 14,²¹⁵ court records indicate that police and prosecutors in Zimbabwe often treat sexual offenses against minors, including nonconsensual intercourse and intercourse with girls under the age of 12, as cases of statutory rape.²¹⁶ Statutory rape carries a lower penalty than a rape conviction.²¹⁷ Due to lack of evidence to support a rape conviction, some accused have been convicted of indecent assault and have spent as little as 3 months in prison.²¹⁸

The Zimbabwean media, which is controlled by the government to a large extent, has been giving prominence to issues relating to sexual violence against women.²¹⁹ Pilot projects on victim friendly courts, with particular emphasis on the girl child, have been launched in Harare and Bulawayo.²²⁰

Greater sentences are now being imposed on convicted rapists than was the case in the past. Where an average sentence used to be two years imprisonment with one year suspended, sentences of at least five years for rape and seven years for statutory rape have been imposed recently.²²¹

Although no statistics on sexual harassment are available,²²² informal reports from the Zimbabwe Congress of Trade Unions indicate that harassment is a common complaint of women workers.²²³

There have been reports of actual and threatened rape and sexual violence aimed specifically at gay women.²²⁴ Examples include the case of a woman who was raped twice on the instructions of her parents, a woman who was sexually assaulted by a group of men from her home village when they found out she was gay, and gay women at the annual Zimbabwe International Book Fair being threatened with sexual violence. Homosexuality has been the target of much political rhetoric, which has created a climate of intolerance.

2. Domestic Violence

Laws and Policies

No law specifically addresses domestic violence in Zimbabwe.²²⁵

A victim of domestic violence may apply to a court for a “binding-over” order, which is available to anyone complaining of a threatened assault or breach of the peace and which may require the batterer to pay a fine or post a bond not exceeding Z\$200 (approximately U.S.\$22.50).²²⁶ If the order is violated, the perpetrator forfeits his bond and may be arrested.²²⁷

Victims of domestic violence may also bring criminal charges or apply to a court for civil damages.²²⁸

In a registered customary marriage, domestic violence is a ground for separation or divorce.²²⁹ Customary law provides for social dispute resolution in cases of domestic disputes or domestic violence. The families of a couple may mediate or provide refuge for the victim, and may require the perpetrator to post a “peace bond” to ensure his compliance with the families’ resolution of the dispute.²³⁰

Reality

There are no official statistics available on the incidence of domestic violence.²³¹ The police often treat cases of domestic violence as domestic disputes, rather than criminal matters.²³²

A survey conducted by an NGO in 1996 found that one in two respondents had been psychologically abused by men (in most cases by their partners or other men they knew), one in three had been sexually abused or raped and one in six had been physically abused.²³³ Lack of knowledge about the law, women’s lower socio-economic status and societal attitudes prevent women from enforcing their rights.²³⁴

Traditional social dispute resolution in cases of domestic violence has not been effective within the modern social organization of Zimbabwean families.²³⁵

WiLDAF identified domestic violence as an issue of national concern in 1990. Since then it and its network members have produced lobbying documents and statements about the issue of domestic violence in order to ensure that the government starts taking it seriously. They have also taken part in national and regional campaigns on violence, including domestic violence. WiLDAF and its network members hold an annual “sixteen days of activism,” with a different theme each year. In 1995, WiLDAF produced a quilt with details of women and girls who had died as a result of violence. This has been used to raise national awareness.²³⁶

3. Violence and/or Coercion in Health Services

Laws and Policies

There are no laws or policies dealing specifically with coercion in health services. All persons over the age of 18 and “of sound mind” have a constitutional right to “security of their person,”²³⁷ which includes the right to determine their own medical treatment.²³⁸

Reality

Violence or coercion in health services has not been documented and does not seem to be a problem in Zimbabwe. A few cases of doctors sexually harassing female patients have been reported, but no information is available on the measures taken against such doctors.²³⁹

D. EDUCATION AND ADOLESCENTS (ARTICLE 10)

1. Access to education

Laws & Policies

The Ministry of Education provides some donor-funded scholarships that are reserved for the disadvantaged children of commercial farm workers and are disbursed in favor of girls.²⁴⁰

The government has actively pursued educational programming to neutralize gender biases in curricula.²⁴¹ In addition, the Ministry of Education has instituted a counseling program within each school that targets female students, providing career and educational guidance and information on sexual health, including information on AIDS.²⁴²

Reality

Between 1979 and 1989, the number of primary schools increased by 88%,²⁴³ and attendance by female pupils increased 195%.²⁴⁴ The reintroduction of school fees in 1991 has had a negative impact on enrollment rates, especially of female students.²⁴⁵ Although the government provides additional funds to aid low-income families with health and education fees,

difficulties in access and in the application procedure have contributed to the low numbers of families benefiting from these funds.²⁴⁶ 46% of female students aged 15-24 who leave school do so because they cannot afford school fees.²⁴⁷

Although the initial enrollment of girls and boys at the primary level remains equal, the attrition rate for girls is much higher, and this disparity increases in the higher levels of education.²⁴⁸ Pregnancy is a common factor disrupting the education of female students, as pregnant students are required to leave school.²⁴⁹ The student may be readmitted after she gives birth, but is usually transferred to a different school.²⁵⁰

Nearly three times more women than men have had no formal education.²⁵¹

2. Information and Education on Sexuality and Family Planning

Laws and Policies

In cooperation with the MHCW, the Ministry of Education and Culture, UNICEF, and the ZNFPC has introduced a compulsory Family Life Education (“FLE”) program to incorporate family planning into the formal educational system.²⁵² The FLE program will replace life skills curricula with materials that directly address gender and reproductive issues. Educational programs have been supplemented by youth counseling and parent education programs that address adolescent sexuality.²⁵³

