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Access to Reproductive Health and Rights for Indigenous women in Zimbabwe: A case of the San community in Tsholotsho and Plumtree

By

Sindiso Nozitha Nkomo

Student Number: 3079091

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Supervisor: Professor Ebenezer Durojaye

Co-supervisor: Professor Usang Maria Assim

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ABSTRACT

Access to healthcare, including reproductive health, is an essential human right that necessitates the attainment of human development, non-discrimination between genders, and promotes women's rights. Reproductive health and rights enable women to make independent decisions and choices relating to their bodies and make it possible to keep women healthy, safe, and dignified. Despite this importance, indigenous women often struggle to have access to satisfactory reproductive health services and have poorer outcomes compared to the general populace. Indigenous women from Zimbabwe are not exempt from this predicament. It is against this background that this study aims to interrogate the extent to which San indigenous women in Zimbabwe enjoy access to reproductive health and rights. The elements of reproductive health and rights which are the main focus of this study are: "prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS and cervical cancer; maternal health; and voluntary informed and affordable family planning services." Studies have been conducted on access to other rights by San people, such as their right to education and to decide their cultural and ethnical integrity. From the studies conducted on indigenous people in Zimbabwe, no study analyses the extent to which San women access their reproductive health and rights. Therefore, this study seeks to address this gap and contribute to the literature. This study adopts the intersectionality and substantive equality theories to understand the depth of the struggles encountered by indigenous women when they want to enjoy their reproductive health and rights and the extent to which they enjoy these rights. These theories show that indigenous women face multiple factors that perpetuate their discrimination and marginalisation. Therefore, to achieve equality and advance indigenous women's rights, there is a need to come up with measures that will warrant indigenous women to be treated differently from their counterparts. Methodologically, this qualitative study analyses the work of different scholars, treaty bodies, case law, legislation, and reports of different organisations to address the subject matter. Further, it draws exemplars from experiences of other jurisdictions such as Botswana and Canada, to enhance and enrich its analyses on the enjoyment of reproductive health and rights of women from indigenous populations in different ways. The study also provides recommendations that can be implemented by different stakeholders to improve indigenous San women's access to reproductive health and rights.

KEY WORDS

1. Access to healthcare
2. Right to Health
3. Indigenous women
4. Plumtree District
5. Reproductive health
6. San Community
7. Tsholotsho District
8. Zimbabwe

LIST OF ACRONYMS AND ABBREVIATIONS

AANDC:	Aboriginal Affairs and Northern Development Canada
ACRWC:	African Charter on the Rights and Welfare of the Child
AIDS:	Acquired Immuno Deficiency Syndrome
ACHPR:	African Charter on Human and Peoples' Rights
ACHPR Commission:	African Commission on Human and Peoples' Rights
African Women's Protocol:	Protocol to the African Charter on the Rights of Women in Africa
CAT:	Convention Against Torture
CCW:	Child Care Worker
CEDAW:	Convention on the Elimination of Discrimination Against Women
CRC:	Convention on the Rights of the Child
CSOs:	Civil Society Organisations
DDC:	District Development Coordinator
DAW:	Division for the Advancement of Women
EPR:	Education, Promotion and Research
FBOs:	Faith-Based Organisations
GoZ:	Government of Zimbabwe
ICCPR:	International Covenant on Civil and Political Rights
ICESCR:	International Covenant on Economic, Social and Cultural Rights
ILO:	International Labour Organisation
IASG:	Inter-Agency Support Group on Indigenous Peoples' Issues
CERD:	Convention on the Elimination of Racial Discrimination
CESCR:	Committee on Economic, Social and Cultural Rights
CHT:	Canada Health Transfer
CKGR:	Central Kalahari Game Reserve
DDR:	Disarmament, Demobilisation and Reintegration
ECHR:	European Convention on Human Rights

FGM/C:	Female genital mutilation/cutting
GBV:	Gender-Based Violence
GoB:	Government of Botswana
GNU:	Government of National Unity
HPPA:	Health Protection and Promotion Act
HRBA:	Human Rights-Based Approach
ICs:	Independent Commissions
ICPD:	International Conference on Population and Development
HPV:	Human Papilloma Virus
HRC:	Human Rights Committee
MDGs:	Millennium Development Goals
MoHCC:	Ministry of Health and Child Care
MOHW:	Ministry of Health and Wellness
MoJLPA:	Ministry of Justice, Legal and Parliamentary Affairs
MoWASME:	Ministry of Women Affairs, Small and Medium Enterprises
MWH:	Maternity Waiting Home
NAC:	National AIDS Council
NGOs:	Non-Governmental Organisations
PHC:	Primary Health Care
LRF:	Legal Resources Foundation
PIZ:	Plan International Zimbabwe
OHCHR:	Office of the High Commissioner for Human Rights
RTIs:	Reproductive Tract Infections
SDGs:	Sustainable Development Goals
SRHR:	Sexual and reproductive health and rights
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
TWG:	Thematic Working Group
UDHR:	Universal Declaration of Human Rights

UNDRIP:	United Nations Declaration on the Rights of Indigenous Peoples
UNFPA:	United Nations Population Fund
UNIFEM:	United Nations Development Fund for Women
VHW:	Village Health Worker
WHO:	World Health Organisations
ZGC:	Zimbabwe Gender Commission
ZHRC:	Zimbabwe Human Rights Commission
ZNFPC:	Zimbabwe National Family Planning Council
ZNASP:	Zimbabwe National HIV and AIDS Strategic Plan
ZWLA:	Zimbabwe Women's Lawyers Association

DECLARATION

I, **Sindiso Nozitha Nkomo**, declare that 'Access to Reproductive Health and Rights for Indigenous women in Zimbabwe: A case of the San community in Tsholotsho and Plumtree' is my own research and that it has not been submitted before for any degree or examination in any other university, and all sources I have used or quoted have been indicated and acknowledged as complete references.

Sindiso Nozitha Nkomo Signature:……..

Student

Prof. Ebenezer Durojaye Signature:……..

Supervisor

Prof. Usang Maria Assim Signature:……

Co-supervisor

DEDICATION

To my mother for always believing in me and encouraging me to pursue my dreams.

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND AND PROBLEM STATEMENT

The term reproductive health is a broad concept that includes health and social conditions that impact one's reproductive functioning, including a woman's choice to procreate or not.[1] According to the United Nations International Conference on Population and Development (ICPD), "reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[2] To this end, the ability of women to access reproductive health services contributes to their increased self-esteem and reproductive autonomy.[3] From time immemorial, women have felt a need to regulate and control their fertility despite barriers such as patriarchy, cultural beliefs, and lack of power and safe means to control their fertility.[4] Giving women the authority to regulate and control their fertility is a basic necessity for their health, well-being, and quality of life. Giving women such power is also a prerequisite for enjoying other social rights.[5] This is especially true for indigenous women,[6] who in the African continent are considered one of the most vulnerable groups that face challenges in controlling their fertility and sexual lives.

Reproductive health and rights are human rights related to upholding one's reproductive health and welfare.[7] Since reproductive health and rights are regarded as human rights, they have

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[1] Gable L 'Reproductive health as a human right' (2010) 60(4) *Western Reserve Law Review* 958.

[2] United Nations International Conference on Population and Development (1994).

[3] Troskie R and Raliphada- Mlaudzi FM 'Reproductive health rights of rural communities' (1999) 4 (1) *Health SA Gesonheid* 42.

[4] Fathalla MF 'Family planning services' (1995) 44 *American University Law Review* 1181. Fathalla asserts that "in many societies, the predominant objection to the use of contraception was really an objection to the control of contraception by women, rather than against contraception itself. Male dominated societies resented giving control of the process of reproduction to women. Patriarchal societies reasoned that if women had control over their reproduction, they would also have the unthinkable control over their own sexuality."

[5] Fathalla MF (1995) 1179.

[6] An in-depth definition of indigenous peoples is provided for under a separate heading that provides explanations of key concepts, definitions and clarifications related to this study. Kindly see sub-heading number 1.9.2. Sub-headings 1.9.1 and 1.9.3 provide definitions of women and reproductive health respectively.

[7] Gable L (2010) 960. According to the ICPD: "reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

human rights characteristics; thus, they are inalienable, indivisible, universal, and interrelated.[8] Moreover, these rights are intertwined with other important human rights, such as the right to life, the right to equality and non-discrimination, the right to privacy, the right to dignity, the right to medical abortion, the right not to be tortured, the right to health, the right to decide the number and spacing of one's children and the right to be free from sexual violence.[9] The 1994 ICPD Programme of Action provides an in-depth definition of reproductive health and rights as follows:

> "Reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[10]

Thus, deducing from the definition provided by the ICPD Programme of Action, reproductive health and rights consist of the following human rights related aspects:

> "i. Voluntary, informed, and affordable family planning services
>
> ii. Pre-natal care, safe motherhood services, assisted childbirth from a trained attendant (e.g., a physician or midwife), and comprehensive infant health care;
>
> iii. Prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS and cervical cancer;
>
> iv. Prevention and treatment of violence against women and girls, including torture;
>
> v. Safe and accessible post-abortion care and, where legal, access to safe abortion services; and vi. Sexual health information, education, and counselling, to enhance personal relationships and quality of life."[11]

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[8] Amnesty International USA 'Sexual and reproductive health rights' available at *https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/ (acces*sed 23 February 2023).

[9] Amnesty International USA 'Sexual and reproductive health rights' available at *https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/ (acces*sed 23 February 2023).

[10] United Nations Report of the International Conference on Population and Development (1994).

[11] Amnesty International USA 'Sexual and reproductive health rights' available at *https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/ (acces*sed 23 February 2023).

The right to reproductive health is an essential aspect of international law conferred upon women. In terms of international law, State Parties, are obliged to put in place measures that will ensure that this right is respected, protected and fulfilled.[12] General Comment No. 2 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol/ African Women's Protocol) which was adopted by the African Commission on Human and Peoples' Rights (ACHPR Commission) to interpret provisions of Article 14 of the African Women's Protocol is very instrumental in articulating the obligations which State Parties should meet to ensure the realisation of women's reproductive health and rights.[13] According to this General Comment, the duty to respect is met when State Parties refrain from directly or indirectly hindering women's reproductive health and rights.[14] This obligation also mandates States Parties to develop measures that will guarantee women's access to information related to reproductive services, such as information on different types of family planning methods.[15] In terms of this obligation, these services should be "available, accessible, acceptable and of good quality."[16]

Furthermore, the duty to protect is met when State Parties take necessary and reasonable measures that ensure that third parties do not interfere with women's enjoyment of their reproductive health and rights.[17] The obligation to promote, places an expectation on States to create legal, economic or social conditions that will allow women to realise and enjoy their reproductive health and rights.[18] The obligation to fulfill rights obliges State Parties to enact and adopt relevant laws, policies, programs and other measures to guarantee the fulfilment of women's reproductive health and rights.[19] This obligation also requires States to provide

[12]Hendriks A 'Promotion and protection of women's right to sexual and reproductive health under International Law: The Economic Covenant and the Women's Convention' (1995) 44 (4) *American University Law Review* 1123.
[13] See General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2014. Some of the issues discussed in this General Comment relate to different aspects of women's reproductive health such as their right to control their bodies and fertility, access to family planning services and information as well as access to safe abortion services.
[14] Paragraph 42 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.
[15] Paragraph 42 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.
[16] Paragraph 42 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.
Paragraph 42 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.
[18] Paragraph 44 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.
[19] Paragraph 45 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.

sufficient resources to ensure that women fully realise their reproductive health and rights.[20] States are thus obligated to ensure that every woman and adolescent girls[21] from indigenous communities (indigenous people/ indigenous peoples), enjoys equal access to reproductive health services.[22]

In fulfilling some of the obligations that Zimbabwe has under international law, Zimbabwe ratified a plethora of critical human rights instruments and policies at regional and international levels that bind governments to create conducive environments for the enjoyment of reproductive health and rights. These include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[23] the International Covenant on Economic, Social and Cultural Rights (ICESCR),[24] the African Charter on Human and People's Rights (ACHPR/African Charter),[25] UN Declaration on the Rights of Indigenous Peoples (UNDRIP),[26] the United Nations Commission on Life-Saving Commodities for Women and Children,[27] the Abuja Declaration, the 2030 Agenda for Sustainable Development,[28] among others. Zimbabwe domesticated some of the provisions from these instruments on the right to health into its Constitution Amendment (No.20) Act of 2013 (Constitution/ Constitution of Zimbabwe) and also enacted laws such as the Termination of Pregnancy Act,[29] Criminal Law (Codification and Reform) Act[30] and Domestic Violence Act[31] to protect the rights of all

[20] Paragraph 45 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the African Women's Protocol.

[21] The rate for adolescent birth is defined as "the number of births to women aged from 15 years to 19 years during the three-year period preceding the survey divided by the average number of women aged 15 years to 19 years during the same period, expressed per thousand women. The statistics relating to receipt of antenatal care, and to skilled birth attendance, are both based on the experience of women aged 15."

[22] UNFPA 'Indigenous women's maternal health and maternal mortality' available at https://www.unfpa.org/resources/indigenous-womens-maternal-health-and-maternal-mortality (accessed on 29 June 2020).

[23] Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) A/RES/34/180. Zimbabwe acceded to this Convention in May 1991 but has not yet ratified the Optional Protocol to CEDAW.

[24] International Covenant on Economic, Social and Cultural Rights (ICESCR) A/RES/2200. Zimbabwe acceded to the ICESCR in May 1991.

[25] The African Charter on Human and Peoples' Rights (ACHPR) was adopted in June 1981 and entered into force in October 1986. Zimbabwe signed this instrument in February 1986 and ratified it in April 1986.

[26] United Nations Declaration on the Rights of Indigenous Peoples A/RES/61/295.

[27] The UN Commission on Life-Saving Commodities for Women and Children (the Commission) takes on the challenge outlined in the UN Secretary-General's Global Strategy for Women's and Children's Health of saving lives through improving equitable access to life-saving commodities.

[28] Sustainable Development Goals Knowledge Platforms 'Transforming our world: the 2030 Agenda for Sustainable Development' available at *https://sustainabledevelopment.un.org/post2015/transformingourworld* (accessed 10 July 2020). Sustainable Development Goal 3 (SDG 3) which speaks to ensuring healthy lives and promoting the wellbeing for all at all ages.

[29] Termination of Pregnancy Act 15:10.

[30] Criminal Law Codification and Reform Act Chapter 9:23.

[31] Domestic Violence Act Chapter 5:16.

women, including indigenous women such as women in the San Community in Zimbabwe. Policy-wise, Zimbabwe has, among other policies, promulgated the Reproductive Health Policy[32] and the HIV and AIDS Policy[33] which seek to advance the reproductive health and rights of all, including the indigenous San women in Zimbabwe.

Despite these legal initiatives, women still struggle to access health care services, especially reproductive health care, in most cases, due to patriarchy and poverty.[34] Of all women, those from indigenous communities are affected the most by limited access to reproductive health services.[35] This is because the medical and health practice in general disregard indigenous people's concept of health which often infuses a lot of factors, such as their spiritual and cultural beliefs, emotional and social dimensions, thus creating barriers for indigenous people to access health care.[36] Furthermore, the limited recognition of indigenous women's rights is further exacerbated either by the non-recognition of indigenous people's identity or the failure to disaggregate information relating to indigenous people in national statistics.[37] Thus, without their recognition and statistics, many indigenous communities face many challenges not only in enjoying their right to health but also in enjoying a wider spectrum of their rights. These are their right to determine their destinies, their right to adequate food, clean, safe and potable water, education, and culture, among other rights. Indigenous communities' underlying poverty situation, as exemplified by limited access to basic needs, education, and work, compromises their enjoyment of their right to health care.[38] Their access to health is further constrained by

[32] The Reproductive Health Policy is a policy that provides the framework for the regulation of integrated maternal health, family planning, STI, HIV and AIDS services.

[33] The HIV and AIDS policy was updated in 2005 to deal with some gaps in the policy such as limited attention to child-related issues.

[34] Manor-Binyamini I 'School-parent collaborations in indigenous communities: providing services for children with disabilities' 2013 *Springer Science & Business Media* 14.

[35] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, A/HRC/29/33.

[36] Report of the UN Expert Mechanism on the Right of indigenous peoples: the right to health and indigenous peoples with a focus on children and youth (2016).

[37] The Government of Zimbabwe does not recognise any specific group as indigenous as it argues that all Zimbabweans are indigenous peoples. There are two groups of people who self-identify as the indigenous peoples of Zimbabwe, and these are the Tshwa (Tyua, Cuaa) who are also known as the San and the Doma people. Zimbabwe is made up of ten administrative provinces, with eight of the provinces being rural and the provinces where the San in Zimbabwe live in are rural. Statistics provide that 67% of Zimbabweans live in rural areas where "availability, accessibility and affordability" are main barriers to health utilisation. The San are found in Tsholotsho District which falls under Matabeleland North Province and the Plumtree District (Bulilima) which falls under Matabeleland South Province in the western part of Zimbabwe.

[38] Indigenous Health 3 'Health of Indigenous people in Africa' available at *https://www.who.int/social_determinants/resources/articles/lancet_ohenjo.pdf* (accessed 29 June 2020). Indigenous peoples are victims of direct discrimination which they experience in their daily lives. Derogatory attitudes shown by the community and shown by health workers create hindrances to accessing health care.

the fact that many indigenous communities live in secluded and remote rural communities, where they are easily forgotten, and access to general health is highly compromised.[39] A good example is that of the San communities who are inhabitants of Southern Africa whose poor health outcomes are closely related to their marginalisation and poverty.[40] The focus of this study as indicated in its title is on the San community of Zimbabwe. The study, as further explained below under point 1.2, seeks to examine the extent to which reproductive health and rights of the San women of Zimbabwe are protected and fulfilled.

In crisis-ridden nations like Zimbabwe, with a crumbling economy[41] and a collapsing health system[42] characterised by dilapidated infrastructure, shortage of drugs and personnel, indigenous populations' limited access and utilisation of health care services are also intensified.[43] Particularly this might be so for indigenous women in need of maternal health, family planning services, and HIV and STIs services. A possible reason for the marginalisation of the San women when it comes to the enjoyment of their rights, as established in Ndlovu's study is that their problems seem not to be addressed by the Government due to discrimination and neglect by Government.[44] In addition, the Constitution of Zimbabwe and subsidiary legislation do not recognise or provide specific protection of the rights of groups who self-identify as indigenous people such as the San community.[45] This non-recognition plays a big

[39] Report of the ACHPR Working Group of Experts on indigenous populations/ communities (2005).

[40] Manor-Binyamini I 'School-parent collaborations in indigenous communities: providing services for children with disabilities' 2013 *Springer Science & Business Media* 14.

[41] According to Munangagwa CL 'The Economic Decline of Zimbabwe' (2009) 3:9 *Gettysburg College* 110, for the past decade, Zimbabwe has been experiencing an economic decline that has resulted in an inflation rate of 231 million percent and an unemployment rate of over 90 percent.

[42] According to Cuneo C, Sollom R and Beyrer C 'The Cholera Epidemic in Zimbabwe, 2008–2009: A Review and Critique of the Evidence' (2017) 19:1 *Health and Human Rights Journal* 256, "the acute collapse of the health system in Zimbabwe culminated in the dramatic November 17 closure of the Parirenyatwa Hospital and the Medical School as well as Zimbabwe's premiere medical institutions at the height of the Cholera epidemic due to a lack of water supply. Other hospitals became non-functional due to shortages in essential medicines and supplies and staff absenteeism as a result of the prohibitive costs of transportation."

[43] Dodzo MK and Mhloyi M Home is best: Why women in rural Zimbabwe deliver in the community (2017) 12(8) *Centre for Population Studies* 1-2.

[44] Ndlovu NK *A social history of the San of Tsholotsho District Ward 7 and 10 from the Colonial Era to Independence* (unpublished Bachelor of Arts Honours Degree, 2017) 41. According to a study by Ndlovu D *A new age for the San in Zimbabwe* (2017) 54, Zimbabwe's small community of Butabubili (Tsholotsho District) next to Mgodimasili has shifted the blame for their ongoing economic hardships to the Government which they accuse of neglecting and discriminating them. Butabubili village founded by Butabubili Maphosa is a mixture of sprawling and dilapidated thatch and mud huts in western Tsholotsho. It is home to about 200 to 3500 San people in the country. In comparison with neighbouring villages, just a few kilometres east of the parched soil, lies the neighbouring village of Sikente, which boats of neat houses with corrugated iron roofs. The unequal living conditions of the two communities brings into sharp view the undeniable poor living conditions of the San.

[45] Ndlovu NK (2017) 41-42. See detailed discussion of indigenous people from Zimbabwe's Constitution and Indigenisation and Economic Empowerment Act in 4.2.2.

role in perpetuating the human rights violations against the San.[46] They often face discrimination from their neighbours who belong to other dominant tribes who view the San as an inferior tribe.[47] Furthermore, the San community fails to enjoy their rights including their reproductive health and rights due to poverty. Studies conducted on the San in Zimbabwe reveal that the San community is one of the tribes in Zimbabwe that has had a belated encounter with modernisation and globalisation which has caused them to remain poor and marginalised.[48]

Studies have shown that women's right to health, in particular, has not yet been fully recognised in many countries in the world.[49] The high maternal mortality rates confirm this position among indigenous women as well as lower rates of voluntary contraceptive usage.[50] For example, a study conducted by the United Nations Population Fund (UNFPA) found that indigenous women and adolescent girls worldwide experience inferior maternal health outcomes compared to the non-indigenous populations.[51] This study also found that in Africa, especially Namibia, San women have a high probability of giving birth without skilled personnel.[52] To support this point, the report of the Expert Mechanism on the Rights of Indigenous People emphasised that maternal mortality rates are very high among indigenous women compared to non-indigenous women worldwide. This is because indigenous women have limited or close to no access to

[46] Ndlovu NK (2017) 41-42.

[47] Ndlovu NK (2017) 41-42. According to Dube T, Dube C, Moyo P *et al* 'Marginal communities and livelihoods: San communities' failed transition to a modern economy in Tsholotsho, Zimbabwe' 2021 *Development Southern Africa* 2, the San took a second-class position with regards to the Kalanga and the Ndebele ethnic neighbours in Bulilima (Plumtree).

[48] Dube T, Dube C, Moyo P *et al* (2021) 2.

[49] Cook RJ 'The Promotion and Protection of Women's Health through International Human Rights law' (1994) Women's Health and Human Rights v, states that: "in terms of contemporary human rights law, which provides for equity between the sexes, most of the health disadvantages of women can be regarded as injustices. For example, maternal death is only the end point in a number of injustices experienced by a lot of women. They eat last and eat little food, are undereducated and overworked. They are acknowledged for their childbearing capacity with little attention paid to anything else they can do."

[50] 'Inter-Agency Support Group on Indigenous Peoples' Thematic paper towards the preparation of the 2014 World Conference on Indigenous Peoples (2014). In Zimbabwe, maternal mortality is constantly high in rural areas where San women live in. In many instances pregnancies end in casualties with either the mother, baby or both dying. The causes are many and the circumstances for the deaths are complex. One known and common cause of high maternal mortality is community births in the without skilled personnel, inadequate equipment and drugs.

[51] Fact Sheet 'Indigenous Women's Maternal Health and Maternal Mortality' available at https://www.un.org/development/desa/indigenouspeoples/wpcontent/uploads/sites/19/2018/04/factsheet_print_Mar 27.pdf (accessed 10 June 2020).

[52] Fact Sheet 'Indigenous Women's Maternal Health and Maternal Mortality' available at https://www.un.org/development/desa/indigenouspeoples/wpcontent/uploads/sites/19/2018/04/factsheet_print_Mar27.pdf (accessed 10 June 2020).

basic maternal services such as antenatal, intrapartum, and postnatal care.[53] The reasons attributed to the bad outcomes in maternal health include that indigenous women are regarded as one of the most marginalised people in their societies as they are denied access to basic services such as education and health. They are candidates of high poverty levels and preventable diseases and victims of gender-based violence.[54] In addition, indigenous women experience high maternal mortality rates. They are excluded from enjoying reproductive health services because they lack healthcare services that are "available, accessible, acceptable and of good quality."[55]

Furthermore, the intersecting and multiple forms of discrimination indigenous women face proves that they are not a homogenous group. The various grounds such as age, gender, location, sexual orientation, ethnic origin, and status on which indigenous women face discrimination negatively impact the experiences of individual women and their patterns of experiences.[56] Indigenous women seem to be affected more by limited access to healthcare services due to these multiple or intersectional discrimination which limits access to their rights such as the right to healthcare.[57]

It is the author's observation that while a lot has been written on the subject of reproductive health and rights in Zimbabwe, the available data and analysis do not reflect the status of the San women in Zimbabwe, with regards to the realisation of their reproductive health rights. Much has been stated about indigenous women, including San women's access to the right to health including reproductive health and rights in Africa, specifically in Kenya, Botswana, South Africa, and Namibia. However, limited information is available concerning the realisation of reproductive health and rights of the San women in Zimbabwe. The researcher will focus on three elements of reproductive health and rights for this study. These are: "(1)

[53] Report of the UN Expert Mechanism on the right of indigenous peoples: The right to health and indigenous peoples with a focus on children and youth (2016).
[54] United Nations Office of the Special Adviser on Gender Issues and Advancement of Women and the Secretariat of the United Nations Permanent Forum on Indigenous Issues 'Briefing Note No. 6, Gender and Indigenous Peoples' Human Rights' available at https://www.un.org/esa/socdev/unpfii/documents/Briefing%20Notes%20Gender%20and%20Indigenous%20Women.pdf (accessed on 10 June 2020).
[55] Report of the UN Expert Mechanism on the right of indigenous peoples: The Right to Health and Indigenous Peoples, with a Focus on Children and Youth (2016).
[56] Fact Sheet 'Indigenous Women's Maternal Health and Maternal Mortality' available at https://www.un.org/development/desa/indigenouspeoples/wpcontent/uploads/sites/19/2018/04/factsheet_print_Mar27.pdf (accessed 10 June 2020).
[57] Forest Peoples Programme 'Toolkit on Indigenous women's rights in Africa' available at http://www.forestpeoples.org/en/topics/african-human-rights-system/publication/2011/toolkit-indigenous-women-s-rights-africa (accessed 25 June 2020).

prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS and cervical cancer;[58] (2) maternal health as well as (3) voluntary informed and affordable family planning services."

1.2 PURPOSE OF THE STUDY

The main aim of this study is to assess the extent of the legal protection of the reproductive health and rights of San women in Zimbabwe.

1.3 RESEARCH QUESTIONS

The overall research question guiding this study is as follows:

- Are the reproductive health and rights of San women in Zimbabwe legally protected?

Within this main question, a number of sub-questions such as the following, will be addressed:

i. How do the concepts of substantive equality and intersectionality help in understanding the reproductive health and rights of indigenous women in Zimbabwe?
ii. What are the norms and standards existing under regional and international law for realising reproductive health and rights of indigenous women?
iii. Are the legal, policy, and institutional frameworks and interventions for ensuring access to reproductive health and rights by San women in Zimbabwe adequate and consistent with the government's obligations under regional and international law? and
iv. What lessons can Zimbabwe learn from other jurisdictions regarding realising the reproductive health and rights of indigenous women?

1.4 LITERATURE REVIEW

While many studies have been conducted on indigenous people's rights, no legal research directly focuses on access to reproductive and health rights by the San women in Tsholotsho and Plumtree Districts of Zimbabwe. A lot of studies that nearly focused on the San people and their enjoyment of rights tended to concentrate on the San community's human rights.[59]

[58] The data obtained from a study Adjorlolo-Johnson G, Unger ER and Boni-Ouattara E *et al* 'Assessing the relationship between HIV infection and cervical cancer in Côte d'Ivoire: A case-control study' (2010) 10:242 *BMC Infectious Diseases* 7 is in favour of the notion that HIV infection is a contributing factor to cervical cancer in women with Human Papilloma Virus (HPV) infection.

[59] See the studies by Ndlovu NK *A social history of the San of Tsholotsho District Ward 7 and 10 from the Colonial Era to Independence* (unpublished Bachelor of Arts Honours Degree, 2017) and Hitchcock RK *et al* 'The San in Zimbabwe: Livelihoods, Land and Human Right' IWGIA Report (2012).

Furthermore, an abundance of literature exists on women's reproductive health and rights at an international, regional, and even national level.[60] However, from the available literature, nothing was said about the experiences of the San women of Zimbabwe in accessing their reproductive health rights. The available literature that attempted to discuss the reproductive health and rights of the San women in Zimbabwe was a newspaper article by the Inter-Press Service News Agency, which was not grounded in law. The article did not review important national, regional, and international frameworks that protect reproductive health and rights. In their study, the Inter-Press Service News Agency talks about awareness and accessibility of HIV/AIDS services by San people in the Tsholotsho District.[61] The article highlighted that despite success stories about the San community's strides in combatting HIV/AIDS, most San members have not been consistent in taking their ARV treatment due to poverty and ignorance.[62] The study further lamented how long distances of about 15 to 20 kilometres to access health centers for treatment and check-ups largely hinder indigenous women's enjoyment and accessibility of sexual health rights by the San community.[63]

Moreover, a study by Ndlovu focused on analysing the social life of the San people of Tsholotsho from selected wards of Tsholotsho District from the colonial era up to independence.[64] The study by this scholar sought to bring attention to the challenges faced by San people, who, as one of the world's oldest indigenous groups, has significantly experienced neglect, discrimination, and cultural assimilation by other dominant tribes and social groups.[65] This study slightly discussed the right to health of the San community. It mentioned positive developments on the realisation of the right to health of the San community through building

[60] See Cook RJ 'State accountability for women's health' (1998) 49 *International Digest of Health Legislation Volume* 265-282 and Benhura A 'Displaced and Dispossessed: Sexual and Reproductive Health Rights for Women in Hopley, Zimbabwe' (2016) 16(2) *The Oriental Anthropologist* 215-227.

[61] Moyo J 'Once Decimated by AIDS, Zimbabwe's Khoisan Tribe Embraces Treatment' *Inter-Press Service News Agency* 31 August 2017.

[62] Moyo J 'Once decimated by AIDS, Zimbabwe's Khoisan tribe embraces treatment' *Inter-Press Service News Agency* 31 August 2017.

[63] Moyo J 'Once decimated by AIDS, Zimbabwe's Khoisan tribe embraces treatment' *Inter-Press Service News Agency* 31 August 2017.

[64] Ndlovu NK (2017) ix.

[65] Ndlovu NK (2017) ix. A newspaper article by NewsDay highlighted that Zimbabwe was ranked as one of the countries which is not performing well when it comes to the protection and promotion of indigenous people's rights. These were findings obtained from the International People Under Threat World report which highlighted that in 2018, Zimbabwe was ranked number twenty-four out of twenty-five world rankings where countries with indigenous populations face violations. It is the author's observation that this newspaper article refers to the Ndebele and white people as the indigenous minority groups facing gross human rights violations in Zimbabwe. In addition, the article does not specify the particular rights that are mostly violated. See Ndlovu N 'Zim ranked among worst countries in protection of indigenous people's rights' *NewsDay* 12 June 2019.

a clinic close to one of the San community villages.[66] The study highlighted that the construction of the clinic would be beneficial to young women by reducing home births and assisting in reducing maternal mortality.[67]

Another study that discussed the barriers faced by San women in exercising their rights did not center around San women's reproductive health rights *per se* but discussed how intersectional discrimination contributes to the marginalisation of San women, which hinders their enjoyment of many of their human rights. This study was conducted by Sylvain who focused on highlighting how San women in one of the regions in Namibia deal with multiple forms of inequality. It made an illustration of how intersectional discrimination often puts the human rights priorities of these women at odds with the international indigenous movement aimed at securing group rights.[68] According to this study, the literature on indigenous women tends to magnify this problem by explaining the distress faced by indigenous women in ways that isolate their identities.[69]

Furthermore, a study by Lennox and Stephens focuses on unpacking the right to health of minorities and indigenous peoples. These scholars argue that where there is available data, evidence shows that in all settings, minority and indigenous peoples suffer heightened ill-health because socio-political factors linked to their marginalisation are seen as fundamental determinants to their health.[70] According to these scholars, there is evidence obtained globally that suggests that women belonging to minority and indigenous communities experience unreasonably high maternal mortality rates. In addition, these women are said to have limited access to reproductive health services as evidenced by some serious cases where indigenous and minority women have been forced or intimidated to make involuntary decisions relating to their reproductive health matters, such as abortion.[71] In addition, a study by Dodzo and Mhloyi[72] focused on the rationale behind community deliveries by most rural Zimbabwean women, whom San women are part of, as they are found in the rural parts of Tsholotsho and Plumtree Districts. According to this study, there is limited information about the basis of community deliveries except that people end up giving birth in their communities because of

[66] Ndlovu NK (2017) 23.
[67] Ndlovu NK (2017) 23.
[68] Sylvain R (2011) 89.
[69] Sylvain R (2011) 91.
[70] Lennox C and Stephens C 'Realizing the right to health for minorities and indigenous peoples' 2013 *Minority Rights Group Internationa*l 2.
[71] Lennox C and Stephens C (2013) 7.
[72] Dodzo MK and Mhloyi M (2017) 1.

the negative attitudes associated with health facilities.[73] These include the issue of costs, poor attitudes of health personnel, lengthy waiting times and the distances that people have to travel to the nearest health facilities that offer reproductive health services.[74]

A thesis by Ferguson examined the value and relevance of reproductive health and rights to women living in a rural area of Zimbabwe.[75] The study further described the relations between health workers and citizens and the impact of these relations on women from Mabika, a rural community in Zimbabwe, and the gender relations that shape their lives.[76] This scholar asserts that the subject of reproductive health and rights is crucial because of many reasons. One of the reasons is that the subject of reproductive health and rights provides an analysis of the value of human rights as a means of transforming gender relations considering that family planning services are an area of social provision which the State is responsible for and has been fought out on the grounds of women's rights principles.[77] It is my observation again that this research focuses on rural women in Zimbabwe, and the San women are part of them. This means the issues examined in the thesis also indirectly touch on this group of indigenous minorities in Zimbabwe.

Lastly, a study by Cook focused on addressing human rights applications to protect and promote women's health.[78] This study argues that the significance of human rights in advancing the health of women and self-determination gained momentum and recognition through the ICPD, the World Conference on Women, which was held in 1995, and through the Programme of Action, which recognises the importance of human rights in the protection and promotion of women's reproductive health.[79] The study further lays down what comprises the State's duty to protect, promote and fulfill women's health rights.[80]

From the literature discussed above, as pointed out earlier, none of the studies directly focuses on access to reproductive health and rights by San women in Zimbabwe. Therefore, this study seeks to cover this gap and contribute to the existing literature. The results of this study will play a pivotal role in influencing policy change that will promote the benefit of other minority

[73] Dodzo MK and Mhloyi M (2017) 1.
[74] Dodzo MK and Mhloyi M (2017) 1-2.
[75] Ferguson C *Reproductive rights and citizenship: Family planning in Zimbabwe* (Published PHD thesis, London School of Economics and Political Science, 1999) 2.
[76] Ferguson C (1992) 2.
[77] Ferguson C (1992) 2.
[78] Cook RJ (1998) 266.
[79] Cook RJ (1998) 266.
[80] Cook RJ (1998) 267-271.

groups in Zimbabwe, and rural women in particular, regarding the enjoyment of their reproductive health and rights.

1.5 THEORETICAL FRAMEWORK

This study was informed by the substantive equality and intersectionality theories. One of the key insights of the substantive equality approach is the realisation that it is not factors such as colour, gender, or some other group characteristic that is an issue, instead, it is the attendant disadvantage.[81] This focus on disadvantage means that, for substantive equality to be effective, it should include a positive duty to provide.[82] According to Fredman, at the core of substantive equality is the realisation of the link between status and disadvantage, where status refers to factors such as race, gender, disability, or other prohibited ground of discrimination, and disadvantage is mainly concerned with socio-economic disadvantage.[83] While formal equality deals with discrimination that is based on status, substantive equality, on the other hand, provides that it is not status *per-se* which is problematic, instead, it is the disadvantage that attaches to status.[84] Therefore, in order to understand the discrimination faced by indigenous women in accessing reproductive health rights, it is important to not only focus on their disadvantage as women but to consider the challenges attached to them because of their indigenous minority status, such as high poverty levels, low literacy levels and non-recognition of their indigenous status by the Government.

The term *intersectionality* was propounded by Kimberly Crenshaw, who focused on women in the United States society.[85] According to Crenshaw, black women were failed by anti-racist campaigns, which focused on the experiences and needs of black men, and the feminist campaigns, which were led by white women and focused on their experiences. As a result of this shortcoming, discrimination law using a "single-axis" style of identity failed black women, as their experiences of oppression were overridden by the dominant narrative within the categories "women" and "black."[86] This is true in the lives of indigenous women as the unique challenges/forms of discrimination they face in accessing reproductive health are ignored. Still,

[81] Fredman S 'Providing equality: Substantive equality and the positive duty to provide (2005) 21(2) *South African Journal on Human Rights* 163.
[82] Fredman S (2005) 163.
[83] Fredman S 'Facing the future: Substantive equality under the spotlight' Legal Research Paper Series 57/2010.
[84] Fredman S 'Facing the future: Substantive equality under the spotlight' Legal Research Paper Series 57/2010.
[85] See Smith B 'Intersectional discrimination and substantive equality: a comparative and theoretical perspective' (2016) 16 *The Equal Rights Review* 73.
[86] Crenshaw K 'Demarginalizing the intersection of race and sex: a black feminist critique of anti-discrimination doctrine, feminist theory and anti-racist politics' 1989 *University of Chicago Legal Forum* 139-140.

they are generalised under one umbrella when discussing challenges faced by women in general.

Furthermore, Crenshaw asserts that:

> "[…] Intersectionality simply came from the idea that if you're standing in the path of multiple forms of exclusion, you are likely to get hit by both. These women [ed. black women] are injured, but when the race ambulance and the gender ambulance arrive at the scene, they see these women of colour lying in the intersection and they say, Well, we can't figure out if this was just race or just sex discrimination, and unless they can show us which one it was, we can't help them."[87]

The accident metaphor is used to question what takes place when multiple forms of discrimination or of disadvantageous conditions intersect on the same subject. In terms of the intersectionality theory, "when this happens, the result is not the mere sum of the negative effects of the different forms of discrimination, but rather, a new, peculiar and specific form of discrimination that can have very different expressions and consequences with regards to the two originating discriminations."[88] Thus, this theory analyses how social and cultural categories link, creating unusual kinds of discrimination.[89] In the context of indigenous women, they face challenges firstly because they are women, and they face other forms of discrimination, such as poverty and low levels of education because of their social status as indigenous minority. When these two factors emerge, indigenous women's situation worsens, as they face multiple forms of discrimination that hinder them from accessing reproductive health rights.

1.6 SIGNIFICANCE OF THE STUDY

As already highlighted, a gap exists in women's reproductive health and rights literature where the subject of access to reproductive health and rights by San women is not adequately captured, especially in the Zimbabwean context. Therefore, this study remains significant in providing literature to assist in understanding indigenous women's enjoyment of reproductive health and rights. Thus, this research proffers the possible solutions that can be applied to improve access to reproductive health and rights by San women and other indigenous minority

[87] Crenshaw K 'Intersectionality: the double bind of race and gender' *2004 American Bar Association* 2.
[88] Angelucci A 'From Theory to Practice. The Intersectionality Theory as a Research Strategy' IFS Working Paper (2017) 3.
[89] Angelucci A (2017) 3.

groups in Zimbabwe. Furthermore, this study significantly contributes to the debates on the justification or validation of women's reproductive health and rights both from a theoretical and practical point of view. This is because the study focuses on an area that has not been directly focused on in Zimbabwe, concerning the legal protection of reproductive health and rights of indigenous and minority groups such as San women.

The study also provides an opportunity for promoting awareness of the existing laws, policies, and institutions that are meant to promote access to reproductive health and rights by San women and women as a whole. This research is of significance to Zimbabwe as it will inform policy makers and other key stakeholders, such as the Ministry of Health and Child Care (MOHCC), Independent Institutions such as the Zimbabwe Gender Commission (ZGC), Zimbabwe Human Rights Commission (ZHRC), Civil Society Organisations (CSOs) and Faith Based Organisations (FBOs), on their role in ensuring improved and easy access to reproductive health and rights by San women in Zimbabwe.

This study is also significant because it gives recommendations on strategies that should be implemented to improve indigenous women's access to reproductive health and rights.

1.7 RESEARCH METHODOLOGY

This study identifies the problem of poor protection legally of reproductive health and rights of San women in Zimbabwe. This study employs a desktop research methodology, which examines and analyses the international and regional human rights instruments, national laws, policies, programmes and other frameworks in place to protect the reproductive health and rights of women, including indigenous women. Furthermore, information from sources such as textbooks, book chapters, journal articles, reports of treaty bodies at regional and international levels, country reports, internet sources, reports of Government Ministries and Departments, Non-Governmental Organisations (NGOs), Civil Society Organisations (CSOs), Faith Based Organisations (FBOs), Independent Commissions (ICs), such as ZHRC and ZGC, and newspaper articles dealing with the subject in question were used. The author believes that the methodology employed for this study did justice to this research.

1.8 LIMITATIONS OF THE STUDY

This study is limited because it does not bring out the lived experiences of the San women regarding their accessibility to reproductive health and rights. This is because the researcher

relies on the desktop research method. The San community of Zimbabwe is found in Tsholotsho (Matabeleland North Province) and Plumtree (Matabeleland South Province) Districts. They are settled in the remote rural areas of those Districts, which made it hard for the researcher to reach them due to several reasons, such as, bad road network and the COVID-19 lockdown movement restrictions. Therefore, the analysis that the researcher drew on the accessibility of San women's reproductive health and rights might not represent the actual situation on the ground. The study is also limited in terms of literature since much has not been written on the subject specifically focusing on the San women in Zimbabwe.

1.9 KEY CONCEPTS AND CLARIFICATIONS

1.9.1 Women

This study adopts the definition of "women," which includes girls as defined in the African Women's Protocol. The African Women's Protocol states that "women mean persons of female gender, including girls."[90] This definition is of paramount importance to this study because both San women and girls face similar challenges regarding the realisation and enjoyment of their reproductive health and rights.

1.9.2 Indigenous people

Durojaye posits that attempts have been made to provide a broad definition of the term "indigenous people" despite the challenge of adopting a universally acceptable definition.[91] "lndigenous people" have thus been defined to include the following people who:[92]

i. "Identify themselves and are recognised and accepted by their community as indigenous.
ii. Demonstrate historical continuity with pre-colonial and/or pre-settler societies.
iii. Have strong links to territories and surrounding natural resources.
iv. Have distinct social, economic or political systems.
v. Maintain distinct languages, cultures and beliefs.
vi. Form non-dominant groups of society.

[90] Article (1) (k) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[91] Durojaye, E 'Human rights and access to healthcare services for indigenous peoples in Africa' (2018) 13(10) *Global Public Health* 1-2.
[92] Durojaye, E (2018) 1-2.

vii. Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities."

Raper asserts that "indigenous" means "not introduced directly or indirectly according to historical record or scientific analysis into a particular land, region or environment from the outside."[93] Raper concludes that an analysis of this definition implies that the Bushmen, also known as the San, are the true and original indigenous inhabitants of the Southern African continent.[94]

The San are said to have been the first people to settle in what is known as present Zimbabwe today.[95] The San people who are found in Zimbabwe make up only a small portion of the total San population of Southern Africa.[96] The San in Zimbabwe identify themselves as the Tshwa.[97] The Tshwa in Zimbabwe, who are approximately 2500, reside mainly in two provinces, namely, Matabeleland North (Tsholotsho District) and Matabeleland South (Plumtree District). The San are said to be among the poorest and most marginalised people in Zimbabwe.[98] The IWGA Report states that a survey that was conducted in 2016 indicated that 73 per cent of the San households have less than five United States Dollars per month income, and a sizeable portion of the San receive food distributed through Central Government and NGOs, and a considerable number of them still rely on traditional methods.[99]

1.9.3 Reproductive health

Reproductive health refers to "a state of complete physical, mental and social well-being in all matters relating to one's reproductive system and its processes and functions."[100] Reproductive health for women and men implies that they have the ability to have a safe and satisfying sex life and the capacity to reproduce, including the freedom to decide if, when, and how often to do so.[101]

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[93] Raper, PE 'Khoisan indigenous toponymic identity in South Africa' in Clark ID *et al* (eds) *Indigenous and Minority Placenames* (ANU Press) 381.
[94] Raper E (2014) 381.
[95] Ndlovu D (2017) 4.
[96] Hitchcock RK, Begbie-Clench B and Murwira A T*he San in Zimbabwe: Livelihoods, land and human rights* IWGIA Report (2016) 7.
[97] Hitchcock RK, Begbie-Clench B and Murwira (2016) 7.
[98] Hitchcock RK, Begbie-Clench B and Murwira (2016) 7.
[99] Hitchcock RK, Begbie-Clench B and Murwira (2016) 7.
[100] Mulugeta A 'Slow steps of progress: the reproductive health rights of refugee women in Africa' (2003) 55 *African Refugee Women's Reproductive Health Rights Briefing* 74.
[101] Mulugeta A (2003) 74.

On the other hand, sexual health is defined by the World Health Organisation (WHO) as follows:

> "Sexual Health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[102]

The fulfillment of sexual health is tied to the extent to which human rights are "respected, protected and fulfilled."[103] It is important to highlight that sexual rights are rights that embrace certain human rights already recognised in regional and international human rights documents and national laws.[104]

1.9.4 Prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS and cervical cancer

Research by the WHO indicates that there is a 25 per cent rate of stillbirths, 14 per cent of neonatal deaths, which makes up an overall perinatal mortality of about 40 per cent, which is caused by untreated syphilis in pregnant women.[105] Research shows that globally, approximately four thousand new-born babies become blind every year because of eye infections caused by untreated maternal gonococcal and chlamydial infections.[106] Moreover, research also shows that infections with sexually transmitted pathogens other than HIV impose a big burden of morbidity and mortality in both developed and under-developed countries. Both directly, through their impact on factors such as the quality of life, and indirectly, through their role in facilitating the transmission of HIV and the impact they have on economies at individual and national levels.[107] Thus, preventing and treating other sexually transmitted infections

[102] World Health Organisation 'Sexual health and its linkages to reproductive health: an operational approach' (2017) 3.
[103] World Health Organisation (2017) 3.
[104] World Health Organisation (2017) 3. According to WHO, "rights critical to the realisation of sexual health include the right to life, liberty, autonomy and security of the person, the right to equality and non-discrimination, the right to be free from torture or cruel, inhuman or degrading treatment or punishment among other rights."
[105] Global Strategy for the prevention and control of sexually transmitted infections: 2006-2015, World Health Organisation 2007. According to WHO the prevalence of syphilis in pregnant women in Africa ranges from 4% to 15%.
[106] Global Strategy for the prevention and control of sexually transmitted infections: 2006-2015.
[107] Global Strategy for the prevention and control of sexually transmitted infections: 2006-2015.

(STIs) reduce the risk of sexual transmission of HIV, especially among people who are highly likely to have more than one sexual partner.[108]

1.9.5 Pre-natal care, safe motherhood services, assisted childbirth from a trained attendant (e.g., a physician or midwife), and comprehensive infant health care; (Maternal Health)

According to the WHO, a lot of maternal deaths could be prevented if women are given access to basic health care during pregnancy, childbirth, and the postpartum periods.[109] Therefore, there is a need to strengthen health systems and link communities and health institutions to provide care when and where women need it.[110] Research from WHO has shown that many maternal deaths happen either during or shortly after delivery, yet this is when women are least likely to receive the health care they need.[111] Thus, giving quality health care during and immediately after labour and delivery is the most crucial intervention for preventing maternal and new-born mortality and morbidity.[112]

1.9.6 Voluntary, informed, and affordable family planning services

In terms of the WHO standards, everyone is entitled to receive reproductive health information, such as information about contraceptive measures and their use, family planning services, and information about their sexuality.[113] Obtaining this information is important in enabling people to make informed decisions about safe and reliable contraceptive measures, whether to have children or not, and the number of children they want to have.[114] It has been proven that lack of access to family planning services is a major cause of the high rates of abortions, including unsafe abortions.[115] Furthermore, the presence of legal barriers preventing women and men

[108] Global Strategy for the prevention and control of sexually transmitted infections: 2006-2015.
[109] Mother-Baby Package: Implementing Safe Motherhood in Countries, World Health Organization, Geneva, 1994.
[110] Mother-baby package: Implementing safe motherhood in countries, World Health Organization, Geneva, 1994.
[111] Coverage of Maternal Care: A Listing of Available Information (in press), World Health Organization, Geneva 1997.
[112] World Health Day: Safe motherhood, World Health Organisation, Geneva, 1998.
[113] World Health Day: Safe motherhood, World Health Organisation, Geneva, 1998.
[114] United Nations Handbook for National Human Rights Institutions 'Reproductive rights are human rights' (2014) 106.
[115] United Nations Handbook for National Human Rights Institutions (2014)16. According to this handbook: "of the estimated 80 million unwanted or unintended pregnancies each year, an estimated 45 million are terminated. Of these 45 million abortions, 19 million are unsafe with 40 per cent done on women below 25 years of age. About 68, 000 women die every year from complications of unsafe abortion. Family planning, on the other hand, allows potential parents to focus on the future. When individuals and couples can plan when and whether to have children, they can focus on both their own education and that of their children."

from accessing family planning services violates their right to choose the number of children they want as well as the spacing and timing of their children.[116]

1.9.7 Use of terms interchangeably

Throughout this study, the following terms are used interchangeably:

"intersectionality theory" and "intersectionality concept;"

"substantive equality approach" and "substantive equality theory;"

"indigenous people," "indigenous peoples," and "indigenous communities;"

"Government," "Government of Zimbabwe;" Zimbabwean Government and "GoZ;"

"Government of Botswana," "GoB," and "Government;"

"Canadian Government," "Government of Canada" and "Government;"

"San people," "San community," "San" and "indigenous people;"

"Aboriginal people," "Aboriginal community" and "indigenous people."

1.10 CHAPTER OUTLINE

Chapter One: this chapter offers background and introduction to the study, problem statement, purpose of the study, research questions, literature overview and the methodology of the study. It offers a brief overview of the thesis chapters.

Chapter Two: this chapter discusses the substantive equality and intersectionality theoretical frameworks to understand the plight of San women in accessing their reproductive health and rights and to justify why they should get preferential treatment which should not be given to non-indigenous women.

Chapter Three: this chapter looks at the international and regional standards on protecting the reproductive health and rights of indigenous women. The chapter does this by analysing the human rights linked to reproductive health and rights.

Chapter Four: this chapter outlines different laws, policies, other frameworks and programmes set up by the Government of Zimbabwe concerning reproductive health and rights.

[116] United Nations Handbook for National Human Rights Institutions (2014)16.

The focus is to assess whether they promote access to reproductive health and rights by San women and where there are gaps, the researcher highlighted them. This chapter also discusses the challenges of San women in enjoying their access to reproductive health and rights. The focus was on assessing whether national laws, policies, other frameworks, and programmes adequately respond to those challenges.

Chapter Five: this chapter discusses the position in Canada and Botswana when it comes to the realisation of indigenous women's reproductive health and rights. The chapter also discusses lessons that Zimbabwe can learn from those jurisdictions. The indigenous women that will be the focus of this chapter are Aboriginal women in Canada and San women in Botswana. The author chose to focus on the San women in Botswana because, like in Zimbabwe, San women in Botswana are one of the most marginalised indigenous groups.[117] The author has also chosen to focus on Botswana because Botswana, like Zimbabwe, is in Southern Africa,[118] and recognises common law, judicial precedent, customary law and legislation as the basis of its law.[119] This made it easy to compare and analyse the laws, policies and measures in place to ensure the realisation of reproductive health and rights of the indigenous women in that country. In addition, the author also chose to focus on the San in Botswana because, according to statistics, Botswana has the largest San population in Africa.[120] Therefore, focusing on the San will help understand how the Government of Botswana (GoB/ Government) protects their rights, given that they are a major group compared to the San in other African countries. The author also focused on Aboriginal women in Canada to draw good practices from Canada, given that Canada is a more developed country[121] compared to Zimbabwe, and it is said to be one of the countries with the best health systems in the world.[122] Furthermore, since Canada, like Zimbabwe, is a pluralist country with common law and

[117] Nyati-Ramahobo L 'Minority tribes in Botswana: The politics of recognition' available at *https://www.refworld.org/pdfid/496dc0c82.pdf* (accessed 29 June 2022). There are about thirty-six other tribes that exist in Botswana, although the Government does not recognise them.

[118] Botswana is located in Southern Africa and is positioned between South Africa, Namibia, Zambia, and Zimbabwe.

[119] See Fombad MC 'Update: Botswana's Legal System and Legal Research' available at *https://www.nyulawglobal.org/globalex/Botswana1.html* (accessed 19 July 2022).

[120] Cadger K and Kepe T 'Contextualising development projects among the San of Botswana: Challenges of community gardening' (2013) 7 *Development in Practice* 813.

[121] Paragraph 3 UN Committee on Economic, Social and Cultural Rights (CESCR), *UN Committee on Economic, Social and Cultural Rights: Concluding Observations, Canada*, 22 May 2006, E/C.12/CAN/CO/4; E/C.12/CAN/CO/5.

[122] See Cigna 'Top 10: Countries with the best healthcare system' available at *https://www.cignaglobal.com/blog/healthcare/top-10-countries-best-healthcare-system* (accessed 9 April 2022).

legislation as part of the basis of its law, it was easy to draw practices from Canada's legislation and judicial precedents relating to the rights of Aboriginal people in that country.[123] In addition, Canada is also party to a plethora of UN treaties on the protection of reproductive health and rights. Therefore, Zimbabwe can be influenced by Canada's legal developments and ratify more human rights treaties that facilitate the protection of women, including indigenous women.

Chapter Six: this chapter concludes and provides recommendations for further study.

[123] Government of Canada 'Where our legal system comes from' available at *Where our legal system comes from - About Canada's System of Justice* (accessed 31 August 2022).

CHAPTER TWO

'INTERSECTIONALITY AND SUBSTANTIVE EQUALITY: THEORETICAL FRAMEWORKS FOR REALISING THE REPRODUCTIVE HEALTH AND RIGHTS OF SAN WOMEN'

2.1 INTRODUCTION

The overall research question of this study is: Are the reproductive health and rights of San women in Zimbabwe legally protected? In other words, is the legislation promulgated by the Government of Zimbabwe (GoZ) in compliance with its regional and international obligations on protecting the reproductive health and rights of indigenous women adequate to ensure the realisation of the reproductive health and rights of San women in Zimbabwe? This thesis adopts the intersectionality and substantive equality approaches as the framework for analysing the realisation of reproductive health and rights of San women in Zimbabwe.

This study investigates the role played by the Government of Zimbabwe and other factors, such as socio-economic and cultural factors, in limiting the San women's access to maternal health services, prevention of STIs, including HIV and AIDS, and voluntary informed and affordable family planning services. To understand the challenge of limited access to reproductive health and rights of the San women in Zimbabwe, adopting an intersectionality theory lens helps prove that San women face many forms of discrimination. These include economic disadvantage, gender, race, and non-recognition by the Government of their indigenous minority status. In addition, employing a substantive equality approach to this study will assist in justifying why San women should not receive the same treatment as other women in Zimbabwe regarding accessing reproductive health and rights as they are a disadvantaged group compared to other women in Zimbabwe. Employing these theories in this study will assist in understanding the plight of San women with regard to their enjoyment of reproductive health and rights and the justification for why they should not receive the same treatment as other women when it comes to accessing reproductive health services as well as enjoying reproductive health rights.

This chapter is guided by the following research question: how do the concepts of substantive equality and intersectionality help in understanding the reproductive health and rights of indigenous women in Zimbabwe? The chapter also defines the intersectionality theory, highlights its history and origins, and also gives an overview of the theory. The author shows its relevance to the study throughout the discussion of this theory. In discussing the

intersectionality theory, the study refers to the work of Crenshaw and Collins as well as other proponents of the intersectionality theory. The chapter also discusses the application of the intersectionality theory in regional and international human rights frameworks. This thesis in chapter three looks at how regional and international human rights instruments have dealt with protecting the reproductive health and rights of indigenous women. It is, therefore important to highlight how the intersectionality theory that shapes the whole thesis is incorporated into those frameworks. The chapter further discusses the intersectionality theory in the African context. Discussing the intersectionality theory in the African context is essential, seeing that the theory originates from Europe, it is crucial to understand its application in the African context. The chapter also refers to the criticisms of the theory. This is useful in showing that this theory is not perfect, although it is the best theory to use for this study.

