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WOMEN'S RIGHT TO ACCESS FAMILY PLANNING, INFORMATION AND SERVICES DURING HUMANITARIAN EMERGENCIES: A CASE OF CYCLONE IDAI IN CHIPINGE AND CHIMANIMANI DISTRICTS OF ZIMBABWE

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Laws (LLD) in the department of Public Law and Jurisprudence, Faculty of Law at the University of the Western Cape.

By Patience Ndlovu

Student Number: 4078487

Supervisor: Professor Ebenezer Durojaye

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ABSTRACT

Women's access to family planning information and services during humanitarian emergencies is a key component in the advancement of gender equality, women's empowerment and social development. The exercise of women's reproductive rights allows them to make informed choices, take control of their bodies and is a crucial determinant of their enjoyment of other rights. The domain of reproductive rights enables women to live lives endowed with dignity and well-being.

International and regional norms and standards require that state parties respect, protect, promote and fulfill reproductive rights. Zimbabwe has registered commitments to upholding reproductive rights through the Constitution and other laws. Despite these provisions, rural women affected by humanitarian emergencies are confronted by a host of challenges in accessing family planning information and services, in contravention of Zimbabwe's human rights obligations.

The aim of this study was to interrogate if Zimbabwe's laws, policies and programmes adequately advance women's family planning, information and services during humanitarian emergencies using the case of Cyclone Idai in the Chipinge and Chimanimani districts of Zimbabwe.

Utilising a desktop review, the research identified gaps in Zimbabwe's laws, policies and programmes due to a lack of attentiveness to women's reproductive health during emergencies. Furthermore, limited access to reproductive information, poverty, patriarchal norms, child marriages, restrictive abortion provisions, high staff turnover of experienced health personnel, limited access to essential drugs and supplies, and poor access to water and sanitation militated against women's access to reproductive health services during Cyclone Idai.

To redress the identified challenges, the thesis recommended that Zimbabwe crafts a disaster risk management statute with a chapter which advances women's reproductive rights during humanitarian emergencies. The study recommended that Zimbabwe borrows lessons from the Philippines' natural disaster and Ethiopia's armed conflict contexts. Key legal, policy and programmatic elements from these

two jurisdictions, coupled with international humanitarian standards and guidelines, are suggested for Zimbabwe.

Informed to a larger extent by the capabilities approach and to a lesser extent by radical African feminism, the study proffers recommendations to the government to align laws and policies to its international and regional commitments on women's reproductive rights, among other issues. It recommends that civil society ensure advocacy and legal reform around the domain of reproductive rights. Further, the judiciary is encouraged to enhance the quality of judgements on sexual and reproductive health and rights (SRHR). Additionally, National Human Rights Institutions are recommended to play their investigative role and proffer evidence-based sector-specific recommendations to ensure women's right to access family planning information services is amplified.

KEYWORDS

Chimanimani

Chipinge

Family planning

Humanitarian emergencies

Information services

Reproductive

Women

Zimbabwe

ACRONYMS/ ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
ASRHRS	Adolescent Sexual and Reproductive Health Rights Strategy
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CSW	Committee on the Status of Women
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
ESAP	Economic Structural Adjustment Programme
FWCW	Fourth World Conference on Women
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
HRC	Human Rights Committee
IASC	InterAgency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive health in crisis
ICESCR	International Covenant on Economic, Social and Cultural
ICPD	International Conference on Population and Development
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MoHCC	Ministry of Health and Child Care
NDS	National Development Strategy
NFIs	Non-food items

PLHIV	People Living with HIV
RDC	Rural District Council
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
Sphere Standards	Humanitarian Charter and Minimum standards in humanitarian response
SRHR	Sexual and Reproductive Health and Rights
SRRWA	Special Rapporteur on the Rights of Women in Africa
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VAW	Violence Against Women
VDPA	Vienna Declaration and Plan of Action
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZGC	Zimbabwe Gender Commission
ZHRC	Zimbabwe Human Rights Commission
ZIMSTAT	Zimbabwe National Statistics Agency
ZNFPC	Zimbabwe National Family Planning Council

DECLARATION

I, Patience Ndlovu, do hereby declare that 'Women's right to access family planning information services in humanitarian emergencies: A case of Cyclone Idai in Chipinge and Chimanimani districts of Zimbabwe' is my work and that it has not been submitted for other degree or to any other institution of higher learning. All sources used have been duly acknowledged and referenced accordingly.

Patience Ndlovu Signature…….
Student

Prof. Ebenezer Durojaye Signature:……..
Supervisor

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‘*Planting is hard, seeds look lifeless, they are not attractive to anyone; taking care of the plants is even harder! External factors such as weather conditions and pests can discourage anyone. However, it is believing in the future of the lifeless seed that triggers the farmer to start planting. It is the hope for a tomorrow of harvest that keeps him focused on the cause’*

Mamokhethi Phakeng, Vice Chancellor of the University of Cape Town 2022.

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CHAPTER 1: INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Zimbabwe is not new to natural disasters, hazards and pandemic outbreaks. The history of Cyclones in the country includes Cyclone Eline in 2000, Cyclone Japhet in 2003, Cyclone Dineo in 2017 and Cyclone Idai in 2019.[1] Apart from these, Zimbabwe has seen recurring cholera outbreaks in 1999, 2002 and 2008.[2] Due to Cyclone Idai, approximately 270 000 people were affected by flooding and landslides, with the majority (240 000) located in Chimanimani and Chipinge districts. Nearly 4,500 people were displaced, and at least 16,000 families were in need of shelter assistance.[3] UNFPA reported that of the 270 000 people affected by Cyclone Idai in Zimbabwe, 382 women were HIV positive, 67 500 were women of reproductive age, and 1250 were pregnant. Due to the cyclone in neighbouring Malawi, the risk of Sexually Transmitted Infections (STIs) and unwanted teenage pregnancies was high. Most sites had no access to Sexual and Reproductive Health and Rights (SRHR) services due to long distances from health facilities and low levels of knowledge on SRHR issues.[4] Similarly, in Mozambique[5], 55 500 women

[1] Bonga W G 'Poverty and pandemic response in Zimbabwe' (2020) 10 Dynamic Research Journals, *Journal of Economics and Finance* 5.

[2] WHO 'Cholera in Zimbabwe' available at *https://www.who.int/csr/don/2008_12_02/en/* (accessed on 7 December 2020).

[3] CARE Rapid Gender Analysis, 'A Commitment to Addressing Gender and Protection Issues in Cyclone-and Flood-Affected Malawi, Mozambique and Zimbabwe' (2019) 2.

[4] IPPF 'Cyclone Idai, the impact so far in Malawi and Mozambique' (2 April 2019) available at *https://www.ippf.org/blogs/cyclone-idai-impact-so-far-malawi-and-mozambique* (accessed 20 February 2020).

[5] UNFPA 'Responding to women and girls' sexual and reproductive health needs and prevention and response to gender-based violence in cyclone-affected Malawi, Mozambique and Zimbabwe'(2019)7 available at *https://esaro.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Flood%20Appeal%2004-04-2019.pdf (*accessed on 20 February 2020).

were expecting to give birth in six months, 462 000 were women of reproductive age, 77 000 women were living with HIV when cyclone Idai struck. In a way, Cyclone Idai created a health crisis in the affected areas, hampered the realisation of the right to health, particularly access and availability of SRHR services.

The impact of Cyclone Idai on the health sector in Zimbabwe added to the already existing challenges to the attainment of the right to health due to governance problems which had been partly fuelled by the Economic Structural Adjustment Programme[6] (ESAP), which became operational in 1991 with the design and loan support from the World Bank.[7] The World Bank disbursed loans to Zimbabwe in 1986, 1991 and 1993 aimed at among other things supporting improvements in the quality and availability of health services. However, flaws in the design of ESAP resulted in strains on the health sector. Furthermore, failure to repay and control the budget deficit plunged Zimbabwe into an economic crisis and further undermined the health sector.[8] Esser[9] highlights that Zimbabwe's economy plummeted in the mid-90s, with the downturn fuelled by the country's involvement in the war in the Democratic Republic of Congo, unbudgeted payments to 'war veterans' and a controversial land reform programme in the 2000s. Resultantly the health sector, like other sectors, suffered due to the economic meltdown. In the 2000s, the economy collapsed under the burden of debt and corruption, which resulted in infrastructural decay and a lack of basic health

[6] ESAP is a neo-liberal market-driven policy measure adopted in Zimbabwe as a prescriptive solution to the economic crisis of the 1980s. Zimbabwe implemented the trade-policy liberalization component of the economic program. See Structural Adjustment Participatory Review International Network, 'A multi country Participatory Assessment of Structural Adjustment' (2002)33.

[7] World Bank 'Meeting the Health Care Challenge in Zimbabwe' World bank Operations Evaluation Department Winter Number 176 (1999)1.

[8] World Bank (1999)2.

[9] Esser C 'Neither bad luck nor chance, the health crisis in Zimbabwe in the context of human rights' Jg. 1, (2011)1-17 Menschenrechte und Gesundheit / Amnesty-Aktionsnetz Heilberufe,

supplies.[10] By 2009, public hospitals were extremely short of water, electricity, paper, drugs, gloves, bed sheets, syringes, needles, disinfectants, or operating equipment.[11]

The Zimbabwe National Family Planning Costed Implementation Plan[12] further outlines challenges faced by the national family planning programme, namely: an inadequate enabling environment, poor commodity security, service delivery pitfalls, gaps in demand creation, inefficient and ineffective research, monitoring and evaluation. Recent studies carried out in Zimbabwe indicate inadequacies in the six-health system building blocks, namely: human resources, medical products, vaccines and technology, health financing, health information, service delivery, leadership and governance,[13] and prerequisites for a functional health delivery system.[14]

What is evident is that when Cyclone Idai hit Zimbabwe in 2019, the health sector was already in a crisis. Coverage of antenatal care was slightly higher in urban than rural areas and cities,[15] thus leaving rural women in a precarious position regarding their reproductive rights. Choguya paints a multi-faceted crisis of Zimbabwe's health care delivery system characterised by poor infrastructure, poor roads to reach health facilities, and unavailability of trained personnel, especially in government

[10] Kidia K K 'The future of health in Zimbabwe' (2018)1 Global health Action, Taylor and Francis Group.