Reality

Sex education has been introduced into the primary and secondary school curricula. Many secondary schools also include sex education in their biology classes. Issues covered include STDs and STIs, HIV/AIDS, and access to and use of various contraceptives.²⁵⁴ AIDS awareness is now included in the school curricula of everyone over the age of eight.²⁵⁵

Those who have left school can only access such information from the Youth Advisory Services of the ZNFPC. The ZNFPC has also produced a variety of posters, as well radio and television programs on sex education.²⁵⁶

E. EMPLOYMENT RIGHTS (ARTICLE 11)

1. Maternity Leave

Laws & Policies

Pursuant to the Labour Act, employers must provide their female employees with partially paid maternity leave for a minimum of three months without prejudice to their accrual of any entitlements or benefits.²⁵⁷ A woman on maternity leave is entitled to a minimum of 60% of her salary; if she chooses to forego any accumulated vacation leave, she must receive at least 75% of her salary.²⁵⁸ Maternity leave as provided for in the Labour Act may only be taken once in a 24-month period and a maximum of three times with each employer.²⁵⁹ Women taking

maternity leave are entitled to return to their employment on the same or better terms.²⁶⁰ In addition, the Labour Act requires employers to furnish nursing women, at their request, at least one hour or two half-hour periods during normal working hours to nurse their children.²⁶¹ There is no legislation that provides for leave to attend antenatal care clinics.²⁶²

The current labor laws only cover private sector employees. There is currently a bill before parliament, which, if approved, will make the labor laws applicable to employees in the public sector as well.²⁶³

Reality

Some employers do not pay women a salary during maternity leave or do not offer maternity leave at all. The laws are easily flouted unless workers belong to a strong labor union which can advocate and lobby for their rights. In some cases workers fear victimization by their employers should they belong to a union. Due to the high unemployment rate, many employees in the private sector, and female employees in particular, do not attempt to enforce their rights for fear of losing their jobs.²⁶⁴

2. Protection in Pregnancy

Laws and Policies

Except for a prohibition against exposure to pesticides, working conditions for pregnant women are not regulated by law.³⁵⁸ The MCH department has advocated for the improvement of employment conditions affecting the health status of women workers.²⁶⁵

Reality

It is against the law to discriminate against anyone on the grounds of sex.²⁶⁶ However, there are still some private companies that discriminate by not employing women of childbearing age.²⁶⁷

Women constitute about 70% of the seasonal workers and about 10% of the permanent workers on the majority of farms throughout the country. Many farmers do not observe the labor laws. Salaries are very low, working conditions are poor and most of the accommodation is below standard. Work on farms includes plowing, planting, weeding and spraying pesticides on plants. Some farmers do not offer protective clothing to their workers handling chemicals. In some areas, farm workers' compounds are very close to the fields and workers are exposed to chemicals sprayed by airplanes. Communal farmers are also at risk as some of them are illiterate and cannot read and follow instructions before using chemicals.²⁶⁸

ENDNOTES

¹ Growth with Equity: An Economic Policy Statement ¶ 85, at 12 (Republic of Zimbabwe 1981).

² U.N. Dep't of Int'l Economic and Social Affairs, III World Population Policies 232, U.N. Doc. ST/ESA/SER.A/102/Add.2 (1990); FIRST FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1986-1990 art. 3.8, at 36 (Republic of Zimbabwe 1986).

³ Dep't of Health Services Planning & Management, Ministry of Health [Zimb.], Planning for Equity in Health: 1992 Revision art. 2.1, at 3 (1992) [hereinafter "Dep't of Health Services Planning & Management"].

⁴ Telephone interview with Luta Shaba, Attorney and Member, WiLDAF (Feb. 20, 1997).

⁵ The practice of a traditional medical practitioner is defined to be "every act, the object of which is to treat, identify, analyse or diagnose, without the application of operative surgery, any illness of body or mind by traditional methods." Traditional Medical Practitioner Act, ch. 27:14, § 2(2).

⁶ Natural therapists include homeopaths, naturopaths and osteopaths. Natural Therapists Act, No. 31, § 2(1) (1981). Natural therapists are usually white Zimbabweans or foreigners. Women in Law & Dev. in Africa (WiLDAF), Reproductive Health Rights in Zimbabwe 1 (1996) (unpublished paper on file at The Center for Reproductive Law and Policy) [hereinafter WiLDAF] at 3.

⁷ Dep't of Health Services Planning & Management, *supra* note 3, art 4 at 7.

⁸ *Id.*

⁹ CENTRAL STATISTICAL OFFICE [ZIMB.] & MACRO INTERNATIONAL, INC., ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, at 4 (1995) [hereinafter ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994].

¹⁰ See Godfrey B. Woelk, "Primary Health Care in Zimbabwe: Can It Survive?", 39 SOC. SCI. MED. 1027, 1030 (1994) (noting current trend to centralize village community workers).

¹¹ Dep't of Health Services Planning & Management, *supra* note 3, art 4.2 at 7.

¹² ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, *supra* note 9, at 4.

¹³ Dep't of Health Services Planning & Management, *supra* note 3, art. 4, at 7.

¹⁴ Technical Note: Assessing and Addressing the Social Dimensions of Adjustment, in Zimbabwe: A Framework for Economic Reform (1991-1995) Annex III, at 21 (Republic of Zimbabwe 1991) [hereinafter Technical Note]. The Family Health Project is in its second phase, encompassing the years 1991-95. *Id.*

¹⁵ SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, at 74 (1991).

¹⁶ POPULATION ACTION INT'L, REPRODUCTIVE RISK: A WORLDWIDE ASSESSMENT OF WOMEN'S SEXUAL AND MATERNAL HEALTH: 1995 REPORT ON PROGRESS TOWARDS WORLD POPULATION STABILIZATION (1995).