Furthermore, the study provides an overview of the substantive equality theory to highlight why indigenous women must not be treated the same as other women in relation to the realisation of their reproductive health rights. In giving an overview of this theory, reference was made to the work of the different proponents of substantive equality theory, such as Fredman. The chapter discusses the concept of affirmative action, linked to the substantive equality theory. The advantages and disadvantages of the substantive equality theory were also addressed in this chapter. The chapter also discussed how substantive equality is dealt with in the regional and international human rights plane, as most women-specific human rights instruments seem to echo this principle. A discussion was presented on how courts have dealt with substantive equality, a fundamental concept used in concluding issues related to the principle of equality and non-discrimination. The author highlighted the relevance of the substantive equality theory throughout the discussion of this theory. Finally, the chapter provides an in-depth analysis of the relevance of this theory to this study and also gives a conclusion to the whole chapter.

2.2 INTERSECTIONALITY THEORY

2.2. 1 Definition, Origins, and Overview of the Intersectionality theory

According to Hills:

> "no standard definition of intersectionality exists but it can be associated with one or more of the following principles: interconnectedness of racism, sexism, class exploitation and similar systems of oppression; configurations of social inequalities take form within

> intersecting oppressions; perceptions of social problems as well reflect how social actors are situated within the power relations of particular historical and social contexts; and because individuals and groups are differently located within intersecting oppressions, they have distinctive standpoints on social phenomena."[124]

Hill further states that the intersectionality theory is an analytic term that focuses "mostly on the dynamics of dissimilarity and the unification of sameness in the context of positive discrimination and social movement politics."[125] Stamper asserts that:

> "before intersectionality became popular, its meaning was already being moved further afield of Crenshaw's definition as this is evidenced by a 2014 movie review in the Washington Post which defined intersectionality as something that seeks to describe how identity is conditioned, not by one reductive quality, but by multiple tastes, impulses, desires and fears."[126]

Crenshaw offers a threefold definition of intersectionality in her 1991 famous essay "Mapping Margins."[127] The first aspect of the definition is "structural intersectionality" frequently invoked in the operationalisation of the concept in the literature.[128] Structural intersectionality is defined as how the location of Black women at the intersection of race and gender makes their actual experiences of domestic violence and rape different from that of white women.[129] The second aspect is political intersectionality, which depicts that traditionally, women's movements and antiracist politics in the United States have functioned side by side to marginalise issues faced by Black women.[130] This is because Black women are positioned within at least two suppressed groups regularly following conflicting political agendas.[131] Another characteristic of political intersectionality is that no agenda is constructed around the encounters, needs, or political ideas of Black women to the extent that antiracism replicates patriarchy and feminism replicates racism.[132] As a result, Black women are asked to choose

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[124] Collins PH 'The difference that power makes: intersectionality and participatory democracy' (2017) 8(1) *Investig. Fem* 20.
[125] Cho S, Crenshaw K and Mccall L 'Toward a field of intersectionality studies: theory, applications, and praxis' (2013) 38:4 *Journal of Women in Culture and Society* 786.
[126] Stamper K 'A brief, convoluted history of the word intersectionality' available at *https://www.thecut.com/2018/03/a-brief-convoluted-history-of-the-word-intersectionality.html* (accessed 31 October 2020).
[127] Carastathis A 'The concept of intersectionality in feminist theory' (2014) 9:5 *Philosophy Compass* 306.
[128] Carastathis A (2014) 306.
[129] Carastathis A (2014) 306. See also Kahn Best RK, Krieger LH and Edelman LB *et al* 'Multiple disadvantages: An empirical test of intersectionality theory in EEO litigation' (2011) 45:4 *Law and Society Review* 991-1026.
[130] Carastathis A (2014) 306. See also Katyal SK 'Trademark intersectionality' (2010) 57:6 UCLA *Law Review* 1640.
[131] Carastathis A (2014) 307.
[132] Carastathis A (2014) 307.

between two insufficient analyses, each of which accounts for a denial of an essential dimension of their subordination.[133] The third aspect, "representational intersectionality" covers the production of images of Black women derived from sexist and racist narrative symbols, as well as the ways that make an analysis of these representations, relegate or duplicate the objectification of Black women.[134] When looking at the San women in Zimbabwe, they are affected by multiple forms of discrimination because firstly, they are black, secondly, they are women and thirdly, they are women from a poor social class compared to other women from other ethnicities found in Plumtree and Tsholotsho districts. By virtue of them being women from an inferior social class, they already do not have privileges that women from other social classes have. As women, they have suffered from historical injustices and continue to suffer due to issues such as patriarchy. In addition, the San community in Zimbabwe lacks a political representative (they have no Member of Parliament or a Councillor) and have limited representation in traditional structures (for example, the Government of Zimbabwe appointed a male chief amongst the San in Tsholotsho district to represent the San in that area.[135] The San in Plumtree district do not have a chief who is a San or who is a San woman. This lack of leadership representation further exacerbates their problems because the problems that affect their livelihoods including easy access to reproductive health services are not addressed either at a national or local level by someone familiar with their unique challenges.

According to Stamper, intersectionality was introduced in a 1989 paper by Crenshaw, a legal expert and civil rights activist who established the African American Policy Forum at Columbia University.[136] This term was also coined by feminist and womanist scholars who believed that feminism at that time was all about middle-class, educated white women. They believed that it is essential for feminism to use another angle to view oppression, like using race or even social

[133] Carastathis A (2014) 307.

[134] Carastathis A (2014) 307. See also Katyal SK (2010) 1640.

[135] According to the Community Pordium News 'New substantive chief for San Community' available at *https://communitypodiumnews.org.zw /?p=4298* (accessed 19 November 2022), "President Mnangagwa has appointed Christopher Dube as the substantive Chief Goledema for the San Community in Tsholotsho District, Matebeleland North." With regards to when this appointment was going to be effective, this newspaper article stated that "His Excellency, the President of the Republic of Zimbabwe has with effect from 10 November 2022, appointed Christopher Dube as substantive Chief Goledema…"

[136] Stamper K 'A brief, convoluted history of the word intersectionality' available at *https://www.thecut.com/2018/03/a-brief-convoluted-history-of-the-word-intersectionality.html* (accessed 31 October 2020). "Crenshaw introduces the metaphor of intersectionality in a legal academic context drawing on and citing this movement history. While Crenshaw was the first to coin the term intersectionality, references to the same phenomenon appeared in the writing of African American women of the nineteen century such as Sojourner Truth."

position.[137] They stipulated that it is crucial to include women's standpoint in the intersections of gender with other significant social identities such as the health of an individual, class, and race.[138] This term was extended beyond the scope of black women's experiences. It appeared in queer theory, feminist legal theory, studies on race, gender, and sexuality, and as a result, this became an instant hit among academics.[139] In line with this claim, when programmes meant to benefit communities in Zimbabwe are started, particular regard must be given to different classes of people that will be targeted by the interventions so that everyone benefits. Ignoring issues such as people's status or the category they fall under results in some classes of Zimbabweans, such as the San women being marginalised and affected more by poverty compared to other classes of Zimbabwean citizens. This perpetuates inequalities in the Zimbabwean society. Therefore, when it comes to matters regarding access to reproductive health and rights, regard must be given to how San women's access to such services and rights can be improved considering that they are treated as an inferior group of people by other tribes where they live.

Carastathis states that the beginning of the1980s was characterised by the publication of various important texts in antiracist feminist theory in which the intersectionality theory was clarified.[140] Carastathis further posits that it is important to recognise the origins of intersectionality in the political movement of Black women, Chicana and Latina women, and other women of colour who have mostly been identified as lesbians.[141] Further, Carastathis, avers that although the concept of intersectionality was introduced and later elaborated by Crenshaw, intersectionality has an extensive background in Black feminism.[142] The predecessors of intersectionality believed in the concept of double jeopardy (also known as Beal) or multiple jeopardies (also known as King)[143] and interlocking oppressions (also known

[137] Stamper K 'A brief, convoluted history of the word intersectionality' available at *https://www.thecut.com/2018/03/a-brief-convoluted-history-of-the-word-intersectionality.html* (accessed 31 October 2020).
[138] Collins PH (2017) 21.
[139] Stamper K 'A brief, convoluted history of the word intersectionality' available at *https://www.thecut.com/2018/03/a-brief-convoluted-history-of-the-word-intersectionality.html* (accessed 31 October 2020).
[140] Carastathis A (2014) 306.
[141] Carastathis A (2014) 306.
[142] Carastathis A (2014) 305. See also Simien EM 'Black feminist theory: charting a course for black women's studies in Political Science' (2004) 26(2) *Women & Politics* 83-85.
[143] According to Nash JC 'Home truths on intersectionality' (2011) 23:2 *Yale Journal of Law and Feminism* 446: "The term multiple jeopardy comes from Deborah King's work, Multiple Jeopardy, Multiple Consciousness: The Content of a Black Feminist Ideology; the term is, in many ways, a reference to Frances Beale's work, which argued that black women experience double jeopardy."

as Combahee River Collective).[144] At the beginning of the 19th Century in the United States, Black feminists challenged the conjunction of a "woman question" and a "race problem" and by the period that Crenshaw instigated the concept of intersectionality to assess leading notions of discrimination in law and social movements, the discourse of "intersections" had already been spreading in contemporary antiracist feminist notions.[145] In the initial stages of the work of Crenshaw, the concept of intersectionality became so popular, and its common usage made it admissible in certain spheres for one to cite intersectionality as an alternative expression for oppression without describing what exactly is intersecting or how.[146]

Intersectionality played an important role in showing how single-axis thinking challenges legal theory, disciplinary knowledge development, and the fight for social justice.[147] According to Cho, Crenshaw and McCall, the intersectionality theory has proven to be a progressive theory that has been implemented in different areas such as anthropology, feminist studies, legal studies, ethnic studies, history, sociology over the past years, literature and philosophy.[148] The intersectionality theory's claim on investigating the dynamics of difference and sameness has played a crucial role in furthering the consideration of factors such as gender, race, and other axes of power in a broad spectrum of political dialogues and academic fields, including new changes in disciplines such as geography and organisational studies.[149] Focusing on intersectional discrimination shows how sexuality is involved in the racialisation, gendering, and class positioning of San people generally and San women in particular. Sylvain states that historically, the white colonial community regarded the San as "promiscuous primitives who were strangers to domestic happiness."[150] The term "primitive promiscuity" was intended to label the San as racially inferior, as this notion served as evidence of the Europeans' beliefs of the civilised and nurturing family. [151] As a result, the San were and are still subject to

[144] Carastathis A (2014) 305. "In 1974 Barbra Smith, Beverly Smith, and Demita Frazier founded the Combahee River Collective (CRC) as a radical queer Black feminist organisation with the goal of combating the omnipresence of capitalist heterosexist patriarchal white supremacy in society through establishing a socialist agenda that articulates the primacy of the unique oppression faced by Black women." See also Gnassi A 'Analyzing the Combahee River Collective as a social movement' 2019 *The Trinity Papers (2011 - present)* 1.
[145] Carastathis A (2014) 305.
[146] Carastathis A (2014) 305'
[147] Cho S, Crenshaw K and Mccall L (2013) 787.
[148] Cho S, Crenshaw K and Mccall L (2013) 786.
[149] Cho S, Crenshaw K and Mccall L (2013) 787.
[150] Sylvain R (2011) 103.
[151] Sylvain R (2011) 103.

sexualised racism which reduces the moral value of racially segregated groups by labeling them as morally corrupt.[152]

According to Gadkar-Wilcox, regarding intersectionality, Crenshaw avers that incidents of discrimination are reliant upon an appreciation of individuals as being comprised of multiple identities.[153] For example, she argues that for Black women in the United States, the connection of race and gender generates a great sense of marginalisation than that of Black men or white women, both of whom are also marginalised groups.[154] The political environment of the United States in the Twentieth Century led to the formation of two very dissimilar sociopolitical groups which were supposed to account for the needs of their members who were at the time political minorities and were currently political minorities and frequently victims of social unfairness. The first group, whose members identify as women mainly takes care of the needs of superior white women instead of the interest of Black women, and the second group, whose members are made up of women of a particular race or colour takes care of the needs of males.[155] The outcome is that the women of colour who are familiar with the needs of both groups end up being alienated by both groups since they only account partly for the interest of these women. Women of colour cannot be situated exclusively into one of the available groups because their interests remain with both groups and both groups frequently depend on the interests of other members first.[156] Moreover, the political ideology of such groups most of the time may be incompatible, which can cause women of colour to be divided in their interests.[157] It is my observation that San women's experiences in enjoying access to basic services are impacted by them having multiple identities. For example, they believe in collective group rights when it comes to exercising their right to health.[158] Furthermore, they are regarded as a class of people who are backward and subjected to poverty because they live in remote rural areas where they are quickly forgotten.

[152] Sylvain R (2011) 103.
[153] Gadkar-Wilcox S 'Intersectionality and the under-enforcement of domestic violence laws in India' (2012) 15(3) *University of Pennsylvania Journal of Law and Social* Change 469.
[154] Gadkar-Wilcox S (2012) 469.
[155] Gadkar-Wilcox S (2012) 469.
[156] Gadkar-Wilcox S (2012) 469. See Fair BK 'Intersectionality theory, the anticaste principle, and the future of brown' (2009) 60:5 *Alabama Law Review* (2009) 1119.
[157] Gadkar-Wilcox S (2012) 469.
[158] Sylvain R (2011) 96 argues that "while the international indigenous women's movement can be credited with raising awareness of multiple discrimination, in much of the literature outlining rights priorities the intersections of multiple forms of discrimination are rarely emphasised, and so a hierarchical relationship between collective rights and individual rights has developed."

Fair posits that the works of Crenshaw serve as a reminder that intersectional subordination, whether structural or political, must not be intentionally produced as it is commonly the result of the enforcement of one problem that interfaces with existing vulnerabilities to generate another aspect of marginalisation.[159] It has been proven that women of colour are situated differently in the economic, social, and political domains; hence, when development efforts carried out on behalf of women abandon this fact, chances become limited for women of colour to have their needs responded to than women who are racially advantaged.[160] Thus, one key insight of intersectionality theory is that uniform requirements of need expectations may obstruct the capacity of government representatives to deal with the special needs of non-white and impoverished women.[161] Therefore, in this regard, the intersectionality theory aims to center and declare multidimensional caste clearly so that all forms of caste can be investigated.[162] In the context of the San women in Zimbabwe, they are not as privileged as other women regarding economic and social issues. As a result, if reform efforts such as the building of clinics are made without their input, they suffer injustices as they neglect using such facilities claiming that they rely on traditional methods to cure sickness, including sicknesses related to reproductive health. There is, therefore, a need to engage San women in building health facilities so that they are aware of the importance of such facilities for their health and well-being. There is need also to capacitate health practitioners on the traditional health methods employed by the San so that they can incorporate them into treatment processes. This will help ensure that the San also enjoy their right to health like any other ordinary citizen in Zimbabwe.

Moreover, Crenshaw concludes that the failure of feminism to critically examine race means that the resistance strategies of feminism will repeatedly duplicate and strengthen the relegation of Black women, and the failure of antiracism to critique patriarchy means that antiracism will repeatedly replicate the powerless position of women.[163] Fair states that for Crenshaw, another common challenge is that the political or cultural interests of the community are understood in a way that excludes complete public acknowledgment of the hidden difficulties encountered by the community especially Black women.[164] Black women must navigate between distorted public perceptions of them and their conditions, on the one hand, and against the need to

[159] Fair BK (2009) 1119.
[160] Fair BK (2009) 1119.
[161] Fair BK (2009) 1119.
[162] Fair BK (2009) 1119.
[163] Fair BK (2009) 1119-1120.
[164] Fair BK (2009) 1120.

acknowledge and address intra-community problems on the other hand because of their subordinate status and the failure to recognise their caste fully.[165] Thus, another benefit of intersectionality theory is that those mired in caste become engaged with their status inequality, and can critique it as outsiders and insiders.[166] In the context of San women, what furthers their oppression and subordination, which affects their enjoyment of reproductive health rights, is that there are distorted public perceptions about them as the public perceives them as a group that is backward and that shuns development. Yet, their behaviour is rooted in their beliefs as a San community.[167]

Omoruyi posits that the theory of intersectionality originates from the claim that people have multiple identities acquired from social interactions and the operations of structures of authority.[168] Thus, the intersectionality theory provides a plan or an approach for comprehending how intersecting structures of control impact the experience of groups of people bound by the same characteristics in society. Control, in this instance, refers to the practice of favouring, normalising, and attaching a significant value to certain identities over others.[169] It is a common cause that control in most societies is managed along the axes of characteristics such as gender, race, class, sexuality, ability, age, nationality, and religion, among others.[170] In this structure, some characteristics are given more worth or normalised than others because they are distinguished from characteristics regarded as little worth or less normal, thus inventing opportunities and drawbacks.[171] Furthermore, these power structures exceed differentiating individuals but ascertain to a more significant extent how people gain access to resources and numerous social institutions such as government, work, education, law, family, and medicine, among others.[172] As a result, this structure generates special identities together with disadvantaged intersecting identities.[173] For example, women who live in the Tsholotsho and Plumtree Districts (mostly Ndebele and Kalanga tribes) are given more value as they are considered to belong to tribes that are claimed to be superior to the San community. As a result, this creates challenges for San women as they lose confidence in themselves, and

[165] Fair BK (2009) 1120.
[166] Fair BK (2009) 1120.
[167] Ndlovu D (2017) 5.
[168] Omoruyi A *forced sterilisation as a continuing violation of human rights in Africa: possibilities and challenges* (Unpublished Doctor of Laws Degree, 2020) 40.
[169] Omoruyi A (2020) 40.
[170] Omoruyi (2020) 40.
[171] Omoruyi (2020) 40.
[172] Omoruyi (2020) 40.
[173] Omoruyi (2020) 40.

they shun participating in community programmes meant to benefit them the same way they are anticipated to benefit the other tribes.[174]

Furthermore, in "Demarginalizing the Intersection of Race and Sex," Crenshaw proves that the limitations of sex and race discrimination ideology are conceptualised by white women and Black men's experiences.[175] In this article, Crenshaw's analysis of three discrimination cases brought against commercial employers by Black women proves that "antidiscrimination laws protect Black women only to the extent that their experiences of discrimination concur with those of Black men or with those of white women."[176] Thus, placing Black women at the core of an analysis of the United States antidiscrimination law associated with the intersection of juridicial groupings of race and sex discrimination reveals the insufficiency of doctrinal descriptions of discrimination to document and come up with solutions for Black women's practical experiences of discrimination.[177] It is important to highlight that racially-based sexual objectification is a traditionally deep and ongoing process that adds to being indigenous such as San women's susceptibility to exploitation.

Crenshaw's ideology was that because modern feminist and antiracist debates have failed to account for intersectional characteristics such as women of colour, women of colour end up suffering from marginalisation propagated by debates designed to respond to racism or sexism only.[178] Through her writings, Crenshaw also emphasised that "intersectional subordination whether structural or political need not be intentionally produced rather, it is frequently the consequence of the imposition of one burden that interacts with preexisting vulnerabilities to create yet another dimension of disempowerment."[179] Furthermore, in its structural viewpoint, Black women are differently positioned in the economic, social, and political worlds.[180] Hence, when reform efforts are made on behalf of women, they ignore the fact that, "Black women are less likely to have their needs met than women who are racially privileged."[181] Thus, one key

[174] Ndlovu D (2017) 5.
[175] Carastathis A (2014) 306.
[176] Carastathis A (2014) 306. Carastathis posits that: "In her landmark essay in 1989, Crenshaw used cases on employment discrimination to show that while women encountered discrimination for their gender, black women were more disadvantaged because of the added influence of race discrimination." See the cases of *DeGraffenreid v. General Motors* 413 F Supp 142 (E D Mo 1976) and *Moore v. Hughes Helicopters, Inc.* 708 F2d 475 (9th Cir 1983) where the Courts ignored the intersection of race and sex in conceptualising the experiences of discrimination faced by black women in the employment sector and determined their experiences on that of white women and black men whose experience of discrimination could be established on single grounds.
[177] Carastathis A (2014) 306.
[178] Fair BK (2009) 1119.
[179] Fair BK (2009) 1119.
[180] Fair BK (2009) 1119.
[181] Fair BK (2009) 1119.

understanding of intersectionality theory is that standardised guidelines of need presumptions may obstruct the capability of government representatives to deal with the special needs of non-white and poor women.[182] Intersectionality theory seeks to center and render multifaceted caste noticeable so all caste forms can be investigated.[183]

Fair asserts that "part of the project for theorists like Crenshaw, Darling, and Wildman has been to show how the intersectionality theory can help to reveal privilege especially when one takes into consideration that the intersection is multidimensional, including intersections of both subordination and privilege."[184] Fair argues that whilst he embraces the important insights of the intersectionality theory regarding the insufficiency of available reform discourse, he wants to further define a new discourse that may deconstruct intersectional caste.[185] Fair uses the term intersectional caste to define the combined forms of marginalisation one might face because one is female, coloured, non-Christian, gay, disabled, poor, and so on.[186] Fair further agrees that sometimes, to treat people the same, there is a need to treat them differently, specifically regarding the numerous ways they experience discrimination.[187] This theory is relevant to this study because San women experience various forms of marginalisation, for example, they are considered as a poor tribe, they are female, they are women of colour, and so forth. Therefore, in order to remedy the marginalization and oppression they face, they need to treat them differently from other women who are not San.

Smith states that when intersectionality is reduced to its core, it denies that identity can be dissected into "mutually exclusive categories of experience and analysis," instead declaring that identity is a complex consolidation of different categories.[188] Therefore, Smith concludes that a genuinely intersectional approach states that, for example, the discrimination faced by a homosexual woman is different from that experienced by other women and different from that experienced by other homosexuals.[189] Like other scholars, Smith posits that many academic debates about intersectionality revolve around the interaction of race and gender, particularly the experiences of Black women, and argues that the oppression and discrimination faced by

[182] Fair BK (2009) 1119.
[183] Fair BK (2009) 1119.
[184] Fair BK (2009) 1121.
[185] Fair BK (2009) 1121.
[186] Fair BK (2009) 1121.
[187] Fair BK (2009) 1121.
[188] Smith B (2016) 76.
[189] Smith B (2016) 76.

these women is different from other forms of oppression.[190] Smith further states that intersectionality has the potential to go beyond merely interrogating the interaction of any specific bilateral grouping of identity categories to come up with a general theory of identity.[191] For example, in the context of San women, the challenges they face when accessing reproductive health services and enjoying their reproductive health rights are different from the hurdles faced by women from other tribes. Likewise, they are different from the challenges faced by other San women who are, for example, able-bodied and have no disabilities.

Carastathis posits that it has become common within the feminist theory to assert that women are affected by numerous intersecting forms of oppression.[192] This assertion that oppression is not a singular process or a binary political relation but is better understood as created by several, converging or intertwined systems originates in antiracist feminist critiques who claim that the oppression experienced by women could be captured through an examination of gender alone. As a result, intersectionality is given as a theoretical and political solution to the most persistent problem facing modern feminism.[193] Furthermore, the intersectionality theory has been distinguished as the essential contribution that women's studies have made so far.[194] This is because its influence has extended beyond the academic sphere to international human rights discourses, as shown by references made to it by the UN documents and some regional human rights instruments.[195]

Omoruyi states that intersectional standpoint assists in examining how structures of privilege and disadvantage interrelate in people's lives based on their unique identities, including the ways these structures of power inseparably connect with and shape each other to create exceptional and qualitatively different experiences of oppression.[196] Omoruyi asserts that this theory proves that oppression cannot be compressed to one fundamental type, but that oppressions work hand in hand to produce "interlocking systems of oppression."[197] In the context of San women, they face oppression because of many factors. As already mentioned above, if the oppressions are combined, they worsen the situation of the San women, especially when accessing basic services.

[190] Smith B (2016) 76.
[191] Smith B (2016) 76.
[192] Carastathis A (2014) 304.
[193] Carastathis A (2014) 304.
[194] Carastathis A (2014) 304.
[195] Carastathis A (2014) 304.
[196] Omoruyi A (2020) 40.
[197] Omoruyi A (2020) 40-41.

Omoruyi further asserts that intersectionality is not mainly concerned with finding possible intersecting identities but about how structures make particular identities the channel of vulnerability.[198] Hence, intersectionality is not considered a merger of identities that intensify one's burden but rather as an intersection or overlapping of marginalised identities to create different experiences.[199] Therefore, an intersectional examination requires focus on points of intersection, complexity, dynamic processes, and structures that define access to rights and opportunities and not on defined identity categories.[200] More so, it also requires a people-centered approach that accounts for the factors that shape women's lives mostly those living at the margins and who suffer different forms of oppression compared to those who are not subject to similar influences.[201] Omoruyi further asserts that given that intersectional viewpoint can expose the interlinking power structures that positioned some women at more risk of breaches of human rights than other women, the intersectionality theory is a valuable instrument for realising human rights and social justice for all women.[202] Therefore, the intersectionality theory is relevant to this study because it will serve as a tool for advocating for the realisation of indigenous women's reproductive health and rights and social justice.

According to the United Nations Working Group on Women and Human Rights, an intersectional approach to analysing the disempowerment of marginalised women tries to capture the outcomes of the interaction between two or more types of subordination.[203] It deals with how factors such as racism, patriarchy, class subjugation, and other discriminatory systems form inequalities that structure the respective positions of women, races, ethnicities, and so forth.[204] Moreover, intersectionality deals with how specific laws and policies function hand in hand to produce more disempowerment.[205] For example, elements such as race, ethnicity, gender, or class, are frequently understood as distinct spheres of experience which regulate social, economic, and political dynamics of oppression, yet the systems often overlap

[198] Omoruyi A (2020) 42.
[199] Omoruyi A (2020) 42.
[200] Omoruyi A (2020) 42.
[201] Omoruyi A (2020) 42.
[202] Omoruyi A (2020) 42.
[203] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[204] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[205] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).

thereby, forming intricate intersections at which two or more of these axes may meet.[206] As a result, racially subordinated women and other multiple troubled groups situated at these intersections due to their particular identities must negotiate the traffic that flows through these intersections for them to be able to acquire the resources for the normal activities of life.[207] This is a particularly risky assignment when the traffic flows at the same time from many directions, as this often leads to the contexts in which intersectional damages take place. Moreover, when disadvantages or conditions interact with already existing vulnerabilities to create numerous forms of disempowerment.[208]

In the feminist discourse, an intersectional assessment unravels the fundamental social, political, and economic institutions that mirror gender ranking.[209] This manifests in racism, patriarchy, class oppression, and other biased systems that have been proven to operate through institutions to aggravate inequalities.[210] Therefore, one can conclude that in the situation of San women, an intersectional analysis reveals how numerous facets of identities are indivisible and how the combination of racial or ethnic, gender and class inequalities impact on the forms of discrimination that are faced by the San women. As a result, the intersectional discrimination experienced by San women reduces their capacity to benefit from laws and policy initiatives that are gender progressive and causes them to be mainly vulnerable to racially or ethnically inspired group-based harms.[211] Sylvain argues that racism, sexism, cultural and ethnic stigmatisation work hand in glove to minimise San women's ability to enjoy the full range of political, civil, social, economic, and cultural rights entrenched in national, regional, and international human rights laws.[212]

Scholars have largely debated whether intersectionality operates as a general theory of identity or simply a way of describing multiple marginalised experiences.[213] For example, some scholars argue that intersectionality refers not only to how race and gender interact but, more

[206] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[207] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[208] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[209] Omoruyi A (2020) 41.
[210] Omoruyi A (2020) 41.
[211] Sylvain R (2011) 103.
[212] Sylvain R (2011) 103.
[213] Smith B (2016) 78.

generally, to all women because differences in sexual orientation, age, and physical ability are all areas of oppression.[214] Although it is factual that intersectionality began in feminist discourse, to allow its development is not to deny the significance of women or to sideline their oppression. Thus, one of the significant advantages of intersectionality, as it pertains to law, lies in its ability to offer a comprehensive theory of identity.[215] Therefore, "to define intersectionality as a general theory of identity would be to realise a hypothetical under-privileged white, able-bodied, heterosexual, cis-gender, upper-class man as an example of an intersectional identity, but this is not to cede power to the privileged."[216] Privilege will not and should not become the focal point of one's assessment, as intersectionality is a concept that highlights oppression and is an instrument to be used in addressing that oppression.[217]

Due to the complexity of its subject, the intersectionality theory was systematised from the procedural point of view and positioned into two groupings: additive and transverse intersectionality.[218] In the first case, categories are examined distinctly, as entities *per se*. Their effect in creating social differences and disadvantages is seen as increased by the synchronicity of different categories, but they are not understood as jointly interacting.[219] The second approach examines how categories link and the procedure of differentiation and discrimination standing at the crossroads among them.[220] The second category also conceptualises intersectionality as the connection among several dimensions and modalities of social relationships and subject formation. It differentiates three ways to address the intricacy of intersectional analysis.[221] The first category is the "anti-categorical complexity approach is the approach of post-structuralist and deconstructivist feminism and its aim is to delegitimate categories in themselves and to refuse them." Therefore, power and knowledge are assessed through "inclusion and exclusion mechanisms."[222] The second category, which is the "intra-categorical complexity" is primarily adopted by Black feminists and Crenshaw, among others. This category aims to "explore crossing categories to underline the position of peculiar disadvantaged social groups standing at their intersection."[223] The "inter-categorical

[214] Smith B (2016) 78.
[215] Smith B (2016) 78.
[216] Smith B (2016) 78.
[217] Smith B (2016) 78.
[218] Angelucci A (2017) 2.
[219] Angelucci A (2017) 2.
[220] Angelucci A (2017) 2.
[221] Angelucci A (2017) 2.
[222] Angelucci A (2017) 2.
[223] Angelucci A (2017) 2.

complexity" approach is the last category that was created by Leslie McCall to elucidate her position within the intersectionality framework.[224] She uses investigative categories tactically, analysing them comparatively with quantitative methods. It is important to highlight that each of these approaches discussed here outlines a different way to deal with and scrutinise categories, and each adopts various investigative tools.[225]

Sylvain states that the available writings on indigenous women seem to escalate this challenge by describing the harms experienced by indigenous women in ways that separate components of their identities so that indigenous women suffer from "double repressions" as "indigenous peoples" and as "women;" or they suffer "multiple oppressions" as an "indigenous person, as women, and as members of the poorer classes of society."[226] Sylvain further argues that such "additive" approaches propose that, as degendered indigenous persons, indigenous women face the same group-based harms in the same ways as indigenous men.[227] This assertion also suggests that indigenous women deal with the same gender-based ills as mainstream non-indigenous women, which is often not the case.[228] As a result, indigenous women are repeatedly required to speak either as indigenous people or as women. There are low chances of coming up with a vocabulary that expresses their experiences as gendered members of marginalised indigenous communities.[229]

2.3 CRITIQUE OF THE INTERSECTIONALITY THEORY

The intersectionality concept as "an analytical tool or a theoretical construct" has faced much criticism. For example, it has been rejected by other scholars such as Conaghan, who claims it has reached the bounds of its potential. Conaghan states that there is not much that the intersectionality theory can do to advance the feminist project, whether in law or more broadly.[230] Furthermore, the denunciation of this theory is based on the assumption that intersectionality scholarship concentrates on identity at the expense of assessing the various ways inequality is formed and sustained.[231] However, this seems to misstate the issue,

[224] Angelucci A (2017) 2.
[225] Angelucci A (2017) 2.
[226] Sylvain R (2011) 91.
[227] Sylvain R (2011) 91. Bauer GR, Churchill SM and Mahendran M 'Intersectionality in quantitative research: A systematic review of its emergence and applications of theory and methods' available at *https://www.sciencedirect.com/science/article/pii/S2352827321000732* (accessed on 25 November 2022).
[228] Sylvain R (2011) 91.
[229] Sylvain R (2011) 91.
[230] Smith B (2016) 77.
[231] Smith B (2016) 77.

"intersectionality is a tool that can be used for precisely the examination of the root causes of inequality that Conaghan calls for, and the language of identity is just the way that the inquiry into the power structures operating beneath discrimination is articulated."[232]

Furthermore, as Crenshaw reflects on the journey of the theory, it is apparent that the intersectionality theory has had a widespread influence, but not a very deep one, as it appears to be both over and underused to such an extent that it becomes difficult to recognise it in literature.[233] To support this point, Carastathis states that Crenshaw offered intersectionality as a metaphor (Demarginalising Intersectionality) in 1989, and she clarified it as a temporary theory to prove the insufficiency of approaches that separate systems of oppression, isolating and focusing on one while occluding the others in 1991 (Margins).[234]

Smith further argues that intersectionality can be difficult to define because of its apparent simplicity. It has undoubtedly not been acknowledged without question because, much like equality, it can be seen to have very little substantive content of its own.[235] For some scholars such as Nash, intersectionality offers significant insights that "identity is complex, subjectivity is messy, and that personhood is inextricably bound up with vectors of power" but the inconsistencies within the concept have yet to be dealt with.[236] For example, Nash makes much of an apparent paradox in Crenshaw's work, where the experience of Black women is dominant. Yet, Crenshaw claims that her focus on race and gender "highlights the need to account for multiple grounds of identity when considering how the social world is constructed."[237] As a result, this paradox seems to be an incorrect one as Crenshaw concentrates on the practical experiences of Black women because she is a Black woman, thus, partly addressing the litigation strategies of Black women.[238] However, nothing in her writing averts the extension of intersectionality.[239]

However, the intersectionality theory can also be credited for many reasons. The advantage of constructing intersectionality as a universal theory of identity is that it permits the attention of

[232] Smith B (2016) 77.
[233] Carastathis A (2014) 305.
[234] Carastathis A (2014) 305.
[235] Smith B (2016) 76.
[236] Smith B (2016) 76.
[237] Smith B (2016) 76.
[238] Smith B (2016) 76.
[239] Smith B (2016) 76.

discrimination law to move from difference to domination. By so doing, it breaks down the leading model of equality law where there is a norm from which "difference" is measured.[240]

2.4 INTERSECTIONALITY THEORY IN THE AFRICAN CONTEXT

It has been suggested by scholars such as Oyewumi that there is a need to consider African experiences when building theories because interests, concerns, predilections, prejudices, social institutions, and social categories of Euro or Americans have dominated the literature of human history.[241] Thus, this global context for producing literature must be considered to understand African realities and the human condition.[242] The purpose of considering African realities in theory building is to develop ways to ensure that African research can be better informed by local concerns and interpretations and, at the same time, for African experiences to be taken into account.[243] Thus, understanding intersectionality through the African lens is relevant to this study because the study focuses on women in Zimbabwe, particularly, the San women of Zimbabwe.

The intersectionality theory has found expression in comprehending and coming to terms with issues relating to African, Zimbabwean women. Despite its origin in western feminist ideology and experience, it has been custom-made for the specific experiences of women in Africa in general.[244] For example, this theory found expression in various campaigns led by students in South African universities, such as the #FeesMustFall and the #EndRapeCulture campaigns, among others. Gouws postulates that the #FeesMustFall campaign was started by the intersection of race, class, and gender, which caused students to rally around not only their class interests but also the interests of workers who were outsourced during the time of the campaign.[245] Class identity was at the forefront of this campaign but there was revelation that there was an intersection between class identity, race and gender.[246] During this campaign, a joint solidarity was established between subcontracted workers (who were made up of mostly

[240] Smith B (2016) 79.
[241] Oyewumi O 'Conceptualising gender: Eurocentric foundations of feminist concepts and the challenge of African epistemologies' in African gender scholarship: Concepts, methodologies and paradigms (2004) Dakar: CODESRIA 1.
[242] Oyewumi O (2004) 1.
[243] Oyewumi O (2004) 1.
[244] Omoruyi (2020) 52.
[245] Gouws A 'Feminist intersectionality and the matrix of domination in South Africa' (2017) 31:1 *Agenda* 25. Gouws states that: "in the case of settler colonialism it is important to keep in mind the idea of the matrix of domination in relation to the intersections of colonialism, heteropatriarchy and white supremacy. Indigenous populations are all differently located in this matrix."
[246] Gouws A (2017) 25.

women) and students because both were disadvantaged at the time of the campaign as African women experience marginalisation and oppression in their everyday encounters because of many factors such as patriarchal oppression, racialised labour exploitation, and racism.[247]

In addition, arguments have been made that how experiences of African women's sexual violation is used leads to a certain essentialisation of racial identity because boundaries among identity categories are fluid and permeable.[248] This was evidenced by the fact that throughout the #EndRapeCulture campaigns, references to white female students as "Beckys" (implying that these students were sexually promiscuous or "loose") were made because of their limited participation in the campaigns.[249] As a result of this, questions were posed about whether or not white women were supposed to have welcomed these references to their sexual identity in a counter-hegemonic way to build up alliances or did their race identity make them less motivated to participate in the #EndRapeCulture campaign, even though sexual violence knows no racial boundaries?[250] In response to this, Gouw asserts that it was the "essentialisation of race and gender that was at work, something that is challenged by intersectionality."[251]

Furthermore, the intersectionality theory has been discussed in relation to the situation of persons with disabilities (PWDs) in Africa, with a specific focus on South Africa.[252] A study by Humphrey, revealed that South Africa has some of the highest rates of gender-based violence (GBV) globally and from the national studies conducted, the statistics obtained did not account for the experiences of women with disabilities.[253] Therefore, these rates become even more alarming after understanding that women with disabilities experience violence in unusual ways and more frequently than women without disabilities.[254] This study also provides that many organisations in South Africa seldom incorporate an intersectional approach when dealing with issues as they are said to throw a wide net and not narrowly focus on individual matters such as violence.[255] This study also emphasises that the unpleasant experiences of many

[247] Gouws A (2017) 25.
[248] Gouws A (2017) 24.
[249] Gouws A (2017) 24.
[250] Gouws A (2017) 24.
[251] Gouws A (2017) 24-25.
[252] Humphrey M *The intersectionality of poverty, disability, and gender as a framework to understand violence against women with disabilities: A case study of South Africa* (Unpublished Masters Research Paper, Clark University, 2016) 29.
[253] According to Humphrey M (2016) 29, "rates have garnered international attention as an urgent human rights violation. A national study concluded that in South Africa a woman is killed every six hours by an intimate partner."
[254] Humphrey M (2016) 29.
[255] Humphrey M (2016) 35.

women with disabilities in South Africa result from the intersectionality of poverty, disability and gender, each of which contributes to and worsens their abuse and neglect.[256]

The intersectionality theory has also been used to understand the challenges experienced by refugee women. The different experiences faced by refugee women due to many factors such as "their refugee status, age, disability, residence, length of displacement, experiences of gender-based violence, as well as their unique positions in specific social, cultural, and political spheres" have been realised from an intersectional standpoint.[257] Additionally, arguments have been put across that there is an intersectionality of disadvantage brought about by a merging of individual and systemic features that cause refugee women in Africa to be even more deprived of accessing and experiencing sustainable, long-lasting solutions.[258]

With regard to children in Africa, the intersectionality approach has been applied to assess the effect of the Disarmament, Demobilisation, and Reintegration (DDR) programmes for child soldiers in Sub-Saharan Africa. In this instance, it has been revealed that child soldiers are exclusively underserved in the DDR programs due to misapprehension of the differences in identities.[259] It is thus suggested that the programmes can only be effective if they take into consideration "the intersection of gender, age, class, tribal affiliation, and geography."[260]

The discussion above shows that the concept of intersectionality is not new in the African context. The discussion also elaborates how social status, gender, nationality, context, place, and history might be essential identity categories in the African context.

2.5 INTERSECTIONALITY THEORY IN THE HUMAN RIGHTS FRAMEWORKS

Intersectionality has evolved in human rights dialogues over many years to become a central theme within the broader topic of discrimination, although it was not until later that the phrase "intersectionality" was explicitly adopted.[261] Chow posits that the intersectionality theory in the human rights sphere "owed its roots in international legal discourse to declarations calling

[256] Humphrey M (2016) 33.
[257] Omoruyi A (2020) 56.
[258] Omoruyi A (2020) 56.
[259] Omoruyi A (2020) 53.
[260] Omoruyi A (2020) 53-54.
[261] Chow PS 'Has intersectionality reached its limits: Intersectionality in the UN human rights treaty body practice and the issue of ambivalence' (2016) 16:3 *Human Rights Law Review* 454. "The recognition that intersectionality gained over the years was also evident in the express and implicit references across the practice of the UN human rights treaty bodies, where the concept was used to highlight how gender discrimination is often intertwined with discrimination on other grounds, such as race, ethnicity and socio-economic background, thus 'complicating simplistic, singular understandings of the nature of women's disadvantage."

for the need to address the particular vulnerability of minority women to specific forms of human rights abuses and the multiple barriers that these women face in realising their rights."[262] It is important to highlight that consequent effort to integrate intersectional viewpoints were not without challenges because the UN human rights instruments were drafted in a manner that compartmentalised matters relating to women, race, and other social groupings.[263] Furthermore, Chow asserts that apart from CEDAW, where matters concerning minority women explicitly come into scope,[264] it was not clear at the time that the gender-neutral language used in other human rights instruments, such as the Convention on the Elimination of Racial Discrimination (CERD) warranted the treaty bodies placing a special emphasis on indigenous minority women.[265] There was a belief that such an emphasis would cause treaty bodies to have competing mandates.[266]

An important landmark for the development of intersectionality in the context of the treaty bodies was seen through the Tenth Meeting of the Chairpersons of the Human Rights Treaty Bodies on Integrating the Gender Perspective into the Work of the UN Human Rights Treaty Bodies which was held in 1998.[267] This meeting acknowledged the need to interrogate intersectional inequalities as shown by the following recommendation by the Chairpersons:

> "In order to strengthen the knowledge base about the impact of gender on the conceptualization and implementation of human rights, treaty bodies could call on their secretariats to commission, and on NGOs and the academic community to undertake, studies that would contribute to the clarification of the gender dimensions of rights. Such studies might, for example, explore the intersection of race and gender in the context of the [CEDAW]."[268]

The intersectionality concept was gradually brought into the work of treaty bodies through General Comments, Recommendations, Reporting Guidelines, and Concluding Observations demanding intersectional discrimination to be sufficiently dealt with and tackled through States' laws and policies. Thus, the Human Rights Committee (HRC) in 2000 issued its General

[262] Chow P S (2016) 462.
[263] Chow P S (2016) 465.
[264] Chow P (2016) 454.
[265] Chow P S (2016) 465.
[266] Chow P S (2016) 465.
[267] Tenth meeting of persons chairing human rights treaty bodies: Integrating the Gender Perspective into the work of the UN human rights treaty bodies 1998.
[268] Paragraph 112 Tenth meeting of persons chairing human rights treaty bodies: Integrating the Gender Perspective into the work of the UN human rights treaty bodies 1998.

Comment No 28 on Article 3 regarding the equality of rights between men and women, which provides as follows:

> "[d]iscrimination against women is often intertwined with discrimination on other grounds ... State parties should address the ways in which any instances of discrimination on other grounds affect women in a particular way and include information on the measures taken to counter these effects."[269]

It is important to state that even though the HRC's General Comment did not explicitly use the term "intersectionality," the idea was passed by recognising that discrimination on other grounds may affect women in multiple and specific ways.[270]

Furthermore, the intersectionality concept was expressly endorsed in General Recommendation No. 28 of the CEDAW where it was stated that:

> "Intersectionality is a basic concept for understanding the scope of the general obligations of States parties contained in article 2. The discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste and sexual orientation and gender identity. Discrimination on the basis of sex or gender may affect women belonging to such groups to a different degree or in different ways to men. States parties must legally recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them. They also need to adopt and pursue policies and programmes designed to eliminate such occurrences..."[271]

Thus, in adopting such policies, State Parties are expected to disaggregate data collection to correctly define the multi-facets of women's realities.[272] To formalise this requirement, CEDAW's 2008 Reporting Guidelines made disaggregated data collection an official requirement. States are thus required in their reports to add information related to different

[269] Paragraph 30 UN Human Rights Committee (HRC) CCPR General Comment No. 28: Article 3 (The equality of rights between men and women) 2000 CCPR/C/21/Rev.1/Add.10.
[270] Paragraph 3 Committee on the Elimination of Racial Discrimination (CERD) General Recommendation No 19: The prevention, prohibition and eradication of racial segregation and apartheid 1995.
[271] Paragraph 18 UN Committee on the Elimination of Discrimination Against Women (CEDAW) General Recommendation No. 28 on the core obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women 2010 CEDAW/C/GC/28. However, Chow P (2016) 454, states that: "despite such express acknowledgements by the Committee, the effectiveness of the concept remained uncertain. In particular, it remained unclear whether the juridical understanding of intersectionality could fully honour the complexity that intersectional analysis demands."
[272] Chow P S (2016) 468.

groups of women, particularly those who are victims of multiple forms of discrimination.[273] The reason behind doing this was because of the belief that disaggregated data would make it possible to identify the extent of the effect of specific challenges and policies on particular classes of women (for example, the effects of poverty on different classes of women).[274]

Although intersectionality has been adopted in UN human rights treaty bodies, its limitation in the context of indigenous minority women is demonstrated in the works of the treaty bodies.[275] For example, it is common cause that often cultural and religious practices are considered harmful and discriminatory, but the women in question may not be agreeable to the assertion that these practices are discriminatory.[276] As a result, this raised difficult questions regarding whether human rights law could appropriately cater to their multiple identities, both as women and as members of their cultural group.[277] Furthermore, it is increasingly acknowledged that the engagement of such practices is often marked by a form of hesitation that can be described as "a feeling of open-endedness, incompleteness and uncertainty."[278]

Moreover, the 1991 Guidelines on the Protection of Refugee Women were drafted to deal with the issues of refugee women precisely because these women are regarded as more vulnerable to different forms of abuse, such as sexual abuse and human trafficking, compared to other women.[279] In a similar vein, in emphasising the vulnerability of other categories of women to oppression, the 1993 Declaration on the Elimination of Violence against Women stated the following:

> "some groups of women, such as women belonging to minority groups, indigenous women, refugee women, migrant women, women living in rural or remote communities, destitute women, women in institutions or detention, female children, women with disabilities, elderly women and women in situations of armed conflict, are especially vulnerable to violence."[280]

[273] Paragraph E5 Annex I Reporting guidelines of the Committee on the Elimination of Discrimination against Women A63/38.
[274] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[275] Chow PS (2016) 454-455.
[276] Chow PS (2016) 454-455.
[277] Chow PS (2016) 455.
[278] Chow PS (2016) 455.
[279] Chow PS (2016) 462-463.
[280] UN Declaration on the Elimination of Violence against Women, A/RES/48/104 1993.

Furthermore, in a landmark case, *Prosecutor v Akayesu*, the International Criminal Tribunal for Rwanda held that "genocide could be perpetrated through rape and other forms of sexual violence and acknowledged the link between gender and extreme forms of racial discrimination."[281] The Trial Chamber stated that:

> "Sexual violence was an integral part of the process of destruction, specifically targeting Tutsi women and specifically contributing to their destruction and to the destruction of the Tutsi group as a whole ... [T]utsi women were subjected to sexual violence because they were Tutsi. Sexual violence was a step in the process of destruction of the [T]utsi group."[282]

The Beijing Declaration and Platform for Action echo the belief that numerous identities have a possibility of contributing to multiple hindrances to equality.[283] Accordingly, the Beijing Declaration and Platform for Action called enjoined States to:

> "intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people."[284]

More so, by the beginning of the 2000s, phrases such as "intersection," "intersectional" and "intersectionality" began to emerge.[285] Thus, towards the end of 2000, an expert group organised by the UN Division for the Advancement of Women, the Office of the High Commissioner for Human Rights (OHCHR), and the UN Development Fund for Women met to deliberate the connection between gender and racial discrimination.[286] The identified areas where gender and racial discrimination overlap was expressly examined and the following was highlighted:

> "The idea of intersectionality seeks to capture both the structural and dynamic consequences of the interaction between two or more forms of discrimination or systems of subordination. It specifically addresses the manner in which racism, patriarchy, economic disadvantages and other discriminatory systems contribute to create layers of

[281] Chow PS (2016) 463.
[282] Paragraph 731 *Prosecutor v Akayesu* ICTR-96-4-A. See also the Declaration of the World Conference against racism, racial discrimination, xenophobia and related intolerance 2001 (Durban Declaration). The Declaration states that "racism, racial discrimination, xenophobia and related intolerance occurs on grounds of race, colour, descent or national or ethnic origin and that victims can suffer multiple or aggravated forms of discrimination based on other related grounds."
[283] Beijing Declaration and Platform for Action 1995.
[284] Article 32 Beijing Declaration and Platform for Action.
[285] Chow PS (2016) 463.
[286] Chow PS (2016) 463.

> inequality that structures the relative positions of women and men, races and other groups. Moreover, it addresses the way that specific acts and policies create burdens that flow along these intersecting axes contributing actively to create a dynamic of disempowerment."[287]

Since that period, the intersectionality approach has been adopted by other actors within the UN human rights system.[288] For example, in 2001, the then Special Rapporteur on Violence against women issued a report which requested action "to be taken at both the national and international levels to raise awareness of the multiple nature of discrimination experienced by marginalised women and to mainstream an intersectional or more holistic approach ... at a theoretical level and addressed at a practical level" to fight violence against women.[289]

Furthermore, the UN Commission on Human Rights adopted a resolution related to "Integrating the Human Rights of Women throughout the United Nations System" which acknowledged the importance of investigating the intersection of many forms of discrimination, including their original causes from a gender viewpoint.[290] The integration of an intersectional approach to dealing with women's human rights was regularly called for and considered an essential part of gender mainstreaming.[291] The content of an intersectional approach was further explicitly explained in background research which was conducted by the UN Working Group on Women and Human Rights, where it was stated that:

> "An intersectional approach to analyzing the disempowerment of marginalized women attempts to capture the consequences of the interaction between two or more forms of subordination. It addresses the manner in which racism, patriarchy, class oppression and other discriminatory systems create inequalities that structure the relative positions of women, races, ethnicities, class and the like ... racially subordinated women are often positioned in the space where racism or xenophobia, class and gender meet. They are

[287] Report of the Expert Group Meeting 2000. The Division for the Advancement of Women (DAW) in collaboration with the Office of the High Commissioner for Human Rights (OHCHR) and the United Nations Development Fund for Women (UNIFEM), held a meeting for experts which ran under the theme "Gender and racial discrimination." The meeting was hosted by the Government of Croatia from the 21st to the 24th of November 2000.

[288] Chow PS (2016) 463.

[289] 15 years of the United Nations Special Rapporteur on violence against women, its causes and consequences A critical review, (1994–2009).

[290] UNHRC Resolution on the Integration of the Human Rights of Women and the Gender Perspective 2002 E/CN.4/2002/L.59.

[291] UNHRC, Resolution on the Integration of the Human Rights of Women and the Gender Perspective 2003 E/CN.4/2003/L.11/Add.4.

> consequently subject to injury by the heavy flow of traffic travelling along all these roads."[292]

On the African plane, there are two parallel and possibly incompatible movements: the clarification of indigenous peoples' rights on the one hand and the clarification of women's rights on the other.[293] Women's rights are often designed to protect women from the claims of culture; on the other hand, collective rights can serve to promote and protect culture and this tension becomes problematic for indigenous women.[294] Sylvain argues that while the African Charter proscribed discrimination based on sex, the provisions in the African Charter proved insufficient for protecting women's rights and dealing with women's issues. Of specific concern was the terminology of responsibilities and understanding culture and family in the African Charter.[295] The African Charter defines the family as "the natural and fundamental unit of society and the custodian of morals and traditional values recognised by the community."[296] The importance of family and community implied by the wording of obligations is clearly articulated in the African Commission's Guidelines for Periodic National Reports, which provides that:

> "Personal and private rights shall not be selfishly insisted upon at the expense of family, society, state, other legally recognised communities' and international community's interests. Individual rights are to be enjoyed with due regard to the rights of others, collective security, morality and common interest. Activities in curbing personal and private interests for the benefit of the interests protected by the article."[297]

According to Article 18(4) of the African Charter, the State "shall ensure the elimination of every discrimination against women."[298] However, the imposition of obligations strengthens common expectations of female self-sacrifice, and the extensive identification of women with the family and reproductive roles overload women with custodial responsibilities to uphold morals and traditional norms.[299] Sylvain also argues that the sacredness of the family and culture offers validation for continuing domestic relationships and cultural practices that are

[292] United Nations 'Background briefing on intersectionality, working group on women and human rights available at *https://www.cwgl.rutgers.edu/docman/csw-2001/80-working-group-on-women-and-human-rights/file* (accessed 4 December 2020).
[293] Sylvain R (2011) 91.
[294] Sylvain R (2011) 91.
[295] Sylvain R (2011) 91.
[296] Article 18 African Charter.
[297] Paragraph 5 African Commission's Guidelines for Periodic National Reports (General Guidelines regarding the form and contents of reports to be submitted on specific duties under the Charter).
[298] Article 18 (4) African Charter.
[299] Sylvain R (2011) 91.

oppressive to women.[300] Concerns about the conflict between collective cultural rights and individual women's rights are echoed in several provisions in the African Women's Protocol that specifically proclaim the importance of women's rights in issues related to culture, tradition, and the family.[301]

A discussion of the intersectionality theory in human rights frameworks is relevant to this study because the study will have a separate chapter that discusses the protection of reproductive health and the rights of indigenous women in regional and international frameworks.

2.6 SUBSTANTIVE EQUALITY THEORY

Before delving into a whole discussion on what the substantive equality theory entails, it is crucial to first discuss how substantive equality differs from formal equality as there is often a tendency to confuse the two.

2.6.1 Distinction between formal and substantive equality

There is a difference between formal and substantive equality, where formal equality denotes that people are supposed to be treated the same way regardless of their socioeconomic circumstances.[302] In simpler terms, this means that formal equality is only concerned with treating men and women equally, regardless of whether they are treated equally badly or equally well.[303] While formal equality aims at "equalisation of rights," practically it tends to intensify inequality in society because it disregards structural differences that exist within societies that may place certain groups of people at a disadvantage.[304] On the other hand, substantive equality treats individuals equally but pays attention to their unique situations.[305] It

[300] Sylvain R (2011) 91.
[301] Sylvain R (2011) 91.
[302] Durojaye E 'Between rhetoric and reality: the relevance of substantive equality approach to addressing gender inequality in Mozambique' (2017) 30 (1) *Afrika focus* 34. See also Fredman S (2010) 5 who provides that: "Formal equality is based on the premise that individuals should be treated as individuals, on the basis of their own merit, rather than on attributions based on irrelevant characteristics such as race, colour, gender, caste or other analogous status. It is usually summed up by the Aristotelian formula that likes should be treated alike. In legal contexts, it finds expression in the principle of direct discrimination or equal treatment, which makes it unlawful to treat a person less favourably on grounds of her gender, race or other status than a person of a different gender, race or other status."
[303] Durojaye E (2017) 34, also states that "Formal equality is often associated with the highly mechanical and discredited similarly situated test which has been understood to require women to show that they are just like men in order to establish their entitlement to equal treatment and to require remedies that treat women the same as men."
[304] Durojaye E (2017) 34.
[305] Durojaye E (2017) 34.

endeavours to do this by creating equal opportunities for everyone, regardless of socioeconomic circumstances, gender, or race.[306]

Furthermore, formal and substantive equality reinforce dissimilar and possibly inconsistent results.[307] This is so because formal equality is said to be "colourblind" because it demands that "likes be treated alike," and can often dismantle obvious, unjustifiable race-based classifications.[308] On the other hand, substantive equality demands a thorough assessment of the situation and the actual disadvantage faced by specific groups and individuals due to belonging to a particular group.[309] Thus, when minority communities try to exercise their rights from disproportionate starting points, the rigorous application of a formal equality principle could end in *de facto* discrimination.[310] On the other hand, substantive equality attempts to identify and rectify patterns of injustice and relegation.[311]

Furthermore, substantive equality aims to address the limitations posed by formal equality. For example, its aim is not to abstract the individual from the social context, but it takes into consideration available structures of authority and the responsibility of status or identity within them.[312] Furthermore, unlike formal equality, substantive equality is concerned with results instead of treatment.[313] Unlike formal equality, substantive equality appreciates that identity can be a basis of worth; as a result, it expects social institutions to adjust instead of expecting the individual to adapt.[314] In addition, substantive equality does not mistreat all equal or by taking away privileges from the underprivileged group like what formal equality endeavours to do.[315] Finally, substantive equality can go beyond a fault-based model to one which includes positive duties to "respect, protect, promote and fulfill."[316]

2.7 OVERVIEW OF THE SUBSTANTIVE EQUALITY THEORY

[306] Durojaye E (2017) 34.
[307] Loper K (2011) 9-10.
[308] Loper K (2011) 10.
[309] Loper K (2011) 10.
[310] Loper K (2011) 10.
[311] Loper K (2011) 10, provides that "A robust equality principle, therefore, requires an empirical assessment of the relative disadvantage of the group concerned, the past and ongoing discrimination it has faced, the impact of apparently neutral measures on relevant communities, and other factors, such as the uniqueness of the group's culture, and, in the extreme, possible threats to its survival."
[312] Fredman S (2010) 7.
[313] Fredman S (2010) 7.
[314] Fredman S (2010) 7.
[315] Fredman S (2010) 7. The substantive equality approach is substantive in the sense that it improves individuals rather than formal in guaranteeing only consistency.
[316] Fredman S (2010) 7.