[11] Esser (2011)4.

[12] Ministry of Health and Child Care, Zimbabwe National Family Planning Costed Implementation Plan 2016-2020.

[13] WHO 'Zimbabwe Multi sectoral Cholera Elimination Plan 2018-2028' available at *https://www.afro.who.int/publications/zimbabwe-multi-sectoral-cholera-elimination-plan-2018-2028* (accessed on 19 November 2022).

[14]World Health Organisation 'Emergencies' available at *ttps://www.who.int/europe/emergencies/our-work-in-emergencies/health-systems-for-emergencies/medical-products* (accessed on 19 November 2022).

[15] Choguya Z 'Traditional birth attendants and policy ambivalence in Zimbabwe' (2013)4 *Journal of Anthropology,* Hindawi publishing Corporation.

institutions, among other factors.[16] As a result, Zimbabwe's maternal mortality ratio was unacceptably high at 651 per 100 000 live births[17] caused by deliveries without skilled care, inadequate facilities to handle complications and a general lack of sustainable interventions.[18]

Despite these challenges, one has to be mindful that Zimbabwe still has obligations as a state party to international and regional instruments and policies whose persuasive value is to advance the enjoyment of women's reproductive services. These include the United Nations World Conference on Human Rights,[19] Continental Policy Framework for Sexual and Reproductive Health and Rights,[20] Plan of Action on Sexual and Reproductive Health and Rights,[21] Universal Declaration of Human Rights,[22] International Covenant on Civil and Political Rights,[23] Convention on the Elimination of All Forms of Discrimination against

[16] Choguya (2013)1-12.

[17] Ministry of Health and Child Care, 'Family Planning Guidelines for Zimbabwe' 2018 (1).

[18] Dodzo MK Mhloyi M 'Home is best: Why women in rural Zimbabwe deliver in the community' (2017)1-23 *PLoS One Journal*.

[19]Vienna Declaration and Plan of Action, available at *https://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.asp* (accessed on 18 February 2020).

[20] African Union, Sexual and Reproductive Health Rights, continental Policy Framework available at *https://au.int/sites/default/files/documents/30921-doc-srhr_english_0.pdf (*accessed on 18 February 2020).

[21]Maputo Plan of Action, available at *https://www.ippf.org/sites/default/files/maputo_plan_of_action.pdf* (accessed on 18 February 2020).

[22]Universal Declaration of Human rights, available at *https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf* (accessed on 20 February 2020*).*

[23] International Covenant on civil and political rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 49, available at *https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx* (accessed on 20 February 2020).

Women,[24] International Conference on Population and Development,[25] African Charter on Human and Peoples Rights,[26] and Protocol to the African Charter on Human and People's Rights on the rights of women in Africa (known as the African Women's Protocol).[27]

While this study focuses on women's access to family planning information and services, it is inevitable that it also refers to the broader sphere of 'women's reproductive health rights', which encompasses goods and services. Women's right to family planning information and services during humanitarian emergencies is guided by, among other guidelines: the Humanitarian Charter Minimum standards as set out in the Sphere handbook,[28] The Inter-Agency Working Group (IAWG) field Manual on reproductive health in crises,[29] Special Rapporteur reports, General Comments, General Recommendations and major international and regional norms and standards relating to women's reproductive health rights among others.

[24] Convention on the elimination of all forms of discrimination against women, available at *https://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pd* (accessed on 20 February 2020).

[25] Plan of Action adopted at the International Conference on Population and Development 1994, available at *https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf* (accessed on 20 February 2020).

[26] African Charter on human and People's rights, adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986) available at *https://www.achpr.org/legalinstruments/* (accessed on 18 February 2020).

[27] Maputo Protocol, at *https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf* (accessed on 18 February 2020).

[28] The Humanitarian Charter available at *https://spherestandards.org/wp-content/uploads/2018/07/the-humanitarian-charter.pdf* Accessed on 9 August 2022.

[29] IAWG is an international coalition of organisations and individuals working collectively to advance sexual and reproductive health and rights in humanitarian settings available at *https://iawg.ne* accessed on 9 August 2022.

Goal number 3 of the Millennium Development Goals (MDGS Framework of 2000-2015) set targets to achieve gender equality.[30] Upon their termination in 2015, the MDGs were substituted by the Sustainable Development Goals[31], which aim to ensure universal access to sexual and reproductive healthcare services. CESCR General Comment No. 14 on the right to health emphasises the significance of the availability of good quality health care as a basic human right for all. It thus provides guidance on the dispensation of women's family planning information and services during humanitarian emergencies.[32] General Comment 22 explicitly interprets state obligations to respect, protect and fulfil the right of everyone to sexual and reproductive health.[33] It is of utmost importance that this study, therefore, assesses women's access to family planning information and services during humanitarian emergencies in terms of "*availability, accessibility, acceptability and quality,*"[34] having regard to what transpired during Cyclone Idai in Chipinge and Chimanimani in 2019. CEDAW Committee General Recommendation No. 37 contains fundamental cross-cutting principles which should guide state parties in drafting legislation, policies, plans of action, programmes, budgets and other measures on gender-related facets of disaster risk reduction.[35] Furthermore, CEDAW General Recommendations No. 33 on women's

[30] United Nations Development Programme, Millennium Development Goals available at *https://www.undp.org/content/undp/en/home/sdgoverview/mdg_goals.html* (accessed on 20 February 2020).

[31] United Nations, Sustainable Development Goals SDG 3.7 by 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and integration of reproductive health into national strategies and programs available at *https://sustainabledevelopment.un.org/* (accessed on 1 March 2020).

[32] 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)*, 11 August 2000, E/C.12/2000/4, available at: *https://www.refworld.org/docid/4538838d0.html* (accessed 20 November 2022).

[33] CESCR General Comment No 22.

[34] CESCR General Comment No. 14.

[35] CEDAW General Recommendation No. 37 (2018) on the gender related dimensions of disaster risk reduction in a changing climate available at

access to justice allows women whose family planning rights are violated to seek redress[36] Due to several factors, rural women are disproportionately affected by a lack of access to family planning services. Thus, considering CEDAW General Recommendation No. 34[37] is significant for protecting their human rights, which applies even during humanitarian emergencies.

In order to assess Zimbabwe's compliance with its obligations to advance women's family planning information and services during humanitarian emergencies, it becomes crucial that this study interrogates the country's legal, policy and programmatic framework on women's reproductive rights during humanitarian emergencies against the stated instruments, guidelines and best practice stated above in this section.

1.2 Thesis Statement and Justification of the Study

The overall thesis of this study is that women's right to access family planning information and services is violated during humanitarian emergencies. This is in breach of Zimbabwe's commitments to international, regional norms and standards expressed through various legal and policy instruments and even through Zimbabwe's Constitution and other domestic laws. Of the available literature, studies tend to focus more on the deteriorating health service delivery sector in Zimbabwe in the context of human rights,[38] poverty and pandemic response in Zimbabwe[39], a generalised analysis of disaster management legislation.[40]

https://documents-dds-ny.un.org/doc/UNDOC/GEN/N18/068/98/PDF/N1806898.pdf?OpenElement (Accessed on 3 September 2022). */98/PDF/N1806898.pdf?OpenElement* (accessed on 3 September 2022).

[36] CEDAW), General Recommendation No.33: On women's access to justice CEDAW/C/GC/33.

[37] CEDAW General recommendation No. 34 (2016) on the rights of rural women CEDAW/C/GC/34.

[38] Esser C 'Neither bad luck nor chance: The health crisis in Zimbabwe in the context of human rights' (2011)1

[39] Bonga W G (2020)7.

[40] Mavhura E (2016) 605-621.

Furthermore, studies focus on how rural and urban Zimbabwean women face obstacles in accessing antenatal care and institutional deliveries attended by skilled health personnel[41] , among others, because of a frail health system. Despite these observations, there is an academic literature gap to specifically document and gauge the extent of women's access to family planning information and services during humanitarian emergencies.

Mc Coy's study focuses on women's unmet need for family planning and unintended pregnancy in Zimbabwe. According to this study, the unmet need for family planning and contraceptive failure contributes to unintended pregnancies among women.[42] A study by Choguya focuses on a situational analysis of traditional and skilled birth attendants. The study attributes inadequate and unavailable health care services as well as deep-rooted traditional practices, as the main drivers for the utilisation of traditional birth attendants.[43] In addition, a myriad of socio-economic and geo-physical factors come into play to limit women's access to reproductive health care.

Dodzo and Mhloyi draw attention to push factors that act as barriers to formal health care utilisation and drive women to opt for community maternal care providers. The study attributes high maternal mortality to deliveries without skilled care in places without appropriate or adequate facilities to handle complications.[44]

[41] Choguya N Z 'Traditional and skilled birth attendants in Zimbabwe: A situational analysis and some policy considerations' (2015) 3 *Journal of Anthropology* available at *http://downloads.hindawi.com/archive/2015/215909.pdf* (accessed on 24 May 2020).

(2015)1-12.

[42] Mc Coy SI et al 'Unmet Need for Family Planning, Contraceptive Failure, and Unintended Pregnancy among HIV-Infected and HIV-Uninfected Women in Zimbabwe' (2014)5 PLoS ONE journal.

[43] Choguya (2015) 3.

[44] Dodzo MK & Mhloyi M (2017)1.

The hurdles that all women face in enjoying their reproductive rights are reportedly aggravated for rural women, who may experience multiple layers of discrimination that result in additional impediments and marginalisation.[45] Mutowo argues that poverty increases vulnerability to unsafe sexual behaviours and practices and decreases access to sexual and reproductive health information and service.[46] Moreover, Mutowo's study sample in Zimbabwe echoes the sentiments that culture still inhibits women's assertiveness on sexual matters and that women are expected to be passive, as assertiveness on sexual matters makes them viewed as unfeminine.