¹⁷ SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, *supra* note 15, at 69.

¹⁸ For the fiscal year 1989-90, fees provided MHCW revenue of Z\$15 million (approximately U.S.\$1.7 million). Technical Note, *supra* note 14, at 14.

¹⁹ WiLDAF, *supra* note 6, at 3

²⁰ Technical Note, *supra* note 14, at 20. The Department of Social Welfare has instituted training to aid staff in identifying low-income individuals who qualify for fee exemption and has deployed personnel to major urban health facilities to issue fee exemption papers. *Id.*

²¹ Patient's Charter: Zimbabwe 1996 § 4 (Ministry of Health & Child Welfare 1996). In addition, there is no charge for treatment for tuberculosis or leprosy. *Id.*

²² *Id.* at §1

²³ *Id.* §§ 1.2-1.4.

²⁴ Medical Practitioners (Professional Conduct) Regulations, S.I. 252, § 22, (1987). For example, any investigation or procedure initiated under the provisions of the Public Health Act dealing with infectious diseases may require disclosure of patient information. In addition, communications between medical practitioners and their patients are not privileged under Zimbabwean law and may be disclosed in legal proceedings. GEOFF FELTOE & TIMOTHY JOSEPH NYAPADI, LAW & MEDICINE IN ZIMBABWE 3 (1989) at 67. The appropriate civil action for breach of patient confidentiality is a suit to recover damages from an *actio injuriarum*, an act resulting in defamation, insult, degradation, humiliation or an invasion of privacy without public benefit. There have been no reported cases of suit for an *actio injuriarum* in Zimbabwe. *Id.* at 63-64.

²⁵ WiLDAF, *supra* note 6, at 3.

²⁶ WiLDAF, unpublished report of 12/1997 (on file at CRLP) [hereinafter "WiLDAF report"].

²⁷ *Id.* (citing an interview with a medical practitioner).

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- ²⁸ Id. (citing a National Shadow Report meeting).
- ²⁹ WiLDAF report, supra note 26.
- ³⁰ Id. (citing interviews with a medical practitioner and representative of a medical aid society).
- ³¹ WiLDAF report, supra note 26.
- ³² Dep't of Health Services Planning & Management, supra note 3, art. 4, at 7.
- ³³ WiLDAF report, supra note 26.
- ³⁴ RENE LOWENSON ET AL., REPRODUCTIVE HEALTH RIGHTS IN ZIMBABWE 40 (1996).
- ³⁵ WiLDAF, supra note 6, at 3.
- ³⁶ WiLDAF report, supra note 26.
- ³⁷ MINISTRY OF HEALTH & CHILD WELFARE, WOMEN'S HEALTH IN ZIMBABWE: A PATH TO DEVELOPMENT 2 (1994); see also WiLDAF, supra note 6, at 2.
- ³⁸ MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 59.
- ³⁹ Zimbabwe National Family Planning Council Act, ch. 15:11.
- ⁴⁰ Id. § 3; see also MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 59.
- ⁴¹ Zimbabwe National Family Planning Council Act, ch. 15:11, §22 (1).
- ⁴² LOWENSON, ET AL., supra note 34, at 22.
- ⁴³ Zimbabwe National Family Planning Council Act, ch. 15:11, § 27(1).
- ⁴⁴ Technical Note, supra note 14, ¶ 59, at 16.
- ⁴⁵ FIRST FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1986-1990, supra note 2, at 37 (citing Dep't of Health Services Planning & Management, supra note 3); SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, supra note 15, at 68 (citing WORLD HEALTH ORG., HEALTH CARE FOR ALL BY THE YEAR 2000).
- ⁴⁶ U.N. Dep't of Int'l Economic & Social Affairs, supra note 2, at 231.
- ⁴⁷ WiLDAF report, supra note 26.
- ⁴⁸ Dep't of Health Services Planning & Management, supra note 3, art. 9.11, at 17-18.
- ⁴⁹ Id.
- ⁵⁰ WiLDAF report, supra note 26
- ⁵¹ WiLDAF, supra note 6, at 5
- ⁵² ZIMB. NAT'L FAMILY PLANNING COUNCIL, ZIMBABWE: A SITUATION ANALYSIS OF THE FAMILY PLANNING PROGRAM (1992), cited in Barbara Mensch et al., Using Situation Analysis Data to Assess the Functioning of Family Planning Clinics in Nigeria, Tanzania and Zimbabwe, 25 *STUD. IN FAM. PLANNING* (1994) 18, at 21.
- ⁵³ Id., at 22-23.
- ⁵⁴ Id. at 20.
- ⁵⁵ Zimb. Nat'l Family Planning Council, Statement of Client Rights (1994), quoted in Lowenson et al., supra note 34, at 13.
- ⁵⁶ MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 61.
- ⁵⁷ Phyllis T. Piotrow et al., Changing Men's Attitudes and Behavior: The Zimbabwe Male Motivation Project, 23 *STUD. IN FAM. PLANNING* 365, 366 (1992).
- ⁵⁸ WiLDAF report, supra note 26
- ⁵⁹ WiLDAF report, supra note 26.
- ⁶⁰ Id.
- ⁶¹ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 63.
- ⁶² WiLDAF, supra note 6, at 6.
- ⁶³ Bill Keller, Zimbabwe Taking a Lead in Promoting Birth Control, *N.Y. TIMES*, Sept. 4, 1994, at 16.
- ⁶⁴ Id.; WILDAF, supra note 6, at 6.
- ⁶⁵ LOWENSON ET AL., supra note 34, at 29.
- ⁶⁶ CENTRAL STATISTICAL OFFICE [ZIMB.] & MACRO INTERNATIONAL, INC., ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, SUMMARY REPORT 11 (1995).
- ⁶⁷ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 3.
- ⁶⁸ Id.
- ⁶⁹ Mensch et al., supra note 52, at 20.
- ⁷⁰ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 3. NORPLANT® can also be obtained from private practitioners in both Harare and Bulawayo. See also WILDAF, supra note 6, at 6.
- ⁷¹ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 3.
- ⁷² MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 59.
- ⁷³ Id., at 60.