According to Westen, substantive equality can be defined as "a class of agents having the chance to attain the same goal in the absence of the same specified obstacle or set of obstacles."[317] Ferdinand and McDermott define substantive equality as a notion that pays attention to the characteristics and experiences of men and women in society and strives to cater to each fulfillment within their differences.[318] The right to equality is regarded as a fundamental commitment in human rights law because the objective of equality resonates strongly in the preambles of a plethora of human rights instruments and national constitutions, and the rights to equality and non-discrimination are invariably among the fundamental rights entrenched in these instruments.[319] Despite its importance, the definition of the right to equality is strongly disputed. For example, scholars like Westen argue that equality is a concept that should be dismissed from moral and legal dialogues as an illustrative norm.[320] For other scholars, the right to equality does not go a long way because even if equality before the law has been determined, disadvantage continues and this disadvantage seems to be intense in groups with a specific status such as women, persons with disabilities (PWDs), indigenous and ethnic minorities and others.[321]

Durojaye asserts that the whole spirit of substantive equality is not to change the disadvantage encountered by a certain category of people but instead to rectify any disadvantage any group of people may have experienced in the past.[322] In a nutshell, substantive equality can be considered as "a departure from classic or formal equality (or treating likes alike) and from equal treatment (ensuring that laws or policies apply to everyone in the same way)."[323] Substantive equality is mainly concerned with ensuring that laws and customary practices do not reduce women's access to societal goods or further discrimination.[324] Hence, the substantive equality theory's main objective is to use the law to address past and present disadvantage by assessing the context or practical experiences of those to whom equality in outcome is due.[325] Thus, substantive equality is important in ensuring the realisation of the

[317] Westen P 'The concept of equal opportunity' (1986) *Ethics* 95 (4) 838.
[318] Ferdinand TN and McDermott M 'Joining punishment and treatment in substantive equality' (2002) 13(2) *Criminal Justice Policy Review* 91.
[319] Fredman S (2016) 712.
[320] Fredman S (2016) 712.
[321] Fredman S (2016) 712-713.
[322] Durojaye E 'A gendered analysis of Section 48(2) (d) of the Zimbabwean Constitution of 2013' (2017)38 (2) *Statute Law Review* 11.
[323] Rebouché R 'The substance of substantive equality: Gender equality and Turkey's headscarf debate' (2009) 24 (5) *American University International Law Review* 712.
[324] Rebouché R (2009) 712.
[325] Rebouché R (2009) 712-713.

reproductive health and rights of San women in Zimbabwe because relying on this theory will mean that San women should be given preferential treatment compared to other women because San women are a group of people who suffered discrimination in the past and continue to suffer discrimination. By giving them preferential treatment, the disadvantages that they face in the realisation of their rights and access to services will be addressed.

Furthermore, it has been noted by the advocates of substantive equality that resemblance in status and condition often hide important and highly significant differences so that technically equal chances become practically unequal.[326] Therefore, an officially equal system, for example, may bestow similar rights and treatment to all people. Yet, it may still be technically discriminatory when the people claiming those rights encounter significantly different paths and challenges in benefitting from certain programmes or enjoying their rights because of their race, gender, or other characteristics.[327] This is because the law might recommend or prohibit "equally," but the effects of the law will be experienced differently.[328] Thus, substantive equality philosophers embrace "targeted interventions designed to equalise opportunity when they conclude that nominal formal equality cannot overcome institutional or other impediments to a truly fair system."[329] Substantive equality demands that regulators deal with this unjust reality directly and in ways formal equality simply cannot.[330] Employing substantive equality will play a crucial role in the realisation of reproductive health rights of the San women because they will be treated differently from other groups of people who are disadvantaged because of race and gender. The justification for this differential treatment will be based on the fact that San women, compared to other women and other people of colour face obstacles in benefitting from certain programmes because of their indigenous minority status. Thus, adopting a substantive equality approach in ensuring that San women enjoy their reproductive health and rights will require them to be prioritised according to their needs.

Proponents of substantive equality further argue that we cannot treat a whole population the same when substantial and persistent structural barriers effectively avert entire sections of that population from contending for success on even distantly equal terms.[331] To buttress this point, they state that features beneath the level of the highest shared denominator, such as race,

[326] Stancil P 'Substantive equality and procedural justice' (2017) 102: 4 *Lowa Law Review* 1637.
[327] Stancil P (2017) 1637.
[328] Stancil P (2017) 1637.
[329] Stancil P (2017) 1637.
[330] Stancil P (2017) 1637.
[331] Stancil P (2017) 1645.

gender, and socio-economic class, predictably and insistently drive results. Therefore, it is only rational to develop categories based on those features.[332] As a result, when the results in question technically discard the core postulate of equality, everyone cannot be made equal by just affirming it is so.[333] Therefore, to ensure that San women enjoy access to reproductive health and rights like women from other tribes, there is a need to treat San women differently from other women because they are not the same despite the fact that they are both women.

Furthermore, substantive equality aims to further equality of results and equality of opportunity. Generally, a substantive approach to equality is created on the essential value of accommodating people's differences to reach equality of outcome.[334] In addition, substantive equality is primarily concerned with achieving an egalitarian society.[335] According to supporters of substantive equality, in certain instances realising equality may involve treating those different the same and in some instances it may require treating those who are different differently.[336] A good example of the substantive equality concept is highlighted in the judgement of the International Court of Justice in the South West African case, where the court stated that:

> "The principle of equality before the law does not mean… absolute equality, namely the equal treatment of men without regard to individual, concrete circumstances, but it means… relative equality, namely the principle to treat equally what are equal and unequally what are unequal… To treat unequal matters differently according to their inequality is not only permitted but required."[337]

Thus, the substantive equality approach can be used to justify treating San women differently from other women as long as the intended goal is to place them in the same position of advantage as other women at the end of the day.

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[332] Stancil P (2017) 1645.
[333] Stancil P (2017) 1645.
[334] Durojaye E (2017) 34. Durojaye argues that "whereas formal equality is concerned with treating men and women the same, the whole point of a substantive equality approach is to achieve equality of results, through whatever measures may be necessary to overcome women's acknowledged inequality. This necessarily entails recognizing that equality cannot be achieved by adopting a merely negative or hands-off approach to government responsibility for addressing women's material conditions of inequality, including their disproportionate poverty."
[335] Durojaye E (2017) 34.
[336] Durojaye E (2017) 34.
[337] See South-West Africa Cases *(Ethiopia v. South Africa; Liberia v. South Africa)* Second Phase International Court of Justice (ICJ) 1966 available *at https://www.refworld.org/cases,ICJ,4023a9414.html* (accessed 15 January 2021).

More so, scholars such as Fredman recommend an idea of equality to reach four main objectives, which show a substantive theory.[338] These include:

> "the promotion of respect for the equal dignity and worth of all, to redress stigma, stereotyping, humiliation, and violence because of membership of an out-group; the accommodation and positive affirmation and celebration of identity within community; the breaking of the cycle of disadvantage associated with status-groups; and the facilitation of full participation in society."[339]

Fredman further adds that participation is a multi-layered notion; therefore, equality law should endeavor to particularly make up for the lack of political control of minority groups.[340] Fredman postulates that the differential treatment of powerless social groups can be accepted as substantive equality when it assists them on four interconnected dimensions: "redistribution, recognition, transformation, and participation."[341] Firstly, the main focus of redistribution is on resources and benefits such as representation in jobs, pay levels, and access to loans and property.[342] Secondly, recognition focuses on eradicating status-based discrimination, humiliation, and violence.[343] Thirdly, transformation removes traditionally prejudiced institutions that convert differences into a disadvantage. Lastly, participation focuses on the comprehensiveness of political and other scopes of decision-making where minorities have historically been absent.[344] Thus, the substantive equality theory is relevant in pushing for the advancement of the rights of San women because if the four primary objectives of substantive equality are met, San women will be placed on an equal footing with other women.

Moreover, Stancil argues that substantive equality theorists like Aristotle, believe that justice requires people to look beyond superficial similarity (for example, what is termed "personhood") to assess some form of desert or merit as the characteristic that applies to the "treat-like-as-like" analysis.[345] However, whilst Aristotle seemed to define substantive equality positively on merit or virtue, contemporary substantive equality philosophers focus mainly on

[338] Loper K 'Substantive equality in International Human Rights Law and its relevance for the resolution of Tibetan Autonomy claims' (2011) 31 (1) *North Carolina Journal of International Law and Commercial Regulation* 10.
[339] Loper K (2011) 10.
[340] Loper K (2011) 10.
[341] Dupont P (2016) 292.
[342] Dupont P (2016) 292.
[343] Dupont P (2016) 292.
[344] Dupont P (2016) 292.
[345] Stancil P (2017) 1644.

features like race, gender, or socio-economic status that can position particular categories of people at a disadvantage relative to those having different features.[346]

Therefore, in broader terms, substantive equality philosophers embrace an Aristotelian proportionate equality approach, but generally in ways that are directly opposite to Aristotle's views.[347] For instance, Aristotle would not have stretched substantial rights or distributional bounties to enslaved people, and women because he believed they were lower than free men of noble birth.[348] On the contrary, contemporary substantive equality advocates who are strongly influenced by the post-Aristotelian idea that all persons are ethically equal would instead put a thumb on the scale in support of racial minorities, women, and other structurally underprivileged groups.[349] Despite this reasoning, substantive equality remains Aristotelian proportionate equality since substantive equality thinkers would allocate extra resources to minorities and women because they are of the opinion that those categories of people deserve such benefits.[350] Indeed, ethnic minorities like the San women, black people, and disabled people tend to be in the majority of those living in poverty or social segregation.[351] Thus, it is not much about an individual's status or group identity, which is the issue, but the unfavourable outcome attached to that status.[352]

Furthermore, supporters of substantive equality suggest legal and policy methods that move beyond officially equal legal answers in support of affirmative interventions, which are sincerely envisioned to level the playing field.[353] For example, suppose an African-American woman has the deck stacked against her by virtue of both her race and her gender. In that case, it is not adequate to secure her supposedly equal rights, but the law should instead vigorously endorse her interests in ways that finally produce true equality.[354] In the context of the San women, to address their plight, the government needs to go an extra mile and promote laws and policies that will actively promote their enjoyment of reproductive health and rights.

"Due to feminist and anti-racist struggles, the judicial standard of substantive equality is regarded as a still-young offspring of the anti-discrimination principle established in domestic

[346] Stancil P (2017) 1644.
[347] Stancil P (2017) 1644.
[348] Stancil P (2017) 1644.
[349] Stancil P (2017) 1644-1645.
[350] Stancil P (2017) 1645.
[351] Fredman S (2016) 729.
[352] Fredman S (2016) 729.
[353] Stancil P (2017) 1645.
[354] Stancil P (2017) 1645.

and international law over the past half century."[355] Early explanations of this principle stated that non-elective features such as sex and race should not interfere with the way the state and other influential actors treated people.[356] Dupont asserts that even if the primary objective of the anti-discrimination principle was to generate opportunities for underprivileged social categories, its formation as difference-blindness was also gathered in legal grievances against guidelines of affirmative action.[357] This principle left the door open for applying legally impartial rules and procedures with exclusionary effects.[358] In response to the anti-discrimination principle, courts began to formulate many context-sensitive and result-based anti-discrimination standards, which permitted the justified consideration of immutable personal features in cases brought before the courts.[359] In the European context, these "substantive equality" approaches take numerous forms.[360] While some courts only need differential treatment to be reasonably reinforced by a valid intention, others focus on the widespread circulation of vital public goods, the prevention and correction of status harms, or the general duty of public and private organisations to encourage equal chances.[361]

Some scholars assert that from a feminist viewpoint, "Equality requires same or different treatment, depending on the circumstances and the position of the individual in relation to his or her group-based systemic disadvantage."[362] This reasoning is equivalent to the concept of substantive equality.[363] It is important to highlight that although not all discrimination amounts to an infringement of rights, adverse discrimination, which takes when one is being treated unfairly, is unjustifiable by law.[364] Furthermore, one of the objectives of the substantive equality approach is to address structural and deep-rooted disadvantage in society while simultaneously aiming to maximize human development.[365] Moreover, arguments have been put across that "committing to substantive equality requires the examination of the context of an alleged rights violation and its relationship to systemic forms of domination within a

[355] Dupont P 'Human rights and substantive Equality in the adjudication of ethnic practices' (2016) 34:*4 Nordic Journal of Human Rights* 292.
[356] Dupont P (2016) 292.
[357] Dupont P (2016) 292. See also Brest P 'In defense of the anti-discrimination principle' (1976) 90: 1 *Havard Law Review* 1.
[358] Dupont P (2016) 292.
[359] Dupont P (2016) 292.
[360] Dupont P (2016) 292.
[361] Dupont P (2016) 292.
[362] Durojaye E (2017) 35.
[363] Durojaye E (2017) 35.
[364] Durojaye E (2017) 35.
[365] Durojaye E (2017) 35.

society."[366] Thus, unlike formal equality, which does not acknowledge individual differences, substantive equality recognises such individual differences and adopts a practical approach to deal with and accommodate them.[367] To succeed in ensuring equality in the access to reproductive health and rights amongst the San women and other women, there is need to realise the differences peculiar to this group and find ways to address those differences and accommodate them. Differences such as that this group of women believe in exercising or claiming their rights as a group and not individually as well as that they believe in using indigenous health systems should be taken into account in ensuring that they enjoy their reproductive health and rights.

It is essential to highlight that there is a "four dimensional framework" of intentions and objectives that must be considered in reconceptualising substantive equality.[368] In terms of this framework, the right to substantive equality should intend to rectify the disadvantage.[369] Secondly, it should strive to oppose prejudice, stigma, discrimination, shame, and violence based on a protected feature.[370] Thirdly, the right to substantive equality should enhance freedom of expression and participation, opposing political and social segregation.[371] Finally, it should take into account differences and reach structural transformation.[372] This "four dimensional approach" is derived from the prevailing appreciation of the right to substantive equality by different scholars.[373] The first two dimensions of this approach, disadvantage and stigma or discrimination, are explicitly discussed in Canadian and South African jurisprudence.[374] For example, the Canadian Supreme Court summarised its position in the case of *Withler* where the court referred to substantive equality as the "animating norm" of the right to equality in the Canadian Charter of Human Rights. The court further stated that, in deciding whether substantive equality had been violated, the question should be whether "having regard to all relevant factors, the impugned measure perpetuates disadvantage or stereotypes the plaintiff group."[375] In addition, in the South African Constitutional Court case of *Brink v*

[366] Durojaye E (2017) 35.
[367] Durojaye E (2017) 35. See also Fredman (2016) 732.
[368] Durojaye E (2017) 35. See also Fredman S (2016) 727.
[369]Fredman S (2016) 727. See also University of Oxford Social Sciences 'A fresh approach to assessing equality in human rights law paves the way for a fairer world' available at *https://www.socsci.ox.ac.uk/a-fresh-approach-to-assessing-equality-in-human-rights-law-paves-the-way-for-a-fairer-world* (accessed on 25 November 2022).
[370]Fredman S (2016) 727.
[371]Fredman S (2016) 727.
[372] Fredman S (2016) 727.
[373] Fredman S (2016) 727.
[374]Fredman S (2016) 727-728.
[375] See paragraph 3 *Withler v Canada* (Attorney General), [2011] 1 S.C.R. 396.

Kitshoff,[376] the court identified the aim of the right to equality entrenched in the South African Constitution as improving patterns of disadvantage. In the cases that were heard after the *Brink* v *Kitshoff* case, the Constitutional Court effectively positioned dignity at the core of the equality right.[377] It is paramount to highlight that none of these two jurisdictions has expressly stated the connection between dignity and disadvantage or how tensions between them should be dealt with.[378] As already mentioned above, this four-dimensional framework of substantive equality is founded on existing understandings, generalising from what is already evident in the viewpoints of courts and other national and international decision makers regarding substantive equality.[379] Hence, by drawing these implied understandings together into a multi-dimensional set-up, it is believed that the subsequent combination advances the approach to substantive equality in ways that can be extra receptive to real societal wrongs.[380]

One of the advantages of the multi-dimensional approach to substantive equality has been argued that it enables one to deal with the interlinkage between different sides of inequality.[381] Theorists and Political Scientists seem to focus a lot on "distributive inequality," while to discrimination lawyers, the right to equality is mainly concerned with opposing bias and stereotyping, concerning "distributive inequalities" as the domain of policy makers.[382] In response to this, Fredman argues that both play a crucial role in the right to equality; however, these do not deplete the field.[383] Moreover, it is also crucial to incorporate inequalities in participation and structural barriers to equality and how they interrelate must be understood and addressed.[384] Thus, given that San women have been exposed to discriminatory practices and programmes compared to other women, remedial actions are required to lessen the pains of the past and provide assistance to women to enable them to reach their full capacity in life.

In addition, Brodsky and Day posit that substantive equality requires that the poverty experienced by women be alleviated by governments.[385] They argue that there are limitations within the discussions about the justiciability claims related to poverty because such claims do

[376] *Brink v Kitshoff* (CCT15/95), [1996] Z.A.C.C. 9 42 (S. Afr.)
[377] *Brink v Kitshoff*.
[378] Fredman S (2016) 727.
[379] Fredman S (2016) 727-728.
[380] Fredman S (2016) 728.
[381] Fredman S (2016) 728.
[382] Fredman S (2016) 728.
[383] Fredman S (2016) 728.
[384] Fredman S (2016) 728.
[385] Brodsky G and Day S 'Beyond the social and economic rights debate: Substantive equality speaks to poverty' (2002) 14 (1) *Canadian Journal of Women and the Law* 189.

not address poverty as a sex equality question.[386] Furthermore, the right to a satisfactory standard of living as entrenched in the ICESCR provides a ground for arguing that this instrument incorporates subsistence rights.[387] However, a feminist substantive equality approach reveals another ground for finding that government cuts to basic social programs, such as welfare, are not in line with the guarantees in the Covenant as they worsen women's already existing economic and social inequality and cause gender-specific problems.[388] It is argued that "this separation of poverty from the inequality of women and other disadvantaged groups mirrors and, therefore, tends to reinforce the traditional division between social and economic rights and civil and political rights."[389] This separation also reinforces the opinion that claims related to poverty are non-justiciable and allows equality rights guarantees to be understood as having nothing to say about physical circumstances.[390]

Rosenfeld posits that "in order to have a better understanding of the substantive equality approach, there is need to distinguish between equality in a descriptive sense and equality in a prescriptive sense."[391] Equality in a descriptive sense notes what is while equality in a prescriptive sense suggests what ought to be.[392] In a descriptive sense, equality "requires that equals be treated equally and as a corollary, that unequals be treated differently."[393] Of paramount importance is to note that descriptive equality does not state who are supposed to be regarded as equals or in what sense they must be alike for them to be eligible to equal treatment.[394] Thus, when an assumption is made that no two people are similar, the same treatment of persons who are the same in a particular area will involve unequal treatment of persons who are alike in another area.[395] For instance, if need instead of merit was the factor which was to be taken into account in choosing people who were eligible for equal treatment, all those having similar needs would be given an equal allocation of goods to the extent that

[386] Brodsky G and Day S (2002) 1898.
[387] Brodsky G and Day S (2002) 188.
[388] Brodsky G and Day S (2002) 188.
[389] Brodsky G and Day S (2002) 188. Brodsky G and Day S (2002) 188 further argue that poverty is a sex equality issue because women's poverty is a manifestation of persistent discrimination against women. These scholars argue that their claim is that women's right to substantive equality must be understood to include a right to basic income security because, without that security, profound deprivations of personal autonomy, and of physical and psychological integrity-which are incompatible with women's equality-result.
[390] Brodsky G and Day S (2002) 188.
[391] Rosenfeld M 'Substantive equality and equal opportunity: jurisprudential appraisal' (1986) 74 (5) *California Law Review* 1700. See also Rosen MD 'Making sense of equality' (2018) 33:3 *Constitutional Commentary* 496.
[392] Rosenfeld M (1986) 1700.
[393] Rosenfeld M (1986) 1700. Rosen MD (2018) 502.
[394] Rosenfeld M (1986) 1700.
[395] Rosenfeld M (1986) 1700.

people having equal value may not possess the same needs they would be treated unequally.[396] It should be noted that equality is bound to create some inequality because of its relational nature.[397]

Ronsenfeld further argues that substantive equality is born out of dissatisfaction and disappointment at the limits imposed by formal equality because of its primary aim to address the gaps created by formal equality.[398] However, while it is now considered quite easy to reach an agreement and conclusion on the confines of formal equality, there remains a lot of unanswered questions about the strategies to be used for substantive equality to exceed these limitations.[399]

MacKinnon posits that a substantive equality approach does not fully fit into any ordinary equality doctrine and changes the results of discrimination cases and alters the situations that are recognised contributing to equality questions in the first place.[400] MacKinnon further postulates that:

> "the core insight of the substantive equality approach is that inequality, substantively speaking, is always a social relation of rank ordering, typically on a group or categorical basis-higher and lower, more and less, top and bottom, better and worse, clean and dirty, served and serving, appropriately rich and appropriately poor, superior and inferior, dominant and subordinate, justly forceful and rightly violated or victimized, commanding and obeying-that precedes the legal one."[401]

Unequal treatment in this approach poses some challenges because it is considered to be harmfully predicated on a rating of one's group that regards some as powerless than others when they are not, for example, based on their group affiliation, as the suitable targets of violence or violation, or as unfitting to be paid a lot like others.[402] "It is thus fundamentally, factually false because when a society makes a decision that a particular ground is a prohibited basis for discrimination, the question whether the group(s) defined by that ground are appropriately placed in caste like arrangements, some being treated and considered better than

[396] Rosenfeld M (1986) 1700.
[397] Rosenfeld M (1986) 1700.
[398] Fredman S (2010) 5.
[399] Fredman S (2010) 5.
[400] MacKinnon CA 'Substantive equality: A perspective' (2011) 96(1) *Minnesota Law Review* 11.
[401] MacKinnon CA (2011) 11.
[402] MacKinnon CA (2011) 11-12.

others, is no longer open for discussion."[403] If this is done, the subsequent material and notable deprivations and infringements are practical signals and consequences of this hierarchy, but it is the hierarchy itself that outlines the central inequality problem.[404]

In addition, arguments have been made that the substance of substantive inequality can be visited on a single person, grounded in the tangible historical discriminatory social truth of group affiliation.[405] The problem with using this approach is that the discrepancy often shows the disparities that affect women as a group in numbers in comparison with men, but the range and deepness, which is the reality of the inequality, is not exhausted by head-counting.[406] The failure to do this shows the reason why substantive equality cannot be fully articulated by the principle of "disparate impact or discrimination in effect," even though it is as close as the mainstream United States' approach gets to it.[407]

Scholars such as Barnnard and Hepple argue that the limitations of the principle of formal equality have played a huge role in developing the concept of substantive equality.[408] Fredman has identified four different but overlapping approaches to substantive equality.[409] The first one is equality of results which, in summary means that constant treatment violates the aim of substantive equality if the outcomes are unequal.[410] According to Fredman, this concept can be used in three different senses. The first is the effect of seemingly equal treatment on the individual; the second is concerned with the outcomes on a group such as women and ethnic minorities, and the third demands a result that is equal, for instance, equal pay for women doing

[403] MacKinnon CA (2011) 12. See also Varcoe AR 'The Boy Scouts and the First Amendment: Constitutional Limits on the Reach of Anti-Discrimination Law' (1999-2000) 9 *Law & Sexuality: A Review of Lesbian, Gay, Bisexual and Transgender Legal Issues* 168.
[404] MacKinnon CA (2011) 12.
[405] MacKinnon CA (2011) 13.
[406] MacKinnon CA (2011) 13.
[407] MacKinnon CA (2011) 13. MacKinnon further argues that "presuming equality of entitlement without requiring sameness of traits, the substantive question centers on dimensions for comparison: What is the substance of each inequality, such that each plaintiff is or is not an example of it? In this approach, equality remains concretely comparative and operates on material rather than ideational ground. And since failure to act is as substantively potent as acting, there is no distinction between negative and positive rights."
[408] Barnnard C and Hepple B 'Substantive equality' (2000) 59 *Cambridge Law Journal* 564.
[409] Barnnard C and Hepple B (2000) 564.
[410] Barnnard C and Hepple B (2000) 564 state that "a similar redistributive approach is taken by the Canadian Employment Equity Act 1995, which utilises the concept of employment equity to indicate that equality means more than treating persons in the same way but requires special measures and the accommodation of differences." In the Great Britain, the Employment Equality Act: 2010, proscribes discrimination in the work place including in the employment process on grounds of protected characteristics such as gender, race, sexual orientation, disability among others.

work of the same value with that of men or equal representation of women and men in a similar rank.[411]

The second approach to characterising substantive equality is in terms of equality of opportunity, which aims to equalise the starting point.[412] In attempting to elucidate this point, Fredman posits that by making use of the graphic symbol of competitors in a race, this approach emphasises that it is impossible to achieve true equality if individuals begin the race from different starting points.[413] Furthermore, the third approach to substantive equality treats equality as secondary to substantive rights.[414] This is demonstrated by Article 14 of the European Convention on Human Rights (ECHR), which calls for non-discrimination on particular grounds in applying the rights in this Convention.[415] Although this averts leveling down of substantive human rights, it limits equality to a subordinate role, and it is only applicable to state action.[416] The fourth and final approach to substantive equality is called a broad value driven approach. In terms of this approach, one set of values places emphasis on the dignity, autonomy, and worth of every person.[417] Such an approach is found in the constitutional provisions of numerous other European Union Member States,[418] and in case law in other countries such as Canada.[419]

Furthermore, Albertyn posits that it is vital for judges and lawyers to understand the context in which inequality occurs and identify the social and economic conditions that structure action and create unequal and exclusionary consequences for groups and individuals because substantive equality is understood as a remedy to systemic and entrenched inequalities.[420] Albertyn further argues that the investigation of the real social, political and legal background in which an alleged rights violation takes place requires a scrutiny of the substantive arrangements that regulate a group's social or economic standing, including the relationship

[411] Barnnard C and Hepple B (2000) 564.
[412] Barnnard C and Hepple B (2000) 565. See also Pobjoy J 'Treating like alike: the principle of non-discrimination as tool to mandate the equal treatment of refugees and beneficiaries of complementary protection' (2010) 34:1 *Melbourne University Law Review* 181-229.
[413] Barnnard C and Hepple B (2000) 565.
[414] Barnnard C and Hepple B (2000) 567.
[415] See Article 14 European Convention for the Protection of Human Rights and Fundamental Freedoms.
[416] Barnnard C and Hepple B (2000) 567.
[417] Barnnard C and Hepple B (2000) 567.
[418] See for example Article 23 of the Belgian Constitution of 2014, Article 2 of the Greek Constitution of 2001 and Article 2 of the Constitution of Italy 1947.
[419] Barnnard C and Hepple B (2000) 567.
[420]Albertyn C 'Substantive equality and transformation in South Africa' (2007 23 (2) *South African Journal on Human Rights* 259.

between "disadvantaged or vulnerable groups and more powerful and privileged groups."[421] Thus, due diligence is required to evade the use of a comparator that deliberately or unintentionally reproduces inequalities because it strengthens dominant customs and standards.[422] Thus, using the substantive equality approach in ensuring the realisation of reproductive health and rights by San women will require scrutiny of the substantive measures that regulate the San women's social or economic position, including the relationship between them and other tribes that they live with.

It is important to mention that substantive equality is a common principle in the Zimbabwean context. Section 56 (6) of the Constitution of Zimbabwe echoes the substantive equality principle because it enjoins the State to "strive towards addressing past historical disadvantages suffered by certain categories of people."[423] This provision is detailed as it proscribes discrimination on numerous grounds, including "sex, gender age and marital status."[424] In addition, Section 56 recognises situations where discrimination may be acceptable; that is, the discrimination must be "fair, reasonable and justifiable in a democratic society based on openness, justice, human dignity, equality, and freedom."[425]

2.7.1 Affirmative action and substantive equality

Linked to the substantive equality approach is affirmative action. The understanding of affirmative action has been recognised by the South African Constitution, which makes express provisions for affirmative action as a means of attaining substantive equality.[426] According to section 9(2) of the South African Constitution:

> "Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken."[427]

The meaning of this provision was explicitly explained in *Minister of Justice v Van Heerden (Van Heerden* case),[428] where a claim of discrimination on the grounds of race was brought

[421] Albertyn C (2007) 259.
[422] Albertyn C (2007) 259.
[423] Section 56 (6) of the Constitution of Zimbabwe.
[424] Durojaye E (2017) 9. See also section 56 (3) of the Constitution of Zimbabwe.
[425] Durojaye E (2017) 9. See also Section 56 (5) of the Constitution of Zimbabwe.
[426] See Section 9(2) South African Constitution.
[427] Fredman S (2010) 13.
[428] *Minister of Justice v Van Heerden* 2004 (6) SA 121 (CC); 2004 (11) BCLR 1125 (South African Constitutional Court).

before the court by a white Afrikaner member who was aggrieved at a measure which increased the pension contributions of post-apartheid Members of Parliament but not pre-apartheid Members.[429] In this case, the court took an emphatically formal view of equality concerning the fairly privileged status of the affected white members as immaterial. Based on this, the court dismissed the programme as unfair discrimination.[430] The case was brought to the Constitutional Court, and the court reversed the decision.[431] The court stated that "instead of being an exception to equality, restitutionary measures are an essential part of it."[432] The court further stated that:

> "What is clear is that our Constitution and in particular section 9 thereof, read as a whole, embraces for good reason a substantive conception of equality inclusive of measures to redress existing inequality. ...Such measures are not in themselves a deviation from, or invasive of, the right to equality guaranteed by the Constitution. They are not "reverse discrimination" or "positive discrimination" as argued by the claimant in this case. They are integral to the reach of our equality protection. In other words, the provisions of section 9(1) and section 9(2) are complementary; both contribute to the constitutional goal of achieving equality to ensure full and equal enjoyment of all rights."[433]

In addition, the Canadian Charter of Human Rights clearly states that measures whose aim is to ameliorate the conditions of disadvantaged individuals or groups will not be a violation of the equality guarantee in Section 15(1) of the Charter.[434] Section 15(2) of the Charter states the following:

> "Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."[435]

This position was further confirmed in a court decision in *R v Kapp* (*Kapp* case).[436] In this case, the court held that:

[429] *Minister of Justice v Van Heerden.*
[430] *Minister of Justice v Van Heerden*.
[431] *Minister of Justice v Van Heerden.*
[432] *Minister of Justice v Van Heerden*.
[433] *Minister of Justice v Van Heerden*.
[434] Fredman S (2010) 14.
[435] Section 15 (2) Canadian Charter of Rights and Freedoms Constitution Act of 1982.
[436] See *R v Kapp* 2008 SCC 41.

> "Sections 15(1) and 15(2) work together to promote the vision of substantive equality that underlies s15 as a whole. Section 15(1) is aimed at preventing discriminatory distinctions that impact adversely on members of groups identified by the grounds enumerated in s. 15 and analogous grounds. This is one way of combating discrimination. However, governments may also wish to combat discrimination by developing programs aimed at helping disadvantaged groups improve their situation. Through s. 15(2), the Charter preserves the right of governments to implement such programs, without fear of challenge under s. 15(1). This is made apparent by the existence of s. 15(2). Thus s. 15(1) and s. 15(2) work together to confirm s. 15's purpose of furthering substantive equality. Moreover, Section 15(2) supports a full expression of equality, rather than derogating from it."[437]

It is important to highlight that affirmative action is echoed in the current Zimbabwean Constitution.[438] In terms of the Constitution of Zimbabwe, affirmative action comprises the provision of "special advantages" through laws and policies to deal with discrimination suffered by disadvantaged groups, such as women.[439] Thus the Constitution of Zimbabwe excludes affirmative action programmes from being considered discriminatory.[440] However, it is important to highlight that whilst this is a positive development, the Constitution does not make affirmative action mandatory as it merely states that "it shall not be regarded as discriminatory in instances where it is applied."[441] Therefore, there is an opportunity for taking a more practical approach to affirmative action which would ensure that the State takes necessary steps to introduce affirmative action in areas where it is required.[442]

There are challenges associated with relying on affirmative measures, and one of them is that at a certain level, affirmative action constitutes a valued combination between status and disadvantage, particularly ascribing socio-economic benefits to those disadvantaged by status. However, there is a risk that this link furthers status inequality as it is not certainly the case that a programme that selects one group for special protection will advance substantive equality, as there are chances that such a programme may restrict individuals into the very status identity

[437] See paragraph 37 *R v Kapp* 2008 SCC 41.
[438] See Section 56 (4)- (6) of the Constitution of Zimbabwe.
[439] Tsanga S 'Towards a democratic and inclusive Constitution for Zimbabwe' *The Scope for Addressing Gender Equality' Parliamentary Briefing Paper* (2010) 3. See also Section 56 (6) of the Constitution of Zimbabwe.
[440] Tsanga S (2010) 3.
[441] See Section 56 (4) and (5) of the Constitution of Zimbabwe.
[442] Tsanga S (2010) 3.

which substantive equality intends to eradicate.[443] This is particularly true in cases concerning giving exceptional measures to support women in their child-caring role.[444]

It is of paramount importance to highlight that when it comes to applying affirmative measures, there remains a significant duty for judicial management despite the fact that substantive equality is not followed in principle by applying such measures.[445]

> "The controlling mechanism used by most courts is that of proportionality: are the aims legitimate, and do the means 'fit' the aims. However, courts vary widely in the intensity of scrutiny. This is true both for the definition of a legitimate purpose and for the tightness of the fit between the affirmative action measure and that purpose."[446]

This distinction is accounted for by the court's comprehension of equality and the degree to which they consider it proper to defer to legislative or executive decision-makers' understanding of equality.[447]

From the above discussion, the author believes that relying on substantive equality and affirmative action is relevant to this study because such principles are echoed in the Constitution of Zimbabwe, which is the highest law of the land of Zimbabwe. Furthermore, this theory is relevant because it forms part of the Constitution of Zimbabwe, which will be part of the discussion in Chapter 4 on the role of legislation and institutions in Zimbabwe in ensuring the protection of the reproductive health and rights of indigenous women in Zimbabwe who include the San women.

2.8 ADVANTAGES AND DISADVANTAGES OF SUBSTANTIVE EQUALITY

One of the key advantages of substantive equality over formal equality is its skewness.[448] This implies that it is not race or gender considered difficult, but the disadvantage related to subdued groups such as black people, women, or other identified groups.[449] This irregularity means that equality is not necessarily violated by measures that specifically use race or gender to allocate benefits and burdens, provided that they intend to benefit the subordinated group, race, or

[443] Fredman S (2010) 15.
[444] Fredman S (2010) 15.
[445] Fredman S (2010) 16.
[446] Fredman S (2010) 16.
[447] Fredman S (2010) 16.
[448] Fredman S (2010) 13.
[449] Fredman S (2010) 13.

gender; specific measures may be necessary to achieve substantive equality.[450] Thus, while formal equality would consider affirmative action a violation of equality, substantive equality sees such programs as a way of attaining equality.[451]

In addition, another advantage of the substantive equality approach is that it offers noteworthy benefits compared to formal equality approaches, provided that they maintain a devotion to the proposition that all persons are inherent of equal moral value.[452] In addition, when a system that is based upon substantive equality principles is properly designed and executed, it can play a major role in alleviating the effects of the structural imbalances that tilt so much of the playing field in favour of smaller subclasses rather than assuring everyone the promises of a fair society.[453] Moreover, the tenacity of structurally induced injustice influences exploring the feasibility of substantive equality involvement in various circumstances, including civil procedure.[454]

Although the substantive equality approach is applauded for many reasons, it has been criticised for some of its aspects, such as that aiming at disadvantage rather than impartiality has many shortcomings because targeting disadvantage takes away the likelihood of a levelling down option.[455] For instance, focusing on a disadvantage requires one to clarify the type of disadvantage. In this case, the disadvantage is mainly aimed at a socio-economic disadvantage, and the right to equality regularly operates to deal with underrepresentation in jobs, underpayment for work of the same value, or restrictions on access to credit, property, or similar resources.[456] However, disadvantage should encompass more than maldistribution of resources. It also needs to consider the constraints that power structures impose on individuals because of their status.[457] Therefore, it is argued that rather than concentrating on the

[450] Fredman S (2010) 13.
[451] Fredman S (2010) 13.
[452] Stancil P (2017) 1645.
[453] Stancil P (2017) 1645.
[454] Stancil P (2017) 1646.
[455] Fredman S (2016) 729. Fredman further states the following: "Its asymmetry also means that it is possible to reconcile affirmative action with the right to equality. Although apparently breaching the principle of equal treatment, affirmative action in reality advances substantive equality by taking steps to redress the disadvantage. This is a sounder basis for supporting affirmative action than equality of results. It does not require results to be numerically equal in order to lessen disadvantage. Instead, it leaves open the question as to when disadvantage has been redressed. Indeed, it is compatible with a prioritarian theory."
[456] Fredman S (2016) 729.
[457] Fredman S (2016) 729.

distribution of material objects, the attention should be on control or structures that leave people out from participating in determining their actions.[458]

2.9 SUBSTANTIVE EQUALITY UNDER REGIONAL AND INTERNATIONAL LAW

The concept of equality and non-discrimination is a foundational principle in human rights law that has found expression in core human rights instruments and has been interpreted by the United Nations treaty bodies.[459] It is essential to state that international and regional human rights instruments specifically relating to women seem to have confirmed the substantive equality concept. For example, CEDAW defines discrimination against women broadly to include:

> "[A]ny distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[460]

This provision enjoins State Parties to the treaty to "take steps and measures to eliminate discrimination against women within their territories."[461] Similarly, the African Women's Protocol requires States to eradicate practices that discriminate against women and encourages States to take all necessary steps to eradicate social and cultural patterns and practices that are unfair to women.[462] The African Women's Protocol whose aim is substantive equality, non-discrimination, and human dignity for women and girls draws expansively from CEDAW in giving a comprehensive definition of discrimination against women.[463] It does this by providing extensive grounds on which discrimination is prohibited.[464]

At the international level, affirmative action which is linked to substantive equality, is again endorsed. This is seen through the wording of Article 2(2) of CEDAW, which states that

[458] Fredman S (2016) 729. Fredman further states that: "Domination must not be attributable to the actions of any particular individual but produces constraints which are the intended or unintended product of actions of many people. This is particularly salient in relation to women. Women's disadvantage cannot be characterized solely in terms of income poverty but is centrally related to imbalances of power within and outside the family. choices..."
[459] Loper K (2011) 11.
[460] Article 2 of CEDAW. See also Durojaye E (2017) 35.
[461] Durojaye E (2017) 35.
[462] Preamble of the Maputo Protocol.
[463] Durojaye E (2017) 35-36.
[464] Durojaye E (2017) 35-36.

"adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination."[465] Affirmative action is also endorsed in Article 2(2) of the CERD, which states that:

> "States Parties shall, when the circumstances so warrant, take, in the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms."[466]

In addition to these human rights instruments, other human rights instruments recognise the right to equality and non-discrimination.[467] For example, Article 26 of the ICCPR guarantees the right to equality before the law and "freedom from discrimination."[468] The Human Rights Council (HRC) in its General Comment No. 28, has explained that "Non-discrimination together with equality before the law and equal protection of the law without discrimination constitutes a basic and general principle relating to the protection of human rights."[469] In *Nahlik v Austria,* the Committee explained that "Articles 2 and 26 of the ICCPR obligate states to ensure that all individuals within its territory and subject to its jurisdiction are free from discriminatory practices, whether perpetrated in private or public sphere."[470]

Under the African Charter, Article 2 provides that "everyone is equal before the law and that no one should be discriminated against on grounds such as gender, religion, political beliefs or other status."[471] Similarly, Article 3 guarantees everyone the right to equality and equal protection of the law.[472] The African Commission on Human and Peoples' Rights (African Commission/ ACHPR) in *Purohit and Moore v The Gambia*[473] stated that:

> "Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises, while article 3 is important because it guarantees fair and just treatment of individuals within a legal system of a given country. These provisions are non-derogable and therefore must be respected in

[465] See Article 2 (2) CEDAW
[466] CERD Article 2(2).
[467] Durojaye E (2017) 36.
[468] See Article 26 ICCPR.
[469] See paragraph 12 Human Rights Council General Comment 28.
[470] *Nahlik v Austria* Communication 608/1995. CCPR/C/57/D/608/1995.
[471] Article 2 African Charter.
[472] See Articles 2 and 3 African Charter.
[473] *Purohit and Moore v The Gambia* Communication 241/2001 (2003) AHRLR 96 (ACHPR 2003).

all circumstances in order for anyone to enjoy all the rights provided under the African Charter."

Thus, this statement summarises the importance of realising the substantive equality concept in any society.

Discussing the incorporation of substantive equality in the human rights frameworks is relevant to this study because this study discusses how the realisation of the reproductive health rights of indigenous women, including the San women, is tackled at regional and international levels.

2.10 JUDICIAL APPLICATION OF SUBSTANTIVE EQUALITY

Albertyn posits that the "legal application of substantive equality in South Africa has been developed at some length by the Constitutional Court."[474] Although there has been some unevenness in the Court's approach, the Constitutional Court endorsed four characteristics that give substantive equality its transformative potential.[475] The first characteristic emphasises comprehending inequality within its social and historic setting.[476] The second characteristic primarily focuses on the impact of the alleged inequality on the complainant.[477] Thirdly, transformative substantive equality requires an acknowledgment of difference as a positive feature of society, and lastly, transformative substantive equality requires one to pay attention to the aim of the right and its basic values in a way that shows a direct or indirect concern with alleviating systemic relegation or disadvantage.[478] Moreover, Albertyn states that an added characteristic of transformative substantive equality gained through the above application would be its capacity to confirm or envisage a future society through practical and normative means.[479] Underlying all of the above-mentioned features of transformative substantive equality is a needed retreat from legal formalism and an appreciation of law as a product of social relationships that can be re-inscribed with life-changing ends.[480]

Substantive equality has been applied in several cases in the South African jurisdiction to highlight the legal application of substantive equality. For example, the legal application of substantive equality was echoed in the case of *President of the Republic of South Africa and*

[474] Albertyn C 'Substantive equality and transformation in South Africa' (2007) 23(2) *South African Journal on Human Rights* 258.
[475] Albertyn C (2007) 258.
[476] Albertyn C (2007) 258.
[477] Albertyn C (2007) 258.
[478] Albertyn C (2007) 258.
[479] Albertyn C (2007) 258.
[480] Albertyn C (2007) 258.

another v Hugo[481] where a prerogative of mercy was granted to convicted women with children below the age of twelve years was challenged by male prisoners because it was discriminatory and inconsistent with the equality provision in the Constitution of South African.[482][483] The majority of the Constitutional Court dismissed this argument, citing that given the peculiar situation of women and their role in society, granting the presidential pardon was not discriminatory.

The Court then considered the argument that Presidential Act No. 17 (Act) breached the right against unfair discrimination. In response to this allegation, the majority of the Court held that although the Act was discriminatory towards the respondent based on sex, this discrimination was not unfair. In deciding on whether the discrimination was unfair, the Court took into account the effect of the discrimination on the affected people. Thus, in assessing whether the impact was unjust, the court held that it was essential to "look at the group who had been disadvantaged, the nature of the power used and the nature of the interest which had been affected by the discrimination."[484] Concerning the effect on the fathers of young children who were not released, the court concluded that, although the pardon may have deprived men of an opportunity it presented to women, it could not be said that it primarily reduced their sense of dignity and equal worth.[485]

Furthermore, the courts have also passed judgments to show that the whole spirit of substantive equality is not to change disadvantage but instead to rectify any disadvantage any categories of people may have experienced in the past.[486] For example, in the *National Coalition for Gay and Lesbian Equality v Minister of Justice and others* case,[487] the South African Constitutional Court noted that the criminalisation of same-sex relationships between consenting male adults amounted to a serious breach of the right to equality and non-discrimination. This is because consensual sexual acts between men are punished, while sexual acts between a man and a woman are not punished.[488] The court reasoned that "gay people are a vulnerable minority group in our society and sodomy laws criminalise their most intimate relationships resulting in

[481] Paragraph 47 *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC).
[482] Paragraph 47 *President of the Republic of South Africa v Hugo.*
[483] Paragraph 47 *President of the Republic of South Africa v Hugo.*
[484] Paragraph 47 *President of the Republic of South Africa v Hugo.*
[485] Paragraph 47 *President of the Republic of South Africa v Hugo.*
[486] Durojaye E (2017) 11.
[487] *President of Republic of South Africa v Hugo*.
[488] *President of Republic of South Africa v Hugo*.

devaluing and degrading gay men, and this constitutes a violation of their right to human dignity."[489]

This discussion is relevant because this thesis in chapter four will discuss the role of and work done by different institutions in ensuring the realisation of the reproductive health rights of the San women without discrimination. The jurisprudence developed by the judiciary in the realisation of reproductive health and rights will form part of the discussion in chapter four.

2.11 CONCLUSION

This chapter began by unpacking the intersectionality theory and attempted to bring out its relevance to the study. In unpacking the intersectionality theory, other factors related to the intersectionality theory, such as contextualising the theory in Africa, its application in human rights frameworks were also discussed. The chapter also discussed the substantive equality theory, affirmative action, its application in human rights law, its interpretation in courts, and its critique. It also attempted to bring out the relevance of the theory to the study. This chapter has also revealed how substantive equality and intersectionality theories help understand the reproductive health and rights of the San women in Zimbabwe. Although this chapter has shown the importance of these two theories in understanding the reproductive health and rights of the Zimbabwean San women, the theories have shortcomings, such as the substantive equality, which focuses on disadvantage removes the possibility of a levelling down option. The intersectionality theory is said to be flawed because the theory has had a broad reach, but not a very deep one, as it appears to be both over and underused to such an extent that it becomes difficult to recognise it in literature.

The next chapter addresses the question: what are the norms and standards existing under regional and international law for realising reproductive health and rights of indigenous women? This was done through exploring international and regional standards on the protection of the reproductive health and rights of women.

[489] *President of Republic of South Africa v Hugo*.

CHAPTER THREE

REGIONAL AND INTERNATIONAL STANDARDS ON REPRODUCTIVE HEALTH AND RIGHTS OF INDIGENOUS WOMEN

3.1 INTRODUCTION

Chapter two discussed the intersectionality and substantive equality theories as frameworks for realising San women's reproductive health and rights. The chapter discussed how these two theories are important and useful in understanding the realisation of San women's reproductive health and rights. This chapter examines indigenous women's reproductive health and rights in the international and regional human rights systems. The research question guiding this chapter is: what are the norms and standards existing under regional and international law for realising reproductive health and rights of indigenous women? Put differently, are there standards and norms in regional and international law that serve as guidelines for realising indigenous women's reproductive health and rights? This question is answered in this chapter through a thorough analyses of different human rights norms and standards that exist in regional and international human rights systems, such as treaties, conventions, general comments, general recommendations, concluding observations, resolutions, reports written by special rapporteurs, reports of working groups on indigenous people as well as communications relating to reproductive health and rights of indigenous women.[490] Further, this chapter ascertains the depth and accuracy of human rights norms and standards that specifically focus on indigenous women's reproductive health and rights.

The chapter begins by giving a background of the origins of reproductive health and rights by discussing the role played by women's movements, population movements, and international conferences in the formulation of reproductive health and rights. It shows how the recognition of reproductive health and rights was advocated for and later birthed in the international human rights system. The chapter also discusses reproductive health and rights in the human rights system as it examines and ascertains the depth and inclusiveness of the provisions on reproductive health and rights in international and regional human rights law. In unpacking this section, the author discusses different human rights themes linked and applicable to reproductive health and rights and shows their relevance to this study. Discussing these rights is important because reproductive health and rights may be applied and protected through specific rights. Indeed, one of the major outcomes and resolutions of the ICPD was the firm

[490] See Fokala E 'The relevance of a multidisciplinary interpretation of selected aspects related to women's sexual and reproductive health rights in Africa' (2013) 17 *Law, Democracy and Development* 117-201.

stance of the fact that "reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents."[491]

An analysis of the different human rights themes applicable to reproductive health and rights was made with the aid of various interpretations by different scholars, general comments, recommendations, concluding observations, resolutions, case law, work of special rapporteurs and working groups on indigenous peoples. The discussion also highlighted whether particular human rights instruments specifically entrench the reproductive health and rights of indigenous women. Where treaties do not specifically speak to indigenous women's reproductive health and rights, the author highlighted how the provisions on reproductive health and rights in different human rights instruments are relevant to indigenous women. In discussing the other human rights applicable to reproductive health and rights, the author highlights the relevance of each discussion to indigenous women and the applicability of the theoretical framework informing this study.

The chapter discusses State obligations *vis-a-vis* reproductive health and rights of indigenous women. As highlighted in chapter one of this study, the definition of women adopted in this study includes girls. Therefore, discussing the different human rights themes applicable to reproductive health and rights will refer to relevant provisions of two child-specific human rights instruments, that is, the Convention on the Rights of Children (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). The last part of the chapter is the conclusion. The conclusion highlights whether there are norms and standards existing in regional and international human rights laws that serve as guidelines for realising reproductive health and rights of indigenous women.

3.2 ORIGINS AND BACKGROUND OF REPRODUCTIVE HEALTH AND RIGHTS

3.2.1 Role of women's movements and population movements

Historically, the formulation of reproductive health and rights as human rights was attained by the women's movement and the population movement.[492] Regarding the women's movement, the origins of reproductive health and rights emanate from the work and meetings of

[491] Paragraph 7.3 ICPD. See also Fathalla MF 'Family Planning Services' (1995) 44: 4 *American University Law Review* 1179.

[492] Mattar LD 'Legal Recognition of Sexual Rights- A comparative analysis with Reproductive Rights' (2008) 8 *Sur-International Journal on Human Rights* 67.

Autonomous, Radical and Socialist feminists held in Europe, with their main focus being on issues related to women, health, and the opening of women's centers.[493] Those meetings gave birth to different women's organisations, for instance, in one of the meetings held in Paris, the International Campaign for Abortion Rights (ICAR) was established and later launched in 1978 in London.[494] The reproductive health and rights terminology was introduced in the meetings and work of those feminists.[495] Such work focused on championing women's reproductive health and rights such as abortion rights and the women's freedom to choose how many children to have and the spacing of the children.[496]

According to the population movement prevalent in the 1960s, if the population growth trend was not changed, the world would experience self-destruction.[497] Hence, studies were conducted on strategies for reducing fertility, which led to the introduction of contraceptives such as the pill and intrauterine devices (IUDs), which are commonly used nowadays.[498] Developing countries that were found discouraging the use of contraceptives became a danger to the human race, leading to interference by the international community.[499] Such interference by the international community was not concerned with women as the primary agents of reproduction but merely with reducing population growth.[500] The introduction of contraceptive methods, which were supposed to be tools relied on by women to exercise their reproductive autonomy, were literarily viewed as devices for exerting control over women instead of being tools for female liberation.[501]

3.2.2 Role of international conferences

International conferences also played a vital role in the fight to recognise women's reproductive health and rights. For example, the right of a woman to decide when to have children or to decide how many children to have was initially explained in the late 1960s during the First

[493] Berer M 'Why reproductive health and rights: Because I am a woman' (1997) 5:10 *Reproductive Health Matters* 18.
[494] Berer M (1997) 18.
[495] Berer M (1997) 18.
[496] Berer M (1997) 19. The advocacy for reproductive health and rights done by feminists was seen in the work of the Campaign for Abortion Rights and Against Sterilization Abuse (CARASA) which in 1979 became a co-founder of the Reproductive Rights National Network which was established with the aim to fight for abortion rights, safe contraception and prevention of sterilisation abuse.
[497] Mattar LD (2008) 67.
[498] Matter LD (2008) 67.
[499] Matter LD (2008) 67.
[500] Matter LD (2008) 67.
[501] Mattar LD (2008) 67.

International Conference on Human Rights, which took place in Tehran in 1968.[502] The basic right of parents to "determine freely and responsibly the number and spacing of their children" was identified during this conference.[503] Other international conferences held during the 1970s and 1980s also confirmed the right of women to choose the spacing of their children and expanded this right to include a broader understanding of reproductive health and rights as consisting of a basic right to "reproductive self-determination and autonomy."[504] This realisation and understanding of the nexus between reproductive freedom and women's autonomy influenced the notion that reproductive health and rights were rooted in basic human rights principles based on human dignity and are endorsed by international law.[505]

Furthermore, during the World Population Conference in Bucharest, Romania, in 1974, developing countries supported the notion that there was a link between a country's level of development and the growth of its population.[506] As a result, these countries claimed that the priority of developed countries to control population growth was a strategy of declaring their supremacy on the international stage concerning addressing population issues in developing countries.[507] Thus, this conference broadened its definition to include couples and individuals to reaffirm the right to reproductive choice.[508] Furthermore, the conference also established that for people to exercise their reproductive health and right, they should have the information, education, and means to do so.[509]

The term reproductive health and rights was created at the International Meeting on Women and Health held in Amsterdam, Holland, in 1984. This term was generated with the conviction that this designation would relay a more complete and adequate concept for the comprehensive agenda of women's reproductive autonomy instead of using the concept "health of women."[510] As a result, the definition of reproductive health and rights began to be developed in a non-institutional framework that dismantled maternity as a duty through the struggle for the right to lawful termination of pregnancies and contraception in developed countries.[511] Thereafter,

[502] Bogecho D 'Putting it to good use: The International Covenant on Civil and Political Rights and women's right to reproductive health' (2004) 13: 2 *Southern California Review of Law and Women's Studies* 234-235.
[503] Bogecho D (2004) 235.
[504] Bogecho D (2004) 235.
[505] Bogecho D (2004) 235.
[506] Mattar LD (2008) 67.
[507] Mattar LD (2008) 67.
[508] Mattar LD (2008) 67.
[509] Mattar LD (2008) 67.
[510] Mattar LD (2008) 67.
[511] Mattar LD (2008) 63.

in attempting to give a more precise definition, scholars began to refine the concept of reproductive health and rights.[512]

Women's rights as human rights were specifically examined at the Fourth World Conference on Women (Beijing Platform), held in Beijing in 1995.[513] The Beijing Platform affirmed the connection between human rights and women's reproductive health and rights and pledged to end discrimination against women as well as practices that affect women's reproductive health such as domestic battering, marital rape, and female genital mutilation/cutting (FGM/C).[514] Most of the discussions at the Beijing platform confirmed the discussions at the ICPD and maintained the assertion that reproductive health and rights are human rights that must be respected and protected regardless of religious and cultural differences.[515] With regard to reproductive health and rights, the ICPD also affirmed the following:

> "Reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[516]

Furthermore, the UN Decade for Women, which was held during the last decade of the 20th Century, marked significant achievements regarding the realisation of women's rights on the international stage.[517] During this era, an essential breakthrough in expanding the understanding of human rights in general and women's rights specifically was made by UN conferences.[518] Notable achievements included the international recognition of women's rights as human rights and the recognition of violence against women as an infringement of human

[512] Mattar LD (2008) 63.
[513] According to Cook RJ and Fathalla MF 'Advancing Reproductive Rights Beyond Cairo and Beijing' (1996) 22:3 *International Family Planning Perspectives* 115, "women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights. After decades of struggle, the right to health has finally been implemented as a human right, and international discussions on health and human rights have openly addressed the importance of women's reproductive health in particular."
[514] Bogecho D (2004) 230. This conference stressed the importance of women to have the right to determine freely all matters related to their reproductive health such as issues regarding childbearing.
[515] Bogecho D (2004) 230.
[516] Paragraph 7.3 ICPD Programme of Action.
[517] Nowicka W (2011) 119.
[518] Nowicka W (2011) 119.

rights (UN Conference on Human Rights, Vienna, 1993).[519] In addition, various other measures were taken and are still taken to mainstream reproductive health and rights within a human rights discourse through the auspices of different UN treaty bodies.[520]

3.2.3 Role of the human rights movement

From the beginning of the human rights treaty system, a plethora of rights protected under the different human rights treaties and conventions were divided into different categories, that is, civil and political rights (first-generation rights), economic, social, and cultural rights (second generation rights) and lastly group rights (third generation rights).[521] However, many studies have revealed that women as a group are still not sufficiently regarded as a priority by some State Parties despite articulating all three categories of human rights.[522] This shows that human rights as a concept of law did not essentially embrace issues around women's rights, such as safe motherhood and other reproductive health and rights, because these issues did not come within the scope of men's practice.[523]

The United Nations (UN) signed the Millennium Declaration in 2000, which had a framework of Eight Millennium Development Goals (MDGs), eighteen targets, and forty-eight indicators that committed leaders globally to fight, poverty, diseases, illiteracy, and discrimination against women by 2015.[524] It is important to highlight that when the General Assembly adopted the Millennium Declaration and, later, the MDGs, there was no explicit mention or commitment to achieve the realisation of the reproductive health and rights of women but there was only a vague promise of achieving gender equality.[525] The inclusion of reproductive health and rights in the MDGs was only done after several years of negotiations that led to the drafting of a global agreement that paved way for an additional target under the MDGs that called on global

[519] Nowicka W (2011) 119.