After the Cyclone Idai experience of 2019, there have been a number of studies that do not address women's reproductive service access in disaster settings. A study by Chanza focuses on deficiencies in the country's disaster management systems through narratives highlighting the plight of those who survived Cyclone Idai in the Rusitu Valley of Chimanimani district. The study documents the extra burden of care imposed by Cyclone Idai in Chimanimani on rural women and their role in search and rescue efforts.[47]

In his 2020 study after Cyclone Idai hit Zimbabwe, Bonga exposes deficiencies in the country's disaster management system.[48] Furthermore, he presents an analysis of Zimbabwe's experience in the management of past hazards, pandemics and natural disasters and observes that no significant improvements have been made in alleviating the plight of Zimbabwe's ailing health system. [49] Although Bonga's study indicates disaster management policy deficiency in Zimbabwe, it is

[45] Centre for Reproductive Rights 'Submission for the CEDAW Committee's Half Day of General Discussion on Rural Women" available at *http://www.ohchr.org/Documents/HRBodies/CEDAW/RuralWomen/CRR.pdf,* accessed on 9 September 2020.

[46] Mutowo J *9et al 'Women empowerment and practices regarding use of dual protection among family planning clients in urban Zimbabwe' (2014)2 *Pan African Medical Journal*.

[47] Chanza et al (2020)1-12.

[48] Bonga (2020)10.

[49] Bonga (2020)10.

generalised and silent on disaster-affected populations' reproductive needs, particularly those of women and girls.

A study by Chitongo discusses the nexus between climate change and social relations in Africa using a case study approach of Cyclone Idai in Chimanimani district, Zimbabwe.[50] The study, conducted from a gender studies perspective, views disaster as a gendered-constructed process. The study further states that in order to build resilient communities, there is a need for gender mainstreaming. However, although the study elaborates on male dominance in disaster decision-making processes and ideological constraints that can limit women's access to life-saving public shelters,[51] it is not elaborate on women's capabilities to access reproductive healthcare services during Cyclone Idai. It is this lacuna that this study seeks to bridge by elaborating on the barriers faced by women in their bid to access family planning information and services in the context of humanitarian emergencies.

The Zimbabwe Gender Commission[52] (ZGC) undertook a rapid gender assessment of the national response system to Cyclone Idai through a visit they conducted in Manicaland province in the aftermath of the catastrophe. In its recommendations on the identified needs, capacities and gaps and coping strategies of women, men, girls and boys, the ZGC does not, however, provide gender-disaggregated data or elaborate much on the pertaining situation regarding women's access to family

[50] Chitongo L. et al 'Gendered Impacts of climate change in Africa 'The case study of Cyclone Idai, Chimanimani, Zimbabwe' (2019) 1 The Fountain- Journal of interdisciplinary studies Volume 3 Issue 1.

[51] Chitongo (2019)9.

[52] The Zimbabwe Gender Commission is an Independent Commission constituted and established in terms of Section 245 of the Constitution of Zimbabwe and operationalised through the Zimbabwe Gender Commission Act Chapter (10:31). Available at *https://zgc.co.zw/about-us/* (accessed on 20 November 2023)

planning information and services or provide specific recommendations in the wake of the crisis.[53]

Similarly, the Zimbabwe Human Rights Commission (ZHRC), having monitored the Cyclone situation in Chipinge and Chimanimani in the aftermath of the 2019 Cyclone, produced a report. The findings fall short of elucidating the ranking of women's access to reproductive information and services.[54] A common factor among the available literature is a generalisation of the health challenges experienced during Cyclone Idai without specific elaboration on women's access to family planning information and services during the same period. There are no reports by the Department of civil protection, the government lead agency in disaster management, to provide a sufficient account of women's access to reproductive goods and services, thus presenting a gap in official government literature on institutional response to women's family planning information and services during humanitarian emergencies.

There is a general dearth of literature on judicial interpretation of sexual and reproductive health and rights in cases handled by Zimbabwe's courts. This study mainly relies on the cases of *Mudzuru*,[55] *Mapingure*,[56] and *Masuka*[57] to formulate an understanding of the approach taken by the Zimbabwean judiciary towards women's sexual and reproductive health and rights, as there is no specific litigation on family planning information and services. The lack of cases implies a general

[53] Zimbabwe Gender Commission 2019 Annual Report available at *https://zgc.co.zw/annual-reports/* (accessed on 20 November 2022).

[54] Zimbabwe Human Rights Commission 'Zimbabwe Human Rights Commission Cyclone Idai First Monitoring report' (2019)1-10 available *at https://www.zhrc.org.zw/monitoring-and-inspection/* (accessed on 20 November 2022).

[55] *Mudzuru and Anor v Ministry of Justice, Legal and Parliamentary Affairs N.O and Ors* (CC 12 of 2015; Constitutional Application 79 of 2014.

[56] *Mapingure v Minister of Home Affairs & Others* (SC 406/12) [2014] ZWSC 22 (24 March 2014

[57] *S V Masuku* (CRB 467 of 2014) (2015) ZWHC 106/15.

dearth in developing jurisprudence on sexual and reproductive health and rights.[58] This gap presents an opportunity for the judiciary to explore the nature of Zimbabwe's state obligations in the realisation of reproductive rights in normal and emergency contexts, drawing from the normative content of international, regional reproductive norms and standards as well as from the experiences of other jurisdictions.

Through the available literature generated from Cyclone Idai, the study explores, among other pertinent issues, women's access to family planning information and services, gender equality, women's empowerment, women's agency and autonomy in reproductive health decision-making. A focus on institutional response to women's access to family planning information and services through generated reports compared to other jurisdictions. Additionally, an analysis of the legal, policy and programmatic framework works to inform the government, its agencies, and non-state actors on the gendered humanitarian response, which advances women's access to family planning information and services during humanitarian emergencies.

Given the literature gap, this study imagines a reconstruction of women and girls' lived realities during Cyclone Idai as they sought to access family planning information and services in the confines of the available legal, policy and programmatic environment. This study investigates the adequacy of the available legal, policy and programmatic framework in addressing the unique challenges posed by Cyclone Idai to women's family planning needs, something that other studies have not done. The study can assess whether Zimbabwe is compliant with its state obligations towards advancing women's reproductive rights during humanitarian emergencies. The results of this enquiry will assist the government in reflecting on its state party obligations to international and regional human rights mechanisms, which provide for reproductive rights in general and women's right to access family planning information and services in particular. Furthermore, the

[58] Sithole L 'Judicial interpretation of Sexual and Reproductive Health Rights in Zimbabwe: A comparative analysis' in Tsabora J (ed) 'The Judiciary and the Zimbabwean Constitution' (2020)262.

study seeks to assist the government in assessing the adequacy of the laws, policies and programmes it has in place in the cushioning of women and girls in terms of access to family planning information and services during humanitarian emergencies. Significantly, the study provides guidance for a multisectoral humanitarian response to women's family planning needs during humanitarian emergencies. The study provides strategies for remedial action by justice delivery sector players when faced with adjudicating violations of women's family planning information and services during humanitarian emergencies.

1.3 Research Question

The overall research question of this study is: Does Zimbabwe's legal, policy and programmatic framework adequately address women's right to access family planning information and services during humanitarian emergencies?

The study will address the following sub-research questions

1. What are the international and regional norms and standards on women's right to access family planning information and services during humanitarian emergencies?
2. Are Zimbabwe laws, policies, and programmes sufficient to guarantee women's access to family planning services during humanitarian emergencies?
3. What are the practical barriers to women's access to family planning information and services during Cyclone Idai?
4. Are the capabilities approach and radical African feminism relevant in informing women's right to access family planning information and services in humanitarian emergencies?
5. What lessons can Zimbabwe learn from other jurisdictions in order to advance women's right to access family planning information and services during humanitarian emergencies?
6. What opportunities are there to advance women's right to access reproductive services during humanitarian emergencies?

1.4 Scope of Study

In determining the scope of the study, the researcher was guided by limiting the enquiry to the Chimanimani and Chipinge districts of Zimbabwe, reportedly the hardest hit, highly inaccessible, and with significant damage as a result of Cyclone Idai in 2019.[59] Chipinge and Chimanimani districts are located in the second most populous province in Zimbabwe, with provincial population composed of 52,6 'per cent' females and 47,4 'per cent' males.[60] The study's main limitation relates to its inability to capture the living voices of women, girls, men, boys and other stakeholders who experienced Cyclone Idai in Chipinge and Chimanimani Districts of Zimbabwe in March 2019.

Chanza states that although a Rural District Council (RDC) as governed by the Rural District Councils Act[61] runs Chimanimani Rural District, there is a de facto customary leadership arrangement in terms of the day-to-day affairs of the community.[62] This traditional leadership governance structure is reflective of the entrenched social norms, customs and attitudes towards women and girls subordination to male dominance, which characterises the rural setup. Additionally, rural women in the areas of study face additional barriers in exercising their reproductive rights, which manifest through lack of nearby health facilities, lack of affordable healthcare services, discrimination within traditional families and

[59]UNOCHA,'Tropical Cyclone Idai in Zimbabwe' available at *https://vosocc.unocha.org/GetFile.aspx?xml=6085uelaWNZWm0W7YPunDtoCM4kbHp3yRqlXqE7wYbJ4ZQ8x_l1.html&tid=6085&laid=1* (accessed on 16 April 2020).

[60] Zimbabwe National Statistics Agency, 'Census National Report' (2012)135 The population of Chimanimani being 48,0 males and 52,0 females, and that of Chipinge being 46,2 males and 53,8 females.

[61] Rural District Councils Act Chapter 29:13.