⁷⁴ WiLDAF, supra note 6, at 5.

⁷⁵ POPULATION ACTION INT'L, supra note 16.

⁷⁶ The reported contraceptive prevalence rate for married women in Zimbabwe was 48%. ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY, supra note 9, at 43, 45.

⁷⁷ Id. at 43; The popularity of the contraceptive pill is said to be due to the fact that it is cheap, easy to use and makes it relatively easy for women to hide the fact that they are using contraceptives from their spouses in cases where they do not approve. WiLDAF report, supra note 26 (citing a National Shadow Report meeting).

⁷⁸ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 45

⁷⁹ Id., at 3.

⁸⁰ WiLDAF report, supra note 26 (citing interviews with medical practitioners).

⁸¹ Id.

⁸² WiLDAF report, supra note 26.

⁸³ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 3.

⁸⁴ WiLDAF, supra note 6, at 3.

⁸⁵ Termination of Pregnancy Act, ch. 15:10, § 2(1)&(2), § 3; see also Concealment of Birth Act, ch. 9:04; Infanticide Act, ch. 9:12 (creating the charge of infanticide); Criminal Procedure and Evidence Act, ch. 7:04, § 280(1); FELTOE & NYAPADI, supra note 24, at 79; S.A. STRAUSS, DOCTOR, PATIENT AND THE LAW: A SELECTION OF PRACTICAL ISSUES 204 (1980).

⁸⁶ Rape is defined to be "[i]ntentional, unlawful sexual intercourse by a male over 14 years of age with a woman, without her consent." GEOFF FELTOE, GUIDE TO THE CRIMINAL LAW OF ZIMBABWE 36 (1989), at 120.

⁸⁷ Termination of Pregnancy Act, ch. 15:10, § 2(1). Intercourse with a mentally handicapped woman or girl is a criminal offense. Criminal Law Amendment Act, ch. 9:05 § 3(d).

⁸⁸ See Ian Chikanza & Webster Chinamora, Abortion in Zimbabwe: A Medico-legal Problem, in WOMEN AND LAW IN SOUTHERN AFRICA 237, 242 (Alice Armstrong & Welshman Ncube eds., 1987).

⁸⁹ Termination of Pregnancy Act, ch. 15:10, § 5(1). "Medical practitioner" is defined to be a medical practitioner registered pursuant to the Medical, Dental and Allied Professions Act, ch. 27:08. Id. § 2(1).

⁹⁰ Id. § 5(1).

⁹¹ Id. "Superintendent" is defined to be the medical superintendent of a State hospital or, in other institutions, any person designated by the Minister of Health. Id. § 2(1).

⁹² Id. § 12.

⁹³ Telephone interview with Luta Shaba & Everjoice Win, WILDAF (Aug. 6, 1996).

⁹⁴ Termination of Pregnancy Act, ch. 15:10, § 11.

⁹⁵ MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 39

⁹⁶ WiLDAF report, supra note 26.

⁹⁷ Id. (citing a dissertation by Rumbidzai Nhundu).

⁹⁸ WiLDAF report, supra note 26.

⁹⁹ FELTOE & NYAPADI, supra note 24, at 73.

¹⁰⁰ See id.; WILDAF, supra note 6, at 8.

¹⁰¹ Id.

¹⁰² Id.

¹⁰³ ZIMB. NAT'L FAMILY PLANNING COUNCIL, REVISED PRICES FOR DRUGS: NOVEMBER, 1993 (1993) (document on file at The Center For Reproductive Law and Policy). Government health services are heavily subsidized. In addition, families with incomes less than Z\$400 (approximately U.S.\$45) per month receive all health services for free.

¹⁰⁴ WiLDAF report, supra note 26.

¹⁰⁵ SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, supra note 15, at 67.

¹⁰⁶ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 141. In 1991, the President of Zimbabwe declared a "war on AIDS." SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, supra note 15, foreword.

¹⁰⁷ LOWENSON ET AL., supra note 34, at 30.

¹⁰⁸ Id.

¹⁰⁹ Sunanda Ray et al., Acceptability of the Female Condom in Zimbabwe: Positive but Male Centred Responses, 5 REPRODUCTIVE HEALTH MATTERS 77-78 (1995).

¹¹⁰ Healers Call to Modify Zimbabwean Traditional Practices, AFRICA NEWS, July 1995, available in LEXIS, World Library.