[520] Nowicka W (2011) 119. For instance, the United Nations Population Fund (UNPF) and UNHCR in 1996, organised a joint expert meeting which was aimed at developing methodologies and strategies for UN treaty bodies to urge State Parties to take required steps to facilitate the realisation of reproductive health and rights by women at national levels. Some of the identified areas for intervention include safe abortion, adolescents' health including their reproductive health and rights as well as HIV/AIDS prevention and treatment services.

[521] Bogecho D (2004) 233.

[522] Bogecho D (2004) 233. See also Diala A 'The concept of living customary law: A critique' (2017) 49 *The Journal of Legal Pluralism and Unofficial Law* 143-165.

[523] Bogecho D (2004) 233.

[524] World Health Organisation 'Millennium Development Goals (MDGs)' available at *https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs)* (accessed 22 may 2021).

[525] Sithole L (2020) 55. Sithole posits that the Declaration made a few references for women. For example, the Declaration said, "Men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice." The Declaration did not make reference to women's freedom to control or regulate family size.

leaders to ensure that there is universal access to reproductive health in their countries.[526] In light of this, MDG 5 was created to focus on "Improving Maternal Health."[527] This MDG specifically mentioned reproductive health in two of its targets.[528] While the timeline for the achievement of the MDGs terminated in 2015, little and uneven progress was made toward meeting the agreed targets on reproductive health.[529]

The General Assembly adopted the 2030 Agenda for Sustainable Development (SDGs) in 2015, which are building on the principle of "leaving no one behind."[530] Reproductive health is mentioned under SDG 3, which aims at "ensuring healthy lives and promoting well-being for all at all ages."[531] Two targets under SDG 3 have a bearing on reproductive health and rights. For example, target 3.7 states that "by 2030, ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes."[532] Target 5.6 buttresses the need to "ensure universal access to sexual and reproductive health and reproductive rights…"[533] Sithole posits that **"**although these targets are commendable as they offer a solid basis for moving forward, they do not offer a comprehensive agenda for sexual and reproductive health and rights (SRHR)."[534]

The discussion above has shown that the issue of women's reproductive health and rights started as a general fight for the recognition of some aspects of women's health, such as the ban on abortion by different States. The discussion has also shown how the introduction of contraceptives that give a woman her reproductive autonomy was used by the international community against developing countries to control population growth, hence controlling women's freedom to make decisions concerning their bodies. This shows that women have always faced discrimination when it comes to the enjoyment of their rights dating from the 1940s. The situation worsens for indigenous women who are often affected by multiple forms of discrimination as their situation/ plight was not specifically addressed and catered for during

[526] Sithole L (2020) 53.
[527] Sithole L (2020) 53.
[528] Target A which aimed "to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015" and Target B which aimed at "achieving universal access to reproductive health by 2015."
[529] Sithole L (2020) 53.
[530] The United Nations adopted the Sustainable Development Goals (SDGs) which are also known as the Global Goals in 2015. These goals were adopted with the intention to do the following: "end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity."
[531] SGD 3, 2030 Agenda for Sustainable Development Goals.
[532] GD 3, Target 3.7, 2030 Agenda for Sustainable Development Goals.
[533] GD 3, Target 5.6, 2030 Agenda for Sustainable Development Goals.
[534] Sithole L (2020) 54.

the fight for the recognition of women's reproductive health and rights under different movements and in international conferences. This is in line with the intersectionality theory, as the discussions above have shown that the non-recognition of indigenous women's specific needs in the advocacy for reproductive health and rights might contribute to the many barriers these women face in enjoying their reproductive health and rights. Indigenous women were treated like any other woman, and one can argue that this failure to focus on the unique characteristics and challenges faced by indigenous women birthed the problems they might be facing today to the enjoyment of their reproductive health and rights is concerned. Furthermore, the discussion above has shown that the fight for the realisation of women's reproductive health as human rights paved a way for recognising such aspects of women's health as human rights that were later entrenched in different human rights instruments.

3.3 REPRODUCTIVE HEALTH AND RIGHTS IN INTERNATIONAL AND REGIONAL HUMAN RIGHTS SYSTEMS

This section discusses the different human rights applicable to reproductive health and rights as provided in provisions of different international and regional human rights instruments. The different human rights discussed are the right to health, the right to life, the right to reproductive autonomy, equality and non-discrimination, and the right to be free from inhumane and degrading treatment. It is important to highlight that the list of these human rights is not exhaustive, but the author focused on the above-mentioned human rights because they are more relevant to the three elements of reproductive health and rights that inform this study, that is, "maternal health; voluntary, informed, and affordable family planning services; and prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS and cervical cancer." In this section, the author discussed the normative content of the different human rights as provided for in the work of treaty bodies,[535] such as general comments,[536] general

[535] There are nine treaty monitoring bodies and these are the Human Rights Committee (HRC), the Committee on Economic Social and Cultural Rights (CESCR),the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), the Committee against Torture (CAT),the Committee on the Rights of Children (CRC), Committee on Migrant Workers (CMW), Committee on the Rights of Persons with Disabilities (CRPD), Committee on Enforced Disappearances (CED) and the Committee on the Elimination of Racial Discrimination (CERD). Treaty monitoring bodies have a role of issuing Concluding Observations and developing General Comments related to the respective conventions or treaties.

[536] General Comments are said to be essentially an accurate interpretive guidance issued by the UN or regional treaty bodies such as the African Commission on Human and People's Rights (ACHPR/ African Commission) to assist States in implementing provisions of different human rights instruments. Under the African Charter, the African Commission is tasked with the mandate of adopting General Comments (which usually come in form of Resolutions).

recommendations,[537] concluding observations,[538] and case law. Reference was also made to the interpretation of the rights by different scholars, special rapporteurs, and working groups on indigenous people. The author linked these rights with the plight of indigenous women. The discussion also highlighted the relevance of the theoretical framework informing this study.

3.3.1 (A) Right to health: International Standards

The right to the enjoyment of the highest attainable standard of physical and mental health was first articulated in the 1946 Constitution of the World Health Organisation (WHO). [539] In addition to recognising the right to health in the WHO Constitution, the right to a standard of living that is adequate to one's health and well-being was also first recognised in Article 25 (1) of the Universal Declaration of Human Rights (UDHR).[540] According to the UDHR, "everyone has the right to a standard of living adequate to the health and well-being of himself and of his family…" Hendriks postulates that a woman's right to reproductive health is essential to a woman's general right to health.[541] Therefore, this shows that the WHO Constitution and UDHR recognise reproductive health and rights even without explicitly referring to them.[542] Although the UDHR and WHO Constitution are not binding on State Parties, they play an important role in the interpretation of what constitutes the right to health.

The right to health is also entrenched in the ICESCR.[543] It is of paramount importance to point out that although the right to health, which includes reproductive health, is found in several human rights instruments, the first human rights instrument to vividly outline and lay down the necessary steps to realise this right was the ICESCR.[544]

The right to health in Article 12 of the ICESCR is provided as follows:

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[537] Some treaty bodies such as CEDAW and CERD issue General Recommendations which are an equivalent of General Comments due to the same jurisprudential weight they carry.

[538] Concluding Observations deal with the positive aspects of a State's implementation of the treaty. They also give Governments recommendations on how to improve the implementation of the given relevant treaty or convention.

[539] Preamble of the WHO Constitution 1946. The WHO Constitution was adopted in June 1946 by the International Health Conference held in New York. This Constitution was signed in July 1946 by representatives of sixty-one States and it entered into force in 1948.

[540] Article 25 UDHR. See also Hannum H 'The status of the universal declaration of human rights in national and international law' (1995) 25: 1 & 2 *Georgia Journal of International and Comparative Law* 289. Although this is a Declaration, it is important because it inspired the drafting of the ICESCR and the ICCPR.

[541] Hendriks A (1995) 1128.

[542] Sithole L (2020) 57.

[543] The International Covenant on Economic, Social and Cultural Rights (ICESCR) was adopted by the United Nations General Assembly, through Resolution 2200A (XXI) in 1966 and came into effect in 1976.

[544] Bogecho D (2004) 236.

"1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child…"[545]

In explaining the normative content of this right, the CESCR, in its General Comment No.14, stated that the right to health is not a right to be healthy, but instead, it is an inclusive right which recognises the social determinants of health.[546] The CESCR also stated that this right contains freedoms and entitlements such as the right to make free and responsible decisions and choices, free of violence, force, and discrimination, concerning one's body, health, and entitlements.[547] In explaining the obligations of the State in fulfilling the right to health as stipulated in Article 12 of the ICESR, Lennox and Stephens posit that although the State cannot protect people against ill health, the State can provide services and create an enabling environment for people to achieve the highest attainable standards of health.[548] This includes ensuring that harmful practices do not interfere with family-planning choices; third parties do not coerce women to undergo harmful cultural practices and action is taken to protect all vulnerable or marginalised categories of people within societies, including women, children and adolescents.[549]

Zimbabwe is a State Party to the ICESCR, therefore, Zimbabwe is obligated to put in measures to protect the right to health of marginalised people, including indigenous women. The author argues that although women, in general, are at risk of being forced to undergo harmful cultural practices, the situation is even worse for indigenous women because indigenous people are treated as second-class citizens.[550] Furthermore, indigenous peoples are always marginalised

[545] Article 12 ICESCR.
[546] Paragraph 8 UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) E/C.12/2000/4.
[547] Lennox C and Stephens C (2013) 4. Paragraph 8 General Comment No. 14.
[548] Lennox C and Stephens C (2013) 4.
[549] United Nations Office of the High Commissioner for Human Rights 'Reproductive rights are human rights: A handbook for National Human Rights Institutions (2014) 113.
[550] Amnesty International UK 'Americas: Indigenous peoples second-class citizens in the lands of their ancestors' available at *https://www.amnesty.org.uk/press-releases/americas-indigenous-peoples-second-class-citizens-lands-their-ancestors* (accessed 26 February 2023).

and face discrimination in countries' laws, making them vulnerable to abuse and violence.[551] These challenges faced by indigenous women, when viewed through an intersectionality lens, can be used to explain the barriers that this category of women face in enjoying not only their reproductive health and rights but broadly, all their rights in general.

The right to health, like any other economic, social and cultural right, such as the right to education and the right to an adequate standard of living, is subject to "progressive realisation and resource availability."[552] According to Article 2 of the ICESCR, "Each State Party undertakes to take steps ... to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant."[553] Thus, in terms of this obligation, even countries with significant resource constraints and dilapidating economies like Zimbabwe must prioritise fulfilling this right to the furthest extent of its capacity within a reasonable time.[554]

Noriega asserts that the right to health can be understood as "a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all."[555] As noted in this assertion, the right to health should be "accessible to all," therefore, this implies that the health system should be accessible to all levels of society including those people living in poverty, dominant ethnic groups and indigenous minority people, men and women living in both urban and rural settings, as well as anyone whom the State assumes responsibility over.[556] Noriega argues that this conceptualisation of the right to health shows that the right to health encompasses a lot of entitlements for human beings and places upon State Parties greater responsibilities to fulfill certain obligations, hence, this right is not equivalent to the right to be healthy, or the right to medical care.[557]

The CESCR has also explained the right to health considering the situation of indigenous peoples. In doing this, the CESCR stated the following:

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[551] Amnesty International UK 'Americas: Indigenous peoples second-class citizens in the lands of their ancestors' available at *https://www.amnesty.org.uk/press-releases/americas-indigenous-peoples-second-class-citizens-lands-their-ancestors* (accessed 26 February 2023).

[552] Noriega AI 'Judicial Review of the Right of Health and Its Progressive Realisation: The Case of the Constitutional Court of Peru' (2012) 1:1 *UCL Journal of Law and Jurisprudence* 169.

[553] See Article 2 of the ICESCR.

[554] Noriega IA (2012) 170.

[555] Noriega IA (2012) 170.

[556] Noriega AI (2012) 169.

[557] Noriega AI (2012) 169

> "In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension..."[558]

The CESCR should be commended for explaining what the right to health in the ICESR is in relation to indigenous peoples considering that most treaty bodies have left behind indigenous peoples in interpreting the standardised content of the right to health entrenched in those treaties. In addition, the mention and consideration of what the right to health calls for indigenous people can go a long way in addressing the possible multiple forms of discrimination that indigenous people face in the enjoyment of this right. In line with the CESCR's explanation of what the right to health within indigenous communities' entails, Zimbabwe has to point out the elements that define what the right to health entails for indigenous people in Zimbabwe and include them in health policies and systems. Furthermore, Zimbabwe, through its Ministry of Health and Child Care (MoHCC), must put in measures that will enable indigenous people such as the San women to enjoy their right to health including reproductive health and rights. Such measures can include having mobile clinics targeting San women only and information on reproductive health in formats and languages understood by these women should be shared in such clinics. Introducing such programmes will be in line with the substantive equality approach, which can play a huge role in alleviating the challenges indigenous women face in accessing their reproductive health and rights.

In addition, the right to health in Article 12(1) of the ICESCR has been interpreted by the CESCR as "an inclusive right" which is not limited to timely and appropriate health care but also extends to focusing on the underlying determinants of health which include access to

[558] Paragraph 27 General Comment No. 14.

health-related information including information on reproductive health, clean, safe and potable water, adequate safe food, and adequate sanitation.[559] Another pivotal aspect of this right is the ability of everyone to participate in all decision-making related to health matters at community, national and international levels.[560] Nghana argues that there is a connection between the HIV/AIDS pandemic in sub-Saharan Africa and the questions of allocation of natural resources, such as the provision of water and the risks and burdens assumed by indigenous people.[561] To buttress this point, he asserts that "if we could cure HIV/AIDS with a clean glass of water, we could not deliver that cure to half the people in sub-Saharan Africa who need help."[562] The author argues that this statement emphasises that the limited access to potable water in most of sub-Saharan Africa where indigenous peoples are found, plays a role in the limited enjoyment of the right to health by indigenous people. Nghana further argues that because the "immune systems of HIV-positive individuals are prone to a wider range of illnesses and diseases, they have a greater requirement for potable water than uninfected individuals."[563] Indeed, this shows a connection between the right to health and other underlying determinants of health, such as access to safe, clean, and potable water. However, indigenous communities fail to enjoy their right to health fully because of lack of access to potable water as in many instances the water sources that indigenous people use for a lot of things are often taken away to provide water for domestic purposes for urban areas.[564] One can argue that since indigenous people in many countries are found in secluded areas, women from those communities usually face challenges in enjoying their reproductive health and rights based on many grounds, such as their social status, gender, and geographical location. From an intersectionality approach perspective, this shows the role played by different forms of discrimination faced by this category of women, which poses barriers to their enjoyment of a number of their rights, including their reproductive health and rights.

Furthermore, the CESCR has proposed a framework that conceptualises the minimum standards for delivering on the right to health: "availability, accessibility, acceptability and

[559] Paragraph 11 General Comment No. 14.
[560] Paragraph 11 General Comment No. 14.
[561] Nghana L 'An Issue of Environmental Justice: Understanding the Relationship among HIV/AIDS Infection in Women, Water Distribution, and Global Investment in Rural Sub-Saharan Africa' (2009) 3:1 *Black Women, Gender + Families* 43.
[562] Nghana L (2009) 43.
[563] Nghana L (2009) 43.
[564] Nakashima D and Chiba M 'Water and indigenous peoples' in Knowledges of Nature 2, UNESCO (ed), *Water and Indigenous People* (2006) 12.

quality."[565] Availability implies that health services should always be available to everyone on an equal basis, including adequate provision of health facilities, trained health personnel, and essential medicines.[566] Therefore, in the situation of indigenous peoples such as the San community in Zimbabwe, for them to fully access their right to health, there must be nearby hospitals to serve them, and their traditional medicines must be included in the medicines they receive in health facilities. Furthermore, accessibility implies that health services must be reachable to everyone without discrimination.[567] To achieve this, services must be made financially and physically affordable to everyone.[568] Accessibility is divided into four coinciding dimensions, and these are non-discrimination,[569] physical accessibility,[570] economical accessibility,[571] and information accessibility.[572]

Acceptability requires that healthcare services be provided in a way that is consistent with cultural and linguistic rights, for instance, by providing services that are sensitive to different cultural beliefs and practices and delivering such services in local languages.[573] Agejo asserts that most indigenous peoples are less educated and culturally different from their non-indigenous counterparts.[574] In light of the above, there is a need to embrace intercultural health practices that demand the development and fusion of health models and best practices that link indigenous and western medicine, with complementary practices.[575] Quality means that health services and goods must be culturally acceptable, scientifically, medically appropriate, and exceptional.[576] To achieve this, there must be the presence of trained medical professionals, scientifically certified and unexpired drugs, adequate and functioning hospital equipment, different and safe contraceptive methods, clean, safe, and potable water, as well as adequate

[565] Lennox C and Stephens C (2013) 5.
[566] Lennox C and Stephens C (2013) 5.
[567] Lennox C and Stephens C (2013) 5.
[568] Lennox C and Stephens C (2013) 5.
[569] Non-discrimination implies that reproductive health facilities, goods and services must be accessible to all, especially the most marginalised sections of the population.
[570] Reproductive health facilities and services must be geographically and physically reachable for all categories of people especially marginalised groups, such as women and those living in abject poverty.
[571] Economic accessibility (affordability) means that reproductive health facilities and services must be affordable for everyone. Therefore, payment for reproductive healthcare services must be based on the principle of equality and ensuring that these services are affordable for everyone including socially disadvantaged groups.
[572] Information accessibility involves the right to seek, receive and impart information and ideas related to reproductive health matters. However, this does not mean that personal data should be shared with everyone without indigenous peoples' consent, such information should continue to be treated with confidentiality.
[573] Lennox C and Stephens C (2013) 5.
[574] Agejo PA (2018) 373.
[575] Inter-Agency Support Group on Indigenous Peoples' Issues (IASG) (2014) 5.
[576] United Nations Office of the High Commissioner for Human Rights (2014) 84.

and safe sanitation.[577] Indigenous peoples often have other priorities and perceptions of health.[578] These perceptions can originate from the traditional cultural beliefs that indigenous peoples possess about health and well-being, as well as different customary practices related to health care.[579] Therefore, to achieve better equity in health outcomes in such circumstances, these different attitudes and beliefs must be considered in developing policies and providing services.[580]

The right to health of adolescents is provided for in Article 24 (1) of the Convention on the Rights of the Child (CRC) as follows:

> "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health…"[581]

The normative content of this right proves that the recognition of this right creates the obligation for States to take the appropriate measures to develop and implement an effective health care system for all children.[582] This recognition is expressed in the obligation of States to "strive to ensure that no child is deprived of his or her right to access to health care services and to achieve the full realisation of the right to enjoy the highest attainable standard of health."[583] This right has been traditionally understood as an "inclusive" right that extends beyond protection from immediately identifiable violations such as limited access to health care or healthcare services.[584]

Regarding the right to health of adolescents, the CRC, in its General Comment No. 4, states that "adolescent health should be prominent in States' policies to promote reproductive rights."[585] In relation to STIs, the Committee asserts that "goods and services necessary to prevent and treat them should be provided, taking into account the need to overcome taboos

[577] United Nations Office of the High Commissioner for Human Rights (2014) 84.
[578] Lennox C and Stephens C (2013) 6.
[579] Lennox C and Stephens C (2013) 7.
[580] Lennox C and Stephens C (2013) 7.
[581] Article 24(1) CRC.
[582] Doek J 'Children's Rights in Health Care and the General Principles of the CRC' in Dorscheidt JHMM and Doek JE (eds) *Children's rights in health care* (2018) 49.
[583] Doek J (2018) 49.
[584] UN Office of the High Commissioner of Human Rights (OHCHR) and World Health Organization (WHO) 'The Right to Health Fact Sheet No. 31.' Available at *www.ohchr.org/Documents/Publications/Factsheet31.pdf* (accessed 28 February 2021).
[585] See Paragraph 5-8 UN Committee on the Rights of the Child (CRC), General comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, CRC/GC/2003/4.

and barriers."[586] In line with this, States are also mandated to develop strategies for reducing maternal morbidity and mortality in adolescent girls, specifically caused by early pregnancy and unsafe abortions, and those strategies should support adolescent parents.[587] The Committee should be applauded for taking into consideration issues that might be of particular concern to adolescent girls in relation to the CRC provision on the right to health.

However, it is crucial to point out that this analysis by the Committee, which does not specifically refer to adolescent girls from indigenous minorities, further contributes to the discrimination that they already face in the enjoyment of their reproductive health and rights, taking into account that they are different from other adolescent girls and issues affecting other adolescent girls might not apply to their situation as their situation can be worsened by the fact that they belong to indigenous minority populations. Furthermore, there is evidence that lack of access to reproductive health services and contributing factors such as economic, social, and sexual exploitation, expose indigenous female adolescents to HIV/AIDS.[588] Moreso, there is a long history of mistrust of health services from indigenous people affected by HIV, and this mistrust has led to poor access to health care, late testing for HIV, and poor or no care and support for people living with HIV.[589]

In interpreting the content of Article 24, the CRC, in its General Comment No. 15, states the following:

> "The care that women receive before, during and after their pregnancy has profound implications for the health and development of their children. Fulfilling the obligation to ensure universal access to a comprehensive package of sexual and reproductive health interventions should be based on the concept of a continuum of care from pre-pregnancy, through pregnancy, childbirth and throughout the post-partum period…"[590]

Zimbabwe is a state party to the CRC,[591] therefore, Zimbabwe is obligated to ensure that girls from any background within the country, including those from indigenous communities such as the San community, have access to a complete package of reproductive health services when needed.

[586] Paragraph 27 General Comment No. 4 CRC.
[587] Paragraph 27 General Comment No. 4 CRC.
[588] IASG (2014) 4.
[589] IASG (2014) 4.
[590] Paragraph 53 UN Committee on the Rights of the Child (CRC) General Comment No 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Art. 24),2013, CRC/C/GC/15.
[591] Zimbabwe ratified the CRC on 11 September 1990.

The specific protection of indigenous peoples' right to health is stipulated in the ILO Convention No. 169 (ILO Convention).[592] The right to health in the ILO Convention is guaranteed in Article 25, which states that "Governments shall ensure that adequate health services are made available to the peoples concerned."[593] This instrument further notes that healthcare services for indigenous peoples shall be "planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines."[594] These provisions show international dedication to realise the right to health of indigenous peoples. Therefore, in ensuring the realisation of the right to health of San women, including their reproductive health and rights, Zimbabwe has a duty to ensure that it gives San women special treatment compared to other women by acknowledging their economic situation, geographic location, social and cultural conditions.

Lennox and Stephens postulate that in matters relating to the health of indigenous peoples, the UNDRIP is very detailed as most of its articles have a significant bearing for the right to health and well-being of indigenous peoples.[595] For example, Article 24 of the Declaration recognises indigenous peoples' right to health, including their "use of traditional medicines and to maintain their health practices."[596] The same provision also recognises indigenous peoples' right to enjoy their highest attainable physical and mental health standard.[597] Articles 31 and 24 of the UNDRIP, protect the right to health of indigenous peoples by taking into consideration the use of their traditional medicines.[598]

Lennox and Stephen argue that one of the most promising and effective ways in which the indigenous peoples' right to health can be promoted is in developing intercultural health programmes for both minorities and indigenous peoples. Such programmes can include: the capacitation of allopathic or western-trained medical staff about indigenous health practices and remedies; the training of indigenous and minority community members in allopathic medicine; incorporation of traditional healers from minority and indigenous communities into

[592] The ILO Convention No.157 promoted an assimilationist approach. In the years following its adoption, the limitations of this Convention became evident and indigenous peoples called for new international standards. This led to the ILO Convention No. 169 which establishes a protection of indigenous peoples under international law. This Convention has provided a basis for the development of policies and programmes involving indigenous peoples by several international organisation.
[593] Article 25 ILO Convention No.169.
[594] Article 25 (2) Convention No.169.
[595] Lennox C and Stephens C (2013) 2.
[596] Article 24 UNDRIP.
[597] Article 24 UNDRIP.
[598] Article 31 UNDRIP.

allopathic health services; and the incorporation of traditional medicines and practices into health services.[599] Even if there is a suggestion to develop such programmes, it is important to point out that there are still challenges in achieving the right to health for minorities and indigenous peoples.[600] For instance, one of the challenges for achieving reproductive health and rights of indigenous women is that the cultural background of gender roles assigned to indigenous women blinds them from enjoying their right to maintain good reproductive health.[601]

Although the Declaration does not have specific provisions on reproductive health and rights of indigenous peoples, it can be commended for having provisions describing the right to health of indigenous peoples that take into consideration indigenous peoples' beliefs and cultural systems. The provisions in the Declaration reflect the international commitment to protect and advance the right to health of indigenous peoples, of which reproductive health and rights are an essential part.

3.3.1(B) Right to health: Regional Standards

The African Charter, in its Article 16, presents the first attempt to guarantee the right to health in the African human rights system.[602] Article 16 of the Charter provides the following:

> "1. Every individual shall have the right to enjoy the best attainable state of physical and mental health
>
> 2. State Parties to the present Charter shall take the necessary measures to protect the health of their people…" [603]

This provision implies that for individuals to enjoy their right to health, States must adopt certain measures to make the enjoyment of this right a reality for everyone. For instance, States must ensure that everyone, including those with little or no money, have access to appropriate and adequate medical care if they fall ill.[604] Moreover, this right mandates State Parties to identify categories of people facing greater risks, such as all categories of women, including

[599] Lennox C and Stephens C (2013) 2-3.
[600] Lennox C and Stephens C (2013) 3.
[601] Agejo PA (2018) 384.
[602] Durojaye E (2013) 397.
[603] Article 16 ACHPR.
[604] Amnesty International 'A guide to the African Charter on Human and Peoples' Rights 'available at *https://www.amnesty.org/download/Documents/76000/ior630052006en.pdf* (accessed 11 March 2021).

indigenous women, children, the poor, detainees, and prisoners, and ensure that they have access to special health protection that will deal with their particular health problems.[605]

Balogun and Durojaye posit that when it comes to realisation of the right to health in Africa, "it is a known fact that pregnant women in many African countries lack basic access to common drugs or medicines such as pain killers and this often worsens their problems during pregnancy."[606] Marginalised women, including indigenous women, are at a disadvantaged level in the economic, social, and political worlds; therefore, it is crucial to adopt a substantive equality approach when reform efforts are undertaken on their behalf so that their needs are met. The author argues that if reform efforts are undertaken without acknowledging that indigenous women are different from their counterparts, indigenous women will suffer the most when it comes to allocation of medicines when they are pregnant as they often fail to access health services due to lack of funds to cater for their hospital bills and being situated far from health facilities.

Despite the shortcomings of the right to health entrenched in Article 16 of the African Charter, it is of paramount importance to note that the African Commission established a Working Group on Indigenous Populations/Communities as one of its special mechanisms to deal with the human rights challenges experienced by indigenous people in Africa.[607] Although this Working Group has recorded human rights challenges encountered by indigenous people, it is yet to conduct detailed research on the barriers relating to the enjoyment of the right to health of indigenous peoples.[608]

Article 14 of the African Women's Protocol has one of the most detailed provisions on women's reproductive health.[609] For example, Article 14 (1) provides that:

> "1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
>
> a) the right to control their fertility;

[605] Amnesty International 'A guide to the African Charter on Human and Peoples' Rights available at *https://www.amnesty.org/download/Documents/76000/ior630052006en.pdf* (accessed 11 March 2021).
[606] Balogun V and Durojaye E 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights' (2011) 11 *African Human Rights Law Journal* 382.
[607] This Working group was established by the African Commission with the adoption of Resolution 51 at the 28th Ordinary Session of the African Commission which was held in Benin from the 23rd of October to the 6th of November 2000.
[608] Durojaye E (2013) 397.
[609] Durojaye E (2013) 394.

b) the right to decide whether to have children, the number of children and the spacing of children;

c) the right to choose any method of contraception;

d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;

e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;

f) the right to have family planning education."[610]

With these progressive and comprehensive provisions, the African Women's Protocol has recorded a number of successes under international human rights law.[611] The rights to control one's fertility, to choose when and whether to have children, including the number of children to have and the spacing of births, as well as choosing a contraception method, are linked, interdependent and indivisible.[612] Agejo argues that Article 14 of the African Women's Protocol is a significant step for women in Africa, including indigenous women, because little attention has been paid to reproductive health and rights as they have been viewed as culturally sensitive and dominated by patriarchy.[613]

The provisions of the African Women's Protocol are commendable because this is the first human rights instrument to guarantee a woman's right to self-protection in the context of HIV.[614] Although the Maputo Protocol differentiates between the right to self-protection and the right to be protected from HIV, this provision is interpreted to refer to "States' overall obligation to create an enabling, supportive, legal and social environment that empowers women to be able to fully and freely realise their right to self-protection and to be protected."[615] According to the African Commission, a woman's right to self-protection and the right to be protected are connected to other women's rights, such as the right to equality and non-discrimination, the right to life, the right to human dignity, the right to health and the right to

[610] Article 14 (1) Women's Protocol.
[611] Durojaye E (2013) 398.
[612] Paragraph 23 General Comment No. 2 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[613] Agejo PA (2018) 384.
[614] Durojaye E (2013) 398.
[615] Paragraph 11 General Comments No.1 on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

be free from all forms of violence. Hence, if these rights are violated, a woman's ability to claim and realise her right to self-protection will be negatively impacted on.[616]

The Maputo Protocol urges States in Article 14 (2) to:

> "a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
>
> b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
>
> c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[617]

In articulating the States' obligations imposed by this provision, the African Commission highlighted that it is important to ensure the availability, accessibility (both financial and geographical), and the quality of reproductive health services offered to women, without any discrimination prohibited grounds which include age, residence and disability.[618] Furthermore, the African Commission stated that Article 14(2) requires:

> "States to develop laws that are accompanied by administrative appeal and complaint mechanisms which allow women to fully exercise their rights so that they can equip themselves with knowledge and understanding of the procedures and reasons that led them to being denied family planning or contraception services and how to challenge such decisions."[619]

Article 14(2) also places a duty on State Parties to create a national public health plan containing detailed reproductive health services, protocols, guidelines, and standards that align with those developed by WHO and treaty monitoring bodies.[620]

The discussion above shows how the African Women's Protocol has gone a long way to cover the gaps in the African Charter. The author also observes that the African Women's Protocol's provision on reproductive health and rights is more comprehensive than other international instruments. The discussion has also revealed that the African Women's Protocol in its provisions is silent on the reproductive health and rights of indigenous women, and this is a

[616] Paragraph 11 General Comment No. 1 African Women's Protocol.
[617] Article 14 (2) Maputo Protocol.
[618] Paragraph 29 General Comment No. 2 African Women's Protocol.
[619] Paragraph 29 General Comment No. 2 African Women's Protocol.
[620] Paragraph 30 General Comment No. 2 African Women's Protocol.

shortcoming in the realisation of indigenous women's reproductive health and rights, considering that this Protocol was drafted to remedy the gaps in the African Charter which also did not have laudable provisions on indigenous women's reproductive health and rights.

The right to health in the African Charter on the Rights and Welfare of the Child (ACRWC) is entrenched in Article 14, which provides the following:

> "1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
>
> 2. State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
>
> (a) to reduce infant and child mortality rate;
>
> (e) to ensure appropriate health care for expectant and nursing mothers; …"[621]

This provision is commendable because it incorporates reproductive health elements such as the right to safe maternal healthcare services and the duty of States to warrant the reduction of infant and child mortality rates.[622] Achieving the reduction of infant and child mortality rate is impossible if women cannot access safe maternal health care services.[623] For example, ensuring that women of reproductive age access family planning can limit high-risk births, reducing the chances of giving birth to a baby that will lose its life in infancy.[624] A thematic paper by the Inter-Agency Support Group on Indigenous Peoples' Issues (IASG) highlighted that to enhance the maternal health of indigenous women and girls, there is a need to introduce cost-effective interventions in the form of increased access to family planning services, skilled and trained birth attendants and emergency obstetric care.[625] However, Article 14 has been criticised for failing to address the issue of quality care in that it did not regularise any minimum standard of quality of care for the health issues the State is supposed to undertake.[626] This, therefore, means that a State can get away with just providing minimum quality of care to its children and argue that it is its best attainable state of health.[627]

[621] Article 14 ACRWC. Article 21 ACRWC is also relevant to this discussion as this article emphasises the need to heighten and tighten the protection of the girl-child's sexual and reproductive autonomy by eliminating harmful cultural practices such as child marriage and the betrothal of girls.
[622] Sithole L (2020) 80.
[623] Sithole L (2020) 80.
[624] Sithole L (2020) 80.
[625] IASG (2014) 1.
[626] Ekundayo O (2015) 151.
[627] Ekundayo O (2015) 151.

The African Commission, upon realisation of the threats that the HIV/AIDS pandemic poses to millions of people in Africa and the associated human rights challenges raised by the pandemic, issued a resolution urging African countries to adopt a HRBA to addressing the impact of HIV/ AIDS in Africa.[628] According to the Commission, all the efforts made by African governments towards minimising the spread of HIV must be respectful of individuals' human rights.[629]

Furthermore, with regard to maternal health, this resolution provides as follows:

> "1. Adopt human rights-based approaches in the formulation of country programs and strategies to reduce maternal mortality in Africa."[630]

In meeting this obligation, State Parties should ensure that women participate in the formulation of such strategies and policies, promote non-discrimination in the provision of funding to come up with programmes to address maternal mortality, ensure the provision of well-supplied maternity centers in rural areas, and employment of skilled health workers and birth attendants at rural and semi-urban areas, among other interventions.[631] This resolution is welcome as it takes an approach that includes women in issues affecting them. Therefore, the author believes that if a substantive equality approach is adopted in drafting frameworks and policies related to reproductive health, all categories of women, including indigenous women will be manage to enjoy their rights and the situation of indigenous women can be improved. Agejo argues that to improve indigenous women's maternal health, indigenous women require financial help, employment, and to be included in decision-making positions in local groups.[632] Furthermore, indigenous women's participation in defining priorities, resource mobilisation, planning, access to resources, implementation and sharing of benefits and evaluation of the implementation level are significant to them and other non-indigenous women living in better conditions.[633] Balogun and Durojaye assert that despite initiatives such as introducing resolutions dealing with maternal health of women, there is a need to promote and protect the reproductive health and rights of Africans, particularly African women.[634] This is so because the enjoyment of reproductive health by African women has remained a serious challenge.

[628] Paragraph1-2 Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity adopted at the 29th ordinary session of the African Commission held in Tripoli, Libya, ACHPR Res.53/ (XXIX) 01.
[629] Paragraph 2 Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity.
[630] Paragraph 2 Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity.
[631] Paragraph 2 Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity.
[632] Agejo PA (2018) 376.
[633] Agejo PA (2018) 376-377.
[634] Balogun and Durojaye E (2011) 380.

African women continue to be marginalised, vulnerable and rendered helpless and hopeless in matters relating to their reproductive well-being because of many factors, such as extreme poverty, patriarchal attitudes, and discrimination.[635] In the substantive equality theory, poverty is seen as a sex equality issue because women's poverty is said to be a manifestation of persistent discrimination against women.[636] Poverty affects women in general and certain groups, such as indigenous women. It worsens every form of social and sexual inferiority that women experience.[637]

The recommendations in this resolution are commendable because, like the UNDRIP, they consider using traditional medicines that are often relied on by indigenous peoples. Thus, if governments implement the indigenous peoples' concept of health, it can improve their enjoyment of their right to health, including reproductive health and rights. Furthermore, the prohibition on limiting or denying access to medicines to marginalised communities is a great stride in advancing the right to health of indigenous communities who are considered as a marginalised group.

This discussion has revealed that the regional human rights instruments discussed above do not have provisions that specifically provide for reproductive health and rights but this right is premised on the right to health. It is important also to highlight that although the right to health is recognised in regional human rights instruments, those instruments do not specifically entrench the right to health, including reproductive health and rights of indigenous people. This shortcoming has a potential of exacerbating the challenges faced by indigenous people in enjoying their right to health at national level as it would be difficult for State Parties to enact legislation specifically focusing on the right to health of indigenous people if there is no inspiration from the regional level to do so. It is also of great importance to also mention that although indigenous people rely on the protection of their right to health entrenched in the regional human rights instruments discussed above, indigenous people face a lot of challenges that hinder them from exercising their right to health on the same level with non-indigenous people.

3.3.2 Right to reproductive autonomy

[635] Balogun and Durojaye E (2011) 380.
[636] Brodsky G and Day S 'Beyond the social and economic rights debate: Substantive equality speaks to poverty' (2002) 14 (1) *Canadian Journal of Women and the Law* 188.
[637] Brodsky G and Day S (2002) 188.

Reproductive autonomy is defined as the right of women to choose whether to have children, and if so, the right to determine the number of children they want, the spacing of children, and the freedom to choose who to have children with.[638] Reproductive autonomy is also understood as the freedom of women to choose the means and methods of exercising their choices regarding fertility management.[639] Maheshwari asserts that some of the most fundamental determinants of whether a legal system guarantees reproductive autonomy to women within that legal system are access to contraceptives, access to reproductive and maternal health care, access to pregnancy termination services, and access to economic resources.[640] When viewing the different challenges indigenous women face from an intersectionality lens, there are high chances that they can also be forced or threatened to make involuntary decisions relating to their reproductive health and may end up going through abortions and forced sterilisation.

Fathalla, asserts that the full enjoyment of women's right to health, well-being, and quality of life, is crucial to empower women with the capacity to manage and control their fertility. This is because a woman incapable of regulating and controlling her fertility cannot be regarded as being in a state of complete physical, mental and social well-being.[641] Therefore, a woman in such a position remains disadvantaged because she cannot enjoy privileges such as experiencing the joy of a planned and wanted pregnancy, avoiding the stress that comes with an unwanted pregnancy, planning her life, pursuing her education and undertaking a productive career.[642] Hence, empowering women to manage and control their fertility is a requirement for the enjoyment of other socio-economic rights.[643]

Article 16(1) (e) of the CEDAW asserts that women's equality is linked to their capacity to determine the number and spacing of their children.[644] Article 16 (1) (e) of CEDAW provides that:

> "1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

[638] Maheshwari S 'Reproductive Autonomy in India' (2017) 11 *NALSAR Student Law Review* 31.
[639] Maheshwari S (2017) 31.
[640] Article 25 CRPD.
[641] See the definition of health in the WHO Constitution. See also Fathalla MF (1995) 1180.
[642] Fathalla MF (1995) 1180.
[643] Fathalla MF (1995) 1180.
[644] Miller AM and Roseman MJ (2011) 106. See Article 16 CEDAW.

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights…"[645]

In commenting on the above provision of CEDAW, Sithole postulates that "women's right to full and free exercise of their reproductive functions, including the right to decide whether to have children or not, must not be limited by a spouse or government, and women must also be guaranteed access to information about safe contraceptive methods, sex education and family planning services."[646]

It is important to highlight that, at times, rights may conflict with certain laws, especially laws regulating the minimum age to marry, which may prevent early family formation. However, such laws might be justified to promote maternal survival and the formation of families later in the reproductive life span.[647] Early marriages are linked to harmful cultural practices such as Female Genital Mutilation (FGM) that can affect women's reproductive health. It is estimated that "between 100 and 140 million women alive today have been subjected to FGM/C, while an estimated fifteen million girls marry before the age of eighteen years each year and nearly one in three women has experienced physical or sexual intimate partner violence."[648] The SDGs have confronted these issues. For instance, under Goal 5 which focuses on attaining gender equality, Target 5.2[649] calls for the "elimination of all forms of violence against all women and girls" and Target 5.3[650] aims to "eliminate all harmful practices such as early child and forced marriage as well as FGM/C." Agejo asserts that indigenous women suffer from domestic violence, sexual abuse, and rape like all other women and a lot of these violations go unreported since indigenous women live in hard to reach areas of most countries.[651]

Therefore, Zimbabwe has a duty to ensure that adolescents, especially those from indigenous communities who are vulnerable to extreme poverty, are not taken advantage of by being forced into marriages as a way to cure their poverty. In addition, since most rural areas in Zimbabwe where the San community is found are still patriarchal in nature, Zimbabwe must ensure that patriarchy is addressed, and women are given an opportunity to determine the number of

[645] Article 16 (1) (e) CEDAW.
[646] Sithole L (2020) 66.
[647] Cook RJ and Fathalla MF (1996) 120.
[648] World Health Organisation 'Health in 2015 from MDGs to SDGs' available at *https://apps.who.int/iris/bitstream/handle/10665/200009/9789241565110_eng.pdf* (accessed 15 May 2021).
[649] See Target 5.2 2030 Agenda for Sustainable Development Goals.
[650] See Target 5.3 2030 Agenda for Sustainable Development Goals.
[651] Agejo PA (2018) 374.

children they want to have including when they wish to have children.[652] This decision should not be left at the hands of the men who are considered to be the head of their homes.

Furthermore, the ACRWC specifically proscribes in Article 21 (2) child marriages which negatively impact young girls' ability to exercise and enjoy their right to reproductive autonomy. Article 21 (2) states the following:

> "Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory."[653]

This provision is of paramount importance because it protects children's and particularly, in the context of this thesis, the girl-child's reproductive autonomy by entrusting the girl-child with the power to choose when to get married and when to have children and their spacing.[654] Giving girls the power to exercise their reproductive autonomy by allowing them to decide when to get married is a major step in realising their reproductive health, considering that girls face discrimination on the grounds of their age and gender.[655] Although this provision does not specifically address children from indigenous minority groups, it still provides protection for them.[656] This is a major step in addressing the many forms of discrimination they face based on their age, gender, ethnicity, social status and geographical location. This shows the relevance of the intersectionality theory in understanding the plight of indigenous girls in accessing reproductive health and rights.

3.3.3 Right to life

The right to life applies to reproductive health and rights. This is revealed by the fact that although the ICCPR does not specifically refer to the right to health, it instead entrenches certain important rights that are relevant to the right to health such as the right to life.[657] The right to life was first mentioned in Article 3 of the UDHR, which provides that "everyone has

[652] According to Southern Africa Research and Documentation Centre 'San people in southern Africa demand end to social exclusion' available at *https://www.sardc.net/en/southern-african-news-features/san-people-in-southern-africa-demand-end-to-social-exclusion/* (accessed 28 February 2023), some of the challenges faced by the San community include shifts in health, fertility and mortality patterns.
[653] Article 21(2) ACRWC.
[654] Sithole L (2020) 80.
[655] This is in sync with Article 4(2) of the ACRWC specially the aspect of strengthening a girl-child's autonomy and decision-making ability.
[656] See Article 4(2) ACRWC.
[657] See Article 6 (1) and 9 (1) ICCPR. See also Bogecho D (2004) 241.The ICCPR like the ICESCR was adopted in 1966 and entered into force in 1976. The ICCPR deals particularly with civil and political rights, such as the right to equality, the right to a fair trial, the right to life and the right to privacy among others.

the right to life, liberty, and security of person."[658] Furthermore, the right to life is also entrenched in Article 6 (1) of the ICCPR, which states, "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."[659] Bogecho argues that the expression "inherent right to life" cannot properly be comprehended in a restrictive manner as the realisation of this right mandates State Parties to adopt positive measures. In the words of the Human Rights Committee (Committee/ HRC) "the measures taken by the States should aim to reduce infant mortality and to increase life expectancy."[660] The HRC's sentiments reveal that when dealing with the right to life, the health of a population is a factor that should be taken into consideration.[661] Therefore, Governments must be held liable for infringing the right to life if they fail to reduce the maternal mortality rates in their countries.

Ngwena posits that several African countries have been at the receiving end of Concluding Observations that implicate restrictive abortion laws as catalysts or incentives for unsafe abortion.[662] For instance, in the Concluding Observations made to Gambia, the HRC raised concern over the criminalisation of abortion even in circumstances where the pregnant woman's life is threatened, or the woman's pregnancy is a result of rape.[663] In addition, the HRC in its Concluding Observations made to Kenya noted the high mortality rate that negatively impacted the right to life and derives partly from the prevalence of unsafe and illegal abortion.[664] The HRC recommended that Kenya review its abortion laws to bring them in conformity with the ICCPR.[665] Commenting on the high maternal mortality rates among indigenous women, a thematic paper by the IASG highlighted that the maternal mortality rates are considerably high among indigenous women, and there is evidence of low usage of voluntary contraceptives.[666]

Article 6 of the CRC protects the right to life, which urges State Parties to recognise that "every child has the inherent right to life."[667] Cook and Fathalla argue that this provision provides room

[658] Article UDHR.
[659] Article 6 (1) ICCPR.
[660] Bogecho D (2004) 240.
[661] Bogecho D (2004) 240.
[662] Ngwena CG 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' 4 (2010) 4:32 *Human Rights Quarterly* 792. See also Concluding Observations of the Human Rights Committee: The Gambia U.N. Doc. CCPR/CO/75/ GMB (2004).
[663] Ngwena CG (2010) 792.
[664] Ngwena CG (2010) 792.
[665] Ngwena CG (2010) 793.
[666] IASG (2014) 3.
[667] Article 6 CRC.

to hold Governments liable for their failure to achieve notable reductions in maternal mortality rates nationally.[668] To rely on human rights as a basis for holding a Government liable for the high maternal mortality rates within a particular community, it is important first to understand the causes of maternal mortality in that community.[669] The right to life may be invoked in addition to other rights discussed in this chapter if the causes are many and take different dimensions.[670]

Article 12 of CEDAW, is also related to the right to life. Cook and Fathalla also posit that failure to have effective means of birth control puts a woman's life and health in danger as all pregnancies and births carry different health risks, which increase when pregnancies are too early, too late, too closely spaced, or unwanted.[671] Thus, without much care, women who give birth when they are below the age of eighteen years are at a great danger of dying during delivery compared to women above that age. In order to reduce maternal deaths and increase safe motherhood, there is a need for detailed reproductive health-care, including access to contraceptive services and requested abortions of high-risk pregnancies.[672]

Article 14 (2) (c) of the African Women's Protocol provides that State Parties shall take all necessary measures to: "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[673] Agejo argues that there are higher morbidity and mortality rates among indigenous women due to lack of access to healthcare services.[674]

The HRC has published General Comments that address reproductive health and rights. For instance, General Comment No. 6 in its paragraph 5 refers to the reduction of infant mortality and increased life expectancy.[675] Therefore, Zimbabwe has a duty to ensure that this instrument's provisions related to reproductive health and rights become a reality for all women in Zimbabwe, including indigenous women such as San women.

[668] Cook RJ and Fathalla MF (1996) 117. The main causes of maternal mortality are complex and they range from lack of contraception or trained birth attendants to women's unequal status in society, which contributes to poor schooling and early marriage.
[669] Cook RJ and Fathalla MF (1996) 117.
[670] Cook RJ and Fathalla MF (1996) 117.
[671] Cook RJ and Fathalla MF (1996) 117.
[672] Cook RJ and Fathalla MF (1996) 117.
[673] Article 14 Women's Protocol.
[674] Agejo PA (2018) 372.
[675] Paragraph 5 UN Human Rights Committee (HRC), CCPR General Comment No. 6: Article 6 (Right to Life), 1982.

The African Commission has issued several Resolutions relating to topical issues affecting the reproductive lives of people in Africa. For example, in 2008, the Commission issued a vital Resolution 135 on maternal mortality.[676] This resolution specifies the need for governments to "ensure that health reforms, policies and programmes should make adequate considerations of the right of poor and rural women to access basic healthcare as enshrined in the Maputo."[677] This is a welcome recommendation because if governments follow it, there will be an improvement in the enjoyment of reproductive health and rights by women in disadvantaged positions if governments adopt a substantive equality approach in drafting policies and laws that address indigenous women's unique challenges and ensures that policies favour those women, they will end up in a better position like their counterparts. In addition, if governments apply a substantive equality approach in allocating a greater percentage to indigenous women in the budget allocated to the health sector, it will increase the government's capacity to cater for the health needs of all their citizens regardless of their ethnicity and geographical location. That will mean that indigenous people such as the San women in Zimbabwe who live in secluded and hard to reach areas will be catered for.

3.3.4 Equality and non-discrimination

The CEDAW provides for reproductive health and rights by having provisions that address non-discrimination, in Article 16 (1) (e) discussed under section 3.3.2. CEDAW addresses discrimination issues linked to cultural practices and beliefs that can affect women's access to reproductive health services. This is evidenced by the wording of its preamble, which emphasises the following: "a change in the traditional role of men, as well as the role of women in society and the family, is needed to achieve full equality of men and women."[678] The reproductive health of indigenous women in many societies is affected by discrimination and harmful traditional practices.[679] Agejo posits that in indigenous communities, women encounter a lot of discrimination compared to men because of their inability to make choices related to whether to carry a pregnancy to full term or not and whether to access certain reproductive healthcare services or not because all this is dependent on consent from their

[676] ACHPR/Res 135 (XXXXIIII) 08: Resolution on Maternal Mortality in Africa.
[677] Paragraph 1 Resolution on Maternal Mortality in Africa.
[678] This provision recognises how detrimental cultural practices such as *lobola, ukungena, kuzvarira, wife inheritance* and early child marriages practised in most African countries such as Zimbabwe may negatively affect women's ability to access reproductive health services.
[679] Agejo PA (2018) 371.

husbands.[680] Furthermore, indigenous men perpetuate the marginalisation of indigenous women in different ways, which end up driving these women into a discriminated state of life.[681]

In addition to guaranteeing equality and the freedom to decide one's family size, CEDAW in Article 12 (1) guarantees non-discrimination in access to health care where it states the following:

> "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[682]

Therefore, State Parties such as Zimbabwe have a duty to ensure that women, including indigenous women, can access maternal health care and family planning services. Zimbabwe also has an obligation to ensure that there is no discrimination in accessing reproductive health services. Suppose discrimination on grounds of one's ethnicity and social status is eradicated, there will be an improvement on the exercise of this right by indigenous women who are often left out because of their ethnicity and social status.

In explaining the States' obligations, CEDAW, in its General Recommendation No. 24, emphasises the obligation of States to prevent all discrimination perpetrated against women in access to health services "throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period."[683] The CEDAW further emphasises that the exercise of eliminating discrimination against women should be done by also paying special attention "to vulnerable and disadvantaged groups, such as indigenous women, migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution and women with physical or mental disabilities."[684] Thus, the CEDAW should be applauded for specifically stating that indigenous women should not be discriminated against in accessing reproductive health services. It is the author's observation from the discussion of the provisions of CEDAW above, that although CEDAW is said to be a women's bill of rights, it has shortcomings that include that it treats all women the same and this can further perpetuate the oppression and discrimination faced by women such as indigenous women in the enjoyment

[680] Agejo PA (2018) 372.
[681] Agejo PA (2018) 374.
[682] Article 12 (1) CEDAW.
[683] Paragraph 2 UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1.
[684] Paragraph 6 CEDAW General Recommendation 24.

of their rights. In addition, CEDAW does not have a specific provision dealing with indigenous women's reproductive health and rights. This shortcoming can also play a role in furthering the marginalisation of indigenous women regarding the realisation of their reproductive health and rights.

The Committee has handled cases brought before it on allegations of violations of different reproductive health and rights of women. For instance, in the case of *Alyne v Brazil*,[685] the Committee found that Brazil had violated its obligation under Article 12 (2) to provide "appropriate services in connection with pregnancy, confinement and the post-natal period by failing to provide proper obstetric care following the delivery of a stillborn foetus, which led to the death of the mother." [686]The Committee nullified the argument brought by Brazil that Brazil was free from the responsibility for the death of the victim due to the fact that the service provider was a private enterprise.[687] This was a case of triple discrimination where the Committee found the victim to have been discriminated against on several grounds, such as her sex, ethnicity, African descent, and poor socio-economic background.[688]

The decision of the Committee can be adopted as a best practice in the context of Zimbabwe, where Zimbabwe must be alive of the fact that Zimbabwe can be held liable for violations of reproductive health and rights in private health institutions. This case is also helpful in showing how multiple forms of discrimination intersect and lead to the failure of Black women to enjoy their reproductive health and rights. Indigenous women can face this discrimination, and it can take multiple forms that cannot be experienced by other Black women.

Furthermore, the Committee has tackled cases dealing with discrimination of women enjoying their right to health which includes their reproductive health and rights through its General Recommendation No. 15.[689] This General Recommendation enjoins State Parties to create programs to combat AIDS, paying attention to both the rights and needs of women as well as the factors relating to their reproductive role and their impotent position in society, which makes them vulnerable to HIV infection.[690] The Committee recommends active participation of women in primary health care and amplifying their role as care providers to enhance their

[685] *Alyne Da Silva Pimentel v. Brazil* CEDAW/C/49/D/17/2008.
[686] *Alyne Da Silva Pimentel v. Brazil.*
[687] *Alyne Da Silva Pimentel v. Brazil.*
[688] *Alyne Da Silva Pimentel v. Brazil.*
[689] CEDAW General Recommendation No. 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS) U.N. Doc. A/45/38 (1990).
[690] Paragraph (b) CEDAW General Recommendation No. 15.

position as women in the prevention of infection from HIV.[691] For indigenous women not to be left out, there is a need for participation that specifically targets them. This will be in line with the substantive equality theory, which has participation as one of its objectives. In relation to indigenous women, participation refers to the inclusiveness of such women in political and other areas of decision-making where they have traditionally been absent.[692]

Fathalla postulates that the need to eliminate discrimination against women in the field of health, more specifically in reproductive health matters, is rooted in the fact that motherhood should be a distinguished, informed, and responsible choice.[693] Thus, fertility by choice will amount to nothing when societies allow women only one choice: childbearing and making children, the only goods they can produce and are expected to deliver.[694] Women often face discrimination in the society because of their reproductive subordination.[695] As a result, women in most societies experience the psychological and social burden of infertility because a woman's status is often associated with her fertility, and failure to have children can be seen as a social disrepute or a cause for divorce.[696] Indigenous women are not left out of these challenges faced by their non-indigenous counterparts.

Furthermore, Cusack and Cook postulate that in the reproductive health context, it is important that Articles 2(f) and 5(a) of CEDAW are read together with Article 12.[697] The two articles entrench the States' obligations to eradicate wrongful gender bias. Article 5(a) of CEDAW requires State Parties to take all appropriate measures to:

> "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."[698]

On the other hand, Article 2(f) requires States "to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs, and practices that

[691] Paragraph (c) CEDAW General Recommendation No. 15.
[692] Dupont P 'Human rights and substantive Equality in the adjudication of ethnic practices' (2016) 34:*4 Nordic Journal of Human Rights* 292.
[693] Fathalla MF (1995) 1186.
[694] Fathalla MF (1995) 1186.
[695] Fathalla MF (1995) 1188.
[696] Fathalla MF (1995) 1188.
[697] Cusack S and Cook R J 'Stereotyping women in the health sector: Lessons from CEDAW' (2009) 16:1 *Washington and Lee Journal of Civil Rights and Social Justice* 72.
[698] Article 5 (a) CEDAW.

constitute discrimination against women."[699] Cusack and Cook argue that Article 5(a) of CEDAW is relevant to a preconception or practice that is based on a stereotype related to the inferior or superior position of men or women or a sex-role bias of either sex.[700] On the other hand, Article 2(f) is applicable only upon proving that a law, regulation, custom, or practice enforced a gender role that resulted in discrimination against women. [701] These provisions are important in addressing the plight of indigenous women as they face multiple forms of discrimination in enjoying their rights because of many factors. These factors include their social status, their inferiority as women to men, and the non-recognition of their cultural beliefs in most health-related laws and policies.

Furthermore, Articles 2 to 4 of CEDAW set out the legal, administrative, and otherwise measures to be taken by States to abolish discrimination against women in all fields, including the field of health. These provisions include positive discrimination and altering social and cultural patterns of conduct.[702] Hendriks asserts that gender discrimination is caused by factors, such as underestimating or overestimating the importance of women's childbearing capacities, ignorance, prejudice, and misinformation about women's sexuality.[703] MacNaught states that concerning young persons, unequal access to reproductive health information and services by adolescents amounts to discrimination.[704] The CEDAW should be applauded for having provisions outlining specific areas where discrimination against women must be eradicated. These provisions on non-discrimination can be extended to cover indigenous women who are often discriminated against because of many factors, such as that they are women who are considered to belong to powerless and marginalised tribes. They also live in secluded places where important information such as information related to reproductive health is hard to disseminate.