[62] Chanza (2020)3.

societies, and the disproportionate effect of legal restrictions on accessing reproductive health services.[63]

While the Constitution of Zimbabwe has been commended for its gender-sensitive approach and commitments to gender equality,[64] there remain inconsistencies in the legal and policy framework, gender blind spots and vague provisions that militate against women's attainment of family planning information and services at law. In practice, numerous challenges compound the situation, further heightened during humanitarian emergencies. The section below provides insight into the practical barriers which inhibit women's exercise of their right to family planning information and services, drawing from the case of Cyclone Idai in the Chipinge and Chimanimani districts of Zimbabwe.

1.5 Practical barriers to women's access to family planning information and services during Cyclone Idai

The majority of people in Zimbabwe reside in rural areas[65] where availability, accessibility and affordability[66] are key issues impinging on health utilisation.[67] Zimbabwe's health system is dominated by the public sector, which provides approximately 65% of health care services in the country. In 2020 it was found that in Zimbabwe, 51% of households were reportedly within a distance of less than 5 kilometres from the nearest health facility while 33% were within a range of 5 to 10 kilometres and 16% lived more than 10 kilometres from their nearest health facility.[68] Following Cyclone Idai, pregnant women in Chipinge and Chimanimani

[63] Centre For Reproductive Rights (Half Day General Discussion on rural women) Submission to CEDAW Committee.

[64] Durojaye, E 'A gendered analysis of section 48(2) (d) of the Zimbabwean Constitution of 2013' (2016)1 Statute Law Review Oxford University Press.

[65] National Health Strategy (2016-2020) 5.

[66] CESCR General Comment No.14.

[67] Dodzo, M. K, Mhloyi M (2017)2.

[68] Food and Nutrition Council 'Zimbabwe Vulnerability Assessment Committee 2020 Rural Livelihoods Assessment Report' available at *https://reliefweb.int/report/zimbabwe/zimbabwe-*

were experiencing challenges accessing clinics as a result of impassable roads and flooded rivers.[69] Some women and children travelled long distances multiple times a week, averaging 10km to access food packs and Non-Food Items (NFIs).[70] One can only assume that such distances, coupled with the mountainous terrain, and the deep and steep valley slopes[71] in the districts under study, presented challenges to the rural women seeking to access family planning information and services.[72]

Hospitals and rural health centres were the most damaged due to Cyclone Idai. A rapid impact and needs assessment conducted by the World Bank indicated that in Chipinge and Chimanimani Districts, 41 health facilities were probably damaged due to the cyclone.[73] Apart from the damage due to Cyclone Idai, Zimbabwe's family planning programme already faced challenges in the form of an under-resourced budget which saw the Zimbabwe National Family Planning Council operating at a 55 per cent annual resource gap,[74] a manifestation of a lack of political will and prioritisation of investment into reproductive healthcare by the government.

Violence against women and girls is a common phenomenon in Zimbabwe,[75] and disaster only threatens the already fragile access to family planning information and services. The Inter-Agency Rapid Assessment identified violence against women

vulnerability-assessment-committee-zimvac-2020-rural-livelihoods-assessment (accessed on 3 March 2024).

[69] CARE (2019)3.

[70] CARE (2019)3.

[71] Chanza (2019)4.

[72] A rapid assessment conducted by CARE Zimbabwe on 18-19 March revealed that the majority of health care facilities in Chimanimani district were inaccessible, including the district hospital Mutambara Mission. In addition, access to the provincial hospital was limited due to the destruction of roads and bridges.

[73] World Bank Group, 'Zimbabwe Rapid Impact and Needs Assessment' (May 2019) 36 available at *http://documents.worldbank.org/curated/en/714891568893029852/Zimbabwe-Rapid-Impact-and-Needs-Assessment-RINA* (accessed on 14 May 2020).

[74] Zimbabwe National Family Planning Costed Implementation plan (2016-2020)23.

[75] SADC Gender Barometer (2020)5.

related to a breakdown in police systems as police officers whose reports were also affected by the cyclone, thus affecting reporting and management of Sexual and Gender-Based Violence (SGBV) cases.[76] Reportedly, the nature of transit camps used in Chipinge and Chimanimani during the cyclone lacked privacy and safe spaces, making SRHR and GBV services inaccessible to women and girls.[77]

Child marriages were prevalent in Chipinge and Chimanimani even before the disaster of Cyclone Idai struck.[78] This can be attributed to the heavy presence of the Apostolic church sects, which frequently feature prominently in reported cases of child marriages in the two districts of interest.[79] Due to Cyclone Idai, disruption in the school system exposed girls of school-going age to absenteeism from school and made them more susceptible to child marriages. This study supposes that disasters push girls into poverty and lead them to early marriages, thus robbing them of an opportunity for a brighter future of choices over their reproductive health,

Crises exacerbate gender inequality and discrimination, which are already deeply entrenched in many societies.[80] Because of patriarchy in rural Chipinge and

[76] CARE (2019)9.

[77] CARE (2019)9.

[78] The Manica Post 'Early marriages on the increase in Chipinge' available at *https://www.manicapost.co.zw/early-marriages-on-the-increase-in-chipinge* (accessed on 1 October 2022), See also NEWSDAY 'Child marriages rife in Chipinge' available at *https://www.newsday.co.zw/2019/09/child-marriages-rife-in-chipinge* (accessed on 1 October 2022).

[79] See the Manica Post 'Child marriages epidemic hits Manicaland' available at *https://www.manicapost.co.zw/child-marriages-epidemic-hits-manicaland/* see also Human Rights Watch 'Ensure Justice for Zimbabwe's Child Brides' available at *https://www.hrw.org/news/2021/08/06/ensure-justice-zimbabwes-child-brides* (accessed on 9 February 2023), see also The Herald 'Child Marriages rife in Manicaland province' available at *https://www.herald.co.zw/child-marriages-rife-in-manicaland-province/* (accessed on 10 February 2023).

[80] UNFPA, 'Adolescent girls in disaster and conflict, Interventions for improving access to sexual and reproductive health services' (2016)9 available at

Chimanimani, women are likely to be further excluded from crucial decision-making structures in the disaster management continuum, thereby side-lining their voices to decide on their sexual and reproductive health and rights from the core elements of humanitarian response. To buttress this argument, while giving a witness account of the state of affairs and commenting on the disaster risk management framework during Cyclone Idai in 2019, Chatiza recorded that:

> "Key structures are male-dominated, hence there is a risk of overlooking and failing to respond effectively to women and girls' specific needs and issues in disaster". [81]

Furthermore, CARE, a leading humanitarian organisation that had a field presence during Cyclone Idai, reported that women's participation in disaster response meetings was limited due to their engagement in family care and the entrenched social-cultural norms.[82] Women in some areas in Chipinge were not allowed to speak in public forums. Reportedly meetings were held at village heads' homesteads, and adolescent boys and girls were not allowed to participate in ongoing discussions, thereby excluding them.[83] Reportedly, GBV and SRHR services were inaccessible to women and girls in Cyclone Idai transit camps because of gender insensitive sectorial programming, which saw most of the disaster response teams from government and humanitarian agencies male-dominated,[84] thereby causing discomfort to women and girls who would have preferred to report their cases to other women. This study demonstrates that an intersection of social-cultural norms, clawback on patriarchal power manifest in laws, policies and programmes deny women agency and autonomy, thereby

https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-Adolescent_Girls_in_Disaster_Conflict-Web.pdf (accessed on 8 April 2020)3.

[81] Chatiza K (2019)10.

[82] CARE (2019)8.

[83] CARE (2019)10.

[84] Inter-Agency Rapid Assessment Appraisal update, March 2019.

reinforcing disempowerment which transgresses the arena of their reproductive self-determination.

1.6 Theoretical framework

This study is informed to a larger extent by Martha Nussbaum's version of the capabilities approach and, to a lesser extent, radical African feminism. The capabilities approach, conceptualised by and first articulated by Amartya Sen in the 1980s, is rooted in human development and concerns itself with the persistent inequalities in the quality of life. The theory concerns itself with evaluating how well-off people are in terms of their capabilities to enable them to say they are living the lives they have reason to value. [85] This study is informed by the version of the capabilities approach developed by Martha Nussbaum, inspired by women's development and expounds on the pursuit of ten central capabilities as a bare minimum of respect for human dignity.[86] This research resonates mostly with but is not limited to an enquiry into the central capabilities of practical reason, life, bodily integrity and health. Nussbaum's approach is significant to this study as it pays attention to women's material and social contexts in developing countries and recognises them as ends in their own right. The dignity version of the capabilities approach makes one understand how the ability of women to access reproductive health services is a necessary ingredient to their dignity and ability to chart their destinies.

Radical African feminism concerns itself with seeking redress of women's structural disadvantage in society. This study is informed by a version of Radical African feminism, which pursues substantive equality.[87] Significantly the theory has a transformative role in revamping the patriarchal structures which give birth to and sustain inequalities. Thus, in this study, radical African feminism calls for the re-imagination of power relations which disadvantage women from being a priority

[85] Significant publications include Sen 'Development as freedom' (1999)1-34.

[86]Nussbaum 'Women and Human Development: The Capabilities approach' (2000)4-11, Nussbaum 'Women and equality: The capabilities Approach' (1999)1-19.

[87]Dosekun S 'Defending feminism in Africa' (2007)41-47.

group in accessing family planning information and services during humanitarian emergencies. Therefore, women's rejection of male subordination and oppression is informed by the various realities prevailing in African.

This study argues that radical African feminism plays a pivotal role in unpacking the effect of power relations on women's SRHR, that is how power is distributed in society helps us appreciate who decides who gets what and when in disaster situations. In essence, the basic tenets of radical African feminism demonstrate the confluence of factors that expose women to vulnerability during humanitarian emergencies and impact their capabilities. Being female in a patriarchal setting in rural Zimbabwe during Cyclone Idai contributes to many injustices which inhibit one from accessing family planning information and services. Thus, applying radical African feminism calls for equality and systemic changes in the laws, policies and institutions mandated to guarantee women's access to family planning information and services during humanitarian emergencies. The two theoretical underpinnings are to be discussed at length in the next chapter.