- ¹¹¹ Public Health Act, ch. 15:09, §§ 17-21.
- ¹¹² WILDAF, *supra* note 6, at 7.
- ¹¹³ *Id*
- ¹¹⁴ Criminal Law Amendment Bill, 1996, at §14. Convicted rapists who are infected with HIV at the time of the commission of the rape, will face a maximum sentence of 20 years imprisonment, whether they were aware of their infection or not. *Id.* at §15. The court will be able to direct that an HIV test be done on any person accused of committing a sexual offence. *Id.* at §16.
- ¹¹⁵ Health Information Unit & National AIDS Coordination Programme, Ministry of Health and Child Welfare, HIV, STD and AIDS Surveillance Zimbabwe, QUARTERLY REPORT 2 (July-Sept. 1995).
- ¹¹⁶ “The silent curse of AIDS,” CAPE TIMES, April 16, 1997. Other reports put the number of deaths at more than 100,000. “AIDS toll in Zimbabwe is now 500 deaths a week,” THE STAR, March 20, 1997.
- ¹¹⁷ “The silent curse of AIDS,” *supra* note 116. The unofficial estimate is 1,500 deaths a week.
- ¹¹⁸ Zimbabwe High HIV Infection Reported, AFRICA NEWS, Dec. 23, 1995, available in LEXIS, World Library.
- ¹¹⁹ *Id.*
- ¹²⁰ MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 37, at 44.
- ¹²¹ UNAIDS Press Release, November 26, 1997 (available on the internet at <http://www.unaids.org/highband/press/wadrelease.html>).
- ¹²² *Id.*
- ¹²³ *Id.*
- ¹²⁴ HEALTH INFO. UNIT & NAT’L AIDS COORDINATION PROGRAMME, *supra* note 115, at 1.
- ¹²⁵ *Id.* at 5-6, 11; MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 37, at 42. AIDS and AIDS related deaths among men are the highest in the 30-39 age group.
- ¹²⁶ IMPLEMENTING ICPD AND BEIJING: WOMEN’S HEALTH IN ZIMBABWE 12 (Commonwealth Medical Association & Zimbabwe Medical Association 1996).
- ¹²⁷ “Aids toll in Zimbabwe is now 500 deaths a week,” *supra* note 116 (citing a statement by Deputy Health Minister Tsungirirai Hungwe).
- ¹²⁸ UNAIDS, *supra* note 121.
- ¹²⁹ “Zimbabwe population growth slowing due to AIDS survey,” THE STAR, February 20, 1997 (citing a report by the Blair Research Institute of Harare and Oxford University). The report portrayed the situation in Zimbabwe to be worse than in South Africa, but better than in Zambia and Uganda.); see also “AIDS toll in Zimbabwe is now 500 deaths a week,” *supra* note 116.
- ¹³⁰ HEALTH INFO. UNIT & NAT’L Aids COORDINATION PROGRAMME, *supra* note 115, at 4.
- ¹³¹ *Id.*
- ¹³² Ray et al., *supra* note 109, at 68, 69.
- ¹³³ In addition, home-based care has been the “prescribed treatment protocol” for AIDS in Zimbabwe. Paul Taylor, “AIDS Overwhelming Zimbabwe’s Advanced Defenses,” WASH. POST, April 12, 1995, at A1
- ¹³⁴ WILDAF report, *supra* note 26 (citing a National Shadow Report meeting).
- ¹³⁵ *Id.* A press report in early 1997 stated that the government was to pass legislation later in 1997 to prohibit employers in the private sector from discriminating against employees with HIV/AIDS and that this legislation would be extended to civil servants after further negotiations. “The silent curse of AIDS,” *supra* note 116.
- ¹³⁶ WILDAF report, *supra* note 26..
- ¹³⁷ LAZARUS ZANAMWE, YOUTH SEXUALITY AND REPRODUCTIVE HEALTH: A REVIEW OF LITERATURE AND YOUTH PROGRAMMES IN ZIMBABWE vi (1995).
- ¹³⁸ MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 37, at 60.
- ¹³⁹ FELTOE & NYAPADI, *supra* note 24, at 70-72. There has been no case in Zimbabwe for a prosecution for the dispensation of contraceptives to minors without parental consent.
- ¹⁴⁰ FELTOE & NYAPADI, *supra* note 24, 43-45, 68-69.
- ¹⁴¹ ZIMBABWE DEMOGRAPHIC & HEALTH SURVEY 1994, *supra* note 9, at 2 (citing 1992 census).
- ¹⁴² THE WORLD BANK, WORLD DEVELOPMENT REPORT 1995 212 (1995).
- ¹⁴³ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, *supra* note 9, at 35,36.
- ¹⁴⁴ ZANAMWE, *supra* note 137, at 94.
- ¹⁴⁵ ZANAMWE, *supra* note 137, at 107; Julie Stewart et al., The Legal Situation of Women in Zimbabwe, in II WOMEN AND LAW IN SOUTHERN AFRICA: THE LEGAL SITUATION OF WOMEN IN SOUTHERN AFRICA 165, 198 (Julie Stewart & Alice Armstrong eds., 1990). However, the ZNFPC dispenses contraceptives to teenage girls under the

age of 16 who have already had a child. IMPLEMENTING ICPD AND BEIJING: WOMEN'S HEALTH IN ZIMBABWE, *supra* note 126 at 4.

¹⁴⁶ See Stewart et al., *supra* note 145, at 169.

¹⁴⁷ Amendment No. 14 to the Constitution established gender as an impermissible ground for discrimination.

However, Amendment No. 14 also reversed recent gains concerning the citizenship rights of married women, and removed substantive rights guarantees that had been implicit in the constitutional text. ZIMB. CONST. AMENDMENT, No. 14 (1996) (unpublished departmental draft, on file with The Center for Reproductive Law and Policy); telephone interview with Luta Shaba, *supra* note 4.

¹⁴⁸ ZIMB. CONST. § 23(5)(b), as amended by ZIMB. CONST. AMENDMENT, NO. 14, § 9 (1)(d) (1996).

¹⁴⁹ Legal Age of Majority Act, ch. 8:07.

¹⁵⁰ *Id.* § 3. In *Katekwe v. Muchabaiwa*, 1984 ZLR 112, 128 (1984), the court stated that the purpose of the Legal Age of Majority act was “the liberation of African women from the legal disadvantages of perpetual minority.”

¹⁵¹ WELSHMAN NCUBE, *FAMILY LAW IN ZIMBABWE* (1989), at 156; Stewart et al., *supra* note 145, at 170.

¹⁵² Legal Age of Majority Act, ch. 8:07, § 3(3).

¹⁵³ See Customary Marriages Act, ch. 5:07, § 2 (defining customary marriage to be “a marriage between Africans”).

¹⁵⁴ *Id.* § 1(b).