The UN Special Rapporteur on the right to health also elaborated on the content of the right to health and conveyed his perspectives on equality and non-discrimination as fundamental health system characteristics.[705] In the same report, the Special Rapporteur stated that Governments

[699] Article 2 (f) CEDAW.
[700] Cusack S and Cook R J (2009) 72.
[701] Cusack S and Cook R J (2009) 72.
[702] See Articles 2 to 4 CEDAW.
[703] Hendriks A (1995) 1126.
[704] MacNaughton G 'Untangling Equality and Non-Discrimination to Promote the Right to Health Care for All' (2009) 11:2 *Health and Human Rights* 53.
[705] Hunt P, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, paragraph 15 Annual Report to the Human Rights Council, UN Doc. No. A/HRC/7/11 (2008).

have a duty to ensure that a health system is accessible to everyone on an equal basis and that marginalised people and communities practically enjoy the same access as those who are more advantaged.[706] Therefore, States have an obligation to ensure that marginalised members within their countries, such as indigenous women, access healthcare services on an equal basis as non-indigenous communities by allocating adequate resources to health systems.[707] In terms of the substantive equality theory, to achieve equality, there is a need to treat those who are different differently.[708] Therefore, this means that to achieve equality in accessing healthcare services by different categories of women, there is a need to provide special measures and programmes for indigenous women that will enable them to enjoy their right to health fully like other non-indigenous women.

Furthermore, Article 21 of the UNDRIP notes that "indigenous peoples have the right without discrimination to the enjoyment of socio-economic rights including water, sanitation and health."[709] Therefore, the UNDRIP should be commended for having an explicit provision that proscribes discrimination related to the enjoyment of the right to health.

On the regional plane, Article 2 of the ACHPR provides for "the enjoyment of rights and freedom of every individual, without distinction of any kind such as race, ethnic group, colour, sex, language, religion, or any other opinion, social origin or another status."[710] In line with this provision, the African Commission enjoins States to take solid steps in dealing with stigma and discrimination related to the pandemic, particularly with regard to HIV-positive persons in the region.[711] In addition, the Commission called on pharmaceutical companies to ensure that economic and full-scale health services, including quality low-cost medicines, are made available to African Governments to deal with the negative impact of HIV/AIDS.[712]

3.3.5 Access to information

The right to information is provided in Article 19 (2) of the ICCPR. This Article provides that:

[706] Hunt P, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Annual Report to the Human Rights Council.
[707] MacNaughton G (2009) 54.
[708] Durojaye E 'A gendered analysis of Section 48(2) (d) of the Zimbabwean Constitution of 2013' (2017) 38 (2) *Statute Law Review* 34.
[709] Durojaye E (2017) 5.
[710] Article 2 African Charter.
[711] Paragraph 3 Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity.
[712] Paragraph 3 Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity.

> "Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds…"

This right applies to the advancement of the right to health, including reproductive health and rights, because health-related information is fundamental to the realisation of the right to health. Thus, if indigenous women can access information related to preventing and treating different sicknesses and diseases, they are motivated to make wise decisions about their health.[713] In addition, indigenous women need the information to exercise their reproductive health and rights. To this end, the delivery of reproductive health services, such as family planning services, without full and unbiased information results in the formation and promulgation of laws and policies that deny women the ability to choose the number and spacing of their children.[714]

The right to information in relation to the realisation of women's reproductive health and rights is crucial because women need basic information on a lot of aspects related to their reproductive health. Information such as their reproductive physiology, the impact of pregnancy on their health, how sexual diseases can be transferred and the measures for reducing the transmission, the benefits and risks of using different methods of contraception, including the safe options to rely on when those methods fail.[715] In addition, disseminating accurate information about reproductive health services such as family planning plays a vital role in limiting unwanted pregnancies, spacing births, protecting women against STIs, advancing maternal and infant health, and giving women adequate time, energy, and autonomy over their lives and bodies.[716]

Moreso, Article 10(h) of CEDAW also addresses women's reproductive health and rights by stating that women have the right to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[717] Therefore, Zimbabwe has to ensure that women from all backgrounds are given information in accessible formats and advice on family planning. Fathalla posits that women are at a risk of

[713] United Nations Office of the High Commissioner for Human Rights 'Reproductive rights are human rights: A handbook for National Human Rights Institutions' (2014) 107-108. The dissemination of information related to health is important for developing evidence-based health policies and it is a foundation of any health system that values human rights and democratic principles of transparency, accountability, participation and equality.
[714] Coliver S (1995) 1285.
[715] Coliver S (1995) 1285.
[716] Coliver S (1995) 1285.
[717] Article 10 (h) CEDAW.

being victims of forced motherhood when the States fail to provide adequate and relevant information and means to control their fertility.[718]

In addition, Article 24(2) (f) of the CRC provides that States Parties have obligations "To develop preventive health care, guidance for parents and family planning education and services."[719] The CRC explained the normative content of the right to health-related education in General Comment No. 15 to include reproductive health information by asserting that:

> "Sexual and reproductive health education should include self-awareness and knowledge about the body, including anatomical... It should include content related to sexual health and wellbeing, such as information about body changes and maturation processes, and designed in a manner through which children are able to gain knowledge regarding reproductive..."[720]

A thematic paper by the IASG highlighted the need to introduce education programmes for indigenous adolescents, such as peer education programmes.[721] Peer-education programmes that involve youth and adolescents from indigenous communities are believed to be effective ways to share knowledge and skills on reproductive health and limit the dangers associated with unsafe sex, even though such topics are considered taboos in terms of traditional beliefs in many communities.[722]

Several reasons have been put forward to justify why adolescents should have access to reproductive health information. Some of the reasons include that the fact that there are more than a billion adolescents in the world; thus, an investment in adolescents is an investment in a greater future, as the reproductive health choices made during adolescence have a lasting effect on individual health.[723] Furthermore, available data shows that adolescents participate in sexual activities earlier than in the past, so they face many reproductive health risks and must be well informed to make rational choices.[724] Therefore, ensuring that adolescents have access to contraceptive information and services prevents the reproductive health risks occasioned by the expression of adolescents' sexuality.[725] In addition, the situation is unfortunate for adolescent girls because besides experiencing the same peer pressure as their male counterparts

[718] Fathalla MF (1995) 1186. Not all women expressing a need for fertility regulation have the information and means to fulfill that need in spite of all the rhetoric on population and family planning.
[719] Article 24 (2) (f) CRC.
[720] Paragraph 60 CRC General Comment No. 15.
[721] IASG (2014) 1.
[722] IASG (2014) 1.
[723] Savage-Oyekunle OA and Nienaber A (2015) 365.
[724] Savage-Oyekunle OA and Nienaber A (2015) 365.
[725] Savage-Oyekunle OA and Nienaber A (2015) 365.

to be involved in sexual relations early, most of them are bound to fall victim to sexual violence.[726] The situation of indigenous adolescent girls is worse than other adolescents because of their social status, identity, age, gender, and geographical location. The situation becomes even more precarious when such adolescents are HIV positive, as they can be discriminated against on the grounds of their HIV status. These several forms of discrimination are important in understanding indigenous girls' plight when accessing their reproductive health and rights.

In addressing Section 2 (f) of the CRC, the Committee, in its General comment No.3, enjoins State Parties to ensure that children have the right to access sufficient information related to HIV/AIDS prevention and care through different channels.[727] In addition, States should ensure that such information is tailored according to the children's different levels and capacities of understanding to ensure that children can deal confidently with their sexuality and safeguard themselves from HIV infections.[728]

The CRC provides access to health-related education in its Article 24 (2) (e) as follows:

> "To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of children's health and nutrition, the advantages of breastfeeding, hygiene…"[729]

It is important to state that the right to education is crucial for advancing and protecting health as research has constantly proven that women's education significantly impacts improved reproductive health, including infant survival and the healthy growth of children.[730] Furthermore, there is a strong link between education, health, and other determinants of health that contribute directly and indirectly to better health.[731] For instance, education has an unbiased and considerable important impact on adult mortality and morbidity, and it ultimately affects health through elements such as nutrition, sanitation, prevention and treatment

[726] Savage-Oyekunle OA and Nienaber A (2015) 366.
[727] Paragraph 16 UN Committee on the Rights of the Child (CRC), General comment No.3: HIV/AIDS and the Rights of the Child CRC/GC/2003/3.
[728] Paragraph 16 General Comment No.3: HIV/AIDS and the Rights of the Child.
[729] Article 24 (2) (e) CRC.
[730] Cook RJ and Fathalla MF (1996) 118.
[731] World Health Organisation 'Health in 2015 from MDGs to SDGs' available at *https://apps.who.int/iris/bitstream/handle/10665/200009/9789241565110_eng.pdf* (accessed 15 May 2021).

practices. Therefore, decent health enables people to fully benefit from education, while bad health is directly linked with poor educational accomplishment.[732]

On the regional plane, the right to access information is entrenched in Article 9(1) of the African Charter, which guarantees "the right to receive information."[733] This right can be invoked in claiming access to health-related information. The African Commission has explained the right to family planning education to imply that States have a duty "to provide complete and accurate information which is necessary for the respect, protection, promotion and enjoyment of health, including the choice of contraceptive methods."[734] To achieve this, States are supposed to put in place measures that include training or promoting health personnel and experienced educators regarding the importance of providing complete information to clients and guaranteeing that information on family planning or contraception is disseminated to communities in accessible languages and in a form that is manageable to all women and girls.[735] In line with its States' obligations, Zimbabwe has to put in place measures to ensure that all women, including the San women and adolescent girls, access reproductive health and rights easily. These measures should include disseminating health-related information in languages that are better understood by indigenous communities. The content of the information should also be understandable by such marginalised communities who are highly illiterate.

3.3.6 Right to be free from inhumane and degrading treatment

The right to be free from inhuman and degrading treatment is recognised in Article 7 of the ICCPR, where the following is stated:

> "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation."

Due to their subordinate position in most societies and their sexual vulnerability, women are tortured, sexually violated. In addition, Cook and Fathalla assert that States can apply the right

[732] World Health Organisation 'Health in 2015 from MDGs to SDGs' available at *https://apps.who.int/iris/bitstream/handle/10665/200009/9789241565110_eng.pdf* (accessed 15 May 2021). Ensuring that females get education is very important as education has proven to be one of the strongest determinants of child survival in societies. Therefore, female education is an important strategy for eradicating preventable maternal and child deaths, as well as improving child, adult and family health.
[733] Article 9(1) African Charter.
[734] Paragraph 28 General Comment No. 2 African Women's Protocol.
[735] Paragraph 28 General Comment No. 2 African Women's Protocol.

to liberty and security of the person to reproductive self-determination in many ways. For example, governments can recognise women's right to personal liberty by agreeing to amend laws that proscribe abortion.[736]

The HRC has received complaints about reproductive health and women's rights and freedom from cruel, inhumane and degrading treatment or punishment. One such case is the case of *KL v Peru*.[737] In *casu*, KL a seventeen-year-old young woman was coerced to carry a pregnancy to full term despite anencephaly, a serious fatal anomaly incompatible with life, even though Peruvian law permits abortion on therapeutic grounds. KL was coerced to carry the pregnancy to term and feed the baby until the baby inescapably died. KL's complaint was brought for consideration before the HRC.[738] The complainant brought to light the failure of the State to protect KL's right to be free from inhumane and degrading treatment. The Committee ruled that rejecting access to lawful abortion infringes on women's most basic human rights.[739] For example, the HRC stated that the failure to permit the abortion of KL's pregnancy in a situation where it was clear that this could have a serious impact on her health amounted to a violation of Article 7 of the ICCPR on the grounds of cruel, inhuman or degrading treatment.[740] The HRC ruled that Peru should pay damages to KL and take proper steps to avoid a recurrence of the violations.[741]

This case shows that reproductive health and rights are linked to a number of rights, as the court referred to several basic rights that were trampled upon by Peru when KL was denied abortion services. In addition, the decision of this case can be used as a precedent by indigenous women in challenging the provisions of the Zimbabwean Constitution that deny women abortion or in challenging the long processes associated with getting an order from court authorising an abortion.

3.4 STATE OBLIGATIONS

Cusack and Cook postulate that one technique of conceptualising the scope of States Parties' obligations to end unfair gender bias in the reproductive health setting is through the tripartite framework of State obligations. This tripartite framework includes the obligation to "respect,

[736] Cook RJ and Fathalla MF (1996) 118.
[737] Paragraph 2.3 *KL v Peru.*
[738] Paragraphs 2.8 and 5.2-3 *KL v Peru.*
[739] Paragraph 3.5 *KL v Peru.*
[740] Paragraph 6.3 *KL v Peru.*
[741] Paragraph 8 and 9 *KL v Peru.*

protect, and fulfill" human rights and freedoms.[742] The State's obligations are explicitly discussed in the CESCR's General Comments No. 14 and 22,[743] and they will form part of this discussion, including what has been elucidated by other scholars. General Comment No. 22 is important in outlining reproductive health and rights because it adopts a HRBA and confirms that this right is an essential part of the right to health that has relished long-standing acknowledgment based on existing international human rights instruments.[744]

3.4.1 Obligation to respect

The obligation to respect requires States to desist from interfering with the enjoyment of reproductive health and rights directly or indirectly and to desist from gender labelling that invalidates women's rights to choose whether or when to have children.[745] In line with this obligation, States are required to refrain from limiting or rejecting anyone's access to reproductive health services, and States must repeal laws that hinder the enjoyment of the right to reproductive health.[746] Such laws include laws criminalising abortion, third-party approval requirements such as parental, spousal, and judicial consent for access to reproductive health services, and laws criminalising transgender identity or expression.[747] Most African countries, including Zimbabwe[748] still retain laws that criminalise abortion despite those countries having constitutions with comprehensive provisions on the right to health and the right to bodily and psychological integrity. These laws limit the enjoyment of reproductive health and rights by women. These laws end up causing adolescent girls to do illegal and unsafe abortions that contribute to the high maternal mortality rates amongst the youths in Zimbabwe. Adolescent girls from indigenous communities are not left out in such predicaments. The situation becomes even more complicated for adolescent girls from indigenous communities such as the San community because their poor economic status and subordinate social status can contribute to their engagement in unsafe and illegal abortions that contribute to the high maternal mortality rates within indigenous communities.

[742] Cusack S and Cook RJ (2009) 73.
[743] CESCR, General Comment No. 22: The Right to Sexual and Reproductive Health, UN Doc. No. E/C.12/GC/22) (2016).
[744] Pizzarossa LB and Perehudoff K (2017) 280.
[745] Cusack S and Cook RJ (2009) 74.
[746] Paragraph 40 General Comment No. 22 ICESCR.
[747] Paragraph 40 General Comment No. 22 ICESCR.
[748] See Section 48 of the Constitution of Zimbabwe Amendment No. 20 of 2013. For example, Rwanda, Uganda, Tanzania, Kenya and Botswana have restrictive abortion laws like Zimbabwe.

3.4.2 Obligation to protect

The obligation to protect mandates States to take steps to stop third parties from directly or indirectly disturbing the enjoyment of reproductive health and rights.[749] The obligation to protect mandates States to ensure that adolescents have access to adequate and relevant information on reproductive health including family planning and contraceptives, the risks of early pregnancy and the prevention and treatment of STIs including HIV/AIDS despite their marital status and whether their parents or guardians consent to respecting their privacy.[750] In most rural parts of Africa, it is usually considered a taboo to educate children on family planning and sexual intercourse. As a result, adolescents end up with unwanted pregnancies and undergo illegal abortions, which are risky because of fear of victimisation, should their parents or guardians discover that they are engaging in sexual intercourse at an early age and before marriage.

Furthermore, for indigenous women such as San women, factors such as poverty, discrimination and stigma also largely hinder their access to reproductive health information and reproductive health services.[751] Evidence has shown that these obstacles persist despite evidence that sharing information on reproductive health, in this instance, improves the enjoyment of the rights to health and life.[752]

3.4.3 Obligation to fulfill

The obligation to fulfill women's reproductive health and rights mandates State Parties to take "appropriate legislative, judicial, administrative, budgetary, economic and other measures to ensure the elimination of wrongful gender stereotyping."[753] In fulfillment of this obligation, States have a responsibility to ensure that there is universal access to a full range of quality reproductive health care services such as family planning services, safe abortion services, and information on diagnosis and prevention of STIs and HIV/AIDS, without discrimination for everyone including those from disadvantaged and marginalised groups.[754] In fulfillment of this obligation, there is a need for States to allocate budgets aimed at specifically promoting the

[749] Paragraph 42 General Comment No. 22 CESCR.
[750] Paragraph 44 General Comment No. 22 CESCR.
[751] Article 19 'Time for change: Promoting and protecting access to information and reproductive and sexual health rights in Peru available at *https://www.refworld.org/pdfid/4754091e0.pdf* (accessed 24 May 2021).
[752] Article 19 'Time for change: Promoting and protecting access to information and reproductive and sexual health rights in Peru available at *https://www.refworld.org/pdfid/4754091e0.pdf* (accessed 24 May 2021).
[753] Cusack S and Cook RJ (2009) 75.
[754] Paragraph 45 General Comment No. 22 CESCR.

reproductive health of marginalised members of society, such as indigenous communities. The obligation to fulfill also requires State Parties to take measures to eradicate practical barriers to the maximum realisation of reproductive health and rights, such as uneven costs and limited physical or geographical access to reproductive health care.[755] There is a need to increase health facilities close to where indigenous communities live to encourage them to seek medical attention without facing challenges. In addition, such facilities must have adequate equipment and skilled personnel who understand the concept of health of indigenous people so that indigenous communities do not come up with excuses for not visiting health facilities. For example, the San communities in Zimbabwe are located in areas that are far from health facilities.[756] As a result, they end up not enjoying access to reproductive health services as they give birth at home with unskilled birth attendants, and in some instances, they give birth in the bush while walking to health facilities.

3.5 CONCLUSION

This chapter deliberated on the historical development and origins of the reproductive health and rights concept. The history and origins revealed the role of feminists and population movements in developing this right. The origins also show the role of international conferences and the human rights system in expanding the notion of reproductive health and rights. The discussion on the origins of reproductive health and rights revealed that the marginalisation of indigenous women when it comes to the recognition of their reproductive health and rights started when the recognition of reproductive health and rights of women were being advocated for as such advocacy did not pay special attention to the plight of indigenous women. A discussion on reproductive health and rights in the international and regional human rights system was also done by discussing different human rights that are linked to reproductive health and rights. This discussion revealed that no treaty specifically entrenches indigenous women's reproductive health and rights. The available instruments discuss the right to health in which reproductive health and rights are essential. The discussion also revealed that certain rights are linked to reproductive health and rights as explained in different general comments and recommendations, case law, concluding observations, and resolutions passed in the regional human rights system. A discussion of those other rights also showed that the different

[755] Paragraph 48 General Comment No. 22 CESCR.

[756] For example, the San in Mtshina make use of the health facilities in Sikente which is very far from where they live. The road to Sikente is not safe as it is infested with dangerous wild animals. As a result, women end up preferring to give birth at home instead of risking their lives by walking through the dangerous bushes.

regional and international instruments that entrench those rights do not make specific reference to indigenous women, but the rights are to be enjoyed by every human being in general. The chapter also showed that even the two child-specific treaties do not entrench provisions on reproductive health and rights of adolescent girls from indigenous populations. The Chapter also revealed that the two international instruments, that is, the UNDRIP and ILO Convention No. 169 that entrench indigenous peoples' rights, do not have provisions that specifically focus on indigenous peoples' reproductive health and rights, but they cover their right to health in general. A discussion on the state obligations *vis-a-vis* reproductive health and rights of indigenous women was also done. Therefore, in terms of these obligations, Zimbabwe is obligated to protect, promote and fulfill the right in question as provided for in the instruments discussed above, to which Zimbabwe is a party. In conclusion, although there is no human rights instrument at the regional and international levels that specifically entrenches the reproductive health and rights of indigenous women, the protection of their reproductive health and rights is catered for in human rights instruments that a

pply to every person in general.

The next chapter assess the adequacy of Zimbabwe's legal response to protecting indigenous women's reproductive health and rights. To bring out whether San women are enjoying access to their reproductive health and rights or not, a discussion of findings from reports and documentaries from ICs, NGOs, media, and other institutions on the state of access to the right to health including reproductive health and rights by San women in Zimbabwe was done.

CHAPTER FOUR

LEGAL AND OTHER FRAMEWORKS TO REALISE THE REPRODUCTIVE HEALTH AND RIGHTS OF SAN WOMEN IN ZIMBABWE

4.1 INTRODUCTION

The previous chapter focused on analysing indigenous women's reproductive health and rights in regional and international human rights law. The chapter also analysed the States' obligations to respect, protect and fulfill those rights in regional and international human rights law. The research question informing this chapter is as follows: are the legal, policy, and institutional frameworks and interventions for ensuring access to reproductive health and rights by San women in Zimbabwe adequate and consistent with the government's obligations under regional and international law? The question seeks to interrogate whether the Government of Zimbabwe (GoZ/ Government) has enacted any laws or policies to ensure the realisation of reproductive health and rights of San women. The question also seeks to establish whether the GoZ has established any institutions that will further the realisation of reproductive health and rights of San women. In addressing this question, this chapter critically analyses how Zimbabwe has complied with its obligations under regional and international human rights law in ensuring that indigenous women in Zimbabwe, San women, have access to reproductive health and rights. This was done through analysing the extent to which the provisions of the Constitution, legislation, policies and programmes that the GoZ has put in place to ensure the realisation of reproductive health and rights of San women comply with regional and international instruments that protect reproductive health and rights of indigenous women. The chapter shows the GoZ's commitment to its regional and international obligations by analysing the institutions it has established to ensure the enjoyment of reproductive health and rights by San women. The provisions that are analysed are those that have a bearing on the three elements of reproductive health and rights that are the focus of this study.

This chapter has a section that unpacks the Constitutional provisions addressing reproductive health and rights in Zimbabwe and their applicability to the San women in Zimbabwe. The chapter also has a section that analyses the legal framework regulating reproductive health and rights, which this study focuses on. Another section in the chapter also unpacks the policy framework addressing reproductive health and rights in Zimbabwe and its relevance to the reproductive health and rights of indigenous women such as the San women. To add on, this

chapter has a section that discusses the programmes that the GoZ has created to further the realisation of the reproductive health and rights of San women in Zimbabwe. After discussions of the legal and policy frameworks as well as the programmes that the GoZ has adopted to ensure the realisation of the reproductive health and rights of San women. The chapter has a section that unpacks the realities of San women in Tsholotsho and Plumtree District, which is the focus of this study regarding their access to reproductive health and rights. The author proceeds to incorporate the theoretical framework informing this study (intersectionality theory and substantive equality theory) throughout the chapter.

4.2 CONSTITUTION OF ZIMBABWE AND REPRODUCTIVE HEALTH AND RIGHTS

4.2.1 Domestication of international law in Zimbabwe

This discussion highlights how the human rights standards at regional and international levels that Zimbabwe ascribes to become binding law in Zimbabwe. Before this discussion, it is important to mention that the Constitution of Zimbabwe is the chief law of the land, and it provides a "yardstick for determining lawful government action and protecting individual rights."[757] Regarding the protection of human rights, including reproductive health and rights, the Constitution is very relevant as it shows the dedication to endorse and defend fundamental human rights and freedoms.[758]

To show Zimbabwe's commitment to meeting its regional and international human rights obligations, ratification is supposed to be followed by the domestication of the provisions of these instruments at a national level.[759] This means that national laws, policies, and services should show a continuous thread of human rights practice as a result of the domestication of regional and international obligations.[760] Section 327(2) of the Constitution of Zimbabwe provides the guiding principles for the ratification and domestication of international and regional human rights standards into domestic law. In terms of this section, treaties that Zimbabwe is a party to become binding in Zimbabwe if they are approved by Parliament and

[757] Kondo T 'Socio-economic rights in Zimbabwe: Trends and emerging jurisprudence' (2017) 17:1 *African Human Rights Law Journal* 174.
[758] Kondo T (2017) 174.
[759] WLSA and LRF 'An Assessment of the Formal Justice System in responding to Sexual and Gender Based Violence (SGBV), Harmful Practices (HP) and Sexual Reproductive Health Rights (SRHR) in Zimbabwe' *Spotlight Initiative* (2021) 37.
[760] WLSA and LRF (2021) 37.

assimilated into domestic law using an Act of Parliament.[761] This provision shows that Zimbabwe is a "dualist country" guided by a "dualist theory" that provides that international law and domestic law are two different legal systems.[762] This means that international law cannot be applied directly at the national law level unless Parliament approves it through a parliamentary process, and thereafter the law is assimilated into domestic law.[763] Furthermore, Section 34 of the Constitution which falls under the national objectives, provides for the domestication of regional and international human rights standards.[764] Therefore, this implies that incorporating international human rights standards into domestic law forms part of the national objectives that can positively impact the protection of women's reproductive health and rights through the law-making processes and the creation of policies.[765]

The Constitution also provides for the domestication of international standards, which occurs when customary international law is interpreted. This is provided for in Section 326(1) of the Constitution, which states that "customary international law is part of the law of Zimbabwe unless it is inconsistent with domestic law."[766] The same provision directs courts to "adopt a reasonable interpretation of legislation consistent with customary law that is applicable in Zimbabwe when interpreting legislation."[767] Therefore, courts can directly apply international legal commitments or obligations that promote reproductive and health rights of indigenous women. However, it is crucial to highlight that the impact and efficiency of human rights treaties depend mainly on the level of dedication of State Parties in making the treaty obligations a reality through domestication into national laws and policies as well as the implementation of these obligations.[768] Thus, the Government has attempted to domesticate international and regional human rights instruments through incorporating human rights principles into constitutional provisions, repealing of laws inconsistent with the Constitution, amendment of laws to align them with constitutional provisions, promulgation of new laws and introducing relevant laws that provide for reproductive health and rights and reproductive health services.[769]

[761] Section 327 Constitution of Zimbabwe.
[762] WLSA and LRF (2021) 37.
[763] WLSA and LRF (2021) 37.
[764] Section 34 Constitution of Zimbabwe.
[765] WLSA and LRF (2021) 37.
[766] Section 326(1) Constitution of Zimbabwe.
[767] Section 326(2) Constitution of Zimbabwe.
[768] WLSA and LRF (2021) 37.
[769] WLSA and LRF (2021) 37.

This discussion on the domestication of international standards in Zimbabwe is critical in understanding the shortcomings in the laws enacted to realise reproductive health and rights in Zimbabwe, as it is difficult to entrench international standards in laws if the requirements laid down in the Constitution are not met. The obstacles faced by San women in accessing their reproductive health and rights can be attributed to the requirement of domesticating international standards first in laws before they become binding as the international and regional standards they can rely on. Protection becomes meaningless in Zimbabwe if such provisions are not domesticated into legislation in Zimbabwe.

4.2.2 Constitutional provisions linked to reproductive health and rights

As discussed in chapter 3, reproductive health and rights is a cluster of rights which are linked or embedded in existing human rights. Therefore, the following section will address the human rights provisions in the Constitution of Zimbabwe linked to reproductive health and rights and show their applicability to the San women in Zimbabwe. However, it is important to mention that currently, the Government does not recognise indigenous people within its borders as it considers all its non-white citizens to be the 'indigenous Zimbabweans' (as already mentioned in chapter one, there are two groups that self-identify as indigenous people in Zimbabwe, that is, the Tshwa or San and the Doma).[770] Furthermore, the Indigenisation and Economic Empowerment Act has attempted to define who an "indigenous Zimbabwean" is by stating that an "indigenous Zimbabwean" is: "any person who, before the 18th of April 1980, was disadvantaged by unfair discrimination on the grounds of his or her race, and any descendant of such person..."[771] Therefore, given that context, it is difficult to define who an indigenous person is in Zimbabwe as the Government does not make a distinction regarding the San community.[772] In addition, there is no domestic legislation specifically promulgated to realise the rights of indigenous peoples within the country's borders, nor does the Constitution embrace the concept of indigenous peoples despite it being the supreme law of Zimbabwe.[773]

[770] Observations on the State of Indigenous Human Rights in Zimbabwe Prepared for United Nations Human Rights Council: 2nd cycle of Universal Periodic Review of Zimbabwe 26th session of the Human Rights Council, 2016 (1).
[771] Section 2 Indigenisation and Economic Empowerment Act [Chapter 14:33].
[772] Makumbe RP 'An alternative conceptualization of indigenous rights in Africa under the international human rights law framework' (2018) 3 *Deusto Journal of Human Rights* 163.
[773] Observations on the State of Indigenous Human Rights in Zimbabwe (2016) 1. See also Makumbe P (2018) 163. Although there are no laws that specifically protect indigenous peoples' rights in Zimbabwe, the "Koisan" language is included in the current Constitution of Zimbabwe as one of the sixteen officially recognised languages in Zimbabwe.

The author argues that the challenges faced by the San women in exercising their rights, including their reproductive health and rights can be attributed to the non-distinction of the San people as an indigenous minority group in Zimbabwe. As an indigenous minority group, there is a need for articulation and emphasis of their rights to improve their situation when it comes to enjoying their rights. The non-recognition of the indigenous minorities' rights in the Constitution and domestic legislation, when viewed from an intersectionality lens, helps understand the magnitude of the discrimination that the San women face.

Right to health

The right to health is provided for in Section 76 of the Constitution. This section provides that:

> "1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services.
>
> 2. Every person living with a chronic illness has the right to have access to basic healthcare services for the illness.
>
> 3. No person may be refused emergency medical treatment in any health-care institution.
>
> 4. The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section."[774]

It is important to mention that the inclusion of the right to have access to reproductive health care services in Section 76(1) is a huge milestone and is praiseworthy as it is evidence of a substantial change from the old Constitution which did not entrench the right to access to reproductive health care services.[775] The Constitution must be commended for having a provision for "everyone" to have access to reproductive health services, as this provision can be relied on by San women to claim their right to access reproductive health and rights. By recognising and protecting the right of everyone, to have access to reproductive health services in the Constitution, the GoZ is, in a way domesticating its obligations as provided for in Article 12 of the ICESCR, Article 14 of the African Women's Protocol, Article 24 of the CRC and Article 14 of the ACRWC which all entrench different types of reproductive health services that women are entitled to.

[774] Section 76 Constitution of Zimbabwe.

[775] Sithole L (2020) 88. According to Sithole, "The Lancaster House Constitution was repealed with the coming of the new constitution Amendment Act NO. 13 of 2013 on 9 May 2013. This was a result of the quantitative changes that had been occurring in Zimbabwean politics the first hint of such being the draft constitution of 2000, which saw a proposed constitution being abandoned after it failed to attain approval at a referendum."

In addition, in terms of Section 76(4), the enjoyment of the right to health including reproductive health is subject to "progressive realisation."[776] The need for "progressive realisation" of the right to health is also stipulated in the national objectives (these are not legally binding) in the Constitution where it is stated that the "State's measures to prevent diseases will be within the limits of the resources available to it."[777] Pillay *et al* argue that this formulation weakens both the right and the States' obligation[778] and it also weakens the public health commitment in the 2016-2020 National Health Strategy to "align the Constitution, the government policy blueprint, and the Zimbabwe Agenda for Sustainable Socio-Economic Transformation with international commitments not to divorce the living conditions of people from their health risks and status."[779] There is a gap in Section 76(4) in that unlike Article 24 (3) of the CRC which requires the State to take "all effective and appropriate measures," Section 76(4) requires the State to take "reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation" of the reproductive health and rights.[780] The wording of Section 76(4) is similar to that of Section 26(2) and Section 27(2) of the South African Constitution in that both provisions impose on the State a positive duty to realise the right to shelter and the right to health through "reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation" of these rights as outlined by Section 76(4) of the Constitution.[781] What amounts to "reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation" was interpreted in two South African cases, the *Government* of the *Republic of South Africa & Ors v Grootboom & Ors* (Grootboom case)[782]and the *Minister of Health v Treatment Action Campaign* (TAC) (2002) 5 SA 721 (CC) (*TAC* case).[783]

In the *Grootboom* case, the respondents were evicted from land that belonged to someone else which they had occupied illegally. They were pushed to do this because they had been living in appalling conditions whilst they were waiting to be allocated low cost housing by government.[784] In this case, the Court broke down Section 26(2) into three elements and

[776] Section 76(4) Constitution of Zimbabwe.
[777] Section 29(3) Constitution of Zimbabwe.
[778] Pillay N, Chimbga D and Van Hout MC (2021) 225.
[779] Pillay N, Chimbga D and Van Hout MC (2021) 225.
[780] Section 76(4) Constitution of Zimbabwe.
[781] See Sections 26(2) and 27(2) Constitution of the Republic of South Africa, 1996.
[782] *Government of the Republic of South Africa. & Ors v Grootboom & Ors* 2000 (11) BCLR 1169. (CC).
[783] *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC).
[784] Paragraph 3-4 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*

interpreted what the elements amount to. The three elements of which Section 26(2) is made are: "(a) the state is obligated to take reasonable legislative and other measures; (b) within its available resources and; (c) to achieve the progressive realisation of the right to shelter."[785] In interpreting Section 26(2), the Court considered international law and, more specifically Articles 11(1) and 2(1) of the ICESCR, which protect the right to adequate housing and the obligation of State Parties to "take appropriate steps which must include legislation."[786] On the other hand, Section 26(2) of the Constitution obligates the South African Government to take "reasonable legislative and other measures."[787] Thus, in interpreting Section 26(2) concerning the *Grootboom* case, the Court had the consideration of the interpretation of Article 2 of the ICESCR but declined to take into consideration the concept of the "minimum core obligations" basing its argument on the complexity of determining a core minimum obligation for the progressive realisation of the right to housing.[788] Therefore, the Court identified the real question to be determined by the court to be "whether the measures taken by the State to realise the right afforded by Section 26 are reasonable."[789]

To answer this question, the Court read sections 26(1) and 26(2) together and interpreted Section 26(1) as placing an obligation on the State to "create the conditions for access to adequate housing for people at all economic levels of society, including those who cannot afford to provide themselves with housing."[790] The Court interpreted Section 26(2) to obligate the State to develop a detailed and reasonable plan to meet its obligations under section 26(1).[791] Thus, the Court argued that the national legal framework on housing existed, but it was not enough as it left out a big part of the South African society. Therefore, the Court ruled that a programme that leaves out a notable group of people cannot be viewed as "reasonable," as demanded by Section 26(2).[792] The Court ruled that the concept of progressive realisation as echoed in General Comment No. 3 of the ICESCR has the similar meaning in the South African Constitution as Section 26 "does not expect more of the State than is achievable within its available resources;" and the availability of such resources may be used to determine what

[785] Paragraph 21 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[786] Paragraph 26-27 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.* Article 11 provides a right to adequate housing, whereas section 26 provides a right of access to housing. In addition, Article 2 obligates "States Parties to take appropriate steps which must include legislation, whilst the Constitution obligates the Government of South Africa to take 'reasonable legislative and other measures."
[787] Paragraph 28 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[788] Paragraph 29 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[789] Paragraph 33 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[790] Paragraph 35 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[791] Paragraph 63 and 66 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[792] Paragraph 64 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*

is reasonable.[793] Thus, the Court found "no provision in the nation-wide housing programme as applied within the Cape Metro for people in desperate need" and concluded that the policy used by Government was unreasonable as it made no provision for relief for such people.[794]

The *TAC* case dealt with the Court's interpretation of the meaning of Section 27(2) regarding the right to access healthcare services. Just like in the *Grootboom* case, the Court held that Section 27(1) should be read in conjunction with Section 27(2) as that is the constitutional standard when section 27(1) is read.[795] The Court ceased with the duty of determining the standard of reasonableness regarding the exclusion of the use of the nevirapine drug in public health facilities which were not identified as test sites despite the administration of the drug being medically indicated.[796] The Court found that the arguments put forward by the Government for rejecting drug distribution were unreasonable as they were not supported by evidence.[797] The Court further refused to consider the Government's argument that it was reasonable to deny drug access by patients from poor backgrounds until a comprehensive plan could be formulated and implemented.[798]

Therefore, the GoZ can learn lessons from the arguments made by the Courts in both cases and see to it that it facilitates the realisation of reproductive health and rights of San women within its available resources despite it having a crumbling economy. The Government should devise programmes and laws that regard the rights of marginalised members of the Zimbabwean society who, include women from indigenous communities such as the San women.

In Zimbabwe, some legislation addresses other reproductive health and rights elements, including those that are a focus of this study. However, as shall be seen in the discussions that follow, such laws and policies do not specifically address the plight of indigenous communities, nor do they provide for the specific protection of reproductive health and rights of indigenous people. Therefore, the author has observed that, indigenous women such as the San women in Zimbabwe face discrimination on many grounds, and this limits the way they enjoy these rights on an equal basis with their counterparts. Thus, in line with the substantive equality theory,

[793] Paragraph 29 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[794] Paragraph 52 and 66 *Government of the Republic of South Africa. & Ors v Grootboom & Ors.*
[795] Paragraph 39 *Minister of Health v Treatment Action Campaign*.
[796] Paragraph 67 and 123 *Minister of Health v Treatment Action Campaign*.
[797] The South African Government's arguments relating to efficacy, risk of developing drug resistance, safety, and capacity-all were unsupported by the evidence. Paragraph 81 *Minister of Health v Treatment Action.*
[798] Paragraph 64 and 70 *Minister of Health v Treatment Action.*

there is a need to ensure that laws and policies do not treat indigenous people like non-other indigenous people to enhance the enjoyment of rights by indigenous people.

Right to life

This right is entrenched in Section 48 of the Constitution. Section 48(1) provides that "every person has the right to life." The author argues that this is a laudable provision considering that many indigenous women lose their lives while giving birth. The Constitution should be applauded for having a provision that protects the sanctity of life and ban the easy taking away of women's lives through failure to provide for and or improve maternal health services.[799] By entrenching the right to life in the Constitution, the GoZ is in line with its regional and international obligations as provided for in Article 6 of the ICCPR, Article 6 of the CRC, Article 4 of the African Charter, Article 4 of the African Women's Protocol and Articles 5 and 30 of the ACRWC which provides for the protection of the right to life. By having a provision that protects the right to life in the supreme law of the land, the GoZ complies with its obligations to respect as explained in General Comment No.36 of the HRC, which provides that the right to life in Article 6(1) of the ICCPR lays the foundation for the obligation of States Parties to respect and give effect to the right to through legislative and other measures.[800] In addition, for Zimbabwe to fully meet its human rights obligations in relation to protecting the right to life, Zimbabwe should comply with the interpretation of the right to life provided in General Comment No. 3 of the African Commission, which provides that the right to life includes the "States' responsibility to implement a legal and practical framework to respect, protect, promote and fulfill the right to life which can be done through the enactment of laws or implementation of other measures."[801] Therefore, there is a need for the GoZ to take necessary measures to safeguard the health and lives of San women.

Although the Constitution protects women's right to life, it should be noted that there is a gap in the provisions of Section 48 (3) which seems to protect the life of an unborn child to the detriment of the pregnant woman. Section 48 (3) of the Constitution states, "An Act of Parliament must protect the lives of unborn children and that Act must provide that pregnancy may be terminated only in accordance with that law."[802] Thus, this Section gives the foetus the

[799] See Amnesty International 'Zimbabwe: Pregnant women and girls face barriers accessing public health facilities and risk life changing injuries' available at *https://www.amnesty.org/en/latest/news/2021/05/zimbabwe-pregnant-women-and-girls-face-barriers-accessing-public-health-facilities-and-risk-life-changing-injuries/* (accessed 1 March 2023).
[800] Paragraph 4 General Comment 36 of the Human Rights Committee.
[801] Paragraph 7 General Comment 3 African Commission.
[802] Section 48 (3) Constitution of Zimbabwe.

right to life and confers upon the State the legal duty to protect the foetus against termination.[803] Chin'ombe postulates that although managing how and when abortion should be permitted, abortion should meet certain minimum standards which recognise the rights accorded to the pregnant woman. The Constitutional question that seems not to be addressed is the extent to which the State's interest in protecting the life of the unborn child ought to be justified. [804]

Chin'ombe further argues that laws and/ policies that seek to liberalise abortion whilst at the same time recognising the right to life of an unborn child have the effect of introducing and authorising a maternal and foetal rights conflict into domestic law at the cost of clarifying the right to abortion which a woman is entitled to.[805] This position is evidenced by Section 48 (3) of the Constitution which in undertaking to protect the life of the foetus impinges on the rights of the pregnant woman when it denies her an opportunity to exercise her reproductive choice.[806] Therefore, there is a need for the law to ensure that whilst recognising the rights of the foetus, the rights attached to the pregnant woman, such as the right to reproductive autonomy, right to human dignity, right to health, and right to life are not violated. The stringent approach in Section 48 (3) makes the Constitution unfavourable to women regarding their enjoyment of their reproductive freedom and fertility.[807] Therefore, this provision is inconsistent with Article 16(1) (e) of CEDAW, Articles 14(1) (a), (b), and Article 14 (2) (c) of the African Women's Protocol which gives women the right to decide their fertility including deciding the number of children to have and when to have children as well as undergoing through a medical abortion. The author is of the view that the failure by the GoZ through this constitutional provision to allow women to terminate pregnancies when they are not ready to carry such pregnancies to term can increase the maternal mortality rates as women will opt for illegal and dangerous routes of getting abortions. Section 48(3) of the Constitution is unfair in that it does not consider the situation of women who might have fallen pregnant because they were unable to access contraceptives and did not have access to family planning information because of their geographical, cultural and social status as is often the case with women from marginalised societies such as the San women in Zimbabwe. This shows the applicability of the

[803] Chin'ombe P *An Analytical Analysis of Abortion Laws in Zimbabwe from a Human Rights Perspective* (unpublished Bachelor of Laws Honours Degree, 2014) 23.
[804] Chin'ombe P (2014) 23.
[805] Chin'ombe P (2014) 23.
[806] Chin'ombe P (2014) 23.
[807] Chin'ombe P (2014) 24.

intersectionality theory in the context of the San as they face additional discrimination due to the laws that do not cater to their peculiar needs.

Right to equality and non-discrimination

The Zimbabwean Constitution is founded on many values, such as equality, including gender equality, as outlined in Section 17 of the Constitution.[808] These values are explained by the Constitution's right to equality and non-discrimination entrenched in Section 56.[809] Section 56(1)-(3) provides that:

> "1. All persons are equal before the law and have the right to equal protection and benefit of the law.
>
> 2. Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres.
>
> 3. Every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their nationality, race, colour, tribe, place of birth, ethnic or social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock."[810]

Both Sections 17 and 56 of the Constitution have broader effects on government policy-making, programming, and law reforms because when these provisions are read together, they impose upon the society and the State the duty to make it a point that women and girls benefit from national laws that further the advancement of reproductive health and rights on an equal basis with men.[811] This assertion is supported by the constitutional position in Section 56 (6) that "the State must take reasonable legislative and other measures to promote the achievement of equality and to protect or advance the rights of people who have been disadvantaged by unfair discrimination."[812] This provision is significant in the protection of the rights of indigenous people, given that they have faced oppression during the colonial era and continue to be alienated and marginalised in post-colonial Zimbabwe.[813] Therefore, in line with the substantive equality theory, one can argue that it is incumbent upon the State to promulgate laws and put in measures that are deliberately targeted at advancing the rights of indigenous

[808] Section 17 Constitution of Zimbabwe.
[809] Section 56 Constitution of Zimbabwe.
[810] Section 56(1)-(3) Constitution of Zimbabwe.
[811] WLSA and LRF (2021) 37-38.
[812] Section 56 (6) Constitution of Zimbabwe.
[813] Makumbe RP (2018) 162.

women such as the San women, as they are a marginalised group that has been disadvantaged by unfair discrimination on a lot of grounds such as sex, gender, ethnicity, and economic and social status.[814] Therefore, such measures will not amount to discrimination but will be justified on the grounds of Section 56(6).

This position is consistent with the preamble of CEDAW as well as Articles 2, 3 and 4 of CEDAW which proscribe discrimination and set out the kind of measures, whether legal, administrative and otherwise, that must be taken by States to put an end to discrimination against women in all fields including health. Section 56(6) also complies with Article 12 of CEDAW, which prohibits discrimination on the grounds of sex regarding access to health care services by men and women, including those related to family planning. In addition, Section 56(6) is also in line with Article 2 of the African Women's Protocol which obliges States to fight all forms of discrimination perpetrated against women through the enactment and adoption of "appropriate legislative, institutional and other measures."

In addition, Section 56(3) of the Constitution also lists other grounds in which discrimination is prohibited, gender, sex, ethnic or social origin, culture, and social or economic status.[815] The incorporation of these elements as grounds in which discrimination is prohibited is commendable as these are some of the areas in which San women face unfair discrimination when they try to access reproductive health care services. These grounds also show the relevance of the intersectionality theory in explaining the marginalisation that the San women face in realising their rights, including their reproductive health and rights. Section 56(3) of the Constitution is consistent with Article 2 of the African Charter, which outlines the grounds of discrimination to include ethnicity, sex, language, social origin, or another status. In addition, Section 56 (3) complies with Article 2 of the UNDRIP which provides explicitly for indigenous people's enjoyment of the right to health on the same level as non-indigenous people. The provisions of Section 56 of the Constitution are also in line with Article 12 of CEDAW, which places a duty on States to ensure that men and women have access to health services, including reproductive health services, on an equal basis. In addition, Section 56(3) complies with Articles 2(f) and 5(a) of CEDAW and Article 3 of the ACRWC, which proscribe discrimination based on the grounds of sex, gender, and culture. Section 56 also complies with Article 2 of the African Women's Protocol which obliges States to eliminate all forms of discrimination to

[814] WLSA and LRF (2021) 38.
[815] Section 56(3) Constitution of Zimbabwe.

warrant that women enjoy all their rights, including their rights such as their reproductive health and rights.

Right to access information

Section 62(1) of the Constitution guarantees the right to "access to information from anyone including the State for the exercise or protection of a right." This section provides the following:

> "Every Zimbabwean citizen or permanent resident… has the right of access to any information held by the State or by any institution or agency of government at every level, in so far as the information is required in the interests of public accountability."[816]

One can argue that this provision guarantees access to information held by State institutions such as the MoHCC, which has the custody of reproductive health information in Zimbabwe.[817] Furthermore, the right to access information involves information related to education and knowledge about how different services can be accessed, especially services related to health, as well as how public policies are formulated and implemented.[818] Mutupo asserts that the right to access information is an essential individual right that places a positive duty upon the State to fulfill it.[819] This provision is in line with Article 19(2) of the ICCPR and Article 9(1) of the ACHPR, which provide the right for everyone to receive information. This section is also consistent with Articles 10(h) of CEDAW, 24(2) (f) of CRC, Article 14(2) of the African Women's Protocol, and Article 14(2)(f) of the ACRWC, which entrench the right to access health education and health-related information which includes information on family planning. In line with the interpretation provided in General Comment No.2 of the African Commission, Section 62(1) of the Constitution of Zimbabwe places an obligation on the Government to provide information that is complete and accurate to necessitate the "respect, protection, promotion and enjoyment" of the right to health, including the choice of family planning methods.[820]

Right to bodily and psychological integrity

[816] Section 62(1) Constitution of Zimbabwe.
[817] See Ministry of Health and Child Care 'Reproductive Health Department' available at *http://www.mohcc.gov.zw/index.php?option=com_content&view=article&id=171:sexual-reproductive-health&catid=14&Itemid=435* (accessed 1 March 2023).
[818] Mutupo P A *human rights based approach to reproductive health amongst adolescent girls in Zimbabwe* (Unpublished Master of Philosophy, Theory, and Practice of Human Rights Degree, 2006) 41.
[819] Mutupo P (2006) 41.
[820] Paragraph 28 General Comment No. 2 African Commission.

Another crucial provision of the Constitution applicable to women's reproductive health and rights is Section 52, which addresses the right to bodily and psychological integrity as follows:

> "Every person has the right to bodily and psychological integrity, which includes the right-
>
> a. to freedom from all forms of violence from public or private sources;
>
> b. subject to any other provision of this Constitution, to make decisions concerning reproduction;
>
> c. not to be subjected to medical or scientific experiments, or to the extraction or use of their bodily tissue, without their informed consent."

This section indicates that women should be allowed to make reproductive decisions, such as choosing a spouse or partner, without any intrusion from the Government or other parties.[821] In addition, the freedom to arrive at any decision regarding reproduction involves many issues, including, among others, decisions on whether to use contraception, the type of contraception to use, whether to abort a pregnancy or not and the number and space between children.[822] Including the right to make decisions concerning reproduction is consistent with Zimbabwe's obligations provided in Articles 12 of the ICESCR, 14 of the African Women's Protocol, and 24 of the CRC. This right, as interpreted by the CESCR in General Comment No. 22, urge State Parties to ensure that women have access to reproductive health care services without interference from third parties.[823] Furthermore, by providing for the right to make decisions regarding reproduction, the Constitution reduces the risk of women having to endure unplanned and unsafe pregnancies, which might lead them to want to undergo unsafe abortions given the long procedures associated with undergoing abortion legally. By giving women their reproductive autonomy, they can enjoy other rights, such as their right to life, health, and dignity. Therefore, this provision is in line with the interpretation provided in General Comment No. 2 of the Maputo Protocol, which provides that administrative laws, policies and procedures that hinder access to family planning violate women's rights because they strip her of her power to make decisions and coerce her to experience early pregnancy, unsafe or unwanted pregnancy with the result of seeking unsafe abortion which can cost her health and life.[824]

[821] Sithole L (2020) 89.
[822] Sithole L (2020) 89.
[823] Paragraph 42 General Comment No. 2 CESCR.
[824] Paragraph 27 General Comment No. 2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

4.3 OTHER DOMESTIC LEGISLATIVE FRAMEWORKS

Legislation plays a vital role in providing a basis for protecting citizens' rights as it is viewed as an expression of a State's allegiance to the realisation and advancement of their rights.[825] In the context of women, legislation plays a vital role in outlining the State's commitment to protect them from issues such as discrimination, exclusion, deprivation, violence, and harmful cultural practices that can negatively affect their enjoyment of their reproductive health and rights.[826] However, in the Zimbabwean context, most legislation supposed to protect women and further their realisation of different rights are outdated, *ultra-vires* the Constitution, and are not in line with regional and international human rights standards.[827] Although the GoZ, through the Ministry of Justice, Legal and Parliamentary Affairs (MoJLPA), has tried to rectify this problem by amendment of some pieces of legislation and aligning some of the laws to the Constitution, the process is slow, and some laws remain archaic.[828] This section will therefore discuss legislation that has been promulgated to ensure that the reproductive health and rights of women, including indigenous women such as the San women, are realised.

As already mentioned, some laws are still not aligned with the Constitution. Therefore, this section highlights such gaps and their implication on the enjoyment of reproductive health and rights by women, including San women. From the onset, it is important to mention that no laws provide for the specific protection of the reproductive health and rights of indigenous women in Zimbabwe, such as the San women. They get protection from the laws that provide for the general populace. This gap in the legislation can be attributed to the challenges faced by the San women in enjoying their reproductive health and rights. Therefore, there is a need for the GoZ to align laws with the Constitution and ensure that they are not discriminatory to women based on their ethnicity and place of origin.

4.3.1 Public Health Act [Chapter 15: 17]

The Public Health Act [Chapter 15: 17] (Public Health Act/ Act) is the primary law that deals with health issues in Zimbabwe. The purpose of this Act is to align public health laws with the Constitution, as this is evidenced by its reference, among other things, "to provide for public

[825] Sithole L and Dziva C Eliminating harmful practices against women in Zimbabwe: Implementing Article 5 of the African Women's Protocol (2019) 19:2 *African Human Rights Law Journal* 578.
[826] Sithole L and Dziva C (2019) 578.
[827] Sithole L and Dziva C (2019) 578.
[828] Sithole L and Dziva C (2019) 578.

health and the conditions for improvement of the health and quality of life and the health care for all people in Zimbabwe, respect for human rights, promote gender equity and the best interests of vulnerable groups."[829] However, this Act is criticised for failing to incorporate a human rights-based framework that is consistent with the Constitution's objectives "to protect health rights, to ensure health equality by addressing the specific health needs of women or to include international law obligations for women with HIV/AIDS."[830] There are some gaps in the Public Health Act because it does not deal with the rights of vulnerable groups such as indigenous women.[831]

This Constitution guides this Act as this is evidenced by its reference to some of the sections of the Constitution, such as Section 29, which provides the following: "The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe…" and Section 76 which provides the following: "Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services." The reference by the Public Health Act to provisions of the Constitution complies with Articles 12 and Article 16 of CEDAW, Article 14 of the African Women's Protocol, and Article 12 of the ICESCR, which places an obligation on States to guarantee women's enjoyment of their right to health including their reproductive health and rights.

In addition, the Act requires the Minister of Health "to implement and monitor Zimbabwe's international commitments and to prioritise and allocate resources for health services."[832] This provision is commendable as it allows the State to implement its international obligations through domestication. This provision complies with Article 14 of the African Women's Protocol and Article 12 of the ICESCR which require states to advance women's reproductive health and rights.

4.3.2 Zimbabwe National Family Planning Council Act [Chapter 15:11] and Zimbabwe National Family Planning Council

[829] Pillay N, Chimbga D and Van Hout MC (2021) 225.
[830] Pillay N, Chimbga D and Van Hout MC (2021) 225.
[831] Pillay N, Chimbga D and Van Hout MC (2021) 225.
[832] Maziwisa MR 'Barriers to access contraceptives for adolescent girls in rural Zimbabwe as a human rights challenge' in Durojaye E, Mirugi-Mukundi G and Ngwena C *(eds) Advancing Sexual and Reproductive Health and Rights in Africa* (2021) 72.

The Zimbabwe National Family Planning Council Act [Chapter 15:11] (ZNFPC Act) is the law that established the ZNFPC as a parastatal under the MoHCC.[833] The purpose of the ZNFPC Act includes, amongst other things, to "establish the ZNFPC and to provide for the structure, functions and powers of the ZNFPC; to provide for child spacing and fertility services in Zimbabwe and the promotion and implementation of primary health care and other community-based development programmes relating to family health."[834] The ZNFPC was established to appreciate the viewpoint that both couples and individuals have the freedom to determine the spacing of children and how many children they want to have.[835] This notion is consistent with Article 16(1) (e) of CEDAW, Article 14(1) (a) and (b) of the African Women's Protocol which asserts the notion that women's equality is linked with their ability to control their fertility and to decide the number and spacing of their children. Some of the functions of the ZNFPC, as provided for in the ZNFPC Act, include coordinating the sharing and provision of family planning information and services, conducting research related to reproductive health, such as research on effects of contraceptives on the health of the users, sexually transmitted infections (STI), conducting research on diagnosis and the available treatment for breast and cervical cancer.[836] This function resonates with Article 14 (1) (d) and (e) of the African Women's Protocol which places an obligation on States Parties to ensure that women are protected from HIV/AIDS and STI infections as well as provide information relating to one's health status. By conducting research on STIs, HIV/AIDS, and cervical cancer, the Government will be better placed to protect women from new infections as they will now know what they should do or not do to stay safe. In addition, women will also know how to take care of themselves if they find themselves with STIs, HIV/AIDS, and cancer and improve their chances of living. Although the provisions of the ZNFPC Act, aim, and work of the ZNFPC align with Zimbabwe's regional and international obligations, there is a gap in that the protection provided in that Act and body does not specifically cater to indigenous people and indigenous women but treats them like any other ordinary Zimbabwean, yet they have peculiar issues which other ordinary Zimbabweans do not face. Therefore, in order to deal with the situation of indigenous people, there is a need to adopt a substantive equality approach in order to endure that there is a specific provision of how this Act will deal with their issues.

[833] Section 3 Zimbabwe National Family Planning Council Act Chapter 5:11.
[834] Schedule Zimbabwe National Family Planning Council Act.
[835] Masakadza RC *The production, distribution and reception of Zimbabwe National Family Planning Council (ZNFPC) reproductive health messages in Chikombedzi rural Zimbabwe* (Unpublished Master of Social Sciences Degree, 2015) 11.
[836] Masakadza RC (2015) 11. See Section 22(1) Zimbabwe National Family Planning Council Act.

During its inception, there was little knowledge on the significance of family planning in Zimbabwe, which led to the acceptance of the services by a small portion of the population.[837] In addressing this challenge, an Information, Education, and Communication (IEC) Unit was formed to regulate the dissemination of family planning and reproductive health information and education countrywide.[838] Through this Unit, the ZNFPC shares reproductive health education, information, and services to both males and females belonging to different age groups who, including adolescents and youths who had been left out in the provision of such services in rural and urban areas of Zimbabwe.[839] In doing this, the ZNFPC employs different strategies that include IEC materials, jingles, and carrying placards with reproductive health messages for awareness raising and imparting knowledge to change people's views towards the non-use of contraceptive methods.[840] Masakadza postulates that one of the successes of the ZNFPC is that it has proven itself as one of the best leading service providers in the provision of reproductive health services and information in Zimbabwe and has witnessed a significant improvement in the usage of reproductive health services by a bigger section of the country.[841]

The functions and work that has been done by the ZNFPC around educating communities on different family planning methods and disseminating information on reproductive health services such as the importance of using contraceptives and the effects of using those contraceptives is in line with Article 24(2) (f) of the CRC, Article 10(h) CEDAW, Article 16 of CEDAW and Articles 14(1)(e), (f) and 14(2)(a) of the Maputo Protocol. They all oblige States to ensure that women and children are educated and given adequate information relating to different reproductive health services, such as family planning and information related to the treatment of STIs and HIV. Although Zimbabwe has comprehensive provisions in the functions of the ZNFPC that address the provision of education and dissemination of reproductive health information, the San women might still not be able to exercise this right because of the high illiteracy levels amongst them. For example, a 2021 report by the ZHRC highlighted that there were high levels of illiteracy amongst the San communities in Tsholotsho District and Plumtree District especially among women as this was evidenced by their failure to complete an attendance register and failure to affix their signatures on the same attendance registers citing

[837] Masakadza RC (2015) 11.
[838] Masakadza RC (2015) 11.
[839] Masakadza RC (2015) 11.
[840] Masakadza RC (2015) 12.
[841] Masakadza RC (2015) 11.

that they were unable to write.[842] Therefore, based on the substantive equality theory, a special arrangement should be made to ensure that San women receive reproductive health education and information in the format and language they understand so that they can effectively use reproductive health services like their female counterparts from non-indigenous communities.