1.7 Significance of study

This study is significant to Zimbabwe because it calls for deep insights into the legal, policy and programmatic framework governing women's right to access reproductive services during humanitarian emergencies. Although the focus of this study is on the humanitarian emergency of Cyclone Idai, the findings are instructive to other humanitarian emergencies not just in Zimbabwe but other countries. The study contributes to contemporary literature timeously as it interrogates women's access to reproductive needs during humanitarian response when Zimbabwe faced Cyclone Idai in 2019 and the Covid-19 pandemic in 2020.The thesis thus contributes to a unique broader body of research that has viewed disasters as gendered events.

The area of women's right to access reproductive health in crises is under-researched. Ngwena and Cook[88] state that a gender-based approach to planning and

[88] Ngwena and Cook (2005) 120.

implementing programmes is part of eliminating discrimination against and realising substantive equality for women. This study calls for recognising reproductive self-determination as a percussor to women's capabilities, dignity, resilience and empowerment. Significantly, reproductive health and rights are vital to people's well-being and survival and, ultimately, the attainment of broader socio-economic development goals.[89]

A review of the experiences and response to Cyclone Idai shows that many institutions play a role in Zimbabwe's multi-sectoral and inter-disciplinary disaster risk management (DRM) system.[90] This study advocates for a disaster management continuum rooted in gender equality and women's participation in key decision-making positions.[91] Further, of significance is a call by this study to emphasise in-country sustained investment in women's reproductive health.

This study draws lessons from the Philippines and Ethiopia on how best to advance women and girls' reproductive health rights during humanitarian emergencies. In the Asia Pacific, the Philippines is considered among the most disaster-prone countries in the world as it is exposed to heatwaves, droughts, floods, cyclones and storm surges, among others.[92] The study also draws lessons from Ethiopia, Africa, particularly the Tigray crisis, which offers a different dimension of a humanitarian emergency arising from armed conflict. Therefore, the study can draw broad lessons from the laws, policies and programmes from the scenarios in the three countries due to their experiences with humanitarian emergencies.

[89] Starrs AM, Ezeh AC & Barker G *et al* 'Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission.' 2018 *The Lancet*.

[90] Chatiza (2019)5.

[91] Hof, H et al 'Risk Management in water and climate, -the role of insurance and other financial services' (2003)5. The disaster cycle or disaster management continuum is described as having various phases of disaster prevention, preparedness and response.

[92] The World Bank Group & Asian Development 'Climate Risk Profile: Philippines' (2021)13-16.

The study proposes that Zimbabwe crafts a Disaster Risk Management Act to be anchored on, among others, international, regional law, norms and standards, Inter-Agency Working Group on Reproductive Health in Crisis Field Manual[93], Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations[94] and the Sphere Humanitarian Charter and Minimum Standards in disaster response.[95] The proposed statute will assist policymakers, humanitarian agencies, rural women, Non-Governmental and Community based organisations to improve the integration of gender and women's rights into humanitarian action and crisis response.

1.8 Research methodology

This research is purely a desktop study. The study reflects on accounts provided on women's access to family planning information and services during Cyclone Idai. It explores efforts made at international and regional levels to provide for women's reproductive healthcare. To substantiate arguments in this thesis, reference was made to primary sources such as national legislation, policy documents, and state and non-state actor reports produced on Cyclone Idai.

The research focuses on women's access to family planning, information and services during humanitarian emergencies and seeks to demonstrate that during Cyclone Idai, humanitarian interventions were generalised, giving no regard to women's lived realities and reproductive health needs.

Relevant international instruments such as the CEDAW, the ICESCR, the ICPD, the Beijing Platform for Action, Special Rapporteur reports, General Comments and General Recommendations from United Nations treaty body mechanisms among others, were analysed. In addition, regional instruments such as the African Charter on Human and People's Rights, the African Women's Protocol, Continental

[93] Inter-Agency Working Group on reproductive health in crises (IAWG), available at *https://iawg.net/* (accessed on 1 July 2020)

[94] IAWG (2018)17.

[95] The Sphere Handbook, available at *https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf.*

Policy Framework on sexual and reproductive health and rights, among others, were employed in this study. Secondary sources, such as textbooks, academic or journal articles, conference papers, internet sites and websites, werealso used in this research.

1.9 CLARIFICATION OF KEY TERMS

1.9.1 Women

This study utilises the definition of women as provided for in the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Women refer to people of the female gender, including girls.[96] In humanitarian emergencies, women, particularly adolescent girls, face the same difficult challenges relating to sexual and reproductive health and rights.

1.9.2 The right to family planning

According to the World Health Organisation, family planning is a way that permits individuals and couples to expect and attain their desired number of children and the spacing and timing of their births.[97] A woman's ability to space and limit her pregnancies directly impacts her health and well-being as well as the outcome of each pregnancy.[98] Family planning programmes enable couples and individuals to freely and responsibly decide the number and spacing of their children, have the

[96] Article 1k of the Maputo Protocol.

[97] World Health Organisation 'Contraception' available at *https://www.who.int/health-topics/contraception accessed on 17 July 2021.*

[98]World Health Organisation 'The ABCs of family planning' available at *https://www.who.int/pmnch/media/news/2010/20100322_d_shaw_oped/en/ (*accessed on 5 July 2021).

information and means to do so, and to ensure informed choices and make available a full range of safe and effective methods.[99]

Contraceptive information and services are fundamental to all individuals' health and human rights.[100] The Committee on the Rights of the Child has urged states to ensure that all adolescents can access free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education both online and in person.[101] Reproductive information must be provided in a manner consistent with the needs of the individual and the community, considering age, gender, language ability, educational level, disability, sexual orientation, gender identity and intersex status.[102]

1.9.3 Humanitarian emergency

A humanitarian emergency represents a critical threat to the health, safety, security or well-being of a community or other large group of people, usually over a wide area.[103] In this thesis, Cyclone Idai and armed conflict constitute humanitarian emergencies.

1.9.4 Agency

In this study, agency is discussed with reference to women. Kabeer defines women's agency in relation to empowerment as the ability for women to not only

[99] ICPD Programme of Action adopted at the International Conference on Population and Development Cairo 5-13 September 1994.

[100] World Health Organisation 'Contraception' available at *https://www.who.int/health-topics/contraception* (accessed on 17 July 2021).

[101] Amnesty International 'Lost without knowledge: Barriers to sexual and reproductive health information in Zimbabwe' (2018)38.

[102] General comment No. 22 (2016) para 19.

[103] Humanitarian Coalition 'What is a humanitarian emergency' available at *https://www.humanitariancoalition.ca/what-is-a-humanitarian-emergency* (accessed on 9 July 2021).

actively exercise choice but to do so in ways that challenge power relations.[104] Agency is viewed as a constituent of women's capabilities, that is, their potential to live the lives they want.[105] Women's agency is also viewed as their ability to define and enact their life choices in contexts where this ability was previously denied.[106]

1.9.5 Autonomy

Autonomy in the context of this study relates to the right of a woman to decide concerning her fertility and sexuality free of coercion and violence.[107] It also means that a woman seeking health care in relation to her fertility and sexuality is entitled to be treated as an individual in her own right, an only client of the health care provider, and fully capable of making decisions concerning her health.[108]

1.9.6 Gender equality

Inherent to the principle of gender equality is the notion that all human beings, regardless of sex, have the freedom to develop their abilities, pursue their professional careers and choose without the limitations set by stereotypes, rigid gender roles and prejudices.[109] In light of women's right to access family planning information and services, gender equality entails that the health needs of women, different from those of men, be considered, and appropriate services be provided for women in accordance with their life cycles.[110] Gender equality is provided for

[104] Kabeer N 'Gender Equality and women's empowerment: A critical analysis of the third Millennium Development Goal' (2005)14.

[105] Kabeer (2005)14-15.

[106] Quteinna et al 'Meanings of women's agency. A case study from Qatar on improvement of measurement in context' (2019)34.

[107] Shalev C 'Rights to sexual and reproductive health: The ICPD and the Convention on the Elimination of Discrimination Against Women' (1998) presented at the International Conference on Reproductive Health, Mumbai (India), 15-19 March 1998.

[108] Shalev (1998) 1-15.

[109] CEDAW Committee, Gen. Recommendation No. 28 para. 22.

[110] General Comment No.22 para 25 on Equality between men and women and gender perspective.

by International human rights instruments such as the CEDAW,[111]ICESCR,[112] and ICCPR.[113] Through General Comment 28 of the ICCPR, the Human Rights Committee[114] provides that state parties must ensure women's rights without discrimination[115] and the equality of rights between men and women.[116]

1.9.7 Rural Zimbabwe

Most countries of the Global South are divided into urban and rural areas. Cities and towns characterise urban areas, whereas rural areas are geographical areas outside such sites. Rural areas are often characterised by poor road networks and limited-service centres with limited service. In cases where services are present, people travel a considerable distance to access them.[117] According to the 2012 National Population Census, Zimbabwe's rural population was reported at 67 % settled in communal lands and resettlement areas.[118] Rural areas are mainly administered by local authorities and traditional leaders who are the custodians of culture and religious values.[119]

[111] CEDAW Articles 1 and 2.

[112] ICESCR Article 3.

[113] General Comment No. 28 of the ICCPR.

[114] The Human Rights Committee is a body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights by its State parties. See *https://www.ohchr.org/en/hrbodies/ccpr/Pages/CCPRIndex.aspx* (accessed on 23 July 2021).

[115] UN Human Rights Committee (HRC), *CCPR General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, 29 March 2000, CCPR/C/21/Rev.1/Add.10, available at: *https://www.refworld.org/docid/45139c9b4.html* (accessed 23 July 2021).

[116] General Recommendation No.28.

[117] Dziva C 'Advancing the rights of rural women with disabilities in Zimbabwe: challenges and opportunities for the twenty first century' (2018)13.