¹⁵⁵ *Id.* § 3(5).

¹⁵⁶ See NCUBE, *supra* note 151, at 138.

¹⁵⁷ Traditionally, payment of a bridewealth (roora or lobolo) signified a transfer of rights in the woman and her children, including the man's sexual right to the “labour value” of the woman. Fareda Banda, *The Provision of Maintenance for Women and Children in Zimbabwe*, 2 CARDOZO WOMEN'S L.J. 71, 72 (1995); JOAN MAY, *ZIMBABWEAN WOMEN IN CUSTOMARY AND COLONIAL LAW* 48 (1983).

¹⁵⁸ Banda, *supra* note 157, at 72.

¹⁵⁹ JOAN MAY, *CHANGING PEOPLE, CHANGING LAWS* 56 (1987).

¹⁶⁰ Customary Law & Local Courts Act, ch. 5:07, §§ 7(1)(b), 15.

¹⁶¹ Marriage Act, ch. 5:11.

¹⁶² NCUBE, *supra* note 151, at 138, 145-46. Parties who are mentally incompetent or under duress are incapable of consenting.

¹⁶³ *Id.* at 153.

¹⁶⁴ See NCUBE, *supra* note 151, at 137. Although the Customary Marriages Act requires that customary law govern the formation of civil marriages between Africans, section 12 (1) (mandating guardian consent and payment of a bridewealth) of the Customary Marriages Act was repealed by implication for women over the age of eighteen by the Legal Age of Majority Act. *Id.* at 143; see also *KNOW YOUR RIGHTS: THE LEGAL AGE OF MAJORITY* 13 (undated pamphlet produced by Legal Resources Foundation, on file with The Center for Reproductive Law and Policy).

¹⁶⁵ NCUBE, *supra* note 151, at 147.

¹⁶⁶ Maintenance Act, ch. 5:09, § 6(3)(a)-(b); See NCUBE, *supra* note 151, at 156. An order for maintenance has the same effect as a civil judgment. *WOMEN AND LAW IN SOUTHERN AFRICA RESEARCH PROJECT, MAINTENANCE IN ZIMBABWE* 33 (1991), [hereinafter *RESEARCH PROJECT, MAINTENANCE IN ZIMBABWE*].

¹⁶⁷ Maintenance Act, ch. 5:09, § 6(2)(b), (4). However, courts will not consider any unwillingness to work, unemployment because of repeated misconduct, or the presence of unreasonable debts in the assessment of maintenance responsibility. *Id.* § 23(4).

¹⁶⁸ *Id.* §§ 4, 6; see also *Children's Protection and Adoption Act*, ch. 5:06, § 50 (authorizing contribution orders for maintenance of a child who is part of a juvenile court proceeding); *Guardianship of Minors Act*, ch. 5:08, § 5(5); *Maintenance Orders (Facilities for Enforcement) Act*, ch. 5:10. Failure to comply with a maintenance order is a punishable offense for omitted payments does not preclude later prosecution. Maintenance Act, ch. 5:09, §§ 23-24.

¹⁶⁹ Maintenance Act, ch. 5:09, § 10.

¹⁷⁰ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, *supra* note 9, at 72-73.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ WiLDAF report, *supra* note 26.

¹⁷⁴ Matrimonial Causes Act, ch. 5:13, § 2(1).

¹⁷⁵ See NCUBE, *supra* note 151, at 135 (citing *Tinga v. Shekeda*, 1970 AAC30). However, pursuant to the Maintenance Act, courts may make orders for spousal and child maintenance at the dissolution of an unregistered marriage. See Maintenance Act, ch. 5:09, § 6(3)(a), (b).

¹⁷⁶ Matrimonial Causes Act, ch. 5:13, § 4. The statute provides several examples of “irretrievable break-down.” Id. §5(2)(d). However, it is unclear if these examples are merely guidelines or if the statute requires courts to grant a divorce in such situations. NCUBE, supra note 151, at 214.

¹⁷⁷ Matrimonial Causes Act, ch. 5:03, § 5(2)(b); See NCUBE, supra note 151, at 218.

¹⁷⁸ Matrimonial Causes Act, ch. 5:03, § 7. This provision also grants the court power over the property of a spouse that is held by a third party. Id. § 7(2)(a).

¹⁷⁹ Id. § 7(3). Communal lands would presumably belong to the male kin group.

¹⁸⁰ NCUBE, supra note 151, at 210.

¹⁸¹ Matrimonial Causes Act, ch. 5:03, § 7(4).

¹⁸² The high court of Zimbabwe may make a custody decision upon the petition of either of the parents; the act affirms the legal capacity of women to make such an application without assistance. Id. § 4(7). After awarding custody, a juvenile court may make any additional orders regarding maintenance and access to the child as required under the settlement agreement. Id. § 5(3)(d).

¹⁸³ See MAY, supra note 159, at 75 (noting that women cannot be guardians).

¹⁸⁴ RESEARCH PROJECT, MAINTENANCE IN ZIMBABWE, supra note 166, at 46.

¹⁸⁵ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 11.

¹⁸⁶ Id.

¹⁸⁷ Id. at 69.

¹⁸⁸ WILDAF report, supra note 26 (citing the Women’s Action Group).

¹⁸⁹ Marriage Act, ch. 5:11, §§ 20(2), 22(1); see NCUBE, supra note 151, at 149. This provision does not apply to girls under the age of 18 who have previously contracted a valid marriage. Marriage Act, ch. 5:11, § 20(4).

¹⁹⁰ NCUBE, supra note 151, at 137 n.12.

¹⁹¹ Customary Marriages Act, ch. 5:07, § 11(1). An earlier version of this act (the African Marriages Act, ch. 238 (1951)) expressly prohibited the pledging of girls under the age of 12.