4.3.3 National AIDS Council of Zimbabwe Act [Chapter 15:14] and National AIDS Council

The National Aids Council of Zimbabwe Act [Chapter 15:14] (NAC Act/ Act) is the principal legislation responsible for addressing HIV/AIDS in Zimbabwe.[843] This piece of legislation enabled establishing the National AIDS Council in 1999, which became operational in 2000.[844] This Act was promulgated to administer and coordinate the response to combat HIV/AIDS nationally by implementing different programmes and measures.[845]

The NAC is tasked with many functions, one of which is to "mobilise and manage resources, whether financial or otherwise, in support of a national response to HIV/AIDS."[846] This function has been discharged through the introduction of the AIDS Levy, a mechanism used within Zimbabwe to raise funds for the national response to HIV/AIDS.[847] Since its inception, the NAC has been focusing on all aspects mandated by the NAC Act, but due to changes in the operational environment and the epidemic, focus is now mainly on implementing programmes in areas where there are major gaps.[848]The enactment of legislation and establishment of a body that addresses matters related to HIV/AIDS complies with Article 14 (1)(d) of the African Women's Protocol which requires States to ensure that women's right to health is promoted, including protecting women from HIV/AIDS and STIs.

4.3.4 Termination of Pregnancy Act [Chapter 15:10]

[842] ZHRC Report: Plumtree and Tsholotsho Districts- Human rights and COVID-19 awareness raising outreaches (ZHRC Plumtree and Tsholotsho Outreaches Report) (2021) 3.
[843] National Aids Council of Zimbabwe Act.
[844] Schedule National AIDS Council of Zimbabwe Act.
[845] Pillay N, Chimbga D and Van Hout MC (2021) 232.
[846] National Aids Council of Zimbabwe Act.
[847] Mathe P (2020) 5, the AIDS Levy was introduced in year 2000 and it consists of 3% of taxable income from PAYE and corporate tax, this scheme has been held regionally and internationally. Disbursements of these funds are done on a quarterly basis for the district response initiatives.
[848] Mathe P (2020) 5.

The Termination of Pregnancy Act [Chapter 15:10] (Act), which Zimbabwe inherited from the Parliament of Rhodesia upon attaining independence, regulates legal abortion in Zimbabwe. Section 4 of the Act lays down the grounds upon which a pregnant woman qualifies to terminate a pregnancy legally. This section provides that pregnancy can only be terminated:

> "(a) where the continuation of the pregnancy so endangers the life of the woman concerned or so constitutes a serious threat of permanent impairment of her physical health that the termination of the pregnancy is necessary to ensure her life or physical health, as the case may be; or
>
> (b) where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped; or
>
> (c) where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse."[849]

This section entirely restricts women to the requirements laid down in the Act to qualify for lawful termination of a pregnancy, as any other reason for termination which is not covered by Section 4 amounts to a criminal offence.[850] Chin'ombe argues that Section 4 of the Act "permits abortion only on therapeutic (to save the woman's life or preserve her physical health), eugenic (to prevent the birth of a child expected to suffer from serious mental or physical defects or deformities) and humanitarian (where the pregnancy resulted from rape or unlawful intercourse as defined by the law) grounds."[851] There is a gap in this Act because of many reasons. For example, Section 4 of the Act implies that one cannot terminate a pregnancy lawfully on socio-economic grounds where the pregnant woman cannot continue with the pregnancy because of poverty or other socio-economic reasons.[852] Therefore, women's reproductive freedom should not be limited to physical conditions, instead, it should be understood within a broader context which includes social, religious, and economic conditions. [853] In addition, Ngwena asserts that the Act does not address the implications that carrying an unwanted pregnancy to term can have on the mental health of the pregnant woman who wants to have an abortion but limits the risks to a woman's health to physical health.[854] Thus, the author shares the same sentiments as Chin'ombe and Ngwena because Section 4 restricts the legal termination of a pregnancy to

[849] Section 4 Termination of Pregnancy Act.
[850] Section 3 (1)- (2) Termination of Pregnancy Act.
[851] Chin'ombe P (2014) 9.
[852] Chin'ombe P (2014) 9.
[853] Chin'ombe P (2014) 29.
[854] Ngwena CG 'An Appraisal of abortion laws in Southern African from a reproductive health rights perspective' (2004) 32:4 *Journal of Law, Medicine and Ethics* 836.

preserve the pregnant women's physical health and to protect the foetus, yet the right to health as provided for in regional and international law applies to the enjoyment of one's physical and mental health. Section 4 of the Act ignores the mental aspect of the pregnant woman's health. It has a danger of leaving women who do not meet the requirements provided for in Section 4 with mental and psychological challenges as they will be coerced to carry their pregnancies to full term when they are not mentally and emotionally prepared to do so.

The grounds laid down in Section 4 of the Act are restrictive on women's reproductive freedom by providing a list of certain grounds to meet to terminate their pregnancy. Women end up not fully enjoying the right to determine freely and responsibly whether they want to carry a pregnancy to full term or not, and end up not having any choice but to carry unwanted pregnancies to a full term as a result of the restrictions under Section 4.[855] This position is inconsistent with Zimbabwe's obligations as explained in General Comment No.2 of the African Commission, which provides that women have a right to benefit from scientific progress and application. Therefore, if women are denied the means to interrupt unwanted pregnancies safely, they will not benefit from the fruits of this progress.[856] In addition, the grounds laid down in Section 4 of the Act violate several rights that the pregnant woman is entitled to, such as the right to privacy, human dignity, personal freedom and security, the right to control their body and to have their bodies respected as well as the right to equality and non-discrimination.[857] Similarly, General Comment No. 2 of the African Women's Protocol and General Comment No. 36 of the ICCPR echo the same principle as they allude to the fact that the right to exercise control over one's fertility, to decide one's maternity, to determine a family planning method, to choose the number and spacing of children are linked, interdependent and indivisible and that measures introduced by States to regulate abortion must not end up violating other rights linked to the woman's right to exercise her reproductive choices.[858] Therefore, the author asserts that if legislation does not confer upon women the right to exercise control over their bodies, it violates other rights related to that right. There is a need for the State to address the natural differences between men and women in a manner that will cause

[855] Chin'ombe P (2014) 11.
[856] Paragraph 33 General Comment No. 2 of the African Women's Protocol.
[857] Chin'ombe P (2014) 11.
[858] Paragraph 23 General Comment No.2 of the African Women's Protocol and Paragraph 9 General Comment No. 36 on Article 6 of the ICCPR on the right to life.

the legal system to be receptive to promoting women's reproductive health and rights despite the biological differences between the two sexes.[859]

The restrictive criteria for legal abortions in the Act compel women to undergo unsafe abortions, which are performed mainly by unskilled and unprofessional people, in most cases, result in the death of the women in question.[860] Scholars such as Ngwena and Brooke, Ndlovu and Farr *et al* assert that the restrictive nature of the abortion law in Zimbabwe causes many service providers to be reluctant to perform abortions, even for women who meet the legal requirements, because of fear of inviting prosecution in the face of high rates of unsafe abortion mortality and morbidity in the country.[861] In addition, Ngwena postulates that the administrative barriers to having a legal abortion have to a greater extent, fortified the restrictive orientation of the Act, as procuring abortion under the Act is lengthy, restrictive, and cumbersome.[862] It is evident that although the country has made great strides with regard to recognising women's right to equality in reproductive freedom matters in terms of the Act, there is still a long way to go, as women have not yet been granted the power to exercise their own decisions on whether to carry a pregnancy to full term or not.[863]

An example of the lengthy procedure of procuring a legal abortion was shown in the *Exparte Miss X* case.[864] In *casu*, a pregnant woman who claimed that her pregnancy was a result of rape applied to the Magistrate Court in terms of the Termination of Pregnancy Act for a certificate that would grant her permission to terminate the pregnancy.[865] However, since the Act is drafted in a way that gives the Magistrate the power to exercise discretion, the Magistrate refused to issue the certificate to the complainant because he was not satisfied that there was a reasonable possibility that the complainant's pregnancy was a result of rape.[866] Part of the judgment, in this case, highlighted that the delay experienced by the complainant was not because of the Magistrate's actions and placed the blame on the complainant for her failure to pursue the matter more "vigorously and timeously."[867]

[859] Chin'ombe P (2014) 11.
[860] Chin'ombe P (2014) 11.
[861] Brooke RJ, Ndlovu S and Farr SL *et al* 'Reducing Unplanned Pregnancy and Abortion in Zimbabwe through Postabortion Contraception' (2002) 33:2 *Studies in Family Planning* 195. See also Ngwena CG (2010) 837.
[862] Ngwena C (2004) 713. See also Batisai K (2014) 184.
[863] Chin'ombe P (2014) 29.
[864] *Exparte Miss X* 1993 (1) ZLR 233(H).
[865] *Exparte Miss X* 1993 (1) ZLR 233(H).
[866] *Exparte Miss X* 1993 (1) ZLR 233(H).
[867] *Exparte Miss X* 1993 (1) ZLR 233(H).

Furthermore, the judgment passed in the *Mildred Mapingure v The Minister of Home Affairs, Minister of Health and Child Welfare and Minister of Justice, Legal and Parliamentary Affairs*[868] is evidence that the law is still repressive regarding women's reproductive freedom. In *casu*, the complainant Mapingure fell pregnant as a result of rape and wanted to have the pregnancy terminated.[869] For her to be able to lawfully terminate the pregnancy in line with the Act, there was need of a police report confirming that indeed she had been raped. However, due to the delays from the police in producing the report, she could not abort the pregnancy within the stipulated legal time frame.[870] When she was finally in possession of all the required documentation, it was too late for a safe abortion to be performed.[871] She appealed to the Supreme Court, which found that the State authorities did not have a duty to initiate that the appellant obtains the certificate of termination.[872] This case overlooked the cumbersome requirements of satisfying the conditions for legal abortion stipulated in the Act as the major cause of the delay in giving Mapingure the greenlight to terminate her pregnancy.[873] This case is evidence that women are denied the right and opportunity to have an abortion in Zimbabwe even if they meet the criteria for eligibility set out in Section 4 of the Act, which is couched in a restrictive manner that limits women's exercise of their reproductive autonomy.

It is important to highlight that although Section 4 of the Act is restrictive, it should be applauded for having a requirement of abortion being offered for a pregnancy obtained due to unlawful sexual intercourse. Ngwena applauds the GoZ for having such a provision that considers the inhumane and degrading nature of requiring a woman to carry to full term a pregnancy resulting from unlawful sexual intercourse.[874] Furthermore, this provision is consistent with the interpretations provided by the HRC in General Comment No.36 of the ICCPR[875] and the African Commission's General Comment No. 2 on the African Women's Protocol which lays down rape as one of the grounds for being allowed to undergo an abortion.[876]

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[868] *Mildred Mapingure v The Minister of Home Affairs, Minister of Health and Child Welfare and Minister of Justice, Legal and Parliamentary Affairs* (unreported case) HH-452-12.
[869] *Mapingure v The Minister of Home Affairs and 2 others.*
[870] *Mapingure v The Minister of Home Affairs and 2 others.*
[871] *Mapingure v The Minister of Home Affairs and 2 others.*
[872] *Mapingure v The Minister of Home Affairs and 2 others.*
[873] *Mapingure v The Minister of Home Affairs and 2 others.*
[874] Chin'ombe P (2014) 26.
[875] Paragraph 9 General Comment No. 36 of the ICCP.
[876] Paragraph 20 General Comment No. 2 of the African Women's Protocol.

The discussion above has shown that the requirements for legal abortion in Zimbabwe are more restrictive than what is permissible under the African Women's Protocol. In terms of the African Women's Protocol, there is need for the law to remove the restrictive adjectives that qualify the grounds upon which abortion can be obtained, so that a mere threat to the life or health of the pregnant woman can become grounds for abortion.[877] Ngwena asserts that if the mental health ground in the Protocol is read disjunctively, it means that Zimbabwe would have to recognise a threat to the woman's mental health as a condition for abortion.[878] Although Zimbabwe is a party to a plethora of regional and international human rights standards that recognise women's reproductive autonomy, the Act interferes with women's freedom of autonomy as women cannot exercise this right without interference from the State.[879]

Regarding abortion laws, Zimbabwe can learn lessons from other countries such as South Africa. For example, South Africa's Choice on Termination of Pregnancy Act 92 of 1996 (Choice Act/ Act), which regulates abortion, compared to Zimbabwean laws, outlines more relaxed conditions under which a pregnancy can be terminated.[880] In terms of the Choice Act, "a pregnancy may be terminated upon the request of a woman during the first twelve weeks of gestation."[881] Zimbabwean courts can also learn lessons from South African courts regarding balancing the compelling interests of the foetus and the woman's right to reproductive autonomy when it comes to terminating a pregnancy legally, as dealt with in the *Christian Lawyers Association*[882] case. In *casu,* the court held that the South African Constitution did not afford the foetus a legal personality or protection and argued that the children's rights clause found in the South African Constitution does not cater to the rights of a foetus. Therefore, the Court concluded that extending the term "everyone" stipulated in Section 11 of the Constitution to include foetuses would enlarge other rights that do not apply to foetuses and create rights that would have anomalous consequences for the rights of women.[883]

In a nutshell, confining the threat of a woman's health to "physical harm" when considering whether she should carry a pregnancy to term or not is inconsistent with Article 12 ICESCR, Article 24 CRC, and Article 24 UNDRIP which recognise that the right to health includes physical and mental health. In addition, the outlawing of abortion except on prescribed grounds

[877] Ngwena CG (2010) 837.
[878] Ngwena CG (2010) 837.
[879] Chin'ombe P (2014) 12.
[880] Sithole L (2020) 98.
[881] Section 2(1) Choice on Termination of Pregnancy Act 92 of 1996.
[882] *Christian Lawyers Association of SA v Minister of Health* 1998 4 SA 1113 (T).
[883] Paragraph 1121G *Christian Lawyers Association of SA v Minister of Health*.

is inconsistent with Article 16(1) (e) of CEDAW and Article 14(1) (a) (b) of the African Women's Protocol which gives women the freedom to decide when to have children and also to decide the number as well as the spacing of children.

4.3.5 Criminal Law (Codification and Reform) Act [Chapter 9:23]

The Criminal Law (Codification and Reform) Act [Chapter 9:23] (Act) "consolidates and amends the criminal law of Zimbabwe." In terms of this Act, the regulation of unlawful termination of pregnancy is provided for in Section 6 as follows:

> "(1) Any person who:
>
> (a) intentionally terminates a pregnancy; or
>
> (b) terminates a pregnancy by conduct which he or she realises involves a real risk or possibility of terminating the pregnancy; shall be guilty of unlawful termination of pregnancy and liable to a fine not exceeding level ten or imprisonment for a period not exceeding five years or both."[884]

This provision restricts women's exercise of their reproductive health and rights because it incriminates women for exercising their freedom of reproductive autonomy by terminating pregnancies they are not ready to carry to term. Batisai states that the criminal tag attached to abortion in Zimbabwe shows the magnitude of the State's control over women's bodies.[885] Hwenjere asserts that many young women in Zimbabwe resort to illegal and unsafe abortions because of the criminalisation and illegalisation of abortion under this Act.[886] Ngwena shares the same sentiments when he mentions that in most circumstances when women have unwanted pregnancies they are likely to have an abortion regardless of whether it is legal or not.[887] The author agrees with both scholars as, in most cases, adolescents find themselves with unwanted pregnancies, and they easily resort to using unsafe ways of abortions as every Zimbabwean clearly knows that abortion is a crime. Adolescents from indigenous communities are not excluded from this predicament, as it is often difficult for indigenous people to talk about contraceptives. Some female adults do not use them but prefer resorting to their traditional

[884] Section 60(1) Criminal Law Codification Act.
[885] Batisai K (2014)175.
[886] Hwenjere VG *Understanding unsafe abortions among young women in Zimbabwe: A socio-legal study on reproductive rights* (unpublished Master of Arts in Development Studies Degree, 2016) 21. See also Zimbabwe National Health Strategy (2016-2020) 27. "Adolescents and young people contribute significantly to maternal deaths. Zimbabwe has a youthful population, with two thirds of the population below the age of 25 years. The youth is one of the key affected population groups as most of the sexual reproductive health indicators for youth are either deteriorating or remaining high."
[887] Ngwena C (2013) 404.

medicines of birth control. Non-indigenous adolescents are also not exempt from the low use of contraceptives as it is taboo in most African countries, including Zimbabwe to discuss family planning methods and to be known that you are engaging in sexual activities at a young age and outside marriage. Undergoing illegal abortions that are usually unsafe has life-changing implications for women, including death and frequent suffering from serious illnesses such as reproductive tract infections (RTIs), secondary infertility, hemorrhage, sepsis, peritonitis and irreparable damage to the vagina, cervix, and uterus..[888] Highly restrictive laws drive women to unsafe abortion services offered by unskilled providers.[889] The restrictive nature of this provision which illegalises and criminalises abortion, contradicts the obligations that Zimbabwe must meet under Article 16(1) (e) of CEDAW, which gives women the freedom to control their reproductive lives by choosing the number of children they wish to have and the spacing of the children.

Furthermore, in Section 60(2), the legally permissible defences that a woman who has done an abortion can rely on are that the pregnancy was aborted as a result of a caesarean section or it was aborted in line with the Termination of Pregnancy Act.[890] Ngwena posits that the provisions of Section 60(2) imply that the unlawful termination of pregnancy is regarded as a crime against a person. This further proves the arguments made by different scholars that Zimbabwean law treats an unborn child as a person with rights worthy of protection.

Ngwena puts forward the argument that when it comes to deciding whether a woman's pregnancy should be terminated due to the "danger to the life of the woman" the pregnancy poses must not be looked at through a medical lens, but it should be considered using a reproductive lens which regards unsafe abortion as a great cause of maternal mortality.'[891] In addition, forcing women to carry an unwanted pregnancy to full term violates their right to privacy.[892] To support this argument, in the *Griswold v Connecticut case*,[893] the court stated the following:

> "If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether or not to bear or beget a child."[894]

[888] Ngwena C (2013) 404.
[889] Ngwena C (2013) 404.
[890] Section 60(2) Criminal Law Codification Act.
[891] Sithole L (2020) 100.
[892] Sithole L (2020) 100.
[893] *Griswold v Connecticut* (1965) 381 US 479.
[894] *Griswold v Connecticut* (1965) 381 US 479.

Furthermore, there is a gap in the Zimbabwean legislation regarding the regulation of abortion because the legislation overlooks the importance of the "provision of mandatory counselling services" before an abortion is done.[895] Providing the pregnant woman with counselling before she undergoes an abortion is important because counselling guarantees that the pregnant woman is furnished with necessary information regarding issues such as the risks associated with abortion.[896] The failure to equip women with information related to abortion before they decide to terminate a pregnancy is inconsistent with the obligations that Zimbabwe has, which are outlined in Article 16 of CEDAW, Article 12 of ICESCR, and Article 14 of the African Women's Protocol which places an obligation on States to provide education and information to women related to reproductive health services such as family planning.

4.3.6 Domestic Violence Act [Chapter 5:16]

Violence perpetrated against women affects women from all walks of life despite racial, geographical, cultural, religious, or linguistic boundaries.[897] Chuma and Chazovachii posit that violence against women infringes on their basic rights, undermines their self-determination and ability to lead successful lives.[898] In response to the rise in domestic violence cases in Zimbabwe, the Domestic Violence Act Chapter 5:16 (DVA), which provides guidelines for protecting victims of domestic violence, was enacted.[899] Chumana and Chazovachii describe the DVA as "the most progressive and panacea law for the empowerment of women in Zimbabwe."[900]

The DVA, in its Section 3, defines domestic violence as:

> "any unlawful act, omission or behaviour which results in death or the direct infliction of physical, sexual, or mental injury to any complainant by a respondent and includes the following: physical abuse, sexual abuse, emotional, verbal and psychological abuse, economic abuse, intimidation, and harassment."[901]

The ambit of what constitutes domestic violence is further extended in Section 3(1)(1), which outlaws the following acts as they are considered as violence against women: "forced virginity testing; female genital mutilation; pledging of women or girls for purposes of appeasing spirits;

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[895] Sithole L (2020) 100.
[896] Sithole L (2020) 100.
[897] Chireshe E (2015) 260.
[898] Chuma M and Chazovachii B 'Domestic Violence Act: Opportunities and challenges for women in rural areas: The case of Ward 3, Mwenezi District, Zimbabwe' (2012) 3: 3.*4 International Journal of Politics and Good Governance* 2.
[899] Chireshe E (2015) 260.
[900] Chuma M and Chazovachii B (2012) 4.
[901] Section 3 Domestic Violence Act Chapter 5:16.

forced marriage; child marriage; or forced wife inheritance; and sexual intercourse between fathers-in-law and newly married daughters-in-law."[902] Chirawu-Mugomba asserts that the biggest strength of the DVA lies in its detailed definition of domestic violence, which takes into consideration the elements cited in Section 3(1) and Section 3(1) (1).[903] Including all these elements is important because violence perpetrated against women manifests in diverse forms.[904] In addition, the definition of violence entrenched in Article 3(1) is consistent with the definition of violence against women entrenched in international law.[905] In addition, outlawing harmful cultural practices that negatively affect women's enjoyment of their rights is consistent with Zimbabwe's obligations which are outlined in Article 5 of CEDAW, Article 5 of the Women's Protocol, and Article 21(1) (a) of the ACRWC.

Chireshe postulates that the DVA was a major accomplishment in Zimbabwe because its provisions admitted the gravity of violence against women in Zimbabwe.[906] Before the enactment of the DVA, there had not been any legislation that was specifically promulgated to address domestic violence. [907] Although the DVA has been described as a progressive law that was promulgated to address domestic violence in Zimbabwe, there is a notable shortcoming in the implementation of the DVA as this is evidenced by the failure of women to exercise control over their bodies as a result of domestic violence and harmful traditional practices that persist.[908] The failure of women to control their bodies as a result of harmful cultural practices and domestic violence is inconsistent with 16(1) (e) of CEDAW and Article 14(1) (a) and (b) of the African Women's Protocol which guarantees women the right to control their bodies in as far as fertility issues are concerned. The continuation of domestic violence despite the presence of the DVA is attributed to many reasons, which include: the shame of being "violated" experienced by victims of domestic violence, respect for the traditional African

[902] Section 3(1)(1) Domestic Violence Act.
[903] Chirawu-Mugomba S 'A Reflection on the Domestic Violence Act [Chapter 5:16] and Harmful Cultural Practices in Zimbabwe' (2016*) The Zimbabwe Electronic Law Journal* 7.
[904] Chirawu-Mugomba S (2015) 8. The effect of the wide definition of domestic violence is that no longer is it seen as just the visible act of physical violence, but it covers all other aspects.
[905] The broad definition of domestic violence takes a cue from international instruments such as the UN 1993 Declaration of Violence against Women which defines gender-based violence as: "Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life. Violence against women shall be understood to encompass but not limited to: Physical, sexual and psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women…"
[906] Chireshe E (2015) 260.
[907] Chireshe E (2015) 260.
[908] Sithole L (2020) 103.

family values which often lead women to ignore the violence perpetrated against them; reluctance by police to record cases of violence as police allege that in most cases women who are victims withdraw their cases before prosecution and inadequate shelters to house victims of domestic violence.[909] The lack of adequate shelters forces women to stay with their abusers as most women, especially in rural areas where the San women reside with no land ownership hence are dependent on their husbands.[910]

4.4 POLICY FRAMEWORKS

Incorporating international and regional human rights instruments into domestic law is further evidenced by adopting policies, strategies, and plans consistent with the Constitution, regional and international human rights instruments.[911] It is important to highlight that although policies cannot be enforced in a court of law, they play a crucial role in addressing reproductive health matters and are instrumental in implementing regional and international human rights standards on reproductive health and rights.[912] In addition, policies and strategies also play a significant role in providing time-frames and strategic actions that must be followed in addressing reproductive health and rights.[913] Although Zimbabwe has enacted progressive policies that align with Zimbabwe's obligations in regional and international law, most of these policies are outdated as they provide regulation of different reproductive health and rights elements until 2020, yet they are still implemented to date. In addition, there are no policies that provide for the specific needs of indigenous women or that specifically address the reproductive health and rights of indigenous women. These shortcomings, when viewed from an intersectionality theory perspective, show the magnitude of the discrimination these women face. This helps come up with ways of addressing their problems.

4.4.1 National Health Strategy (2016-2020)

[909] Chuma M and Chazovachii B (2012) 7-11. In 2012, the CEDAW Committee bemoaned the limited effectiveness of the Domestic Violence Act in relation to the allocation of resources for establishing safe shelters for women. It noted that there was "only one state-established shelter for women victims of violence (the two other shelters were established by NGOs), and that it is not exclusively for women victims of domestic violence." The number of safe shelters has slowly increased since then.
[910] Chuma M and Chazovachii B (2012) 8-9.
[911] Section 34 Constitution of Zimbabwe.
[912] WLSA and LRF (2021) 38.
[913] WLSA and LRF (2021) 38.

This National Health Strategy 2016-2020 (National Health Strategy) "sets out the policy direction for the health sector over the next five years."[914] The National Health Strategy focuses on three main objectives. The first objective deals with strengthening priority health programs; under this objective, reproductive health is priority number three. This is laudable as this priority has objectives that address the reduction of maternal mortality and morbidity rates. In addition, this priority is commendable as many factors in Zimbabwe such as unsafe abortions, cervical cancer, and the absence of skilled birth attendants affect reproductive health, lead to maternal mortality.[915] In compliance with Article 14 (f) of the African Women's Protocol, this Strategy aims to strengthen adolescent reproductive health and rights by improving youth-friendly services and implementing comprehensive education and advocacy activities to reduce maternal deaths amongst adolescents.[916] The creation of such a policy, therefore, is essential for the protection of women's reproductive health and rights as it is in line with Zimbabwe's obligation to fulfill, which requires Zimbabwe to adopt reasonable legislative, judicial, and other measures to ensure the realisation of reproductive health and rights

Furthermore, the Strategy in Goal 1, Priority 1 also talks about preventing new HIV infections and reducing deaths due to HIV by 50%.[917] This is consistent with Article 14(1)(d) of the African Women's Protocol which mandates States to ensure that women's reproductive health and rights are protected by making it a point that women are protected against STIs, including HIV/AIDS.

4.4.2 National Adolescent Sexual and Reproductive Health Strategy (ASRH Strategy) II (2016-2020)

Zimbabwe's National Adolescent and Youth Sexual and Reproductive Health Strategy (ASRH/ Strategy) II was developed to reduce morbidity and mortality related to reproductive and sexual activity amongst adolescents and young persons.[918] The Strategy points out the main challenges experienced by adolescents and young people to be high incidences of unplanned pregnancies,

[914] Zimbabwe National Health Strategy (2016-2020) ix.
[915] Zimbabwe National Health Strategy (2016-2020) 18.
[916] The Strategy acknowledges that "Adolescents and young people contribute significantly to maternal deaths. Zimbabwe has a youthful population, with two-thirds of the population below the age of 25 years. The youth is one of the key affected population groups as most of the sexual reproductive health indicators for youth are either deteriorating or remaining high."
[917] Zimbabwe National Health Strategy (2016-2020) xi.
[918] National Adolescent Sexual and Reproductive Health Strategy (ASRH Strategy II) (2016-2020) xiii and 5.

STIs and HIV,[919] early motherhood, child marriages, GBV, and maternal mortality.[920] The identification of child marriages as a challenge in the exercise of reproductive health and rights and reproductive autonomy by girls is consistent with Article 21 (2) of the ACRWC, which prohibits child marriages because they negatively impact on young girls' ability to realise their right to reproductive autonomy.

4.4.3 National Family Planning Strategy

The 2016-2020 National Family Planning Strategy (National FP Strategy/ Strategy) is aimed at guiding the provision of family planning services within the framework of sexual and reproductive health and rights through various ways such as "creating an enabling environment, building linkages with other programmes, expanding partnerships and working with communities."[921] In addition, this Strategy acknowledges the role played by family planning in empowering people to manage their reproductive health and enhancing the fulfillment of their reproductive health and rights.[922] The Strategy also acknowledges family planning as one of the powerful interventions in reducing maternal mortality and morbidity, as it greatly assists individuals and couples in preventing unintended pregnancies and promotes healthy child spacing.[923]

Regarding adolescents, the Strategy acknowledges the importance of "providing reproductive health and rights information and services for adolescent girls, noting the high incidence of early and more frequent pregnancies than in the past amongst adolescent girls."[924] The Strategy highlights that teenagers from rural areas are "more than twice as likely" as urban teenagers to become pregnant.[925] The acknowledgment of the importance of providing reproductive health and rights information is in line with Articles 10 (h) of CEDAW and 24 (2) (f) of the CRC, which provide for the right to access health-related information which includes information related to reproductive health such as family planning.

4.4.4 Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III)

[919] The ASRH Strategy II (2016-2020) 2 states that "HIV prevalence is high amongst girls. The prevalence for girls is 4.6% whilst for boys the prevalence is 3.7%."
[920] Sithole L and Dziva C (2019) 585.
[921] National Family Planning Strategy (2016-2020) 9.
[922] National Family Planning Strategy (2016-2020) 10.
[923] National Family Planning Strategy (2016-2020) 10.
[924] National Family Planning Strategy (2016-2020) 10.
[925] Maziwisa MR (2021) 73.

The Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III/ Strategic Plan) is aimed at preventing new HIV infections.[926] In achieving its aim, the Strategic Plan provides high-impact interventions targeted at key and vulnerable populations, including "adolescents, young people, girls, and women, among others."[927] The goal of the extended ZNASPIII is "to contribute to achieving improved well-being and healthy lives for all population groups through universal access to HIV prevention, treatment, care, and support services."[928] This goal is in line with Article 12 of the ICESCR, Article 24 CRC, and Article 16 of the African Charter, which provides for everyone's right to health and well-being. This Strategic Plan adopts a human rights-based approach (HRBA) framework as one of its guiding principles. In relation to this principle, the Strategic Plan provides the following:

> "In line with the Constitution of Zimbabwe, the national HIV response recognizes and upholds human rights and non-discrimination of PLHIV, key populations, people with disabilities, youths, women, children and others who may be socially excluded."[929]

The Strategic Plan is devoted to eradicating mother-to-child transmission as an intervention for reducing maternal and child mortality rates.[930] With regards to adolescents, the Plan provides that:

> "Adolescents and young people have been prioritised in Zimbabwe's efforts to revitalise HIV prevention. Initiatives like the Sista2sista and DREAMS have been rolled out in hot spots districts in an effort to empower young women to make informed sexual reproductive decisions."[931]

This Strategic Plan and efforts introduced under the Strategy to improve the reproductive health lives of women and adolescents complies with Zimbabwe's obligation to fulfill, which requires the State to "put in place legislative, administrative and other measures to ensure that women have access to reproductive health services."

4.5 PROGRAMMES TO REALISE THE REPRODUCTIVE HEALTH AND RIGHTS OF SAN WOMEN

[926] Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) (2015-2020) iv.
[927] Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) (2015-2020) iv.
[928] Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) (2015-2020) 8.
[929] Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) (2015-2020) 9.
[930] One of the goals of the Strategic Plan is the reduction of HIV and AIDS related mortality by 50% for both adults and children by 2020 and eradication of HIV related stigma and discrimination by 2020.
[931] Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) (2015-2020) 26.

As discussed in the previous chapter, States Parties to regional and international human rights instruments have tripartite obligations they must meet to ensure the enjoyment of human rights in their countries. The commitment to fulfill mandates States "to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realise the right to health." Other measures can include the introduction of different programmes and activities as well as the establishment of Independent Institutions, Government Ministries and Departments, administrative measures, and other interventions. Thus, this section discusses the programmes adopted by the GoZ in fulfilling its regional and international obligations in realising the reproductive health and rights of indigenous women such as the San women. In discussing the different programmes, reference will be made to various institutions set up by GoZ as the Government often uses these institutions to discharge the different programmes.

4.5.1 Village Health Worker (VHW) Programme

The GoZ, through its MoHCC, has introduced different programmes and initiatives that promote different elements of women's reproductive health rights, such as the Village Health Worker (VHW) programme and Maternity Waiting Homes (MWHs).[932]

Zimbabwe's VHW programme was established when the country adopted a strong focus on primary health care (PHC) in 1981.[933] This programme was established to improve the attempts to promote awareness of health among people and building capacity for behavioural change, adoption of healthy lifestyles, and encourage people to take ownership of their health.[934] The programme is often advertised within communities and mainly targets Zimbabweans at the community level, especially those living in rural areas.[935] The 2016-2020 National Health Strategy emphasises the strengthening of the VHW programme as VHWs are expected to be the key actors in improving key health indicators, which include "the reduction of child mortality; improvement of maternal health; combating HIV/AIDS and other communicable diseases as well as the controlling of non-communicable diseases."[936] The VHWs programme

[932] Perry HB 'Health for the People: National Community Health Worker Programs from Afghanistan to Zimbabwe' (2020) *Maternal and Child Survival programme* 333.
[933] Gore O, Mukanangana F and Muza C *et al* "The role of Village Health Workers and challenges faced in providing primary health care in Mutoko and Mudzi Districts in Zimbabwe' (2015) 4:1 *Global Journal of Biology, Agriculture and Health Sciences* 130.
[934] Gore O, Mukanangana F and Muza C *et al* (2015) 130. Perry HB (2020) 233.
[935] (2015) 134. See also Perry HB (2020) 233.
[936] National Healthy Strategy (2016-2020) 42. VHWs play a crucial role of providing health services to individuals, families, and communities at large. They also encourage the participation and involvement of communities in taking responsibility of their health. According to Gore O, Mukanangana F and Muza C *et al* '(2015) 134, "VHWs were noted to refer clients to local programmes and support groups, for instance participants mentioned that

is in line with Zimbabwe's obligations echoed in Articles 12 of CEDAW, Article 12 of the ICESCR, and Article 14 of the African Women's Protocol which require Zimbabwe to provide access to health care. In addition, the VHW Programme is also in line with the obligation to fulfill that Zimbabwe must meet as the introduction of this programme amounts to the adoption of "other measures" to ensure that women enjoy their reproductive health and rights.

4.5.2 Maternity Waiting Homes (MWHs)

The MoHCC has introduced the concept of MWHs to provide a place where, women who are highly likely to have complications during delivery can be accommodated during the final stages of their pregnancy near a hospital with vital obstetric facilities.[937] The concept of MWHs has existed in Zimbabwe since the early eighties, and better pregnancy outcomes have signalled their efficacy for women who stayed at MWHs compared to women admitted directly from home.[938] All rural district hospitals in Zimbabwe have a MWH, however, they are now underutilised due to the dilapidation of the infrastructure. The 2016-2020 National Health Strategy, in its objective 10 that addresses the reduction of maternal mortality rates, highlights the need to strengthen the quality of MWHs and upgrade the infrastructure of MWH to reduce maternal mortality rates.[939] The establishment of MWHs is in line with Article 12 of CEDAW, Article 14 of the Maputo Protocol, and Article 12 of the ICESCR, which place a duty on Zimbabwe to adopt measures that will enhance women access reproductive health services. Furthermore, the MWHs align with Zimbabwe's obligation to fulfill the introduction of these homes can be interpreted as "other measures" adopted by the State, to ensure that women enjoy their reproductive health and rights.

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some clients were referred to nutrition programmes run either by Government or NGOs within their communities whilst those on ART were referred to People Living with HIV AIDS groups."

[937] Maternity Waiting Homes: Promoting Institutional Delivery and Pregnant Women's Access to Skilled Care Available at *https://zimbabwe.unfpa.org/sites/default/files/pubpdf/MATERNITYWAITINGHOMES.SUMMARY.pdf* (accessed at 18 October 2021). "Maternity Waiting Homes (MWHs) facilitate the reduction in maternal and neonatal mortality and improved maternal and neonatal outcomes by fast tracking women to emergency care should complications arise. They also provide an opportunity for pregnant women to receive health promotion on pregnancy including information on danger signs of pregnancy, labour and childbirth including new-born care."

[938] According to Shrestha SD, Rajendra PK and Shrestha N 'Feasibility study on establishing Maternity Waiting Homes in remote areas of Nepal' (2007) 11:2 *Regional Health Forum* 33, better maternal and new-born outcomes were found among women who stayed in MWHs during delivery in Zambia and Zimbabwe. Studies conducted in Zambia and Zimbabwe also proved better maternal and perinatal outcomes among high-risk pregnancies that involved a stay at a MWH.

[939] National Healthy Strategy (2016-2020) 42-43. There is the need to ensure that all district hospitals, mission hospitals and rural hospitals offering or needing minimal support or capacity building to offer comprehensive emergency obstetric and neonatal care have functional MWHs in order for MWHs to have a greater impact in contributing to the reduction of maternal mortality.

4.5.3 Promotion and investigation of gender-related matters

One of the ways that the GoZ has ensured that women enjoy their reproductive health and rights is through the introduction of programmes that promote gender equality, such as the investigation of gender-related issues, adoption of gender-sensitive policies, and the coordination of those policies. This has been done through the ZGC and the Ministry of Women Affairs, Small and Medium Enterprises (MoWASME/ Ministry). The ZGC is one of the ICs that was established by Section 245 of the Constitution of Zimbabwe and operationalised through the Zimbabwe Gender Commission (ZGC) Act (Chapter 10:31).[940] As one of the ICs supporting democracy, the ZGC is constitutionally mandated to "promote gender equality and advance women's reproductive health and rights."[941] ZGC is tasked with several functions that enable it to provide redress to women who believe they have been discriminated against in accessing reproductive health services. This is because reproductive health and rights violations have a gendered dimension as they largely and disproportionately affect women and girls.[942] They raise serious gender-related concerns and claims, thereby presenting an opportunity for the ZGC to conduct investigations whenever such matters arise. The ZGC can initiate these investigations on its own or in response to a complaint from the public.[943] Although the ZGC has the mandate to investigate gender-related issues, it faces obstacles in discharging its mandate due to financial constraints.[944] As a result of resource constraints, the institution is forced to confine itself to low-cost activities such as publishing press statements denouncing harmful cultural practices that negatively impact the enjoyment of reproductive health and rights by women.[945] Conducting investigations related to gender issues through the ZGC aligns with Zimbabwe's obligation to fulfill as conducting those investigations and establishing institutions to specifically do so amounts to the adoption of "other measures" to ensure that women enjoy their reproductive health and rights. Although the ZGC is mandated

[940] See Section 245 Constitution of Zimbabwe and the Zimbabwe Gender Commission Act [Chapter 10:31].
[941] Section 246 Constitution of Zimbabwe. These objectives are: "to support and entrench human rights and democracy; to protect the sovereignty and interests of the people; to promote constitutionalism; to promote transparency and accountability in public institutions; to secure the observance of democratic values and principles by the State and all institutions and agencies of government, and government-controlled entities; and to ensure that injustices are remedied."
[942] WLSA and LRF (2021) 40.
[943] See 246 (b) and (c) Constitution of Zimbabwe.
[944] Sithole L and Dziva C (2019) 587 postulate that "for the year 2019 the ZGC was given a budget of only US $2 million for employment costs, operational costs and maintenance as well as capital expenditure. This amount is inadequate to ensure that the ZGC effectively carries out its constitutional mandate, including the protection and enforcement of women's rights against harmful practices."
[945] Sithole L and Dziva C (2019) 588.

to address gender equality issues throughout Zimbabwe, the ZGC has not done any research that specifically deals with the needs or challenges faced by the San women.

The MoWASME is a Government Ministry mandated to "promote the empowerment of women, gender equality and equity, and community development."[946] Its overall responsibility is implementing and coordinating policies and programmes on gender through a bottom-up approach.[947] The MoWASME also has the mandate to administer national legislative frameworks protecting women's reproductive health and rights, such as the DVA.[948] This Ministry is also mandated to implement regional and international human rights agreements that are aimed at promoting gender equality and women's rights, namely the Women's Protocol and CEDAW. The Ministry has implemented many policies addressing women's rights including their reproductive health and rights to fulfill its mandate.[949] One of the strengths of this Ministry is that its services are available at provincial, district, and ward levels which makes all its services accessible to everyone, especially women and other categories of vulnerable groups at a community level.[950] As a result of its accessibility, the Ministry is usually the first point of call for people whose reproductive health and rights are violated and those seeking assistance to access reproductive health services when they are faced with situations which leave them with no confidence to approach other stakeholders such as the police for assistance (this is usually the case with victims of rape).[951]

Promoting gender equality through establishing a Government Ministry that deals with gender issues and issues that affect women comply with Zimbabwe's obligation to fulfill, which requires Zimbabwe to take appropriate measures to ensure the elimination of wrongful gender stereotyping.

4.5.4 Awareness raising on human rights

One way that the GoZ has attempted to honour its international obligations relating to the realisation of reproductive health and rights of indigenous women such as San women is through raising awareness on human rights. This function has been carried out by the Zimbabwe's National Human Rights Institution (ZHRC).

[946] WLSA and LRF (2021) 40.
[947] Sithole L (2020) 115.
[948] WLSA and LRF (2021) 40.
[949] An example of the policies is the Revised National Gender Policy.
[950] WLSA and LRF (2021) 40.
[951] WLSA and LRF (2021) 40.

The ZHRC was established by Section 242 of the Constitution of Zimbabwe. It was established in 2009 by the Government of National Unity (GNU), but due to financial constraints, it only became operational in 2014.[952] The ZHRC established a Thematic Working Group (TWG) on Gender Equality and Women's Rights, which is proving to take a leading role in research and awareness raising on issues that negatively affect women's enjoyment of reproductive health and rights, such as harmful practices perpetrated towards women and girls.[953] In line with its mandate to deal with gender equality and issues affecting women,[954] this TWG conducted a public dialogue with government institutions, NGOs, CSOs, and FBOs, which was broadcasted on national television and focused on discussing the strategies to eradicate child marriages in Zimbabwe considering that child marriages negatively affect the enjoyment of rights including reproductive health and rights by young girls.[955] The dialogue led to the production of a documentary and the development of a position paper that was publicised through various media platforms such as print and electronic media, press, and social media platforms. These initiatives raised awareness on the impact and strategies to end child marriages as outlined by the ZHRC's Constitutional mandate entrenched in Section 243 of the Constitution.[956] The efforts by the ZHRC to educate women on their right to health, including reproductive health, is in line with Article 10(h) of CEDAW and 24(2) (f) of the CRC, which protect the right to access health education and health-related information.

Furthermore, the ZHRC also established a TWG on Special Interest Groups. This TWG has conducted visits to the San community in Tsholotsho and produced a report detailing the human rights challenges faced by the San in that District.[957] In addition, this TWG, in partnership with NGOs such as Plan International Zimbabwe (PIZ), drafted a Strategic Plan to track the progress on implementing different rights of the San community in Tsholotsho District. Among the rights monitored, the right to health is one of them. The Action Plan mentions the need to construct health institutions close to areas where the San in Tsholotsho live to enable them to access health services including reproductive services.[958]

[952] Sithole L and Dziva C (2019) 587.
[953] Sithole L and Dziva C (2019) 587.
[954] Zimbabwe Human Rights Commission Act [Chapter 10:30] mandates the ZHRC to establish Thematic Working Groups (TWGs) which are small committees tasked with focusing on key human rights themes.
[955] Sithole L and Dziva C (2019) 587.
[956] Sithole L and Dziva C (2019) 587.
[957] ZHRC Sig Twg Report (2020) 1.
[958] ZHRC: Action Plan on advancement of rights San Community of Tsholotsho District in response to the ZHRC situation analysis (2020) 1.

Moreover, the ZHRC, through its Education, Promotion, and Research Department (EPR), conducted human rights awareness raising outreaches within the San communities in Tsholotsho and Plumtree Districts, and the subject of reproductive health and rights was one of the topics that these communities were capacitated on.[959] The ZHRC should be applauded for discussing this issue with the San community because most stakeholders working in those areas have focused more on the San community's general right to health, neglecting to address the San women's reproductive health and rights. In addition, State Gender Institutions such as the Ministry of Women Affairs and the ZGC, from the work they have done, have not directly addressed the issue of access to reproductive health and rights of indigenous women in Zimbabwe.

The ZHRC also partners with other Chapter 12 institutions, such as the ZGC to enhance women's rights. However, both these institutions' discharge of their mandates is limited by resource constraints.[960] This is so because of many reasons. The budget vote they get from the Treasury (Ministry of Finance and Economic Development) and contributions from donors are inadequate to resource their activities. In addition, a few donors can partner with grant-aided institutions such as these ICs due to the high involvement and the need for the responsible Minister's permission to allow Commissions to seek to partner with a particular donor for funding.[961] Sithole and Dziva argue that the Government has often been criticised for interfering in the work of these institutions and intentionally starving them of resources. As a result, this compromises the independence and effectiveness of these institutions.[962]

The establishment of the ZHRC and the programmes conducted by the ZHRC is consistent with Zimbabwe's obligation to fulfill, which requires the State to come up with legislative, administrative, and "other measures" to enable women to have access to reproductive health services.

4.6 REALITIES OF SAN WOMEN IN TSHOLOTSHO DISTRICT AND PLUMTREE DISTRICT IN ACCESSING REPRODUCTIVE HEALTH AND RIGHTS

This section discusses the realities of San women's access to reproductive health and rights. Hitherto, the analyses on the laws, policies and programs relating to reproductive health and

[959] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 5 and 6-7.
[960] Sithole L and Dziva C (2019) 588.
[961] Sithole L and Dziva C (2019) 588.
[962] Sithole L and Dziva C (2019) 588.

rights, extant in Zimbabwe, this sub-section, discusses the realities of San women regarding the enjoyment of their reproductive health and rights. The discussions below are informed by the findings from reports ofdifferent organisations outlining the situation of the San women relating to their right to health in general, and their reproductive health and rights in particular.

4.6.1 Knowledge of human rights and the Constitution of Zimbabwe

Before delving into discussions on access to reproductive health and rights, it is crucial to understand the San women's understanding of human rights. According to a ZHRC report highlighting its human rights awareness-raising outreaches in Tsholotsho and Plumtree Districts specifically focusing on the San in Makhulela and the San in Sikente and Mtshina (Tsholotsho District), the people in those areas, including the San, failed to define what human rights are but attributed human rights to children's rights, access to civil documents such as birth certificates, and access to food and water.[963] With regards to access to reproductive health services, the ZHRC report, established that female participants at Makhulela (Plumtree District) were unaware that they had reproductive health rights as the MoHCC did not raise awareness on the subject matter in that community.[964] The representative from the MOHCC indicated that they were supposed to have mobile clinics where they could teach women and give them information on reproductive health, but could not do so because of financial constraints and a lack of fuel to move around different places.[965] Thus, when applying the intersectionality theory, this lack of knowledge of what human rights are, including reproductive health and rights by the San women, makes it easy to understand the multiple forms of discrimination these women experience, which contribute to their failure to claim or enjoy their reproductive health and rights. With regards to knowledge of the Constitution, some communities, including the San communities, highlighted that they knew about the existence of the Constitution, but they did not have copies of it, and they, therefore, requested that they be given Constitutions written in the languages they understand.[966]

Since the CESCR has come up with a framework to define the minimum requirements for meeting the right to health as discussed in chapter 3, the discussion below, critically analyses the San women's enjoyment of their reproductive health and rights by using this framework.

[963] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 5.
[964] A few San women at Mtshina were also asked separately about their knowledge of reproductive health rights and they said they were not aware that they had such rights.
[965] ZHRC Plumtree and Tsholotsho Outreaches Report) (2021) 5.
[966] ZHRC Plumtree and Tsholotsho Outreaches Report) (2021) 7.

Therefore, the following discussions were divided into the following sub-headings: availability, accessibility; acceptability, and quality.

Availability

PLAN International Zimbabwe (PIZ), one of the most active development partners in the San Community in Tsholotsho has worked with the MoHCC, the Tsholotsho Rural District Council and the Tsholotsho District Development Coordinator's (DDC) Office to construct Mpilo Clinic in ward seven (some San people are found in this ward) that has a solar powered borehole.[967] The construction of this clinic resulted from the challenges previously faced by the San in the Mpilo ward, who had to walk twelve kilometres to access health services in Phumula Hospital. Mpilo Clinic provides reproductive health and rights community dialogues and has a referral structure for survivors of gender and sexual violence.[968] However, despite the provision of reproductive health services by this clinic, there is still a need to create demand by the San Community to demand reproductive health information and services as they underutilise these services.[969] In addition, the San women in Makhulela lamented that they were fortunate because there was a clinic close to their ward, so it was easy to access health services but in serious cases or where there are complications, referrals are made to Plumtree District Hospital. However, there are challenges with referrals as, in most cases, women are not told in-depth the reason for the referral also, if one is referred to a big hospital like Mpilo Central Hospital, which is in another district and province one faces challenges when they now want to acquire a birth certificate for their child.[970] The failure to give women adequate information when they have challenges concerning their pregnancies is contrary to Article 10(h) of CEDAW and Article 24 CRC, which mandate States to give information so that people can enjoy their right to health, including their reproductive health and rights. The GoZ, through the MoHCC, Ministry of Local Government, and NGOs, should be applauded for providing health infrastructure that will improve the quality of health and life of everyone, including vulnerable groups such as the San as highlighted in the 2016-2020 National Health Strategy. However, there is a need for the GoZ through the MoHCC to interrogate why there is under-usage of reproductive health services amongst the San women so that services that are

[967] ZHRC SIG TWG Report (2020) 7.
[968] ZHRC SIG TWG Report (2020) 7.
[969] ZHRC SIG TWG Report (2020) 7.
[970] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 7. One of the participants during the Makhulela outreach narrated her experience that she was sent back and forth to Mpilo Hospital to get some papers that would assist her to acquire a birth certificate for her child and this was costly.

accommodative of the San people's traditional beliefs are introduced in line with Article 24 of the UNDRIP.

Accessibility

Physical accessibility

During the ZHRC outreaches in Tsholotsho District, participants at Mtshina, where some San people reside, highlighted that they travel ten kilometres to access health services at Sikente Clinic and this made it difficult to receive medical attention when one is critically ill as people often dread walking such long distances for fear of being attacked by wild animals along the way. [971] To reduce the long distances travelled by women to seek health services, two clinics were constructed in Mpilo and Tshitatshawa wards, where San people are found.[972] The construction of these health facilities, given Zimbabwe's economic situation, is commendable as this is in line with Zimbabwe's obligations echoed in Article 12 of the ICESCR for Zimbabwe to ensure the enjoyment of the right to health within Zimbabwe's available resources. However, there is still a need for the construction of another health facility in the Pelandaba Area, to service three wards, namely wards one, seven, and ten, so that people in those wards do not travel long distances to access health facilities.[973] Despite the construction of these health facilities, the San women continue to face several challenges regarding their access to health facilities for many reasons.[974] For example, maternal services such as check-ups for pregnant women are done at the hospital (Phumula Hospital) approximately twenty kilometers from where the San live. Due to the long distance and other factors, the San women are expected to walk for a check-up, they miss appointments. The failure by the San women in Tsholotsho to access maternal health services due to physical barriers contravenes Article 25 ILO Convention, Article 12 ICESCR, Article 24 CRC, Article 16 African Charter and Article 14 ACRWC which place an obligation on States to ensure that women and girls enjoy the highest attainable standard of health. With regards to the accessibility of health facilities by the San community and other community members in Makhulela, the ZHRC learned that there was a clinic nearby; therefore, people were not required to travel long distances to access health services.[975] However, the San community continues to face several challenges with access to health facilities, economic exploitation, sexual exploitation, non-participation in politics and

[971] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 7.
[972] PLAN International Zimbabwe End of Project Report 2019.
[973] PLAN International Zimbabwe End of Project Report 2019.
[974] ZHRC SIG TWG Report (2020) 4.
[975] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 7.

development processes, lack of recreation facilities, challenges with access to national documents, and inadequate school furniture.[976]

Information accessibility

Regarding disseminating health information, including information related to reproductive health and rights, PIZ has been carrying out development programmes on reproductive health and rights, gender transformative child protection, and reduction of child and unplanned youth pregnancies and child marriages.[977] In addition, PIZ in partnership with the MoHCC carried out health awareness campaigns on reproductive health in Tsholotsho District where young girls were capacitated on the control they have over their bodies, the power they have to make informed choices about their identity, relationships, and when to have children.[978] This programme played a crucial role in allowing the San community to thrive and grow up equally valued and free from discrimination, violence, and fear.[979] The dissemination of information related to reproductive health is in line with Article 10(h) of CEDAW and Article 24(2) (f) of the CRC, which provides for the right to access health-related information, which includes reproductive health information.

Hitchcock *et al*, highlighted that during their study period, the San communities in Tsholotsho displayed knowledge of HIV transmission. They also stated that the availability of condoms seemed adequate and often supplied for free amongst all the communities in Tsholotsho, including the San community.[980] However, despite such knowledge and the provision of free condoms, teenage pregnancy rates are reportedly high, especially among the San communities, who are said to fall pregnant before age eighteen.[981] It was also noted that despite the knowledge of HIV transmission, several health issues are prevalent amongst San communities, including HIV/AIDS, high levels of poor nutrition, and substance abuse.[982] Hitchcock *et al.*, found that while, in general, the HIV prevalence rate appears to be comparatively low in Tsholotsho compared to other parts of Southern Africa, a significant number of people were

[976] ZHRC SIG TWG Report (2020) 4.
[977] Zimbabwe Human Rights Commission (ZHRC) Report: Special Interest Groups (Sig) Thematic Working Group Stakeholders' engagement meeting on the human rights situation analysis of the San community of Tsholotsho District (2020) 6.
[978] The PLAN International Zimbabwe End of Project Report 2019 stated that during the health mobile awareness programme people were given a platform to be tested for HIV/AIDS and get initiated into the ART program.
[979] PLAN International Zimbabwe End of Project Report 2019.
[980] Hitchcock RK, Begbie-Clench B and Murwira A 'The San of Zimbabwe: An assessment report' (2014) *Open Society Initiative for Southern Africa (OSISA)* 5.
[981] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60.
[982] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60.

being treated for HIV in the San communities.[983] The reasons provided for the prevalence of HIV amongst the San communities include alcohol and substance and having multiple sexual partners.[984] In order to assist the San communities living with HIV, Antiretroviral drugs (ARVs) are found in clinics and hospitals in Tsholotsho, which are given free of charge.[985] Despite the availability of these drugs free of charge, it was difficult to ensure the effectiveness of the drugs because of factors such as insufficient food and clean water that are prevalent in the San community.[986] The demonstration of knowledge of HIV/AIDS transmission and the provision of free ARVs and condoms complies with Article 14(1)(d) of the African Women's Protocol which places an obligation on State Parties to protect women from the spread of STIs including HIV/AIDS.

In addition, women in Makhulela, including the San women, highlighted that they were not getting information related to family planning, such as information on contraceptives. They stated that only on a lucky day would one access such information when they visited the clinic or receive such information when they asked nurses at the clinic.[987] On the other hand, the women from Mtshina (Tsholotsho) stated that they received information on the different types of contraceptives from VHWs and Child Care Workers (CCWs), but the San women stated that most of them did not use any contraceptives.[988] The women also indicated that they were receiving information on the treatment of HIV and/ STIs from Sikente Clinic whenever they visited the clinic, as the clinic did not have mobile programmes to educate people on such matters.[989] In responding to the question of limited awareness raising on reproductive health and rights, the MoHCC highlighted that they had programmes targeted at teaching communities on the subject matter, but could not carry them out because of resource constraints.[990] The MoHCC, through its VHWs programme should be commended for ensuring that reproductive health information is disseminated to grassroots levels and marginalised groups such as the San

[983] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60. For example, in one group discussion of eleven San women, eight disclosed their status, seven of whom said they were HIV positive.
[984] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60. Several women suggested that a "community wellness programme" should be instituted that includes an alcohol and tobacco awareness component as well as a component dealing with Sexually Transmitted Diseases.
[985] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60.
[986] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60. According to the ZHRC Plumtree and Tsholotsho Outreaches Report (2021), the participants stated that due to the Lockdown they were not able to send ARV treatment to their relatives in the diaspora since borders were closed and this impacted on their relatives' right to health and life.
[987] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.
[988] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.
[989] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.
[990] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.

women receive such information. In line with Article 12 of the ICESCR and the 2016-2020 National Health Strategy, Zimbabwe, through the MoHCC, should raise awareness and disseminating information on reproductive health to all Zimbabwean society within its available resources.