[118] ZIMSTAT (2012)25.

[119] Dziva (2018)13.

1.2 Proposed Chapter Outline

Chapter 1: presents the background to the study, scope of the study, theoretical framework, methodology, significance of the study, thesis statement, justification of the study, proposed chapter outline and a definition of key terms.

Chapter 2: Presents the Capabilities approach and radical African feminism as theoretical underpinnings which inform the study.

Chapter 3: Focuses on international, regional norms and standards on women's access to family planning services.

Chapter 4: Analyses the laws, policies and programmes available in Zimbabwe concerning women's access to reproductive rights during humanitarian emergencies.

Chapter 5: Proposes advancing women's reproductive rights during humanitarian emergencies through lessons learnt from the Philippines, and Ethiopia.

Chapter 6: Proposes an introduction of a disaster risk management Act/ statute with a suggested chapter which speaks to women's sexual and reproductive health during humanitarian emergencies.

Chapter 7: Presents the overall findings, conclusions and recommendations of the study. The chapter raises principal areas of concern to the government of Zimbabwe, civil society, humanitarian agencies, Zimbabwe Gender Commission, Zimbabwe Human Rights Commission, Judicial services commission, Ministry of Local Government Public Works and National Housing, and Department of Civil Protection.

CHAPTER 2

ADVANCING WOMEN'S FAMILY PLANNING RIGHTS DURING HUMANITARIAN EMERGENCIES THROUGH RADICAL AFRICAN FEMINISM AND THE CAPABILITIES APPROACH.

2.1 INTRODUCTION

The main research problem of this study is to analyse if Zimbabwe's legal, policy and institutional framework advances women's right to access family planning information and services in humanitarian emergencies. The study probes the challenges affecting women's enjoyment of family planning information and services in humanitarian emergencies in rural Zimbabwe,specificically focusing on the 2019 Cyclone Idai in Chimanimani and Chipinge districts.[120]

This chapter aims to justify the relevance of guiding theories to this study. This chapter briefly traces the history of feminism through its four waves. Then, the chapter discusses feminist legal theory's core principles which demonstrate that women are not treated the same as men by the legal systems, policies, social structures, institutions and the actors within them.[121]

The study seeks to demonstrate that unequal treatment of women adversely impacts their capability to access family planning services in humanitarian emergencies. Furthermore, the study seeks to elaborate on the effect of patriarchy and male dominance on women's capability to access family planning information and services in humanitarian emergencies. The theoretical underpinnings of this study

[120] Rural women who make up a substantial part of the world's population are disproportionately affected by a lack of realisation of human rights characterised by serious urban/rural discrepancies in terms of poor service delivery in rural areas and rural underdevelopment. Centre for Reproductive Rights 'Submission for the CEDAW Committee's Half Day of General Discussion on Rural Women' (2013) 1.

[121] Amollo R 'Women's Socio-Economic Rights in the Context of HIV and AIDS in South Africa: Thematic Focus on Health, Housing, Property and Freedom from Violence' (2011)1. A thesis in fulfilment of the requirements of the degree of Doctor of Laws University of the Western Cape.

are envisaged to provide a framework that has the potential for the construction and application of law in a manner that eliminates gender inequality while acting as a source of empowerment and transformation.

This chapter draws attention to how multiple layers of discrimination and inequalities experienced by rural women impact their right to access family planning information and services. It is worth noting that women are not a homogeneous group but include women with disabilities, women with HIV, women from minority and indigenous groups, women living in poverty, as well as adolescent girls, all of whom have unique experiences of discrimination, which are compounded by their rural status.[122]

The intersection of patriarchy, gender inequality and discrimination is an underlying barrier to women's access to family planning information and services during humanitarian emergencies. Humanitarian emergencies exposeweaknesses in the health delivery system and disproportionately impact subpopulations, especially women, children and adolescents.[123]

The chapter briefly discusses the relationship between legal, policy and programmatic frameworks and women's agency, capabilities and dignity in reproductive health decision making in humanitarian emergencies. Further, the chapter seeks to demonstrate that absolute freedom and women's empowerment to pursue life choices are prerequisites for human development, ensure women have control of their bodies, and that access to reproductive healthcare enables them to claim their rights in the face of violations.

2.1.1 FEMINIST LEGAL THEORY

The central concern of feminist legal theory is the impact of laws and institutions on women. Feminist theories are a project of rethinking and reshaping human

[122] Centre for Reproductive Rights (2013)1.

[123] World Health Organisation, Askew I et al (eds) 'Sexual and reproductive health and rights in emergencies' (2016)311.

understanding of the world in a manner that reflects and appreciates the contribution of women to society and in a manner that pays attention to their lived realities.[124] The centrality of feminist legal theory to this study lies in that it analyses the exclusion of some of women's needs, interests, aspirations, or attributes from the law's design and/or application.[125] Through a feminist lens, the chapter assesses how law, policy and programmes respond to women's right to access family planning information and services in humanitarian emergencies.

Feminist legal scholars have recognised the exclusion of feminine voices in the legal system, and this study aims to elaborate on how being side-lined in matters that affect one's life prejudices women in the context of humanitarian emergencies. Feminist legal theory utilises general feminist concerns relating to discrimination, gender equality, women's agency, autonomy, dignity, and economic status. This thesis is concerned with how feminist jurisprudence is viewed as the analysis and critique of law as a patriarchal institution.[126] How feminism is aimed at advancing the position of women by putting an end to women's subordination is also significant to this study.[127] The next section briefly traces the history of feminism through its four waves.

[124] Levy E C 'Asking the woman question in international law' (2021)3.

[125]Charlesworth H 'Gender and International Law, in Handbook on gender in world politics' (2016)139 (Jill Steans and Daniela Tepe-Belfrage *(eds*) Edward Elgar pub.

[126] Smith P W (ed) 'Feminist jurisprudence' (1993) 269 New York Oxford University Press.

[127] Jagger A 'Radical feminism and human nature' (1988)15.

2.1.2 Historical trajectory of feminism

Feminist legal theory has evolved through four generations known as the first wave[128], second wave[129] , third wave[130] and fourth wave.[131] These feminist generations have been a subject of debate, but this chapter broadly highlights these waves and does not seek to delve into the variations, diversity and significant disagreements with feminist debate. First-wave feminism refers to an extended period of feminist activity during the nineteenth century and early twentieth century in the United Kingdom and the United States, characterised by women's participation in the anti-colonial nationalist movement.[132] The first wave is known for being principally concerned with the material conditions of women's lives and efforts to improve laws, education and economic aspects pertaining to women.[133]

The second wave of feminism was the period of activity in the early 1960s and lasted through the late 1980s. The second wave of feminism gave rise to an appreciation that gender inequality is not only located in the public sphere but penetrates interpersonal relationships and everyday experience, epitomised by the phrase 'the personal is political'.[134] The phrase underscored the interplay between personal experiences and the larger social, and political sphere. In addition, the period was marked by an emphasis on economic and reproductive autonomy for women, the importance of enabling women to balance marriage, motherhood, and work, while economic individualism was the centrepiece of reform efforts.[135]

[128] Caughie P L 'Theorising the first wave globally' (2010)95.

[129]Moran R F 'How the second wave feminism forgot the single woman' (2014)223-298.

[130] *Eds* Gillis.S, Howie.G, Muford.R,'Third wave feminism- a critical exploration- Expanded Second edition (2007) viii-xxi

[131] Kowaiska D 'The fourth wave of American feminism: Ideas, activism, social media' (2018)8.

[132] Caughie (2010)95.

[133] Tong R 'Feminist Thought: A More Comprehensive Introduction' (2009) (Third Edition*)*, Colorado, Westview Press.

[134]Day K, Wray J R 'Fourth wave feminism and post feminism: successes and failures' (2018)113-1

[135] Moran R F 'How the second wave feminism forgot the single woman' (2014)223-298.

Third-wave feminism which originated in the 1980s and started in the 1990s, saw the expansion of women's opportunities in the socio-economic sphere.[136] One notes that this period saw an awareness of the need to include women's interests in law and policies.[137] The arrival of the fourth feminist wave dispelled the suspected end of feminism, characterised by the online presence and an explosion of feminist blogging; hence it's being known as the digital wave or cyber feminism.[138] One notes that the fourth wave utilised technology to globalise women's shared agendas around gender equality, sexual harassment and violence against women.[139]

The importance of tracing these waves of feminism is that their evolution involves advancing women's position.[140] A common feature is that they are concerned with issues of gender difference, advocate for equality for women and campaign for women's rights and interests.[141] This study utilises radical African feminism and the capabilities approach to critically understand women's right to access family planning information and services in humanitarian emergencies. The following section discusses radical African feminism and justifies its relevance to the thesis.

2.1.3 Radical African feminism

Radical African feminism is how women interpret their interests and empowerment within the context of Africa, where they live, considering their cultural values.[142] Radical feminism is viewed as a movement which uncompromisingly opposes

[136] Yahya U et al 'Third wave feminism and women's invisibility in the discourse of politics' (2021)138,144.
[137] UN Women 'New feminist activism, waves and generations' (2021)8.
[138] Day K (2018)113-137.
[139] See Parry C D et al 'Feminisms in leisure studies: Advancing a fourth wave' (2018)5-9.
[140] Jaggar A 'Feminism as political philosophy' in Radical feminism and human nature (1988) 15.
[141] Amolo (2011)74.
[142] Mikell G 'Defining African feminism' 2019 YouTube video on Voice of America available on *https://www.youtube.com/watch?v=5MlD_FKVfmU* (accessed on 21 July 2021).

patriarchy.[143] This kind of feminism views women as an oppressed group who are accorded what is deliberately designed to be inferior.[144] Radical feminists believe that women have a marginal image that exists as a man's prerogative. At the core of radical feminist thought is male dominance expressed in patriarchy.[145] McKinnon, a major proponent of dominance theory, argues that men and women are different. These differences largely reflect the fact that women are subordinate, and men are dominant in society.[146] Amina Mama posits that radical feminism is a positive, revolutionary movement which refuses internal or external oppression of women by men.[147]

Patriarchy is an external factor that obstruct women from exercising their capabilities. Violations of rural women's rights are often too deeply entrenched in patriarchal notions of women being minors and thus unable to control or make decisions that concern their bodies and lives in general.[148] Women's subordination violates their right to freely decide on what to do with their bodies. Male privilege takes centre stage in African women's reproductive decision-making. The heavy influence of patriarchy is apparent in that reproductive decisions of the African woman are typically made under enormous pressures from family, community, and society in accordance with the prevailing gender and reproductive norms, as well

[143] Patriarchy is a system of social structures and practices in which men dominate, oppress and exploit women. Patriarchy is therefore the institutionalised and systemic dominance of men at the expense of women and everyone who is not identified as masculine. Walby S 'Theorising patriarchy' (1989)214.