¹⁹² Customary Marriages Act, ch. 5:07, §§ 4(2), (3), 7(1), 12. The Customary Marriages Act does not specify who must pay or who is to receive the marriage consideration. This provision does not apply to women over the age of 18 and women who have previously married. NCUBE, supra note 151, at 136, 145 (citing *Katekwe v. Muchabaiwa* SC 87/84).

¹⁹³ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 77, 78.

¹⁹⁴ Id.

¹⁹⁵ Id.

¹⁹⁶ FELTOE & NYAPADI, supra note 24, at 42.

¹⁹⁷ Stewart et al., supra note 145, at 199.

¹⁹⁸ FELTOE & NYAPADI, supra note 24, at 73.

¹⁹⁹ Permanent impotence may render an individual incompetent for marriage. NCUBE, supra note 151, at 147.

²⁰⁰ The mutual right of married couples to procreation is well-established under the Roman-Dutch common law. STRAUSS, supra note 86, at 142. The right to procreation may implicate the distribution of contraceptives or any therapeutic treatment affecting the reproductive functions. However, as of 1989, there had been no case in Zimbabwe on the failure to obtain spousal consent before performance of a sterilization operation on a married woman. FELTOE & NYAPADI, supra note 24, at 75.

²⁰¹ Customary law does not govern criminal offenses. Stewart et al., supra note 145, at 209.

²⁰² FELTOE, supra note 86, at 122; see Stewart et al., supra note 145, at 210.

²⁰³ Intercourse between a married couple, lacking a judicial order for separation or divorce, is presumed to be consensual. FELTOE, supra note 86, at 120; see also NCUBE, supra note 151, at 147 (stating that refusal to consummate a marriage may be a ground for annulment).

²⁰⁴ FELTOE, supra note 86, at 124. A woman may introduce any “immediate complaint” she may have made as evidence of her lack of consent. However, the Zimbabwean courts have often interpreted this rule to require that an immediate complaint support a rape charge. Stewart et al., supra note 126, at 213.

²⁰⁵ FELTOE, supra note 86, at 124. Evidence as to the character of the accused is also sometimes admissible. Criminal Procedure and Evidence Act, ch. 7:04, § 245 (stating that such evidence is permitted only if it is considered admissible “in any similar case depending in the Supreme Court of Judicature in England”).

²⁰⁶ See Criminal Procedure and Evidence Act, ch. 7:04, § 199 (providing for a conviction of assault with the intent to inflict grievous bodily harm following a charge of rape or assault with the intent to commit rape if facts are proven).

²⁰⁷ LOWENSON ET AL., supra note 34, at 14-15; see also Stewart et al., supra note 145, at 213-14.

²⁰⁸ Criminal Law Amendment Act, ch. 9:50, § 3(a)-(b) (1986). To be convicted under the Criminal Law Amendment Act, the accused must be over the age of 16. See *Id.* § 3(i)(b).

²⁰⁹ *Id.* § 3(i)(a).

²¹⁰ Criminal Law Amendment Act, ch. 9:50, § 12.

²¹¹ FELTOE, *supra* note 86, at 122. Girls under the age of 12 are presumed incapable of consenting to sexual intercourse. *Id.*

²¹² LOWENSON ET AL., *supra* note 34, at 16 (citing Zimbabwe Public Service Regulations of 1988). Although sexual harassment constitutes an act of misconduct for public service employees, these regulations are not well-enforced. *Id.*

²¹³ DEVELOPMENT, INNOVATIONS AND NETWORKS (IRED), WOMEN, LAW DEVELOPMENT (1996) (unpublished paper on file at The Center for Reproductive Law and Policy) [hereinafter IRED].

²¹⁴ MINISTRY OF HEALTH AND CHILD WELFARE, *supra* note 37, at 26.

²¹⁵ U.S. Dep't. of State, Zimbabwe Human Rights Practices, 1993, 1993 HUMAN RIGHTS REPORT (1994), available in Lexis, World Library.

²¹⁶ Stewart et al., *supra* note 145, at 214; see *State v. Mwale*, HC-H-11-87, CRB 12371/85 (unreported case Jan. 14, 1987).

²¹⁷ Stewart et al., *supra* note 145, at 214.

²¹⁸ WILDAF report, *supra* note 26. (citing a National Shadow Report meeting).

²¹⁹ *Id.*

²²⁰ *Id.* (citing in addition recent reports in the print media).

²²¹ *Id.* They state that the greatest sentence that has been imposed for rape to date has been ten years imprisonment.

²²² MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 37, at 26.

²²³ *Id.* at 28.

²²⁴ Palmberg, Mai "GALZ won a moral victory – what next?" (August 11, 1996) (available on the internet at www.xmission.com/~sam3195/galz.html). President Robert Mugabe is reported as saying at the opening of the 1995 Zimbabwe International Bookfair that gays are worse than dogs and pigs and have no rights. "Campaign urges Zimbabwean government to castrate gays", THE STAR, March 10, 1997. Mugabe responded to international criticism by saying: "Let the Americans keep their sodomy, bestiality, stupid and foolish ways to themselves. In Zimbabwe gays shall remain a very sad people forever." "Verbatim", the Weekly Mail and Guardian, August 25, 1995. The Gay and Lesbian Organization of Zimbabwe (GALZ) has twice been banned from exhibiting at the ZIBF. *Id.*; see also "Government ruling could see end to premier event", THE STAR, August 14, 1996; and "Gays bear official wrath of Zimbabwe's president," THE DETROIT NEWS, September, 17, 1995.

²²⁵ See LOWENSON ET AL., *supra* note 34, at 19 (discussing how general law is usually not enforced in domestic violence cases).

²²⁶ Criminal Procedure and Evidence Act, ch. 7:04, § 361(3)(a).