In addition to the challenges faced in accessing hospitals which led San women to give birth in bushes, the following were mentioned as contributing factors to having San women giving birth at home or in the bushes: their lack of knowledge of the weeks when they were to get ready to deliver as some women did not have money to do scans; some women would lie to nurses on when they had fallen pregnant, and some women had no knowledge of when they had fallen pregnant which made it hard for the nurses to estimate dates when they were likely to give birth.[991] Therefore, Zimbabwe should ensure that health-related education and information in line with Article 10(h) of CEDAW and Article 24(2) (f) of the CRC is disseminated to San women before pregnancy and at every stage of their pregnancy.

Economical Accessibility

Most San women were giving birth at home with unskilled birth attendants because of many factors. In the case of the San women in Makhulela, the reasons stated, included their lack of financial resources to buy baby receiving clothes that one is supposed to have when going to give birth as well as their lack of knowledge that the clinic was providing food for all the pregnant women who were waiting to deliver.[992] In the case of the San women in Tsholotsho, Sikente Clinic allows expectant mothers to stay at the clinic (MWH) while waiting to give birth, but the challenge was that they had to bring their food and baby-receiving clothes. Women like the San women who did not have their food then opted to give birth at home, mostly with unskilled attendants. The clinic only got to know about these births when the women, later on, came to the clinic to be assisted with acquiring a baby health card.[993] A documentary by Humanitarian Information Facilitation Centre highlighted that due to the long distance to Phumula Hospital and a lack of money to commute to the hospital, most San women were giving birth at home and in the bushes that are infested with wild animals such as buffaloes.[994] For San women to raise money for transport and other items needed at the hospital, such as food and baby clothes, they had to sell livestock. Still, given the poverty of most of the

[991] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.
[992] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.
[993] ZHRC Plumtree and Tsholotsho Outreaches Report (2021) 8.
[994] Humanitarian Information Facilitation Centre 'Women in Tsholotsho forced to deliver in their homes, alone' available at *https://www.youtube.com/watch?v=QZF8BBUJjMg&t=32s* (accessed 20 October 2021).

San people, they could not raise funds because they did not own livestock.[995] Although Zimbabwe's 2016-2020 National Health Strategy speaks to the strengthening of MWHs facilities, the situation prevailing on the ground is contrary to such objectives as San women fail to access services at the MWHs due to a lack of materials things such as food and baby clothes.

Acceptability

According to Hitchcock *et al.*, generally, there is high usage of health facilities amongst the San in Tsholotsho compared to the other San in Southern Africa. This was evidenced by the good knowledge of HIV/AIDS, TB, and aspects related to the health of women and children amongst the San women in Tsholotsho. Such knowledge is impressive compared to the knowledge possessed by a lot of San communities in the Southern African region.[996] For the San who were unable to use health facilities, the reasons given for failure to use those facilities include distance, cost, preference for traditional medicine and irregular incidences of discrimination from health practitioners which in some instances is based on the uncommon scent of traditional perfume used by San.[997]

Quality

Despite the crumbling economic situation in Zimbabwe, Hitchcock *et al.*, argue that the general health of many people in Zimbabwe, especially children, has improved over the past several decades. This is evidenced by the reduction in maternal mortality rates.[998] However, the failure of MWHs to provide food, clothing, and linen for waiting mothers shows the decrease in the quality of maternal services. Therefore, Zimbabwe needs to align with its 2016-2020 National Health Strategy and international obligations to improve the conditions in MWHs within its available resources.

4.7 CONCLUSION

This chapter has shown a link between some constitutional rights and reproductive health rights. A discussion of those rights made it clear that reproductive health and rights in the Constitution of Zimbabwe are justifiable. The discussion also highlighted the importance of

[995] Humanitarian Information Facilitation Centre 'Women in Tsholotsho forced to deliver in their homes, alone' available at *https://www.youtube.com/watch?v=QZF8BBUJjMg&t=32s* (accessed 20 October 2021).
[996] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 43.
[997] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 43.
[998] Hitchcock RK, Begbie-Clench B and Murwira A (2014) 60.

some constitutional provisions in advancing reproductive health and the rights of indigenous people, such as San women. The discussion also showed that the Constitution provides for Zimbabwe's commitment to implementing its international obligations by incorporating the provisions of the human rights treaties and conventions that Zimbabwe is a party to into Zimbabwean laws. The discussion showed that although Zimbabwe is committed to promoting reproductive health and the rights of indigenous people, some constitutional provisions, such as Section 48, are to some extent inconsistent with Zimbabwe's international obligations.

In response to Zimbabwe's regional and international obligations, Zimbabwe has enacted a plethora of legislation to address reproductive health and rights of women, including San women. The discussions revealed that most of these laws are inconsistent with the Zimbabwean Constitution and regional and international human rights standards that Zimbabwe ascribes to. For those pieces of legislation that comply with regional and international human rights standards, there are some hurdles when it comes to the practical implementation of the laws. The laws enacted by Zimbabwe do not specifically provide for regulating the rights of indigenous minority groups such as the San. In addition, the policies discussed comply with regional and international standards that Zimbabwe is a party to but fail to address the plight of indigenous women specifically. The government has introduced good programmes to realise the reproductive health and rights of indigenous women and has done so through the establishment of different institutions. However, the discussion has shown that most programmes do not directly target indigenous communities, including women from communities such as the San women. The government has also failed to discharge a lot of programmes because the institutions established to take a leading role in implementing the programmes are under-resourced. The discussion has also shown that San women continue to face challenges in enjoying their reproductive health and rights despite laws with laudable provisions that align with regional and international human rights laws that protect reproductive health and rights. This failure can be connected with the non-recognition or failure to entrench indigenous people's rights in national laws and policies as well as programmes introduced to address reproductive health matters. The next chapter discusses lessons Zimbabwe can learn from Botswana and Canada regarding the protection and realisation of reproductive health and the rights of indigenous women.

CHAPTER FIVE

ADVANCING REPRODUCTIVE HEALTH AND RIGHTS FOR INDIGENOUS WOMEN: LESSONS FROM BOTSWANA AND CANADA

5.1 INTRODUCTION

Chapter 4, focused on analysing whether Zimbabwe has complied with its regional and international human rights obligations in guaranteeing access to reproductive health and rights by San women. This was done by critiquing the laws, policies, and programmes Zimbabwe has introduced to ensure access to reproductive health and rights for the San women. The chapter also unpacked the realities of San women in Tsholotsho and Plumtree Districts regarding their enjoyment or access to reproductive health and rights. This chapter is guided by the following research question: what lessons can Zimbabwe learn from other jurisdictions regarding the realisation of the reproductive health and rights of indigenous women? In other words, what lessons can Zimbabwe draw from other countries on how they have enacted laws and policies and introduced programmes and other initiatives to ensure that indigenous women in those countries enjoy their reproductive health and rights? In answering this question, the chapter focuses on the treatment of indigenous women in Botswana and Canada.

This chapter is divided into four sections. The first section is this introduction followed by the section which focuses on indigenous people in Botswana. Under that section, a discussion on who indigenous people are in Botswana is made. That section also evaluates the legislative, policy and other frameworks and measures established by Botswana to ensure the realisation of the reproductive health and rights of San women. In addition, this section specifically unpacks the realities of the San women in accessing their reproductive health and rights in light of the legislative, policy, and other frameworks and measures introduced by Botswana to ensure that indigenous women enjoy those rights. The third section discusses who indigenous people are in Canada and assesses the laws, policies, programmes, and other initiatives put in place by the Government of Canada to ensure that indigenous women in Canada enjoy their reproductive health and rights. The section also unpacks Aboriginal women's realities in accessing their reproductive health and rights. In all these discussions, the author highlights the similarities and differences in how the two countries address the access to reproductive health and rights by indigenous women compared to Zimbabwe. Furthermore, the author highlights the lessons Zimbabwe can learn from the two jurisdictions regarding the protection and

realisation of reproductive health and the rights of indigenous women. In unpacking who indigenous people are in both countries, the author highlights the challenges indigenous people face, including the challenges they face in enjoying their rights. Under these headings, the author also discusses the position on the realisation of the socio-economic rights of the San women and Aboriginal women. The discussion on the enjoyment of socio-economic rights of Aboriginal women in Canada and the San women in Botswana is very important in this discussion because the enjoyment of certain socio-economic rights such as the right to education, labour rights and the right to safe water among other rights play a pivotal role in influencing people to claim and access their reproductive health and rights. The final section of this chapter is the conclusion.

5.2 INDIGENOUS PEOPLE IN BOTSWANA

Botswana is situated in the Southern African region and is dominated in geographical terms by the Kalahari Desert.[999] Botswana is bordered by Zambia, Zimbabwe, Namibia and South Africa.[1000] Although the name Botswana suggests that this country is mainly populated by Tswana-speaking people, it is acknowledged that the most indigenous inhabitants of this country are the San, who have traditionally been called the "Bushmen."[1001] The San comprise a distinct minority of approximately three percent of the national population of Botswana.[1002] The San of Botswana were inhabitants of the Central Kalahari Game Reserve (CKGR), one of the largest conserved areas in Africa, which used to be inhabited not only by the San of Botswana but by the San of Southern Africa.[1003] Despite the San of Botswana's close relationship with the Kalahari region, the San have been progressively expelled by the Government from the CKGR and pushed to dilapidated settlement camps.[1004] As a result, they cannot fully enjoy their rights, especially their socio-economic rights, due to the location and

[999] GOV.BW 'About our country' available at *https://www.gov.bw/about-our-country* (accessed 27 February 2023.

[1000] GOV.BW 'About our country' available at *https://www.gov.bw/about-our-country* (accessed 27 February 2023.

[1001] Ng'ong'ola C 'Land rights for marginalized ethnic groups in Botswana, with special reference to the Basarwa (1997) 41: 1 *Journal of African Law* 1. The San people in Botswana consider themselves as the indigenous people of Botswana because they meet the global definition of indigeneity.

[1002] Mazonde I (2004) 153.

[1003] Mzonde I (2004) 153. See also Motzafi-Haller P 'When Bushmen are known as Basarwa: Gender, ethnicity, and differentiation in rural Botswana' (1994) 21:3 *American Ethnologist* 539-563. The Kalahari Desert has historically been home to the Bushmen from different countries such as Zimbabwe, Namibia, Angola and South Africa.

[1004] Mzonde I (2004) 153.

nature of their dwellings.[1005] The dominant Tswana tribes have traditionally been referring to the San people in Botswana as "Basarwa,"[1006] a term viewed as derogatory.[1007] Although the dominant tribes refer to the San as "Basarwa," it is important to highlight that the GoB does not frequently use this term to avoid ethnic classifications but rather refers to them in ethnicity-neutral language and often by the expression "Remote Area Dweller."[1008]

The challenges faced by the ethnic or indigenous minorities in Botswana can largely be attributed to the debate on indigeneity in Botswana, which is evident in the GoB's treatment of the ethnic minorities, including the San people.[1009] The effects of this indigeneity debate have translated to the marginalisation suffered by ethnic minorities such as the San.[1010] Scholars such as Cook and Sarkin argue that although this agenda can be applauded for promoting peace and non-racism, it left a lot of indigenous minorities such as the San at a disadvantaged position as they cannot fully claim their rights without invoking the indigeneity debate.[1011] The author concurs Sarkin and Cook because if the GoB decided to ignore the indigeneity debate or refused to acknowledge the San as the indigenous people of Botswana openly it is be hard or almost impossible for the San to hold the Government accountable if their rights are violated.

[1005] Olmsted N 'Indigenous rights in Botswana: Development, democracy and dispossession' (2004) 3:3 *Washington University Global Studies Law Review* 799. The CKGR was occupied by the San especially the G//ana and the G/we tribes for over two centuries these tribes regarded the reserve as their ancestral or homeland. After independence, the GoB evicted the San and placed them in dilapidated settlements and made way for mining companies to occupy the CKGR.

[1006] Basarwa is a Tswana word meaning 'those who do not rear cattle.'

[1007] Olmsted N (2004) 809. "The term *Basarwa*, though viewed by some as pejorative, improved on the former term, *Masarwa*, which, rather than the 'Ba' prefix used to denote people contains the 'Ma' prefix used to denote objects and animals."

[1008] Olmsted N (2004) 809. Olmsted also postulates the following: "To the disapproval of the United Nations Committee on the Elimination of Racial Discrimination, the GoB has even declined to keep official data on San populations. The phrase 'Remote Area Dweller,' refers to the GoB's Remote Area Development Programme (RADP) and the poor, marginalised, rural residents who are supported by it. This term not only elides ethnic distinctions among the groups participating in the RADP, but it also defines them from the contingent perspective of Tswana groups residing in the urbanised and more densely populated South-Eastern region of Botswana."

[1009] Cook A and Sarkin J 'Who is indigenous: Indigenous rights globally, in Africa, and among the San in Botswana' (2009) 18:1 *Tulane Journal of International and Comparative Law* 117.

[1010] Cook A and Sarkin J (2009) 117 posit ZHRC Plumtree and Tsholotsho Outreaches Report (2021) that "this marginalisation was exacerbated by the attempt by Khama to foster unity and nationality among all the tribes and ethnic groups in Botswana and had those of Tswana ancestry at the forefront of this agenda. As a result, although Khama had good intentions through his nationalism agenda, only those in power at that time were of Tswana ancestry and therefore, this nationalism agenda in Botswana ended up being unconsciously created by and for the Tswana people and excluding other tribes and ethnic groups."

[1011] Cook A and Sarkin J (2009) 118 argue that "the reason behind the criticism of the nationalism agenda and preference of embracing indigeneity when dealing minorities such as the San in Botswana is that minority groups such as the San assert that the title of indigenousness plays a vital part in ensuring that they access certain human rights and to hold the GoB to meet its international human rights obligations."

The main challenge faced by indigenous people in Botswana, including the San, is the absence of clear demographic information and lack of data on their situation and matters that include their ethnicity, religion, or language. This shortcoming contributes to the failure of authorities and policy makers to craft laws and policies and tailor those policies and laws to suit the needs of indigenous people.[1012] Mazonde argues that to alleviate the challenges faced by the San, there is a need to address the ethnicity factor as it is the underlying cause of the challenges they face.[1013] The author concurs with Mazonde because from the author's observations regarding the treatment of indigenous people in many countries, their marginalisation is usually rooted in their tribal or ethnical origins.

The San have historically been victims of inhumane and degrading treatment, including being deprived of their belongings and having their women regarded as concubines.[1014] This action by the dominant Tswana tribe, when viewed from an intersectionality theory standpoint, shows how the San face multiple forms of discrimination which furthers their marginalisation and subjugation. In addition, the expulsion of the San from the CKGR to convert the land they were using for grazing and extractive purposes has created problems in the enjoyment of socio-economic rights and traditional activities by the San.[1015] The rights that have negatively been impacted include land, subsistence, livelihoods, labour rights, culture, and self-determination, among others. The expulsion of the San from the CKGR does not comply with Article 1 (2) of the ICCPR[1016] and Article 1 (2) of the ICESCR,[1017] which reiterate that no circumstance should warrant the deprivation of people from their means of subsistence. The San are traditionally known to have depended on hunting and gathering for several years. This was both a form of subsistence for them and an essential part of their culture.[1018] Therefore, by removing the San by force from the CKGR, where they had the capability and knowledge to hunt, gather, and

[1012] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23 January 2022). The Government of Botswana should review its national census approach as well as collect and analyse data disaggregated by ethnicity, religion and language while being sensitive to and respecting privacy concerns.

[1013] Mazonde I (2004) 138.

[1014] Tingwane A (2013) 32. In a particular incident, a San man was killed by a Tswana man so that he could take his wife to be a concubine and he was not punished for his actions. As a result, the dominant tribes assumed a right of some sort over the San.

[1015] Olmsted N (2004) 799.

[1016] Article 1 (2) of the ICCPR provides that "…In no case may a people be deprived of its own means of subsistence."

[1017] Article 1 (2) of the ICECSR provides that "…In no case may a people be deprived of its own means of subsistence."

[1018] Cook A and Sarkin J (2009) 125.

employ other means of earning a living, the GoB violated its obligations under the ICCPR and the ICESCR.[1019]

Olmsted postulates that although Botswana's economy has experienced rapid growth, the San have been largely denied the fruits of this growth and development.[1020] This has resulted in the San continuing to experience chronic unemployment and poverty,[1021] lack or limited ownership of land and assets, frequent dependency on Government aid, and dependency on livestock owners who are mainly dominant tribes such as the Tswana for their subsistence and income.[1022] Furthermore, the San have been subjected to unpaid labour by the dominant Tswana tribes.[1023] In instances where the San have provided labour for dominant tribes, especially in farms, the average wage is said to be "considerably below" what they would need to take care of their families, which forces them to end up supplementing their remuneration through various means such as foraging, food production and sale of crafts and other goods.[1024] The struggles faced by the San in Botswana are similar to those faced by the San in Zimbabwe, as the poverty levels within the San communities are high. Most of the San people earn a living by herding cattle for dominant tribes such as the Kalanga and Ndebele, who often give them little wages or food in return for the services they would have rendered. These challenges show that the different challenges faced by indigenous people result from other forms of discrimination that compound and end up resulting in a unique form of discrimination.

5.2.1. Laws, policies, and government programmes set up to ensure the realisation of reproductive health and rights of indigenous women

This section analyses the laws, policies, and programmes put in place by the GoB to ensure that indigenous women in Botswana, including the San women, access their reproductive health and rights.

It is important to highlight that generally, the GoB has been lagging in advancing the reproductive health and rights of the San women. However, to a certain extent, the Government has attempted to protect reproductive health and rights of marginalised and vulnerable

[1019] Cook A and Sarkin J (2009) 123.
[1020] Olmsted N (2004) 802.
[1021] Olmsted N (2004) 802, asserts that high inequality, among other factors has impeded the reduction of poverty in rural areas such as the Ghanzi, Kgalagadi and Ngamiland Districts where a large number of the San people is found.
[1022] Olmsted N (2004) 799.
[1023] Tingwane A (2013) 32.
[1024] Olmsted N (2004) 802.

communities through policies and programmes from which the San can benefit since they are a marginalised group. Therefore, Zimbabwe can learn a few lessons from the GoB on the treatment of its San population, particularly, the San women. The following discussion begins by presenting the good policies and measures that Botswana put in place to ensure that the reproductive health and rights of indigenous people in Botswana are realised. This discussion also highlights the lessons that Zimbabwe can learn. Moreover, this discussion is followed by a discussion that shows what influences the GoB to treat the San in the manner in which it treats them and why the Government has failed in some instances to create an enabling environment that promotes the full enjoyment of reproductive health and rights by these women through critiquing the existing laws, policies, programmes, and other measures.

Although the GoB is said to be lagging in the human rights protection of indigenous people, in compliance with its obligation to fulfill, the GoB has put in place some development programmes to advance the rights of the San people. These programmes can also be relied on to deal with the economic pitfalls faced by the San and can serve as best ,practices that Zimbabwe can adopt to improve the lives of the San within its jurisdiction.[1025] One such programme is the Remote Area Development Programme (RADP) which was created to alleviate poverty and promote development amongst those marginalised communities.[1026] This programme was revised so that it could be participatory and provide affirmative action to marginalised communities who have faced discrimination due to many factors, including being dominated by dominant tribes.[1027] Consequently, an affirmative action plan set to cover five years focusing on the appointment of persons belonging to indigenous communities in the security sectors such as police, army, and prison system was devised, and matters affecting indigenous communities, which include access to health and economic development, were also addressed.[1028] In addition, a leadership position has been created within Botswana's Ministry

[1025] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23 January 2022).

[1026] Botswana Institute for Development Policy Analysis 'Report on the Review of the Remote Area Development Programme (RADP)' (2003) x.

[1027] Botswana Institute for Development Policy Analysis 'Report on the Review of the Remote Area Development Programme (RADP)' (2003) 63.

[1028] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23 Janaury 2022).

of Local Government to address issues affecting the San people.[1029] Although Zimbabwe, like Botswana, has decided that positions be created specifically for the San in the police, army, and prison system,[1030] Zimbabwe can still learn lessons from Botswana and observe its international obligations to fulfill as well as its obligations entrenched in Section 56(6) of the Constitution of Zimbabwe and devise programmes such as the Remote Area Dwellers Programme (RADP) which focuses on many aspects meant to better the lives of those living in remote areas where indigenous people are found. If Zimbabwe devises a programme such as the RADP, it can achieve affirmative action in many areas affecting the indigenous people in Zimbabwe, such as the San women. Furthermore, the GoB should be applauded for ensuring that there is a representation of the San in positions of authority through creation of positions in the Ministry of Local Government, which is a lesson that Zimbabwe can learn, considering that the San in Zimbabwe are not represented in positions of authority whether at local, provincial and national levels.

Since the Constitution of Botswana does not entrench reproductive health and rights, the Ministry of Health and Wellness (MoHW), which is the technical lead in drawing up health awareness programmes in the country, has worked with a lot of stakeholders who include development partners, CSOs, media houses as well as the affected populations in raising awareness on reproductive health which includes HIV/AIDS prevention.[1031] Key stakeholders such as development partners[1032] play a pivotal role in providing financial and technical support to the MOHW to ensure efficient education and awareness raising for the public and specific audiences, including indigenous communities such as the San.[1033] Zimbabwe can learn from Botswana about the importance of partnering with other stakeholders in promoting reproductive health and rights awareness, given Zimbabwe's strained financial resources

[1029] Cadger K and Kepe T 'Contextualising development projects among the San of Botswana: Challenges of community gardening' (2013) 7 *Development in Practice* 812.

[1030] A newspaper article by NewZimbabwe.com published on the 28th of July 2021 stated the following: "Cabinet wishes to inform the nation that the Second Republic has made undertakings to ensure that the right to equality and non-discrimination is realised. Cabinet directed Security ministries waiver the entry requirements to enable San or Tjwao citizens to enlist into the respective uniformed services." The uniformed services in question include the Zimbabwe National Army (ZNA), Zimbabwe Republic Police (ZRP) and the Zimbabwe Prisons and Correctional Services (ZPCS).

[1031] Mid-term Progress Report (2020) 32.

[1032] The GoB works in partnership with in-country United Nations Agencies for the success of the HIV/AIDS response. WHO provides the technical and policy guidance for HIV/AIDS TB and other diseases. The HIV Testing guidelines, Anti-Retroviral Therapy and Prevention of Mother to Child Transmission programs all use WHO and UNAIDS guidance. UNICEF and UNFPA also support the country with the paediatric response and sexual and reproductive health and rights.

[1033] Mid-term Progress Report (2020) 32.

conduct such programmes, as alluded to in the previous chapter. The conducting of awareness-raising programmes by the MOHW complies with Botswana's obligation to promote, which requires Botswana to further the awareness and acceptance of human rights such as reproductive health and rights.

In order to improve access to reproductive health and rights by the marginalised and vulnerable members of Botswana, including the San, the Government is implementing frameworks such as the Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Strategy (2017-2021).[1034] This Strategy is important in promoting and protecting the reproductive health and rights of vulnerable communities because it adopts an integrated approach that emphasises prerequisite to providing inclusive care for vulnerable children and women.[1035] To fulfill the purpose of this strategy, reproductive healthcare services are provided throughout the day from Monday to Friday in all health facilities providing such services within the areas where these vulnerable groups reside.[1036] Furthermore, the Government has addressed cervical cancer, which is a big concern for HIV-positive women in Botswana, by introducing innovative methods for screening cancer on the same day and ensuring that these services are provided in all the districts of Botswana.[1037] By implementing such Strategies, Botswana agrees with its obligation to fulfill, which requires Botswana to come up with legislative and policy measures to advance reproductive health and rights.

To show Botswana's commitment to its international obligations and efforts to realise the rights of vulnerable groups, including their socio-economic rights, the decision in *Mosetlhanyane and others v. Attorney General of Botswana* is very relevant. In this case, the San community challenged the Government's decision to deny them access to water by denying

[1034] The strategy aims to ensure that the health system responds comprehensively to the needs of the population at different life stages. In further improving the health structure in Botswana and paying special attention to women and adolescents in rural areas where San women are found, Botswana has adopted the following strategies, policies and programmes: U- Report in collaboration with the United Nations International Children's Emergency FUND (UNICEF); DREAMS Project in partnership with President Emergency AIDS Relief Fund (PEPFAR); Shuga Radio program in partnership with UNICEF; WISE-UP Campaign; AGYW Programme; Life Skills Programme through MOBE; School Health Program through Ministry of Health and Wellness; and the Third National Strategic Framework for HIV/AIDS (2019-2023). Other frameworks that have been adopted that are aligned to the National AIDS strategy include: Botswana Guidelines for HIV/STI Programmes for Key Populations; Adolescent and Young People Framework and Social and Behaviour Change Communication Strategy; Faith Based organisation's Strategy; Communities Acting Together to Control HIV (CATCH) Strategy; and the Comprehensive Condom Strategy.

[1035] See UNFPA, Assessment of the Government of Botswana / United Nations Population Fund (GoB/UNFPA) 6th Country Programme (2017 – 2021). See also Mid-term Progress Report (2020) 54.

[1036] Mid-term Progress Report (2020) 54.

[1037] Mid-term Progress Report (2020) 56.

them to recommission a borehole in the CKGR at their own expense.[1038] The borehole in question was demolished and sealed by the Government after the San community's relocation from the CKGR[1039] and after Government's decision that it did not have a duty to provide vital services to the San who chose to remain at the CKGR after all the San were told to relocate.[1040] The court a quo dismissed the San's case citing that the San were responsible for the challenges they were facing by refusing to relocate from the CKGR. [1041] The Court further cited that since the applicants enjoyed the right to reside in the CKGR, this right was not restricted to a specified area. As a result, the San had a choice to reside in an area closer to where water and other essential services were readily available.[1042] After acknowledging various authorities on the right to water, the Court concluded that the applicant's case would have been valid if there was an obligation on Government to provide water where the applicants chose to stay in the CKGR area.[1043]

In the Appellate Court, the Court considered international consensus on the significance of access to water. Therefore, the Court considered the United Nations General Assembly's recognition of the right to water as a fundamental human right that is vital for enjoying life.[1044] Therefore, the Court concluded that the suffering experienced by the San community because of the lack of access to water and the refusal by the Government to allow the appellants permission to use the bore hole at their expense violated the right not to be subjected to torture or to inhuman or degrading punishment or other treatment as outlined in Section 7(1) of the Constitution of Botswana. [1045] The Appellate Court set aside the decision of the High Court and gave the San community the authority to recommission the borehole in question.[1046] The Courts must be applauded for applying international law and showing judicial independence in handling matters relating to the San, considering how they have been progressively expelled from the CKGR by the Government.[1047] Therefore, Zimbabwe can learn lessons from

[1038] Paragraph 1 *Mosetlhanyane and others v. Attorney General of Botswana Court of Appeal* (unreported case) CALB–074-10.
[1039] Paragraph 1-2 *Mosetlhanyane and others v. Attorney General of Botswana.*
[1040] See *Sesana and Others v The Attorney-General* 2002 1 BLR 452 (HC).
[1041] Paragraph 77 *Mosetlhanyane and others v. Attorney General of Botswana High Court decision MAHLB–000393-09, (unreported).*
[1042] Paragraph 77 *Mosetlhanyane and others v. Attorney General of Botswana.*
[1043] Paragraph 77 *Mosetlhanyane and others v. Attorney General of Botswana.*
[1044] Paragraph 16 *Mosetlhanyane and others v. Attorney General of Botswana.*
[1045] Paragraph 16 *Mosetlhanyane and others v. Attorney General of Botswana.*
[1046] Dinokopila BR (2011) 294.
[1047] Dinokopila BR (2011) 293. See also paragraph 10 Concluding Observations and Recommendations on the Initial Periodic Report of the Republic of Botswana, Consideration of Reports submitted by States Parties under

Botswana on how to independently deal with matters concerning the San when their rights to enjoy essential services that enable them to enjoy their reproductive health and rights are violated. Dinokopila asserts that the Court of Appeal's ruling is vital in that it used civil and political rights to impose socio-economic rights by judicially enforcing the San's right to water through Section 7 of the Constitution of Botswana. The author agrees with Dinokopila's sentiments and applauds the Court for creating precedence for enforcing socio-economic rights in Botswana, given that the Constitution of Botswana does not entrench socio-economic rights. Therefore, the San can use this case as precedence to claim protection of their reproductive health and rights through other civil and political rights linked to their enjoyment of rights linked to their reproductive health.

To understand the way some of the laws, policies, and programmes that negatively impact the enjoyment of human rights, including reproductive health and rights of indigenous women, are crafted, it is crucial to understand how the San are perceived by the GoB and in the Constitution of Botswana which is the supreme law of the country. The GoB has used the concept of primitivism to defend its treatment of the San.[1048] Although the GoB refuses to acknowledge the San as indigenous people of Botswana, it indirectly does so in discordant ways that suggest that the San are not equal to the rest of the citizens of Botswana. For instance, the Government has approved the reference of the San in Tswana textbooks as primitive and stone-age people ignoring the fact that the San are currently living in modern-day Botswana. In addition, the Government, through its RADP,[1049] has also viewed the San as a peculiar group requiring exceptional help from the Government.[1050] Cook and Sarkin assert that the tactic used by the GoB to avoid directly and explicitly acknowledging the San as an indigenous group is to enable the Government to evade fulfilling its international human rights standards easily.[1051] The author shares the same sentiments as Cook and Sarkin because by refusing to acknowledge the San as the indigenous people, it is a mammoth task for the San to hold the Government liable for the non-recognition and non-protection of their rights, which include their reproductive

the Terms of Article 62 of the African Charter on Human and Peoples' Rights, Forty-Seventh Ordinary Session, 2010.

[1048] Cook A and Sarkin J (2009) 120. The GoB claims that the forced removal of the San from their ancestral lands in the CKGR was intended to help them "progress" and integrate them into modem society.

[1049] The purpose of this programme is to ensure "provision of development infrastructure in remote area settlements, promotion of sustainable livelihoods and community engagement in local government issues as well as affirmative action for remote area dwellers. The GoB through this programme has negatively defined the San, categorising them by their absence of valued Tswana qualities by targeting non-Setswana speakers and people who live outside village settlements."

[1050] Cook A and Sarkin J (2009) 120.

[1051] Cook A and Sarkin J (2009) 120.

health and rights as spelled out in the regional and international human rights treaties that Botswana is a party to.

The San people in Botswana, like the San people in Zimbabwe, have also been excluded from the laws of Botswana. For example, no mention of the San people as one of the recognised tribes in Botswana, dating back to Botswana's first Constitution is made.[1052] The current Constitution of Botswana still officially recognises eight tribal groups while the other twenty-six "ethnolinguistic groups" who include the San, are not recognised.[1053] To remedy this anomaly, the Balopi Commission was set up in 2000 to investigate any discriminatory clause in the Constitution of Botswana. Following the findings of the Commission, a policy paper was released by the GoB recommending that the Constitution should be inclusive and ethnically neutral. Of paramount importance is to note that no timeline was given for implementing this recommendation, and it was not clear how the San would benefit from this recommendation as there was no mention of them by the Balopi Commission.[1054]

In addition, the Tribal Land Act of 1968 which divided residents into territories that the country's Constitution recognised does not cater to the San as the San do not have a specific territory that they own. As a result, the San are treated like aliens and continue to be left out in enjoying the socio-economic development that Botswana has achieved over the past years of its high economic growth.[1055] Cadger and Kepe assert that despite introducing development programmes and policies to address the plight of the San, later on, many local economic developments among the San have not succeeded in reducing their poverty.[1056] Olmsted further argues that Botswana's experience shows how the quest for national development and democratisation, although successful in other aspects if not handled well, is likely to marginalise powerless groups such as indigenous groups further.[1057] This study concurs with

[1052] Mazonde I (2004) 137. See Sections 77, 78 and 79 of the Constitution of Botswana 1996. These sections address the rights of the eight ethnic groups in Botswana and leaves out the minority groups who include the San.
[1053] Cook A and Sarkin J (2009) 117-118.
[1054] Mazonde I (2004) 137.
[1055] Mazonde I (2004) 138. Mazonde avers that the San are said to have become poorer economically and socially due to Botswana's relocation policies. In addition, other policies such as the Tribal Territories Act of 1933 and the Chieftainship Act of 1966, contributed to the marginalisation of groups who do not belong to the Tswana tribe. The San have to a larger extent been deprived of the fruits of Botswana's rapid economic growth and social development which has played a role in perpetuating their suffering from chronic unemployment and poverty as well as possessing little land and few assets.
[1056] Cadger K and Kepe T 'Contextualising development projects among the San of Botswana: Challenges of community gardening' (2013) 7 *Development in Practice* 812.
[1057] Olmsted N 'Indigenous rights in Botswana: Development, democracy and dispossession' (2004) 3:3 *Washington University Global Studies Law Review* 799.

these authors because it is important to include all community members, whether powerful or not, when drafting policies or agendas that could bring a huge change in their lives. Including people in matters affecting them makes it easy for their needs and challenges to be adequately addressed.

It is important to mention that what worsens the situation of the San in Botswana is the fact that the regional and international human rights treaties that Botswana is a signatory to,[1058] which the indigenous people can rely on to claim their rights, do not automatically become enforcing in Botswana like in Zimbabwe as they have to be domesticated into Botswana laws given that Botswana is a dualist country.[1059] To this end, indigenous people such as the San often receive little recourse, to seek justice within their borders when their rights are violated.[1060] Cook and Sarkin postulate that although Botswana is a signatory to a plethora of human rights instruments, it has often shown limited support for them as it has been lagging in submitting country reports to the treaty bodies and has not domesticated some of the provisions of these instruments.[1061] For instance, Botswana has been lagging in submitting State reports since it ratified the African Charter.[1062] Although Botswana compiled and submitted its report as provided for under Article 9 of the CERD, the Committee raised concerns over the marginalisation of the San and the non-recognition of their cultural rights and the infringement of their right to possess the land.[1063] One can argue that the concerns raised by the CERD also show that even at international levels, the focus on the promotion and protection of indigenous peoples' rights is usually on their land and cultural rights, and this plays a role in furthering the marginalisation of indigenous people regarding their enjoyment of their reproductive health and rights. This shows that from an intersectionality theory lens, indigenous women face many forms of discrimination, and the situation is worsened by the little influence they have concerning the protection of their reproductive health and rights in international forums.

[1058] Botswana is a party to a plethora of international human rights instruments that detail its obligations to protect indigenous rights which include the UNDRIP, the African Charter, the ICCPR, the ICERD, CRC, CERD and CAT.

[1059] Dinokopila BR 'The Justiciability of Socio-Economic Rights in Botswana' (2013) 56: 1 *Journal of African Law* 109 provides that "as such treaties creating rights and obligations ratified by Botswana do not create rights and obligations enforceable by the courts immediately upon ratification. However, Section 24 of the Interpretation Act (1984) provides that such treaties may be used in the interpretation of the law where the wording of the statute is ambiguous."

[1060] See Dinokopila BR (2013) 109.

[1061] Cook A and Sarkin J (2009) 122.

[1062] Cook A and Sarkin J (2009) 122 provide argue that Botswana has failed to submit a single State report as stipulated in Article 62 of the African Charter. The ACHPR recognised this failure and assigned a team to go on a mission visit to Botswana in 2005.

[1063] Cook A and Sarkin J (2009) 122.

With regards to the protection of the right to health, including reproductive health and rights, it is important to highlight that the Constitution of Botswana, unlike the Constitution of Zimbabwe, offers insufficient protection because it does not provide for the protection of socio-economic rights,[1064] which means that the right to health cannot be enforced under the Constitution. In addition, compared to Zimbabwe, Botswana has not ratified the ICESCR,[1065] and due to its legal system, which is dualist, it is difficult to enforce some rights related to socio-economic rights that are entrenched in some of the treaties that Botswana is a party to.[1066] The Constitution instead provides the protection of civil and political rights in Chapter II.[1067] Therefore, the author argues that although there is a provision of non-discrimination in the enjoyment of the human rights entrenched in the Constitution, this becomes very relevant to civil and political rights outlined in the Constitution. This provision can be relied on by San women in claiming the protection of their reproductive health and rights linked to civil and political rights such as protection of the right to life and protection from inhumane treatment. Non-discrimination in the enjoyment of those civil and political rights is prohibited because includes: race; sex; tribe and place of origin; colour; creed; or sex.[1068] Thus, the San can use these grounds to cite their discrimination. Given the non-recognition of socio-economic rights in the Constitution of Botswana and the non-ratification of the ICESCR, it is clear that there is little commitment to realising those rights. Therefore, there is a need for advocacy to focus on ensuring that the Constitution entrenches socio-economic rights and ensures that substantive equality (affirmative action) is at the core of providing guidelines on the regulation of the enjoyment of those rights by indigenous people.

5.2.2. Realities of indigenous women in accessing their reproductive health and rights

This section unpacks the extent to which the San women in Botswana are accessing their reproductive health and rights. This was done by assessing the situation of the San women in accessing those rights against the CESCR framework.

[1064] Paragraph 33 Concluding Observations and Recommendations on the Initial Periodic Report of the Republic of Botswana, Consideration of Reports submitted by States Parties under the Terms of Article 62 of the African Charter on Human and Peoples' Rights, Forty-Seventh Ordinary Session, 2010.
[1065] Paragraph 34 Concluding Observations and Recommendations on the Initial Periodic Report of the Republic of Botswana, Consideration of Reports submitted by States Parties under the Terms of Article 62 of the African Charter on Human and Peoples' Rights, Forty-Seventh Ordinary Session, 2010.
[1066] Dinokopila BR (2013) 114.
[1067] Sections 3 to 15 of the Constitution entrenches most of the civil and political rights.
[1068] See Sections 3 and 15(3) of the Constitution of Botswana.

5.2.2.1 Availability

The CEDAW, in its Concluding Observations made to Botswana, highlighted that although the State Report compiled by Botswana underscored that there was adequate health coverage in Botswana,[1069] it was concerned about the lack of statistical information highlighting access to health facilities by vulnerable groups who are mostly found in rural areas and the San women form part of those groups. It is the author's belief that the failure of Governments to provide important statistics that could assist in addressing the challenges faced by indigenous people shows the reluctance and lack of seriousness in Governments regarding addressing the challenges faced by indigenous people. Such attitudes show that indigenous people not only face challenges or discrimination on grounds usually listed in national constitutions, but the attitude of those in positions also plays an active role in the discrimination they face. Therefore, a substantive equality approach is very relevant in addressing those challenges. Furthermore, since their reinstatement into the CKGR, the San people have continued to experience challenges due to poor service delivery within the reserve, including health services. This has adversely affected how these women access reproductive health services.[1070]

5.2.2.2 Accessibility

The Concluding Observations given to Botswana by CEDAW reiterated that one of the shortcomings of the report submitted by Botswana did not have statistical information on accessibility to reproductive healthcare services by vulnerable groups such as the San women, including information about the extent and consequences of illegal and unsafe abortions amongst those vulnerable groups and the rate of teenage pregnancy.[1071] It is important to highlight that the GoB continues to make great efforts to ensure universal health coverage for all its citizens. This has been done in many ways, including non-payment of specialised

[1069] According to Ministry of Health (Programmes and Departments' available at *https://www.moh.gov.bw/about_us_departments.html* (accessed 22 July 2022), "Botswana has an extensive network of health facilities (hospitals, clinics, health posts, mobile stops) in the twenty seven health districts…'In paragraph 23 of the Concluding Observations made to Botswana, in the forty-seventh Ordinary Session of the African Commission held in 2010, the African Commission on Human People's Rights commended Botswana for 'ensuring the availability, accessibility and affordability of health care programs and facilities to the entire population of Botswana."

[1070] Minority Rights Group International 'State of the World's Minorities and Indigenous Peoples 2011-Botswana' 6 July 2011 available at *https://www.refworld.org/docid/4e16d37dc.html* (accessed 25 January 2022).

[1071] Paragraph 35, Committee on the Elimination of Discrimination against Women Forty-fifth session: Concluding observations of the Committee on the Elimination of Discrimination against Women, 2010, CEDAW/C/BOT/CO/3.

medical care and ensuring that health facilities are within reach for its citizens.[1072] Despite these efforts by Government, some of the citizens, especially the remote dwellers who include indigenous people such as San women, do not benefit from these efforts by Government because of many reasons, as shall be seen in the discussions to follow.[1073]

A. Physical Accessibility

According to information provided by the MoHW, "approximately eighty-five percent of the total population finds itself in a radius of maximum 15km from a medical centre (from as big as a district hospital to the smallest, which is a health post)." To cater for those living in remote areas, the MoHW provides mobile services in those areas.[1074] The GoB should be commended for making sure that health services are accessible to all sections of Botswana which is a lesson Zimbabwe can learn to improve the scope in which the right to health is enjoyed by all its citizens. Although such services have been provided, community members belonging to indigenous communities have lamented about the exclusion and discrimination they face in accessing public services because of belonging to non-dominant tribes.[1075]

B. Information Accessibility

Although Botswana has taken noteworthy steps to disseminate information on reproductive health among adolescents, those in remote areas continue to be left out of accessing such information, and this situation has been further exacerbated by the COVID-19 pandemic.[1076] Regarding the language used in the provision of health services and the awareness-raising programmes, the Special Rapporteur on Minority Issues commended the GoB through its Ministry of Health for working with local communities to resolve the issue of language.[1077]

[1072] Mid-term Progress Report (2020) 54.
[1073] Mid-term Progress Report (2020) 54.
[1074] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23
[1075] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23
[1076] UNFPA Botswana 'Empowering guidance teachers in remote areas to provide Comprehensive Sexuality Education' available at https://botswana.unfpa.org/en/news/empowering-guidance-teachers-remote-areas-provide-comprehensive-sexuality-education (accessed 10 February 2022).
[1077] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23 January 2022).

However, it was noted that despite these engagements, awareness-raising campaigns continue to be conducted in Tswana and English only and not in minority languages such as Khoisan language.[1078] The challenge of disseminating information in English and other dominant languages is also common in Zimbabwe despite recognising 16 languages as official in its Constitution including Khoisan, the official language recognised for the San community in Zimbabwe. No communication in official documents has been made in this language. As a result, the San end up being forced to learn dominant languages such as Shona, Ndebele, and Kalanga to understand any official communication made in hospitals and other Government offices. In order to disseminate information to people who are not conversant in English and Tswana, the Ministry of Health liaises with local organisations to disseminate the information effectively.[1079] The author argues that this approach by the MoHW might not be as effective as information can be distorted if it is passed down to non-health organisations or a third party, or the information might not have the same impact if it is passed down by a third person who does not belong to the Ministry of Health.

C. Economic Accessibility

As mentioned above, although Botswana has been growing economically to the extent of being considered one of the countries with a thriving economy in Africa, the San are not enjoying the fruits of this development as they continue to be constantly denied the benefits of this economic growth.[1080] Despite the growing economy, the San continue to be adversely affected by poverty, high unemployment rates, and socio-economic exclusion.[1081] These factors make it difficult for the San to access reproductive health care services as they cannot afford the cost of some of the services.[1082] Botswana's Mid Term Report highlighted that the GoB had strived to ensure maternal and new-born care affordability.[1083] However, the author observed that the

[1078] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23 December 2022).

[1079] Statement of the United Nations Special Rapporteur on minority issues, Fernand de Varennes, on the conclusion of his official visit to Botswana, 13-24 August 2018 available at *https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23471&LangID=E* (accessed 23 December 2022).

[1080] Olmsted N (2004) 802.

[1081] Cadger K and Kepe T 'Contextualising development projects among the San of Botswana: Challenges of community gardening' (2013) 7 *Development in Practice* 812.

[1082] See Cadger K and Kepe T (2013) 812.

[1083] Mid-term Progress Report (2020) 57.

report did not specifically highlight the magnitude in which marginalised groups such as the San women are benefitting from these services given their poor economic situation.

5.2.2.3 Acceptability

Although there is limited information on the preference for the use of traditional medicines by the San women in Botswana, there is evidence that the San do not make use of the available health facilities for many reasons. It was noted that HIV infection rates are high among remote area dwellers where the San women are found because this group is unable to make use of the available services due to a lot of challenges. These challenges include financial constraints, language barriers, geographic distance from clinics, insufficient leave from work to travel long distances to clinics, and low literacy and education levels.[1084] In response to these barriers, the UN Special Rapporteur on the Rights of Indigenous Persons made recommendations to Botswana, which include that Botswana should take a consultative approach in development initiatives that impact the lives of remote area dwellers, which should consist of HIV-related programming, policies, and initiatives.[1085] The challenges faced by the San women in Botswana in accessing services are similar to some of the challenges faced by the San women in Zimbabwe. There is a need for the GoZ and the GoB to come up with measures that will warrant that the San women are placed in a better position to access reproductive health care services on an equal basis with non-San or non-indigenous minority members of the two countries.

5.2.2.4 Quality

To strengthen the provision of reproductive health services, the GoB, through its Ministry of Health, has ensured that most healthcare professionals undergo training on emergency obstetric care.[1086] To further strengthen the quality of reproductive health care, the GoB has established maternal national and institutional committees to ensure that all maternal deaths are reported and audited quarterly.[1087] Specialist services which include services of gynaecologists as well as comprehensive post-abortion services, have also been introduced in district hospitals to

[1084] Mid-term Progress Report (2020) 57.
[1085] National Strategic Plan to Reduce Human Rights- Related Barriers to HIV and TB Services: Botswana (2020-25) 5. See also Report of the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people: Preliminary note on the situation of Indigenous Peoples inn Botswana A/HRC/12/34/Add.4, 2009.
[1086] Mid-term Progress Report (2020) 57 provides that "On average Institutes of Health Sciences produce 84 midwifery graduates per year. Furthermore, capacity building on Emergency Obstetric and Neonatal Care (EmONC) continues to be pivotal to improvement of quality care towards reduction of maternal mortality."
[1087] Mid-term Progress Report (2020) 56.

improve the quality of reproductive health services.[1088] Furthermore, twenty-five youth-friendly service clinics have been opened across the country, and an additional twenty have been opened in junior and secondary schools to provide reproductive health services for adolescents.[1089] The question remains whether these youth-friendly centres cater to the peculiar needs of adolescents from indigenous communities such as the San. In addition, despite efforts to improve the quality of health services, including reproductive services, members of indigenous communities, including San women, are not partaking of these developments due to barriers already mentioned in the above discussion. These include inadequate resources to be admitted for more than a day in health facilities as well as discrimination in accessing the services.

5.3 INDIGENOUS PEOPLE IN CANADA

Before delving into the discussion on who indigenous people are in Canada, it is crucial to understand the country profile of Canada. Canada is a Federal State with a Federal Government, ten Provincial,[1090] and three Territorial Governments.[1091] The powers granted to the Provincial and Territorial Governments in their jurisdictions are the same in scope as the powers of the Canadian Federal Government.[1092] Aboriginal people reside in all of Canada's provinces and territories.[1093] Many Aboriginal people also inhabit the metropolitan areas where most of Canada's population inhabits.[1094] The indigenous people of Canada, who comprise the First Nations,[1095] Inuit,[1096] and Métis,[1097] make up approximately 4.3% of Canada's

[1088] Mid-term Progress Report (2020) 56-8.
[1089] Mid-term Progress Report (2020) 58.
[1090] The ten Provinces in Canada are: Alberta; British Columbia; Manitoba; New Brunswick; Newfoundland and Labrador; Nova Scotia; Ontario; Prince Edward Island; Quebec; and Saskatchewan.
[1091] Presentation of Canada's 6th Periodic Report under the ICESCR to the United Nations Committee on Economic, Social and Cultural Rights (ICESCR) February 24-25, 2016. The three territories of Canada are Northwest Territories, Nunavut and Yukon.
[1092] Country Report of Canada, Tenth United Nations Regional Cartographic Conference for the Americas, New York, 19-23 August 2013, E/CONF.103/IP.3.
[1093] Paragraph 4 UN Commission on Human Rights 'Addendum to the Report of the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous People: Mission to Canada' E/CN.4/2005/88/Add.3.
[1094] Paragraph 4 UN Commission on Human Rights 'Addendum to the Report of the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous People: Mission to Canada' E/CN.4/2005/88/Add.3.
[1095] A lot of First Nations people lived in Ontario and the Western Provinces, but they constitute the largest part of the total population of the Northwest Territories, Yukon, Manitoba, and Saskatchewan.
[1096] Almost three-quarters of Inuit in Canada lived in Inuit Nunanga which stretches from Labrador to the Northwest Territories.
[1097] According to census, metropolitan areas such as Winnipeg had the highest population of Metis followed by Edmonton, Vancouver, and Calgary.

population.[1098] The indigenous people of Canada, unlike the indigenous people in Zimbabwe, are constitutionally recognised. The Constitution of Canada Act 1982 (Constitution/ Constitution of Canada) refers to them as Aboriginal people. It defines them as follows: "In this Act, Aboriginal peoples of Canada includes the Indian, Inuit and Metis peoples of Canada."[1099] In terms of the Indian Act RSC 1985, c I-5 (Indian Act), Indian peoples are divided into two groups, that is, 'Status Indians," who is also known as the "First Nations," and "Non-Status Indians," who are also known as the "Unregistered First Nations."[1100] Regarding the Indian Act, Status Indians are subject to the Act, and Non-Status Indians are not.[1101]

The Aboriginal people's human rights situation is not only influenced by their different geographical settings and varied socio-cultural norms. Their human rights situation also emanates from the different perspectives of public policy, the compounded set of laws and jurisdictions governing relations between the Government and the different categories of Aboriginal people.[1102] To this end, Aboriginal people have been affected by the outcome of the Residential School and Sixties Scoop eras[1103] which attempted to assimilate Aboriginal people without their voluntary consent and a cultural dislocation.[1104]

Indigenous women in Canada are said to be victims of violence, homicides, and disappearances, and the international community has urged the Government of Canada to make it clear in its reports the measures it has taken to provide adequate and effective responses to this challenge.[1105] In addition, a high rate of indigenous people, including indigenous women, have also been imprisoned in federal and provincial prisons throughout Canada and have

[1098] Anaya JS 'Report of the Special Rapporteur on the Rights of Indigenous Peoples in the situation of Indigenous Peoples in Canada' (2015) 32:1 *Arizona Journal of International and Comparative Law* 144. See also Presentation of Canada's 6th Periodic Report under the ICESCR to the United Nations Committee on Economic, Social and Cultural Rights (ICESCR) February 24-25, 2016. The Indigenous peoples of Canada make up a total population of about 1.4 million people with more than 600 being First Nations communities and representing approximately fifty cultural groups.

[1099] Section 35(2) Constitution of Canada Act 1982.

[1100] Weeks NC 'Autonomy of indigenous peoples in Canada (1985) 54:1 *Nordisk Tidsskrift for International Ret* 17. See also Anaya JS 'Report of the Special Rapporteur on the Rights of Indigenous Peoples in the situation of Indigenous Peoples in Canada' (2015) 32:1 *Arizona Journal of International and Comparative Law* 144.

[1101] See Indian Act RSC 1985, c I-5.

[1102] Paragraph 16 'Addendum to the Report of the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous People: Mission to Canada.'

[1103] Anaya JS (2015) 152. Aboriginal children were forced to attend Residential Schools which were far away from their families, communities and traditional lands and were banned to speak the only languages they were conversant with. To address the effects of the Residential Schools, schools in areas where Aboriginal people are found especially in reserves have been allowed to provide education in Aboriginal languages.

[1104] Anaya JS (2015) 152.

[1105] Concluding observations on the sixth periodic report of Canada 2015 CCPR/C/CAN/CO/6.

challenged accessing justice.[1106] With regards to the enjoyment of their socio-economic rights, Yee *J et al.*, postulate that there is a high likelihood of Aboriginal women residing in communities characterised by poor socio-economic conditions, which include low educational accomplishment,[1107] low income,[1108] poor quality health services, little employment opportunities,[1109] lack of food security and malnourishment, overcrowded and poor housing and abuse of toxic substances.[1110] These challenges faced by Aboriginal people in Canada are similar to the experiences of the San in Zimbabwe, and they go a long way to prove that from an intersectionality theory perspective, indigenous people, including indigenous women's struggles are a result of the many challenges and marginalisation that they experience.

5.3.1 Laws, policies, government programmes and/ other measures set up to ensure the realisation of reproductive health and rights of indigenous women

This section unpacks the laws, policies, programmes and other measures that the Government of Canada has put in place to ensure the realisation of indigenous women's reproductive health and rights in Canada.

A. Canada's international human rights obligations

Canada has shown international commitments to protect indigenous women's rights, including their reproductive health and rights, through the ratification of the major United Nations human

[1106] Concluding observations on the sixth periodic report of Canada. See also paragraph 15 (a) UN Committee on the Elimination of Discrimination Against Women (CEDAW), *Concluding observations on the combined eighth and ninth periodic reports of Canada*, 18 November 2016, CEDAW/C/CAN/CO/8-9.

[1107] There is a serious gap in educational attainment between the Indigenous and non-Indigenous populations in Ontario. Paragraph 36 (a) of the Concluding Observations given to Canada by the CEDAW on Canada's combined 8th and 9th report highlighted that the Committee was concerned about the continuous lower educational and academic achievements of indigenous women and girls as well as their high dropout rates at all levels of education.

[1108] The annual income of Aboriginal people is notably lower than that of other non-indigenous Canadians. See also paragraph 15 of the UN Committee on Economic, Social and Cultural Rights (CESCR), *UN Committee on Economic, Social and Cultural Rights: Concluding Observations, Canada*, 22 May 2006, E/C.12/CAN/CO/4; E/C.12/CAN/CO/5, which states that "The Committee also notes with particular concern that poverty rates remain very high among disadvantaged and marginalized individuals and groups such as Aboriginal peoples…"

[1109] Aboriginal people face high unemployment rates and the Inuit who are another category of indigenous people have not been integrated in the Public Civil Service as swiftly as had been anticipated.

[1110] Yee J *et al* 'Sexual and Reproductive Health, Rights, and Realities and Access to Services for First Nations, Inuit, and Métis in Canada' (2011) 33:6 *Journal of Obstetrics and Gynaecology Canada* 634. See also paragraph 28 UN Committee on the Elimination of Discrimination Against Women (CEDAW), *Concluding observations on the combined eighth and ninth periodic reports of Canada*, CEDAW/C/CAN/CO/8-9.

rights instruments. Canada is a party to the CEDAW,[1111] ICESCR,[1112] ICCPR,[1113] CRC,[1114] CAT,[1115] Optional Protocol to CEDAW,[1116] Optional Protocol to the ICCPR,[1117] and the Second Optional Protocol to the ICCPR.[1118] Canada also reversed its decision to vote against the UNDRIP and later endorsed the UNDRIP.[1119] In fulfilling its international human rights obligations, Canada has put in place at both the Federal and Provincial levels a plethora of laws, policies, programmes, and other measures aimed at addressing indigenous peoples' concerns,[1120] including their reproductive health concerns. The Government of Canada's efforts to ratify the Optional Protocol to CEDAW and the Optional Protocol to the ICCPR are commendable as these mechanisms can be relied on by indigenous women to bring their complaints on the violation of their human rights including their reproductive health and rights before international treaty bodies. It is important to mention that when it comes to honouring international human rights obligations, all the Governments in Canada, whether Provincial, Territorial or Federal, take their obligations seriously and strive to work towards protecting and advancing human rights in Canada.[1121] This approach is very important because it provides a platform for Provincial and Territorial Governments to come up with local solutions to address local concerns.[1122] When these solutions are combined with Federal policies and commitments, they create a strong foundation for furthering the realisation of the human rights that are entrenched in the different human rights instruments that Canada is a party to.[1123] This is a good practice that Zimbabwe can learn from Canada and give authority to its Provinces, especially the two Provinces where the San are found to draft policies and come up with practical solutions that can benefit and address the different challenges, especially those related to the enjoyment of reproductive health and rights by San women. It is the author's conviction

[1111] Canada signed CEDAW on 17 July 1980 and ratified it on 10 December 1981.
[1112] Canada acceded to the ICESCR on 19 May 1976 and the treaty became effective in Canada in August 1976.
[1113] The ICCPR was ratified by Canada in May 1976.
[1114] The CRC was ratified on 13 December 1991.
[1115] Canada ratified CAT on 24 June 1987.
[1116] Canada became party to the Optional Protocol to CEDAW on 18 October 2002.
[1117] Canada ratified this Protocol in 1976 shortly after it entered into force in March 1976.
[1118] Canada signed this Protocol on 25 November 2005.
[1119] The Government of Canada in 2016, endorsed the UNDRIP without qualification, and committed to its full and effective implementation.
[1120] Many of these laws, policies and programmes such as Canada's policy of negotiating modern treaties with Aboriginal people and addressing their historical claims can be pointed to as a good practice.
[1121] Presentation of Canada's 6th Periodic Report under the ICESCR to the United Nations Committee on Economic, Social and Cultural Rights (ICESCR) February 24-25, 2016.
[1122] Presentation of Canada's 6th Periodic Report under the ICESCR to the United Nations Committee on Economic, Social and Cultural Rights (ICESCR) February 24-25, 2016.
[1123] Presentation of Canada's 6th Periodic Report under the ICESCR to the United Nations Committee on Economic, Social and Cultural Rights (ICESCR) February 24-25, 2016.

that the commitment of Canada to the protection of human rights can be imitated by Zimbabwe, which still has not ratified the CEDAW and ICCPR Optional Protocols.