[144]Millet K 'Sexual politics a manifesto for Revolution' (1968)365.

[145] Patriarchy is defined as an ideology of male supremacy that results from social construction of gender which in turn justifies the social, economic, and political distinction between men and women. Bazili 'Putting women on the agenda' Johannesburg Rowan Press (1991)9.

[146]MacKinnon C 'Feminism, Marxism, method and the state: Toward feminist jurisprudence' (1983) 635.

[147] Okoli A C 'Exploring the Transformative Essence of Intellectual Feminism in Africa: Some Contributions of Amina Mama' (2021)126-135

[148] Sithole (2020)42.

as internalised commitments to act responsibly towards others.[149] In essence, such a setup means a woman's reproductive decisions are not her own per se but that she has to conform to what the patriarchal society dictates. An understanding of radical African feminism as a rejection of patriarchy is especially significant to women's right to access family planning information and services in Zimbabwe, considering the deep-rooted cultural and customary practices which relegate women as inferior.

Millet posits that patriarchal ideology is so powerful that men are usually able to secure the apparent consent of the very woman they oppress.[150] Male dominance is viewed as a result of the interaction of custom and tradition. In a study carried out on factors that influence women's ability to make decisions about their sexual and reproductive health in Ghana, Rwanda, Senegal and Uganda, it was found that men, who generally act as heads of their households, hold full decision-making power, including power over SRHR issues that are socio-culturally perceived as 'women matters.'[151] Furthermore, the study revealed that in rural areas, women rarely decide to use contraception without consulting their husbands first.[152] One notes that this type of male domination, expressed in the private and public sphere,[153] incapacitates women from doing anything freely.[154]

Bajedo defines African feminist ideology as founded upon the principles of traditional African values that view gender as complementary, parallel, asymmetrical, and autonomously linked in the continuity of human life.[155] As such African feminism recognises the multiple roles of women and men in reproduction, production, distribution of wealth and power and the responsibility of sustaining

[149] Sithole (2020)43.

[150] Millet K 'Sexual politics' (1977)35.

[151] UNFPA 'Research on factors that influence women's ability to make decisions about their sexual and reproductive health and rights (2019)9.

[152] UNFPA (2019)9.

[153] Sultana (2011)1.

[154] Sithole (2020)43.

[155] Bajedo D L 'African feminism Mythical and social power of women of African Descent' (1998)94

human life. Women in Africa have multiple intersecting identities that often result in multi-structured levels of oppression.[156]Apart from being African, rural women affected by humanitarian emergencies can be described as women in distress because apart from bearing the burden of care for their families, they bear certain vulnerabilities associated with disaster. This calls for a contextual understanding of how discrimination and inequality are experienced by the affected women and how it can be addressed.

This study aligns itself with the version of radical African feminism rooted in substantive equality proposed by Simidile Dosekun.[157] Substantive equality is a necessary precondition to women's ability to exercise self-determination, particularly in relation to sexual and reproductive healthcare decisions.[158] In the context of women in Chipinge and Chimanimani, substantive equality would require that their well-defined sexual and reproductive health needs, as well as any barriers they faced during Cyclone Idai, be spelt out.[159] In addition, the sexual and reproductive health needs of particular groups should be given tailored attention. The exercise of reproductive rights, including the rights to life, and health, deciding freely on the number and spacing of one's children, privacy and confidentiality, access to information and exercise of informed consent, and being free from violence against women and torture or ill-treatment is essential in ensuring that rural women can achieve substantive equality and overcome discrimination.[160]

In humanitarian emergencies, utilising radical African feminism means tackling challenges women suffer based on disadvantage and difference rather than from a 'one size fits' all approach. Rooted in substantive equality, this feminist approach

[156] Omoruyi J A 'Forced sterilisation as a continuing violation of human rights in Africa: possibilities and challenges' (2020)105 thesis submitted in fulfilment of the requirements for the degree Doctor of Philosophy in the Faculty of Law of the University of the Western Cape.

[157] Dosekun S 'Defending feminism in Africa' (2007)46.

[158] Centre for Reproductive rights (2013)3.

[159] General Comment 22 para 24.

[160] Centre for Reproductive Rights (2013)1.

requires an examination of the actual social and economic conditions of groups and individuals and focuses on equal access and benefits.[161] Further, under substantive equality, the government is required to take positive measures, including the allocation of resources which eliminate conditions that perpetuate inequality.[162] In Zimbabwe, these could be resources allocated through the national budget or donated resources meant to alleviate the effects of Cyclone Idai.

Radical African feminism is not just for women and not to replace men with women but to transform the very structures of societies which produce and perpetuate gender inequalities in the first place.[163] The focus is to suggest transformative agency for women in humanitarian emergencies. The transformative agency suggests an ability of rural women to question, analyse and act upon structures of patriarchal constraint in their lives.[164] Such structures might be those in the disaster management framework comprised of law, policy, and institutions which require reshaping of power relations to enable women to access their right to family planning information and services through consultation and voicing their needs and concerns through inclusion in decision making. The researcher observes that substantive equality is a necessary precondition for women's ability to exercise reproductive self-determination.

Radical African feminism is key to this study as it advocates for creating spaces for women to participate in the management of their societies. This is because, marginalised women often face restrictions in law and practice in the exercise of their reproductive rights. Women's empowerment is manifest through the provision of life-saving family planning information and services when women are at their lowest, having had life disrupted by humanitarian emergencies. Rewriting the identity of rural women affected by humanitarian emergencies from incapacitated, dominated women is imperative.

[161] Ngaba S 'CEDAW Eliminating Discrimination Against Women' (1995)87.

[162] Centre for Reproductive Rights (2013)2.

[163] Dosekun (2007)46.

[164] Kabeer (2005)15.

The main research problem of this study is to analyse if Zimbabwe's legal, policy and institutional framework advances women's right to access family planning information and services during humanitarian emergencies. In this regard, radical African feminism is a crucial ingredient in the analysis. As an advocacy tool, it requires that laws, policies and practices do not nurture but rather ease the inherent disadvantage that women encounter in exercising their right to sexual and reproductive health. Furthermore, substantive equality advocated for by radical African feminism, requires that states are accountable not only for the measures they have taken to address discrimination and inequality but also for the effectiveness of those measures (through laws, policies, and practices).[165]

The implications of women being excluded from decisionmaking are far-reaching. It means if women do not have a voice where key decisions affecting intimate parts of their lives are made, their capacity, full development and equality is severely limited.[166] On a broader scale, women's involvement in decision-making contributes to redefining political priorities, placing new issues on the political agenda which reflect and address women's gender-specific concerns, values and experiences, and providing new perspectives on mainstream political issues.[167] Relatedly, Goal 5 of the Sustainable Development Goals on the achievement of gender equality and the empowerment of women is a priority area within Zimbabwe. Recognising the importance of Goal 5, the Committee on the Elimination of Discrimination Against Women (CEDAW) has urged Zimbabwe to recognise women as a driving force of the country's sustainable development and to adopt relevant policies and strategies to that effect.[168] Advancing women's

[165] Centre for Reproductive Rights (2013)2.

[166] Fayemi B A 'Creating and sustaining feminist space in Africa, Local Global Challenges in the 21st century' (2000)3.

[167] Fayemi (2003)3-4.

[168] Committee on the Elimination of Discrimination Against Women Concluding Observations on the 6th Periodic Report of Zimbabwe 10 March (2020) 2/15.

family planning information and services through law and practice is one strategy towards fulfilling Sustainable Development Goals.

Dosekun imagines a radical African feminism fully grounded in and informed by local African realities, and so far as it is committed to their amelioration.[169] What is radical about this feminism is that it seeks to transform society in its totality for the betterment of all, not just for women or even a specific type or group of women.[170] The belief in radical transformation is that if at first radical African feminists are informed by a deep concern for women's oppression, they, therefore, do not seek to reproduce any other forms of oppression between other social groups.

2.1.4 The capabilities approach

The capabilities approach was first developed by economist and philosopher Amartya Sen in the 1980s and has evolved as a leading alternative to standard economic frameworks for thinking about poverty and inequality.[171] Martha Nussbaum elaborated on the approach in connection to women's development and philosophy. The capabilities approach is a global ethic that measures well-being based on what one is able to do and who one can become. It gained international acclaim due to its use by the United Nations Development Programme (UNDP) in the United Nations Development Index.[172] Sen and Nussbaum recognise empowerment as an essential aspect of human development. Sen posits that one's capability set reflects an individual's freedom to engage the world and make significant decisions about what she will do in her life, thus, a person's capability

[169] Dosekun (2007)46.

[170] Dosekun (2007)46.

[171] Amollo (2011)93.

[172] UNDP 'Human Development Index' available at *http://hdr.undp.org/en/content/human-development-index-hdi* (accessed on 4 May 2021). The HDI was created to emphasize that people and their capabilities should be the ultimate criteria for assessing the development of a country, not economic growth alone.

set can reflect the level of empowerment she is experiencing.[173] According to Sen, well-being can be limited by the power one has to make choices.[174] Individuals who are healthy and have other personal advantages have a greater power to make choices and impact the world. Sen further indicates that the capabilities approach pivots on why there are disparities in people's abilities to utilise the resources available to them.