²²⁷ *Id.* § 361(5), (7), (9).

²²⁸ Maboreke, Mary, Violence against Wives: A Crime *sui generis*, 4 ZIMB. L. REV. 88, 95 (1986). Women may receive compensation for medical expenses. KNOW YOUR RIGHTS: DOMESTIC VIOLENCE 17 (undated pamphlet produced by Legal Resources Foundation, on file at The Center for Reproductive Law and Policy); see also ALICE ARMSTRONG, VIOLENCE AGAINST WOMEN IS AGAINST THE LAW 14 (1989) (noting that it is often difficult to obtain such awards without visible injuries or evidence of medical expenditures).

²²⁹ Matrimonial Causes Act, ch. 5:12, § 5(2)(d) (providing for judicial separation or divorce on the ground of mental or physical cruelty); see also NCUBE, *supra* note 151, at 220.

²³⁰ Maboreke, *supra* note 228, at 90.

²³¹ MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 37, at 26; telephone interview with Luta Shaba, *supra* note 4.

²³² Stewart et al, *supra* note 145, at 214.

²³³ "One in two Zimbabwe women abused by menfolk" THE STAR, February 20, 1997 (citing survey done by Musasa, a women's rights NGO). They also found that one in twelve respondents reported being physically abused while pregnant. Only 17% of respondents reported no violence against them.

²³⁴ *Id.*

²³⁵ Maboreke, *supra* note 228, at 90- 91; ARMSTRONG, *supra* note 228, at 7.

²³⁶ WILDAF report, *supra* note 26.

²³⁷ ZIMB. CONST. § 11(a).

²³⁸ WILDAF, *supra* note 6, at 9.

²³⁹ WiLDAF report, supra note 26.

²⁴⁰ WILDAF, supra note 6, at 13. For every ten scholarships disbursed per province, the Ministry of Education awards seven to female candidates. *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ *Id.*, at 14; LOWENSON ET AL., supra note 34, at 39.

²⁴⁴ LOWENSON ET AL., supra note 34, at 39. Since 1991, the Ministry of Education has received advice on policy and programming from a National Education Advisory Board and regional advisory boards, composed of representatives from local authorities, church organizations and business and industry. Education Amendment Act, No. 26, § 8 (1991) (to be inserted in Education Amendment Act, No. 5, at § 28B, 28H) (1989).

²⁴⁵ WILDAF, supra note 6, at 14.

²⁴⁶ LOWENSON ET AL., supra note 34, at 39-40; see also HOW TO USE THE SOCIAL DEVELOPMENT FUND FOR EDUCATION (undated pamphlet produced by the Zimbabwe Women's Resource Centre and Network on file at The Center for Reproductive Law and Policy).

²⁴⁷ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 20.

²⁴⁸ Stewart et al., supra note 145, at 201; ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 15.

²⁴⁹ The Education Act empowers the Minister of Education to make regulations providing for, inter alia, "the temporary exclusion from any school or college of any teacher, pupil or student, and any other measures necessary or desirable to preserve the well-being of teachers, pupils or students." Education Act, No. 5, § 62(2)(l) (1987).

²⁵⁰ WILDAF, supra note 6, at 13. Returning students are transferred to different schools in order to facilitate their return to student life.

²⁵¹ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, supra note 9, at 19.

²⁵² LOWENSON ET AL., supra note 34, at 14; ZANAMWE, supra note 128, at 2; MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 61. The new curricula has been used with children as young as eight years old.

LOWENSON ET AL., supra note 34, at 14.

²⁵³ ZANAMWE, supra note 128, at 2; MINISTRY OF HEALTH & CHILD WELFARE, supra note 37, at 61.

²⁵⁴ WiLDAF report, supra note 26.

²⁵⁵ "The silent curse of AIDS," supra note 116.

²⁵⁶ WILDAF report, supra note 26.

²⁵⁷ Labour Relations Act, ch. 28:01, § 18(3). A woman requesting maternity leave must furnish to her employer a certificate signed by a registered medical practitioner or state registered nurse certifying that she is likely to give birth within 45 days. *Id.* § 18(1). With proper certification, a woman may extend her leave indefinitely without pay. *Id.* § 18(2)(ii). Regulations providing maternity leave for female public servants are slightly different. See Public Services (Conditions of Services for Employees) (Amendment) Regulations, No. 26, §§ 7, 52A(2),(3),(4),(6), 52B (1989), reproduced in 16 ANN. REV. OF POPULATION L., 1989, at 483 (Reed Boland & Jan Stepan eds., 1992); District Councils (Conditions of Service) (Amendment) Regulations, S.I. 246 (1984), cited in 12 ANN. REV. OF POPULATION L., 1985, at 106 (Reed Boland & Jan Stepan eds., 1988) (providing maternity leave for women employed by the district councils).

²⁵⁸ Labour Relations Act, ch. 28:01, § 18 (1)(a), (b).

²⁵⁹ *Id.* § 18(1)(b)(ii).

²⁶⁰ *Id.* § 18(3).

²⁶¹ *Id.* § 18(4). A woman may combine this period with any of her other breaks; however, an employer may also require that these periods do not disrupt normal business. In addition, most employers do not provide child care facilities, making it difficult for women to exercise this right. See Stewart et al., supra note 145, at 204.

²⁶² *Id.*; see also Hazardous Substances Act, ch. 15:05 § 47(2)(a)(vii). Although the MHCW is empowered to regulate working conditions for pregnant women pursuant to the Factories and Works Act, no regulations have been issued.

²⁶³ WiLDAF report, supra note 26.

²⁶⁴ *Id.*

²⁶⁵ ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY, 1994, supra note 9, at 4.

²⁶⁶ See note 147, supra.

²⁶⁷ WILDAF report, supra note 26.

²⁶⁸ *Id.*