B. Laws and policies for the realisation of reproductive health and rights of Aboriginal women

In fulfilling its regional and international human rights obligations, in particular, the obligation to fulfill, Canada recognises the status of indigenous people through Canadian laws. Unlike Zimbabwe, the relationship between Canada and the indigenous people within its borders is regulated by a comprehensive legal framework that protects indigenous peoples' rights to a greater extent.[1124] Of paramount importance is to note that the Canadian Constitution which is the highest law of Canada was one of the first Constitutions globally to entrench indigenous peoples' rights by acknowledging and affirming the Aboriginal and treaty rights of the First Nations, Inuit and Metis people who are recognised as the indigenous people of Canada in terms of Section 35.[1125] Section 35 of the Constitution of Canada is essential from the perspective of the Metis because it finally recognises them as indigenous people of Canada, a status they previously denied.[1126] The Canadian Government must be applauded for clearly affording a legal status to the indigenous people within the borders of Canada. The author argues that this legal recognition gives the indigenous people authority and confidence to claim the protection of their rights and to hold the Government amenable whenever their rights are violated. This recognition of indigenous people in law resonates with the objectives of the substantive equality theory, which requires that measures be taken to advance a disadvantaged group so that it is better placed to enjoy their rights on an equal basis as any advantaged group. Thus, the author argues that by having laws that specifically regulate the status of indigenous people, indigenous people will be better placed to enjoy their rights as they will have a strong basis to claim the recognition of their rights and to enjoy the rights that non-indigenous people enjoy without any hindrances. To further the advancement rights of the San women in Zimbabwe and other indigenous groups, Zimbabwe can learn lessons from Canada by amending its Constitution and enacting laws that spell out the definition and the status of those groups that self-identify as indigenous people of Zimbabwe.

[1124] Anaya JS (2015) 146.
[1125] Anaya JS (2015) 146. The Constitution protects Aboriginal title which came into effect as a result of historical occupation, treaty rights and culturally important activities.
[1126] Weeks NC (1985) 19.

Furthermore, the Constitution of Canada is very instrumental in the protection of reproductive health and rights as it has a Charter of Rights and Freedoms, which has laudable provisions which indigenous peoples can rely on to claim the protection of their reproductive health and rights. Although the Charter for Human Rights and Freedoms does not entrench the right to health or the right to access reproductive health services like the Zimbabwean Constitution, it entrenches rights and freedoms that are linked to reproductive health and rights that indigenous women in Canada can rely on to ensure that their reproductive health and rights are advanced. These rights include the right to life,[1127] freedom from torture,[1128] equality, and non-discrimination.[1129] By entrenching the right to life in the Canadian Constitution, the Government of Canada has met its obligations outlined in Article 6 of the ICCPR and Article 6 of the CRC which provide for the protection of the right to life. The Government of Canada also complies with its obligations to respect as explained in General Comment No.36 of the HRC. In addition, by having a clause on equality and non-discrimination, Canada complies with the preamble of CEDAW, well as Articles 2 to 4 of CEDAW and Article 12 CEDAW, and which proscribe discrimination and requires States to combat all forms of discrimination against women. Aboriginal women who usually suffer from sexual violence, which negatively affects their reproductive health, can claim the protection of their reproductive health and rights based on rights such as the rights mentioned above. In the case of reproductive health and rights, Section 15 of the Constitution of Canada, which entrenches the right to equality and non-discrimination can hold the Government of Canada responsible if it fails to provide services and programmes aimed at correcting historical disadvantages.[1130] Therefore, this provision can be relied upon by Aboriginal women to claim their reproductive health and rights, given that they have been affected by unfair discrimination in the past, and continue to be affected by it.

In addition, Canada should be commended for being the only high-income country globally with publicly funded universal health care. The regulation of publicly funded income is regulated by the Canada Health Act of 1984, whose primary objective is to "protect, promote

[1127] According to Section 7 of the Constitution of Canada, "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."
[1128] Section 12 of the Constitution of Canada states that: "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."
[1129] In terms of Section 15 of the Constitution "every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."
[1130] Rinaldi J 'Reproductive Inequality in Canada' (2013) 1 *Health Tomorrow* 92.

and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[1131] One of the aims of this Act is to "regulate the conditions to which provincial and territorial health insurance programs must adhere to receive the full amount of the Canada Health Transfer (CHT) cash contribution."[1132] This Act is important in facilitating enjoyment of reproductive health services such as reproductive health in that it directs provinces and territories to "provide universal coverage for all insured persons for all medically necessary hospital and physician services, including abortion."[1133] The Canada Health Act is crucial in ensuring that Aboriginal women access health services for free as provinces and territories are granted the power to regulate their health matters. This, therefore, allows provinces and territories to claim budgets catering for people within their jurisdictions, including Aboriginal women. In addition, this Act also plays a key role in promoting the provision of reproductive health services as it accepts budgets related to reproductive health services such as abortion. The enactment of legislation that provides for the protection and promotion of reproductive health and rights is in line with the obligation to fulfill, which obliges States to put in place legislative measures to ensure the realisation of reproductive health and rights. Therefore, the Government of Zimbabwe can learn from Canada the importance of allowing provinces to create their budgets and release funding based on that.

C. Programmes and/ other measures for the realisation of reproductive health and rights of Aboriginal women

The Canadian Courts since 1982 have been providing recourse to indigenous people when their rights are violated, allowing them to develop important jurisprudence related to Aboriginal and treaty rights. For instance, in the case of *Delgamuukw v British Columbia,*[1134] which concerned the definition, the content, and the extent of Aboriginal ownership of traditional lands, the Supreme Court of Canada observed that Aboriginal people's right to own traditional land is a right protected by Section 35(1) of the Constitution of Canada. This landmark ruling has impacted other court cases about Aboriginal rights. Such notable influence has been seen since the passing of the ruling in the case of *Haida Nation v British Columbia,*[1135] where Federal and

[1131] Canada Health Act 1984.
[1132] See Canada Health Act of 1984.
[1133] Action Canada for Sexual Health and Rights *et al* (2016) 7.
[1134] *Delgamuukw v British Columbia* (1997) 3 SCR 1010.
[1135] *McLachlin CJC Haida Nation v British Columbia (Minister of Forests)* (2004) 3 S.C.R. 511.

Provincial Governments had a formal duty to consult indigenous peoples and accommodate their interests whenever it was foreseeable that their asserted or established aboriginal or treaty rights may be disturbed by Government conduct. The author believes that although the judgements mentioned above did not deal with reproductive health and rights of Aboriginal women, the fact that Canadian courts hear cases from Aboriginal people is an advantage that Aboriginal women can utilise to have their cases related to reproductive health and rights litigated and brought before the courts. Zimbabwe can learn lessons from Canada and raise awareness among indigenous people on their right to access justice in courts of law when their rights are violated. This will help build confidence in indigenous people to approach courts. Once they do so, this will assist courts in building jurisprudence on indigenous people's rights in Zimbabwe. The hearing of cases related to the infringement of the rights of Aboriginal people is in line with the obligation to protect, which requires State Parties to protect people from violation of human rights.

The Canadian Courts have also handled cases relating to the right to equality and non-discrimination, creating precedence on the substantive equality theory. This was done in the case of *Andrews v Law Society of British Columbia*, where the court interpreted Section 15(1) of the Constitution of Canada to imply that "every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality." This case was a landmark in Canadian jurisprudence as far as the equality principle is concerned, as it highlighted the problems associated with formal equality.[1136] After this judgment Canadian Courts began to determine inequality based on discrimination instead of merely differential treatment.[1137] Although Section 15 of the Canadian Constitution does not provide for substantive equality like Section 56(6) of the Constitution of Zimbabwe, which allows for substantive equality to be applied in dealing with groups of people that suffer discrimination and marginalisation, such as indigenous people, the position in the Andrews case addresses this gap. The precedence set up by the Andrews case can be very instrumental in influencing Zimbabwe to put into practice the provisions of Section 56(6) of the Constitution, which relate to substantive equality by ensuring that indigenous people are encouraged to bring their matters to court and for the courts to apply the substantive equality approach when dealing with indigenous peoples' cases including cases relating to the enjoyment of reproductive health and rights by indigenous women.

[1136] Rinaldi J (2013) 92.
[1137] Rinaldi J (2013) 92.

The author believes that although the judgements mentioned above did not deal with reproductive health and rights of Aboriginal women, the fact that Canadian courts hear cases from Aboriginal people is an advantage that Aboriginal women can utilise to have their cases related to reproductive health and rights litigated and brought before the courts. Zimbabwe can learn lessons from Canada and raise awareness among indigenous people on their right to access justice in courts of law when their rights are violated. This will help build confidence in indigenous people to approach courts, and once they do so, this will assist courts in building jurisprudence on indigenous people's rights in Zimbabwe. The hearing of cases related to the violation of the rights of Aboriginal people is in line with the obligation to protect, which requires State Parties to protect people from violation of human rights.

The Government of Canada should be applauded for taking steps to ensure indigenous people's representation in governance structures. The Constitution gives the Federal Government the sole responsibility over Canada's relations with indigenous people through the Parliament's jurisdiction over Indians and lands reserved for them, including the Metis.[1138] On an administrative level, the Minister of Aboriginal Affairs and Northern Development Canada (AANDC) is responsible for managing the relations between indigenous people and the Federal Government.[1139] Most provinces that indigenous people inhabit also have ministries or departments of Aboriginal Affairs which specifically deal with issues that have a bearing on social and economic policies as well as the use of natural resources which the provinces have jurisdiction over.[1140] Ensuring that Aboriginal people are represented in governance positions is in line with the obligation to fulfill, which requires measures to be put in place to ensure that reproductive health and rights are realised.

The author believes that by having a representative of indigenous people in governance structures, it becomes easy for peculiar issues that Aboriginal people face to be addressed better by someone who understands their situation. Since indigenous people have their understanding of the meaning of the right to health, having a representative in positions of authority will aid in ensuring that health policies address the meaning of reproductive health for indigenous people and what it takes for them to exercise this right fully. Ensuring that indigenous people are represented in decision-making positions resonates with the substantive equality theory, as indigenous people in this scenario are represented by people who do not understand their pleas.

[1138] Anaya JS (2015) 147.
[1139] Anaya JS (2015) 147.
[1140] Anaya JS (2015) 147.

Zimbabwe can learn lessons from Canada since Zimbabwe does not have a department or ministry that specifically deals with indigenous people's rights. As a result of this gap, indigenous people continue to be treated like any other ordinary Zimbabwean because their issues are not represented at decision-making levels.

5.3.2 Laws, policies, programmes, and/ other measures for realisation of the reproductive health and rights of Aboriginal people in Ontario

As mentioned in the above discussion, Aboriginal people are found in some of the provinces and territories of Canada. Therefore, it is profound to explore the laws, policies, programmes and other measures such jurisdictions have put in place to ensure that Aboriginal people's reproductive health and rights are realised. This section will briefly discuss the actions taken by one of the Canadian Provinces, Ontario, to further the realisation of Aboriginal women's reproductive health and rights. The rationale for focusing on Ontario is that a variety of Aboriginal people inhabits Ontario.[1141]

To further promote the enjoyment of reproductive health and rights of Aboriginal people in Ontario, the Government of Ontario enacted the Health Protection and Promotion Act (HPPA) which regulates, among other things, "the organisation and delivery of public health programs and services, as well as the promotion and protection of the health of the people of Ontario."[1142] This Act lays down mandatory services and programmes that must be provided in public health facilities in Ontario. Amongst these services is the prevention from cancer and HIV and provision of family health which includes counselling and family planning services, health services to pregnant women in high-risk health and screening programs to reduce the morbidity and mortality of disease.[1143] The enactment of legislation that makes it mandatory for public health facilities to provide services in relation to some aspects of reproductive health and rights is in line with Articles 12 and 16 of CEDAW and Article 12 of ICESCR which places an obligation on State Parties to put in place measures that will ensure that women enjoy their right to health including their reproductive health and rights. Zimbabwe can draw lessons from Canada and ensure that it allows Provinces where indigenous people live to enact their

[1141] Action Canada for Sexual Health and Rights *et al* (2016) 7. Ontario is home to the Algonquin, Mississauga, Ojibway, Cree, Odawa, Pottowatomi, Delaware, and the Haudenosaunee (Mohawk, Onondaga, Onoyota'a:ka, Cayuga, Tuscarora, and Seneca). North-western Ontario is home to Ojibway, Oji-Cree and Cree. See also Doob AN, Grossman MG and Auger RP 'Aboriginal homicides in Ontario' (1994) 36:1 *Canadian Journal of Criminology* 38, the majority of the Aboriginal people are found in Northern Ontario.

[1142] Section 2 Health Protection and Promotion Act (HPPA) R.S.O. 1990.

[1143] Section 5(3) and 5(4) (i)-(ii) and (v) Health Protection and Promotion Act.

legislation and ensure that within its available resources, given the deteriorating economy, certain reproductive health services are made available in all Government health facilities despite geographical location.

Furthermore, Section 7 of the HPPA also enables related regulations such as the Ontario Public Health Standards and Associated Protocols.[1144] These documents regulate, among other things, the requirements for public health programs and services. In terms of the Ontario Public Health Standards, the main focus of public health is on Ontario's population as a whole, and its work is closely linked with the day-to-day lives of the people of Ontario.[1145] These standards allow the Boards of Health established in terms of the HPPA to serve Ontario's urban and rural populations by delivering local public health programs and services within their respective jurisdictions. The delivery of public health is also done in partnership with various entities such as NGOs and indigenous communities, including the First Nations Status or Non-Status, Métis, Inuit, and those people who self-identify as indigenous people of Canada.[1146] The inclusion of Aboriginal people in the delivery of public health shows Ontario's commitment to involving indigenous people to contribute to matters involving their well-being, considering that they are a unique group of people. Zimbabwe can imitate this, given that in most instances, other tribes in Zimbabwe often make decisions and choices for indigenous people, and at the end of the day, indigenous people have to bear the consequences of such decisions. The Public Health Standards, particularly the Policy Framework for Public Health Programs and Services, provides for matters that relate to reproductive health and rights by reducing morbidity and premature mortality as one of the population health outcomes.[1147] The creation of Standards that provide for reproductive health matters aligns with the obligation to fulfill, which requires States to adopt reasonable legislative, judicial, and other measures to ensure the realisation of reproductive health and rights

In addition, the Government of Ontario, through the Ontario Minister of Health, had shown its commitment to women's health since 1988 when it founded the Ontario Women's Health

[1144] Section 7 Health Protection and Promotion Act.The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability are published as the public health standards with a mandate to oversee the mandatory health programs and services established by the Minister of Health pursuant to Section 7 of the Health Protection and Promotion Act.
[1145] Ontario Public Health Standards: Requirements for Programs, Services and Accountability Protecting and Promoting the Health of Ontarians Effective, June 2021.
[1146] Ontario Public Health Standards: Requirements for Programs, Services and Accountability Protecting and Promoting the Health of Ontarians Effective, June 2021.
[1147] Ontario Public Health Standards: Requirements for Programs, Services and Accountability Protecting and Promoting the Health of Ontarians Effective, June 2021.

Council (OWHC/ Council). This Council was created to address the issues related to women's health and improve women's health at all stages of their lives.[1148] The Council fulfill this objective by ensuring that women have access to the special health care and information they require.[1149] Furthermore, the Council plays an active role in improving women's health in Ontario by determining where change is needed and coming up with lasting solutions that can be incorporated into the intricacies of today's healthcare system.[1150] The establishment of a body that addresses women's health complies with the obligation to fulfill, which requires States to adopt reasonable legislative, judicial, and other measures to ensure that reproductive health and rights are realised.

Ontario has also shown its dedication to improving women's health and addressing gendered health inequalities by introducing the first-ever Ontario Women's Health Framework (Framework) in 2011. Echo, an agency of the Ministry of Health, and Long-Term Care, worked with a varied group of individuals and organisations to come up with this framework.[1151] This Framework was built on the "Project for an Ontario Women's Health Evidence-Based Report (POWER Study),"[1152] which revealed that women's health challenges are often associated with issues around access as well as health outcomes that are poor compared to men and; there is often a solution for these challenges.[1153] The Framework identified three strategic priorities for action, and the "reduction of gendered health inequities resulting from women's social status and social roles" was among these priorities.[1154] The author commends the Government for coming up with such a framework as this will lead to improved health outcomes in women, especially if steps are taken to address the priorities.

In line with the obligation to fulfill, Ontario has shown its commitment to the advancement of women's health, including their reproductive health, by establishing a Bureau for Women's Health and Gender Analysis, Health Canada (Bureau), whose role is to act as the focal point on issues related to women's health within the Federal Government.[1155] The Bureau advances

[1148] ECHO: Improving Women's Health in Ontario, Sharing the Legacy, Supporting Future Action, 2009- 2012.
[1149] University of Ottawa, Ontario Women's Health Council Chair, Women's Health Research Unit, Annual Report (2006) 11.
[1150] University of Ottawa, Ontario Women's Health Council Chair, Women's Health Research Unit, Annual Report (2006) 11.
[1151] ECHO: Improving Women's Health in Ontario, Sharing the Legacy, Supporting Future Action, 2009- 2012.
[1152] The multi-year POWER Study examined gender differences in access to care and the quality of outcomes of care for leading causes of morbidity and mortality in Ontario.
[1153] ECHO: Improving Women's Health in Ontario, Sharing the Legacy, Supporting Future Action, 2009- 2012.
[1154] ECHO: Improving Women's Health in Ontario, Sharing the Legacy, Supporting Future Action, 2009- 2012.
[1155] University of Ottawa (2006) 11.

women's health by providing policy advice and taking a leading role in coming up with ways of advancing women's health and increasing the understanding of how sex and gender issues affect women's health outcomes.[1156] The Bureau also plays a critical role in sharing policy relevant research and disseminates information related to women's health.[1157] The creation of a body to address women's health issues, including reproductive matters, is in line with the obligation to fulfill, which requires States to adopt reasonable legislative, judicial, and other measures to ensure the realisation of reproductive health and rights.

Drawing from the experiences of Ontario, Zimbabwe can adopt good practices and ensure that it gives authority to provinces where indigenous people such as the San are found to come up with any measures, whether legislative or not, such as the creation of Boards or bodies that address matters affecting indigenous women's health in those communities. There is also a need to involve indigenous women in creating those bodies and laws. By doing so, Zimbabwe, through the substantive equality lens, would have taken a major step in advancing the reproductive health and rights of indigenous women who suffer marginalisation and discrimination in accessing reproductive health services.

5.3.3 Realities in the enjoyment of reproductive health and rights by indigenous women in Canada

This section will discuss the extent to which Aboriginal women enjoy their reproductive health and rights. This will be done by using the ESCR framework to analyse the extent to which Aboriginal women access reproductive health and rights. Before delving into this discussion, it is important to mention that although the overall health of indigenous communities in Canada has improved over the years, there are still some notable gaps especially in the health outcomes of this group compared to non-indigenous Canadians in matters such as life expectancy, infant mortality[1158] and communicable diseases among other factors.[1159]

5.3.3.1 Availability

[1156] University of Ottawa (2006) 11.
[1157] University of Ottawa (2006) 11.
[1158] According to Kolahdooz F *et al* 'Canadian indigenous women's perspectives of maternal health and health care services: A systematic review' (2016) 13:5 *Diversity and Equality in Health and Care* 335, "Indigenous women in Canada have a two times higher risk of maternal mortality in comparison to the general Canadian population."
[1159] Anaya JS (2015) 152. The health of indigenous people in Canada is a matter of notable concern.

Although health institutions have been established throughout Canada, there are challenges in enjoying reproductive health and rights by Aboriginal women for many reasons.[1160] Firstly, Aboriginal women in rural and urban areas experience limited access to culturally safe health care, and human resources within maternity services are said to be in a particular crisis.[1161] Secondly, Aboriginal women in rural areas have also raised concerns over the lack of female health practitioners or personnel trained in cross-cultural issues.[1162] Due to this shortcoming, women often dread seeking medical attention until they are very sick.[1163] Therefore, to ensure the delivery of culturally safe services, there is a need to promote the cultural competence of health service providers.[1164] Thirdly, in rural and urban communities, it is a mammoth task for women to maintain privacy when seeking health services and to access fundamental reproductive health services such as contraceptive information and services, including counselling services.[1165]

5.3.3.2 Accessibility

A. Physical Accessibility

Although health institutions are available, Aboriginal women are unable to access health information, and access to preventive medical services can be a huge problem as their remote locations and transport often limit them.[1166] In addition, in cases where Aboriginal women can access health facilities, they often face the challenges of inadequate on-site health and educational services.[1167] The Concluding Observations provided to Canada by the Committee on Economic, Social and Cultural Rights highlighted the significant disparities between Aboriginal people and non-Aboriginal people in Canada in access to health.[1168]

[1160] Yee J *et al* (2011) 634.
[1161] Yee J *et al* (2011) 634.
[1162] Prairie Women's Health Centre of Excellence (PWCE) 'Canada's health system failing women in rural and remote regions' available at *ww.pwhce.ca/RR.htm* (accessed 12 April 2022).
[1163] Prairie Women's Health Centre of Excellence (PWCE) 'Canada's health system failing women in rural and remote regions' available at *ww.pwhce.ca/RR.htm* (accessed 12 April 2022).
[1164] Yee J *et al* (2011) 634. According to Morgan L and Wabie JL (2012) 316, "Aboriginal women need Aboriginal health care providers for an opportunity to share and transfer knowledge on an Indigenous woman to woman basis. The Native Women's Association of Canada (NWAC) takes the position that Aboriginal women need to be encouraged to pursue midwifery or to specialise in obstetrics and gynaecology as nurses, nurse practitioners, and physicians."
[1165] Yee J *et al* (2011) 634.
[1166] Morgan L and Wabie JL (2012) 314.
[1167] Morgan L and Wabie JL (2012) 314. This is the case in the northern and rural parts of Canada where most Aboriginal people live.
[1168] Paragraph 15 CESCR, *UN Committee on Economic, Social and Cultural Rights: Concluding Observations, Canada*, 22 May 2006, E/C.12/CAN/CO/4; E/C.12/CAN/CO/5.

B. Economical Accessibility

Due to economic factors, Aboriginal women are limited in their access to reproductive health services. For example, although the Government caters for a certain portion of the medical costs of giving birth outside one's community, Aboriginal women also bear additional financial burdens, which include the cost of childcare, travelling costs for their partner to be present at the birth and the loss of income if they or their partner has to absent themselves from work to take care of children.[1169] A combination of these challenges has been found to be a cause of depression for a lot of Aboriginal women.[1170] In addition, Aboriginal women bear a large portion of the financial responsibility and inconveniences as they are often responsible for scheduling activities, maintaining the home, and monitoring the emotional well-being of their families.[1171]

C. Information Accessibility

Access to reproductive health services by Aboriginal women is limited because of information gaps. Morgan and Wabie postulate that Aboriginal women have complained about the failure of health personnel to acquire their fully informed consent when attending to them.[1172] For women to make an informed decision, the information in question must be provided in plain language and clearly articulate the recommended treatments, dosages, and medications, including their possible risks and side effects.[1173] Kolahoodz *et al.*, assert that indigenous women's access to reproductive health services is limited by a knowledge gap that prevents them from getting an in-depth understanding of maternal health among indigenous women in Canada.[1174] To remedy this anomaly, there is a need for a comprehensive understanding of indigenous women's perspectives on maternal health before enacting and implementing laws and policies that address maternal health issues.[1175] Furthermore, indigenous women are often found abusing toxic substances attributed to postpartum depression as indigenous women get little information on pregnancy-related topics.[1176]

[1169] Kolahdooz F *et al* (2016) 336-337.
[1170] Kolahdooz F *et al* (2016) 336-337.
[1171] Prairie Women's Health Centre of Excellence (PWCE) 'Canada's health system failing women in rural and remote regions' available at *ww.pwhce.ca/RR.htm* (accessed 12 April 2022).
[1172] Morgan L and Wabie JL (2012) 316.
[1173] Morgan L and Wabie JL (2012) 316.
[1174] Kolahdooz F *et al* (2016) 335.
[1175] Kolahdooz F *et al* (2016) 335.
[1176] Kolahdooz F *et al* (2016) 343.

5.3.3.3 Acceptability

Although the Government of Canada has attempted to provide health facilities that provide reproductive health services in areas where Aboriginal people reside, Aboriginal women are skeptical about using the services for many reasons.[1177] For instance, in accessing different reproductive health services, women are often asked different questions by health personnel, and there is often mistrust from indigenous women as they sometimes feel that the interview questions are very personal and they do not feel confident that the information they share will be kept confidential.[1178] In addition, some indigenous women often prefer resorting to getting help from traditionalists in conjunction with or in place of utilising Western methods to address reproductive matters such as pregnancy, childbirth STIs, cervical cancer as they believe that prayer, healing ceremonies, and the use of traditional medicine are very effective.[1179] Moreso, indigenous women, do not welcome the use of Western methods in addressing reproductive matters affecting them as some indigenous women who were pregnant and left their homes to seek medical attention in health institutions felt that they did not have any control of their birthing experiences as they gave birth in unfamiliar environments without the help of their families and community members.[1180]

5.3.3.4 Quality

The Concluding Observations made to Canada by the Committee on the Rights of the Child commended Canada for the free and widespread access to high-quality health care within Canada.[1181] Despite the positive steps taken by Canada to realise the right to health, indigenous women have lamented the ill-treatment and discriminatory behaviour they experience from healthcare providers.[1182] In addition, Aboriginal women suffer more from cervical cancer than non-Aboriginal women because of the low rates of cancer screening and poor attendance for follow-up of abnormal findings.[1183]

[1177] Morgan L and Wabie JL (2012) 316.
[1178] Morgan L and Wabie JL (2012) 316.
[1179] Morgan L and Wabie JL (2012) 316.
[1180] Kolahdooz F *et al* (2016) 336. There is evidence that most of the women who gave birth outside their communities felt disconnected and isolated from their family, community and culture.
[1181] Paragraph 63 Concluding Observations on the combined third and fourth periodic report of Canada, adopted by the Committee at its sixty-first session CRC/C/CAN/CO/3-4.
[1182] Morgan L and Wabie JL (2012) 316.
[1183] Morgan L and Wabie JL 'Aboriginal Women's access and acceptance of reproductive health care' (2012) 10:3 *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* 314.

5.4 CONCLUSION

The chapter has shown that, like the San in Zimbabwe, the San in Botswana are not recognised as the indigenous people of Botswana in the Constitution and some of the laws of Botswana. Their non-recognition in the supreme law explains the discrimination and marginalisation that San women experience in enjoying their rights, including their reproductive health and rights. However, despite the non-recognition of the San as indigenous people of Botswana, the GoB has indirectly acknowledged their indigenous status through the programmes and policies they have introduced to address the poverty and other challenges that these groups face. In addition, a representative has been appointed at a governance level to address the challenges faced by the San. Zimbabwe can learn lessons from those programmes, policies, and governmental structures to create its own to address the hardships faced by the San women in accessing their reproductive health and rights. The Courts in Botswana have dealt with matters brought by the San and have shown their independence in dealing with such cases. By dealing with such matters, the courts have created precedence in dealing with issues involving indigenous people. Zimbabwe can learn lessons from Botswana and ensure that the indigenous people in Zimbabwe's cases are dealt with differently from any other ordinary Zimbabwe. The judiciary should deal with cases independently such that indigenous people will have the confidence to approach the courts when they are ceased with matters affecting the enjoyment of their rights. The chapter revealed that despite the introduction of programmes and the creation of laws and policies that must address the situation of the San, the San women in Botswana, like the San in Zimbabwe, still fail to fully enjoy their reproductive health and rights because of many factors. These factors include language barriers, geographical location of the health facilities, preference of use of traditional methods and failure to pay for health services. In addition, the situation of the San in Botswana is worsened because the Constitution of Botswana does not entrench socio-economic rights, and Botswana has not ratified the ICESCR.

The chapter has shown the strides Canada has made in recognising indigenous peoples within its borders through the promulgation of laws and policies as well as the creation of governance structures and representation of Aboriginal people in those structures. Zimbabwe can learn good practices from Canada by amending its Constitution and legislation to recognise the San as indigenous people of Zimbabwe. Canadian courts have also created jurisprudence on indigenous people's cases, giving indigenous people a starting point when they want to bring their cases before courts of law when their reproductive health and rights are violated.

Zimbabwe can also ensure that San people can take their cases for adjudication in courts of law and that they are represented in positions of authority such as at Ministerial, Parliamentary and Provincial levels. The chapter has also shown that Canada also gives powers to Provinces to create their laws. In the case of Ontario, laws, policies, and other measures have been put in place to advance women's health, including their reproductive health. The chapter revealed that although Aboriginal women seem to be better off in accessing their reproductive health and rights compared to the San women in Zimbabwe, they are not fully accessing reproductive health and rights due to other barriers that are not related to the existing laws and policies, such as their cultural beliefs. The next chapter concludes the whole thesis and provide recommendations.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents the overall findings and conclusions of the study. It does this by providing a summary of the theoretical framework guiding the study and its relevance in providing an in-depth understanding of the challenges and barriers faced by indigenous women. This chapter also summarises how indigenous women's reproductive health and rights are protected in regional and international law. An overview of the laws, policies, and programmes that Zimbabwe has introduced to ensure the realisation of reproductive health and rights by San women will also be made. This overview will be complimented by a summary of the key findings on the realities of San women in accessing their reproductive health and rights. This chapter also gives a snapshot of the lessons that Zimbabwe can learn from Botswana and Canada regarding the measures that the two countries have taken to ensure that indigenous people in those two countries enjoy their rights, including their reproductive health and rights. The chapter then provides recommendations on what can be done to address the obstacles that hinder effective access to reproductive health and rights by San women in Zimbabwe.

This chapter shows how the overall research question guiding this study was answered through the discussion of different sub-research questions under different chapters in this thesis. Thus, in answering the following overall research question: are the reproductive health and rights of San women in Zimbabwe legally protected? the thesis found that there is limited protection of the reproductive health and rights of San women in Zimbabwe because the laws and policies in place that regulate reproductive health and rights in Zimbabwe do not provide specific protection for indigenous women such as the San women. As a result, the San women rely on the laws and policies that have been put in place to regulate and provide protection for the reproductive health and rights of the Zimbabwean population in general.

6.2 GENERAL CONCLUSIONS

6.2.1 The theoretical framework

Chapter two focused on addressing the question related to the relevance of the intersectionality theory and the substantive equality theory in understanding the reproductive health and rights

of indigenous women in Zimbabwe. In answering this question, the chapter unpacked the intersectionality theory by discussing factors related to it, such as its origins, contextualising the theory in Africa, and its application in human rights frameworks. In discussing the intersectionality theory, the study found that according to Crenshaw, there is a threefold definition of the intersectionality concept, which focuses on structural intersectionality, political intersectionality, and representational intersectionality. Thus, applying this threefold definition in the context of the problems faced by indigenous women in enjoying their rights plays a crucial role in also proffering an in-depth understanding of the barriers faced by the San women in accessing their reproductive health and rights and other rights in general. For instance, the San women in Zimbabwe face multiple forms of discrimination because of many factors, including their gender and belonging to a poor social class compared to other women from other ethnicities found in Plumtree and Tsholotsho. As a result of belonging to a poor social class, they are deprived of benefits and privileges enjoyed by other women. In addition, the San community in Zimbabwe lacks representation at the local level (they do not have a Councillor who is a San) and at national levels. This lack of representation in governance structures further exacerbates their challenges, including their access to reproductive health and rights, because they are not addressed at the national or local level by someone who understands their plight.

Exploring the substantive equality theory revealed that this theory is important in ensuring that the reproductive health and rights of San women in Zimbabwe are realised. Thus, when relying on this theory, San women, must not be discriminated against on grounds of their ethnicity and status regarding their access to reproductive health and rights. Thus, they must be placed in a position that will enable them to enjoy their right to health like any other woman in Zimbabwe as this will meet the objectives of the Abuja Declaration. By so doing, the disadvantages and challenges that the San women face in the advancement of their rights and access to reproductive services will be alleviated.

6.2.2 The recognition of reproductive health and rights of indigenous women in regional and international human rights law

Chapter three of this study addressed the question of the availability of norms and standards existing under regional and international law for the protection of indigenous women's reproductive health and rights. In answering this question, the chapter started by discussing the origins of reproductive health and rights by examining the role played by women's movements

and population movements, international conferences, and the role played by the human rights movement. This discussion showed that indigenous women's challenges were forgotten when advocacy activities were done regarding the recognition of women's reproductive health and rights. The author argues that this non-recognition of indigenous women's peculiar challenges in advocacy can be used to explain the challenges that indigenous women face in enjoying their reproductive health and rights. The discussion on the human rights movement revealed the importance of the fight for recognition of women's reproductive health as human rights, paved way for the acknowledgment of different aspects of women's health as human rights that were later entrenched in different human rights instruments. In assessing the protection of reproductive health and rights of indigenous women in regional and international human rights standards, the study discussed the rights linked to reproductive health, such as the right to health, the right to life, and the right to equality and non-discrimination. Reference was made to human rights instruments such as ICESCR, ICCPR, CEDAW, CRC, UNDRIP, ACHPR, African Women's Protocol, and ACRWC in discussing the rights linked to reproductive health. The discussion brought to light that reproductive health and rights are embedded in existing human rights entrenched in regional and international human rights instruments. However, the discussion made it clear that there is no specific protection of reproductive health and rights of indigenous women in those human rights instruments as the provisions of those instruments refer to every human being and women in general. The non-reference of indigenous people and women in these instruments poses a challenge in that indigenous women end up not fully enjoying their rights as their treatment, like any other woman or human being in such authoritative documents, leaves them insufficiently protected.

The chapter revealed that although the UNDRIP and the ILO Convention No. 169, which protect indigenous peoples' rights, do not provide specifically for reproductive health and rights of indigenous women, it embraces this right by having a provision that addresses their right to health. From an intersectionality theory lens, the failure to specifically cater to reproductive health and rights of indigenous women in indigenous people's specific human rights instruments helps in understanding that the failure to fully enjoy rights by indigenous people is a result of multiple forms of discrimination that they face. One can also argue that the non-recognition of indigenous people's reproductive health and rights in human rights instruments is a major cause for the challenges that they are facing in accessing and enjoying their reproductive health and rights. The author argues that from a substantive equality theory point of view, there is a need, therefore, to lobby for the recognition of indigenous women's

rights in the general human rights instruments. There is also a need to see that the indigenous people's specific instruments entrench the reproductive health and rights of indigenous women.

6.2.3 Zimbabwe's legislative, policy, other frameworks and programmes for the realisation of reproductive health and rights of San women

The objective of chapter four was to determine the extent to which Zimbabwe has complied with its regional and international human rights obligations in ensuring that the reproductive health and rights of San women are realised. Thus, the chapter analysed the laws, policies, other frameworks, and programmes that Zimbabwe has put in place to protect and ensure that San women have access to reproductive health and rights. The chapter showed that the Constitution of Zimbabwe, the highest law of Zimbabwe does not provide for the rights of indigenous people as it recognises all its non-white citizens as the indigenous people of Zimbabwe. Moreover, the groups that self-identify as indigenous peoples of Zimbabwe do not satisfy the definition of indigeneity provided in the Indigenisation and Economic Empowerment Act which considers all Zimbabweans that faced discrimination and marginalisation in the past on the grounds of race as the indigenous people of Zimbabwe. Although the Constitution provides for the right to health care, including reproductive health care, it does not specifically cater for the enjoyment of that right by indigenous people or indigenous women. In fulfilling its human rights obligations, the Constitution, in its Declaration of Rights, has laudable provisions that are linked to reproductive health and rights. Although such provisions do not make specific reference to indigenous women such as the San women, the Government should be commended for meeting its human rights obligations by having such comprehensive provisions which San women can rely on to claim the protection of their reproductive health and rights. An example of such a provision is the right to equality and non-discrimination clause in Sections 56 (3) and 56 (6), which provide a platform for the San women to make the Government answerable if they fail to access their reproductive health and rights due to discrimination. In addition, these provisions also provide a platform for the San women to be given better treatment compared to other women to advance their reproductive health and rights. The discussions in this chapter highlighted that the Constitution, like regional and international human rights instruments that entrench the rights linked to reproductive health does not have specific provisions that provide for the protection of indigenous people or indigenous women. Despite this shortcoming, these provisions are still useful in providing protection for women who, including San women.

Furthermore, the Government has enacted the Termination of Pregnancies Act which regulates legal abortion. The restrictive nature of this Act negatively affects women's reproductive autonomy. In many certain circumstances, they are forced to carry a pregnancy to term due to failure to fulfill the requirements of abortion provided in the Act. In addition, the Criminal Codification and Reform Act also limits the enjoyment of women's reproductive choices by criminalising abortion that is done without meeting the requirements provided in the Act. These two pieces of legislation put the lives of San women and girls at risk as, in most cases they might not be aware of the procedures to follow to terminate a pregnancy lawfully. In addition, due to their poor economic backgrounds, San women might resort to illegal ways which are not costly and do not require one to meet the cumbersome requirements to terminate a pregnancy. The Government has also enacted other progressive and reasonable legislation, such as the Public Health Act, Domestic Violence Act, Zimbabwe National Family Planning Council Act, and the National AIDS Council of Zimbabwe Act, to regulate the enjoyment of different elements of reproductive health and rights. However, these pieces of legislation treat indigenous people like any other ordinary Zimbabwean, and this can be used to explain the challenges faced by the San women in enjoying their other reproductive health and rights since there is no specific mention of how these laws will benefit indigenous women.

Furthermore, in line with its human rights obligations, the Government of Zimbabwe has also put different policies and strategies to regulate the reproductive health and rights elements relevant to this study. However, despite the provision of such progressive policies, there is still no specific mention of how these policies will address the plight of indigenous people or regulate how reproductive health services to indigenous people such as the San women should be provided. Furthermore, Government has also introduced programmes to ensure that indigenous women such as the San enjoy their reproductive health and rights. However, no programs have been specifically tailor-made to cater for indigenous peoples' needs, such as the San women.

In using the ESCR framework to assess the extent to which the San women in Zimbabwe are accessing their reproductive health and rights, the author found that the San women are accessing these rights to a lesser extent because of many factors. These factors include their geographical location, failure to raise maternity fees, failure to access reproductive health information in accessible formats, and the discrimination they face when visiting health institutions.

6.2.4 Lessons for Zimbabwe from other jurisdictions

This chapter discussed the accessibility and enjoyment of reproductive health and rights by San women in Botswana and Aboriginal women in Canada. The author focused on Botswana because, like Zimbabwe, Botswana is in Southern Africa, Botswana has the same basis of the law as Zimbabwe, and Botswana has the most significant number of San people compared to Zimbabwe. The chapter revealed that the GoB, like the Government of Zimbabwe, does not recognise the San as indigenous people of Botswana as all non-white citizens in those countries are considered indigenous people. The Constitution of Botswana, like the Constitution of Zimbabwe, does not make specific reference to indigenous people such as the San. However, despite the non-recognition of the San as indigenous people, the GoB has indirectly acknowledged their indigenous status through the programmes and policies they have introduced to ensure that the San enjoy certain rights, including the right to land and self-determination. In addition, the GoB has also ensured that the San people in Botswana are represented in governance structures by creating a junior Minister position to deal with San people challenges. Despite the non-provision of socio-economic rights in the Constitution of Botswana, the GoB, through its Ministry of Health and Wellness, has partnered with many key stakeholders to raise awareness on reproductive health in marginalised communities such as San communities. The GoB has done this by creating policies and conducting radio programmes that address challenges faced by those who stay in remote areas where San women reside. In addition, this Ministry has also introduced mobile reproductive health services to ensure that those who stay far away from health facilities, like the San community, benefit from such programmes. Therefore, Zimbabwe can learn lessons from Botswana by creating policies that address San women's challenges. Since currently there is significantly limited representation of San people in positions of authority, the Government of Zimbabwe can create a Department or Ministry that specifically deals with San challenges so that the unique challenges and barriers that the San people face are addressed by people who understand the San better or who have first-hand experience on San challenges. Although the Government of Zimbabwe has come up with programmes to ensure that San people are recruited in military and law enforcement positions, it will be good to adopt programmes that Botswana has come up with that deal with myriad challenges faced by San people, including challenges related to how they access health services including reproductive health services.

Regarding the treatment of Aboriginal women in Canada, the study revealed that the Constitution of Canada recognises Aboriginal people as indigenous people of Canada. This recognition plays a huge role in influencing laws and policies to cater for Aboriginal people's needs. Zimbabwe can amend its Constitution and subsidiary legislation to recognise San people as indigenous people of Zimbabwe so they can enjoy better protection from the laws of Zimbabwe. The Constitution of Canada also has laudable provisions on the protection of rights linked to reproductive health and rights that Aboriginal women can rely on, given that the Constitution of Canada does not entrench the right to health and reproductive health and rights. Canadian Courts have also been hearing cases related to Aboriginal rights, creating a strong precedent for handling cases concerning Aboriginal people. The Canadian Courts have also handled cases involving Aboriginal people and created jurisprudence on how to deal with matters involving Aboriginal people. One crucial case involved interpreting the right to equality and non-discrimination when determining matters related to Aboriginal people. Although the cases did not directly deal with reproductive health matters, they showed the confidence the Canadian Courts have created for Aboriginal people to bring their cases for determination. Zimbabwe can learn lessons from Canada and develop measures to encourage San people to get their cases before courts so that precedent is created for future purposes. The Government of Canada has also ensured that Aboriginal people are represented in governance structures by creating Ministerial positions in provinces and territories where Aboriginal people are found. This a good practice that Zimbabwe can learn, as having representatives of indigenous people in positions of authority can be instrumental in influencing policy change. Such representatives ensure that socio-economic policies cater for the needs of indigenous people in their jurisdictions. Canada has also promulgated laws and crafted policies that further the realisation of Aboriginal people's reproductive health and rights, which is a lesson Zimbabwe can learn given that the policies and laws in Zimbabwe do not cater for the needs of indigenous people. The Canada Health Act gives territories and provinces the power to come up with their health budgets, and allows them to include costs related to the needs of Aboriginal people in their jurisdictions. Zimbabwe can draw good practices from Canada by ensuring that Districts, where San women are found, are actively involved in the budget formulation so that they can include in the budget components costs that will alleviate San reproductive health problems.

The chapter also explored the measures put in place by Ontario, one of the provinces where a large Aboriginal population is found. The chapter revealed that Ontario made great strides in

ensuring the protection and access to reproductive health and rights of Aboriginal women by enacting laws, frameworks, establishing organisations, and introducing programmes meant to ensure that the reproductive health and rights of these women are advanced. Zimbabwe can adopt these good practices from Canada and ensure that it gives the power to create laws and policies to the provinces where the San and other indigenous people are found in Zimbabwe to advance these people's rights.

6.3 RECOMMENDATIONS

The following section presents recommendations that can be implemented in Zimbabwe to improve access to reproductive health and rights by indigenous women such as the San women. The recommendations are made to stakeholders such as policymakers, Independent Commissions, the Ministry of Finance, and Civil Society Organisations. The recommendations to these stakeholders address legislative and policy amendments, awareness raising and human rights education, practice, and research.

6.3.1 Policymakers

It is recommended that policymakers must adopt a HRBA in policy-making as this will create room for inclusivity and promotion of non-discrimination.[1184] A HRBA in policymaking will go a long way in ensuring that the needs and rights of vulnerable groups are catered for by ensuring that such people are included in the decision and law-making processes.[1185]

There is a need for amendment of Zimbabwean laws. The amendments should relate to the definition of indigenous peoples in the Indigenisation and Economic Empowerment Act and the Constitution of Zimbabwe to include groups who meet the global definition of indigeneity and self-identify as indigenous peoples. This will show Zimbabwe's commitment to fulfilling its international human rights obligations since Zimbabwe voted for the UNDRIP, which means Zimbabwe recognises indigenous groups such as the San within its borders. If the Constitution is amended, some laws and policies that have not been regarding the San as an indigenous

[1184] Cap-net '02/09/2020 Webinar: The Importance of a Human Rights Based Approach to IWRM' available at *02/09/2020 Webinar: The Importance of a Human Rights Based Approach to IWRM - Cap-Net* (accessed 19 August 2022). See also Zweig SA, Zapf AJ and Beyrer C *et al* 'Ensuring rights while protecting health: Importance of using a Human Rights Approach in implementing public health responses to COVID-19' (2021) 23:2 *Health and Human Rights Journal* 173- 186.

[1185] Cap-net '02/09/2020 Webinar: The Importance of a Human Rights Based Approach to IWRM' available at *02/09/2020 Webinar: The Importance of a Human Rights Based Approach to IWRM - Cap-Net* (accessed 19 August 2022).

group and have not been making clear reference to the San as one of the vulnerable groups in Zimbabwe will have to be aligned with the Constitution. There is also need to include indigenous peoples under the category of marginalised and vulnerable people in reproductive health policies and strategies to cater to their peculiar needs.

It is recommended that policymakers should strive to enact laws and policies that ensure that indigenous peoples are represented in governance structures at all levels in Zimbabwe. Since Zimbabwe has an obligation to fulfill, the Government of Zimbabwe should set up a separate Government Ministry or Department to specifically represent the San community in Zimbabwe and address any challenges they face. It is also recommended that such Ministry or Department be headed by a member of the San community or someone who better appreciates the San community.

There is a need for policymakers to ensure that Zimbabwe ratifies important human rights instruments such as the ILO Convention No.169, which has laudable provisions on the right to health of indigenous peoples. Although Zimbabwe, like Canada and Botswana, indicated that they favour the Convention, it is not enough to favour it and not ratify it. It will be important for Zimbabwe also to domesticate the provisions of the Convention in its national laws to make it enforceable. Zimbabwe has ratified the CEDAW, there is a need for Zimbabwe to ratify its Optional Protocols to allow indigenous women whose rights will be violated to rely on these complaints mechanism to get redress for the violation of their rights. Since Zimbabwe voted for the UNDRIP, there is a need for policy makers to adopt a substantive equality approach in putting measures in terms of laws and policies that will specifically articulate and address the rights and plight of indigenous peoples within its borders to alleviate the challenges they are facing in the realisation of their rights. There is also need to make a distinction between ordinary Zimbabweans and indigenous minorities in the Constitution of Zimbabwe for future policies and laws to draw inspiration from the highest law of the land and make such distinctions.

6.3.2 Ministry of Finance and Economic Development (Ministry of Finance/ Ministry)

This study supports the notion that the Government of Zimbabwe must demonstrate political will and, through the Ministry of Finance, increase budgets for independent institutions such as the ZGC and the ZHRC. The author believes that increasing budgets for these independent institutions will enable them to fully discharge their mandates and improve the emancipation of the San communities. The resourcing of these institutions will allow them to effectively

execute their mandates and ensure the progressive realisation of the San women's rights. This study recommends that the Ministry of Finance should also increase budgets for the Ministry of Health and ensure an increased budget catering for reproductive health. It is also important to make it a point that the Ministry of Health is allocated a budget that is meant to cater for indigenous peoples' needs so that they can access reproductive health services even when they do not have money.

Besides funding these institutions, the Government and financial institutions should prioritise indigenous women when disbursing loans and allocating productive resources such as land and capital. This will empower indigenous women such as the San women and cause them to be self-sufficient and be able to cater for many of their expenses, such as their maternity bills.

6.3.3 Ministry of Health and Child Care (MoHCC/ Ministry of Health)

It is recommended that the MoHCC should ensure that Maternity Waiting Homes (MWH) are well resourced so that marginalised women like San women can use the services without paying for food or any other fees. It is also recommended that Government through the MoHCC should provide meals for expecting mothers in the MWH and a starter pack for the expected baby which can include baby clothes, towels, baby powder and bathing liquid. It is also important to include San women in programmes such as the VHW programme so that they can represent issues faced by San women in reproductive health matters. Within its limited resources, the Ministry of Health should raise awareness on reproductive health, especially amongst marginalised women such as the San women. This Ministry should also find ways to disseminate reproductive health information in formats that can easily be understood by women with low literacy levels, mostly found amongst indigenous women.[1186] The Ministry of Health should also strive to incorporate traditional methods believed by indigenous peoples in health matters concerning so that indigenous peoples can have confidence in using services offered by health institutions.

This study recommends that the Ministry of Health should ensure that programmes are introduced to realise the right to health of indigenous people in Zimbabwe by taking into consideration capacitating trained medical staff about indigenous health practices and remedies

[1186] Phiri K, Ndlovu S and Dube T *et al* 'Access to formal education for the San community in Tsholotsho, Zimbabwe: challenges and prospects' available at *Access to formal education for the San community in Tsholotsho, Zimbabwe: challenges and prospects - PMC (nih.gov)* (accessed 20 October 2022). According to Phiri *et al*, "San people's literacy rates are the lowest at 23% while at national level the average is 66%."

as well as conducting trainings for indigenous people on the westernised idea of medical practices and remedies. There is a need for the Ministry of Health to recruit and train children from indigenous communities as nurses or other health personnel in the health sector so that it becomes easy for indigenous peoples to be served by people with the same background and upbringing as theirs. The government, through the Ministry of Health, should apply affirmative action and relax the requirements for being recruited into such positions within the Ministry. This study also recommends that the MoHCC should increase infrastructure providing reproductive health services to people living in marginalised areas so that they do not walk long distances in wildlife-infested bushes to access reproductive health services. Lastly, the MoHCC should strive to move with the times and always use policies that are up to date.

6.3.4 Ministry of Women Affairs, Small and Medium Enterprises

This Ministry should increase its presence in rural areas, particularly within the San community, so that San women can take advantage of the programmes and enjoy their rights. This Ministry should also develop programmes specifically designed to advance the reproductive health and rights of San women and have San women taking leading roles in such programmes. It is recommended that the Ministry of Women's Affairs should raise awareness of its mandate and the programmes it offers to the San women so that San women can take advantage of such programmes to enhance the enjoyment of their rights. The researcher recommends that this Ministry should empower women economically to enable them to enjoy their rights such as their reproductive health and rights as these rights are recognised as the cornerstone for development.[1187]

6.3.5 Independent Commissions/ Institutions

The researcher recommends that to deal with the problem of lack of knowledge on human rights, and reproductive health and rights of San women, ICs such as the ZHRC and the ZGC need to prioritise raising awareness on human rights and reproductive health. This will ensure that indigenous women such as the San women are given the knowledge required to make decisions regarding their reproductive lives. Such awareness will also equip them with

[1187] Obudho N 'Access to Sexual and Reproductive Health is a Right, Not a Privilege' available at *https://www.womenlifthealth.org/article/access-to-sexual-and-reproductive-health-is-a-right-not-a privilge/* (accessed 9 November 2022). See also Introductory Statement by Head of Delegation of Zimbabwe 'Consideration of reports submitted by State Parties under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women' available at *https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/ZWE/INT_CEDAW_STA_ZWE_51_11091_E.pdf* (accessed 12 November 2022).

knowledge required to live healthy lives and not neglect their reproductive health. It is also important for ICs to partner with CSOs at grassroots levels to raise awareness of these rights, as grassroots-level organisations are trusted better by their communities. Once the San women are capacitated on their rights, they will be able to hold the Government and public institutions accountable if their reproductive health and rights are violated. Furthermore, capacitating the San women on their rights will enable them to stand for their rights when they are violated and seek recourse accordingly.

Furthermore, the researcher recommends that ICs such as the ZHRC should capacitate health personnel on human rights and HRBAs to service delivery so that they do not discriminate against the San when they visit health facilities to seek medical help whilst wearing their traditional perfumes. Capacitating health personnel on human rights and the HRBAs will improve service delivery as the health personnel will know that their failure to deliver services to the San properly will amount to a violation of rights for which they can be held accountable. The ZHRC in making recommendations to Parliament on the laws that need to be enacted and amended, should ensure that these laws cater for the human rights of different categories of people in Zimbabwe, such as indigenous women..[1188] Furthermore, the ZHRC should monitor laws, policies and Government programmes and assess whether they align with human rights standards. If they do not, the ZHRC should recommend amendment and adjustment of such laws, policies, and programmes to ensure that they are inclusive and promote human rights.

There is a need for the ZHRC as the NHRI for Zimbabwe to intensify human rights awareness-raising programmes, especially amongst indigenous women.[1189] Capacitating indigenous women about their rights will go a long way in building confidence in them to exercise their rights and seek recourse when those rights are violated.

There is a need to create opportunities for indigenous women to be involved in leadership positions so that they can raise the challenges facing they. The ZGC, which is tasked with promoting women's participation, including in politics and leadership positions, should

[1188] in line with its Constitutional function outlined in Section 243 (1)(i), the ZHRC is tasked to "recommend to Parliament effective measures to promote human rights and freedoms."
[1189] Section 243 (1) (a) of the Constitution of Zimbabwe mandates the ZHRC "to promote awareness of and respect for freedoms at all levels of society."

encourage indigenous women to participate in its training and mentorship programmes for aspiring female candidates.[1190]

6.3.6 Civil Society Organisations (CSOs)

CSOs play an important role in protecting and promoting human rights as they are important players in the development of the current international legal framework.[1191] They have played this crucial role through various means, including engaging and lobbying the executive and legislative branches of their states and different international bodies.[1192] CSOs have also used litigation before courts within their States and international forums to influence the interpretation, development, and enforcement of rules of law, standards, and practices to enhance the protection and promotion of human rights.[1193] CSOs have also used community mobilisation[1194] to empower communities with knowledge about their rights and how to engage the Government to claim the protection of those rights.

Given this background, it is recommended that CSOs lobby the Government to amend reproductive health laws so that they become inclusive and cater to the rights of vulnerable groups such as indigenous women. Furthermore, organisations such as the Legal Resources Foundation (LRF) and Zimbabwe Women's Lawyers Association (ZWLA) can provide legal representation for indigenous women when they want to bring before courts cases related to violation of their rights as women, including their reproductive health and rights.[1195] In addition, these organisations can also be instrumental in raising awareness of indigenous women's rights as these organisations are mandated with raising awareness on human rights to indigent people in Zimbabwe.[1196]

[1190] The ZGC has been rolling out a training and mentorship programme (Women Rise in Politics) for aspiring female candidates. This programme has focused on women from other Districts leaving out San women. In the training conducted in Plumtree in 2022, San women were not represented. The programme has not yet been done in Tsholotsho District.

[1191] Hondora T 'Civil Society Organisations' Role in the Development of International Law through Strategic Litigation in Challenging Times' (2018) 25 *Australian International Law Journal* 115.

[1192] Hondora T (2020) 115.

[1193] Hondora T (2020) 115.

[1194] According to Sithole L (2020) 175, "community mobilisation is the process of bringing together societal and personal influences to raise awareness and to co-ordinate action. Community mobilisation can help to raise awareness around the meaning of the right to health and the right to reproductive health particularly."

[1195] Sithole L (2020) 178.

[1196] The LRF's mission is "to promote access to justice and human rights in Zimbabwe through legal assistance, legal education and advocacy and strengthening the justice delivery system." ZWLA is a non-profit making organisation whose mission is to defend and dialogue on women's rights. ZWLA does this by providing legal aid and education to millions of women and communities. It also lobbies and advocates communities, institutions, Government and policy makers to be sensitive to women's rights.

CSOs also write shadow reports during the UPR process and to treaty monitoring bodies. Given this role, they can raise issues affecting indigenous women so that the Government can be held accountable for these violations. CSOs and NGOs can also work together in disseminating information on reproductive health. Due to the CSOs and NGOs' presence in remote areas where San people are found, it is recommended that these organisations should do programmes specifically dedicated to enhancing the reproductive health and rights of indigenous women. Organisations like PLAN International, which operates in areas where some of the San people live, should continue to promote the right to health of indigenous women by working with the MoHCC to share information on reproductive health with indigenous women in simplified formats. This can be done by simplifying Information, Education, and Communication (IEC) materials and client charters and translating these materials to a language preferred by the San.

6.3.7 Researchers

This study was limited in that it relied on the desktop methodology to highlight the extent to which San women are accessing reproductive health and rights. Thus, the authentic voices of the San women were not captured clearly. Therefore, it is recommended that future research on the similar subject should adopt a quantitative method. In addition, the study did not explore all the elements of reproductive health and rights. Therefore, it is recommended that research on access to reproductive health and rights by San women focusing on the outstanding reproductive health elements should be conducted. The discussion in this study was limited to San women. Thus, it is recommended that future research should focus on Doma women who also self-identify as indigenous peoples of Zimbabwe.

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