Human development is seen as a 'process of expansion of the real freedoms that people enjoy'; that is, expansion of the capabilities that enable people 'to live the life they have reason to value.[175] To Sen, viewing development in terms of expanding substantive freedoms directs attention to the ends that make development important, rather than merely some of the means that play a prominent part in the process.[176] Sithole argues that investing in people empowers them to pursue different life choices, and resultantly this is salient for women's reproductive health as it guarantees they can exercise control over their bodies, access reproductive healthcare services and defend their rights when violated.[177]

Sen propounded the capabilities approach as one which sees human life as a set of doings and beings[178] which he refers to as functionings and relates to evaluating the quality of life and assessing the capability to function. The roots of the approach go back at least to Adam Smith and Karl Marx and to Aristotle. In his investigation of the problem of political distribution, Aristotle extensively used his analysis of the good of human beings, which he linked with his examination of the functions of man and his exploration of life in the sense of activity.[179] Although Aristotle's investigation is broad and highly ambitious in scope, its relevance lies in its

[173] Keleher L 'Sen and Nussbaum: Agency and capability expansion' (2014)62.

[174]Keleher (2014)54.

[175] Sen A 'Development as freedom' (1999)1-6.

[176] Sen (1999)1.

[177] Sithole (2020)38.

[178] Sen A 'Development as capabilities expansion' (2003)2.

[179] Sen (2003)2.

argument for seeing the quality of life in terms of functionings and capabilities.[180] In relation to women's access to family planning information and services, this approach talks about state obligations to improve the quality of life in line with modern trends, such as improving women's access to digital devices and data.

According to Sen, freedom is a constituent part of the process of development.[181] Human development is seen as a process of expanding the real freedoms that people enjoy, that is, expanding the capabilities that enable people to live the life they have reason to value.[182] What people can positively achieve depends on economic opportunities, political liberties, social powers, and the enabling conditions of good health, basic education, and the encouragement and cultivation of initiatives.[183] This speaks to the interconnectedness of human rights, which the state should guarantee to ensure women access family planning information and services during humanitarian emergencies.

Adam Smith and Karl Marx explicitly discuss the importance of functioning and the capability to function as determinants of well-being.[184] The central argument in Sen's theorisation is that one's standard of living is a matter of functionings and capabilities not a matter directly of opulence, commodities, or utilities.[185] Adam Smith analyses how economic conditions of respective societies influence norms and culture and further demonstrates the nexus between commodity possession and capabilities. He contends that the same capability of being able to appear in public without shame has variable demands on commodities and wealth, depending on the nature of the society in which one lives.[186] In relation to women's reproductive health in humanitarian emergencies, this speaks to the evaluation of laws and

[180] Sen (2003)4.

[181] Sen 'Development as freedom' (2000)4

[182] Sen (2000)3.

[183] Sen (2000)5.

[184] Sen (2003)4.

[185] Sen 'The standard of living' (1985)23.

[186] Sen (1985)23.

policies not only for their ability to improve women's economic status in terms of income but for their ability to enhance women's capabilities to perform socially recognisable functions.

Sen views the constituent elements of life as a combination of functionings. This amounts to seeing a person as active rather than as passive.[187] This study observes that the depiction of functionings by Sen enhances the understanding that in humanitarian emergencies, vulnerability should be understood as gendered. To this end, the capabilities approach is preferred because it seeks to remedy the 'gendered vulnerability' which links women with victimhood, dependency, and pathology.[188] Through the capabilities approach, the study seeks to portray women in humanitarian emergencies as possessors of the capacity to exercise full reproductive self-determination, particularly when they have access to information. This study finds that accessing reproductive health information can be especially difficult for rural women and girls.[189] Maziwisa articulates the challenges faced by adolescent girls in rural Zimbabwe who often have to walk long distances to reach the nearest clinic to access SRHR services.[190] The CEDAW Committee, in its General Recommendation No. 21, has recognized the importance of adequate access to information and sex education to support women's reproductive decision-making. This talks about strategies that the State, through its institutions, can implement to ensure women and girls access family planning information and services.

According to Nussbaum, the capabilities approach is a species of human rights approach whose pertinent goal is to enable people to function in numerous areas of

[187] Sen (2003)5.

[188] Fineman M 'Women, vulnerability and humanitarian emergencies' (2011)4.

[189] Centre for Reproductive Rights (2013)4.

[190] Maziwisa MR 'Barriers to access contraceptives for adolescent girls in rural Zimbabwe as a human rights challenge' in Durojaye E et al (*eds*) 'Advancing sexual and reproductive health and rights in Africa: constraints and opportunities' (2021)68.

central importance.[191] Being a broad normative framework, it evaluates individual well-being and social arrangements, the design of policies and proposals about social change in society.[192] This study observes that the capabilities approach is significantin informing response to women's reproductive health and rights in humanitarian emergencies because it does not generalise people's needs but looks at an individual and her functions. Adding voice to this approach, CEDAW has stated that women have reproductive health needs that men do not due to their different reproductive capacities, making the provision of reproductive health services essential for ensuring comparable outcomes. This is supported by Nussbaum, who states:

> "This focus on capabilities, unlike the focus on aggregate utility, looks at people one by one, insisting on locating empowerment in this life and in that life, rather than in the nation as a whole."[193]

Nussbaum argues that the capabilities approach must be able to identify gender-specific harms and have the ability to garner widespread cross-cultural support as a global moral theory.[194] The capabilities approach does this through a recognition that women in much of the world lack support for fundamental functions of human life, and obstacles impede their participation in political life and saddle them with unequal human capabilities.[195] Women's position, as articulated by Nussbaum, necessitates that this study views women in humanitarian emergencies as pillars in the developmental process, not just as rights holders. The approach makes a person a bearer of value and an end.[196] Whereas women have been treated instrumentally

[191] Nussbaum M 'Human rights and human capabilities' (2007) 21-24 *Harvard Human Rights Journal.*

[192] Robeyns 'The capability approach, an interdisciplinary introduction' (2003)5.

[193] Martha C Nussbaum 'Women and Equality: The Capabilities Approach' (1999) International Labour Review Volume 138 No 3.

[194] Kleist C 'Developing capabilities: A Feminist Discourse Ethics Approach' (2009) Dissertation for the degree of Doctor of Philosophy Marquette University.

[195] Nussbaum 'Women and Human Development: The capabilities approach (2000)1.

[196] Nussbaum (2000)2.

as tools to implement population programmes and policies, this study views the approach by Nussbaum as one which is genuinely concerned with women's health and well-being and regarding them as worthy in their own right. Furthermore, the capabilities approach calls for a challenge in the unequal distribution of power in society so that conditions and systems that make women vulnerable to SRHR violations in humanitarian emergencies are identified and corrected.

2.1.5 Flourishing version of the capabilities approach

This study explores what Kleist terms Nussbaum's two-part version of the capabilities approach, namely a flourishing version and a dignified version.[197] The flourishing version is grounded in a 'thick vague theory of the good', which draws heavily from the Aristotelian internalist essentialism tradition.[198] In this version, Nussbaum looks at the functions that constitute human flourishing. The flourishing version is rooted in the thick vague theory of the good. In her version, if one lacks capabilities, that person does not truly possess humanness. The next section looks at the role of essentialism as a constituent element of the flourishing version.

2.1.6 Essentialism as a constituent element of the flourishing version

Nussbaum's flourishing version of capabilities is rooted in Aristotelian internalist essentialism, which generates a set of basic functions representing a conception of the good.[199] The process begins by asking what things are so important that one could not call life truly human without them. According to Kleist, internalism is a method of inquiry that demands one to begin by identifying common human experiences. Essentialism seeks activities that all human beings must be given the

[197] Kleist (2009)2.

[198] The internalist essentialism tradition's goal is to identify the actual essential features of a human life. It seeks to highlight those activities that all human beings must be given an opportunity to perform if their life is to be called a truly human life.

[199] Kleist (2009)10.

opportunity to perform if their life is said to be truly human.[200] These activities give rise to ten essential functions required for a truly human life. Women's "right to the highest attainable standard of health"[201] in humanitarian emergencies thus extends beyond sexual and reproductive health care to other factors which have a bearing on how women exercise their choices, as will be elaborated on in other sections.

Nussbaum's central human capabilities include Life, Bodily Health, Bodily Integrity, the Development and Expression of Senses, Imagination and Thought, Emotional Health, Practical Reason, and Affiliation.[202] She argues that fulfilling these capabilities requires material and institutional support. Further, Nussbaum intends that her approach would push for material redistribution by highlighting that if one lacks the central human capabilities,they do not live a life endowed with well-being. Of the ten central capabilities elaborated on by Nussbaum, bodily health, life, practical reason and bodily integrity appeal to this study and are discussed below.

The right to health is broadly defined in the ICESCR, which recognises the right of everyone to the highest attainable standard of health.[203] Bodily Health is defined as the ability to have good health, including reproductive health, to be adequately nourished, and to have adequate shelter.[204] This capability is concerned with a person's ability to conceive a notion of good and to critically reflect on planning one's own life.[205] Moreover, bodily integrity implies freedom to move from place to place; the ability to stand up against violent assault, including sexual assault and domestic violence; the ability to access opportunities for sexual satisfaction and

[200] Kleist (2009)11-12.

[201] See CESCR General Comment No.14 on Article 12 of the ICESCR.

[202] Nussbaum (2007)21.

[203] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976

[204] Nussbaum (1999)235.

[205] Anand P 'Capabilities and health (2005)300.

reproductive choice.[206] Sithole[207] notes that the significance of such a capability to women's reproductive health cannot be overemphasised and makes reference to Pyle, who states:

> "The reason for setting forth this capability is to recognize the community's responsibility to provide the social conditions (laws, interventions, etc.) that enable this capability in the case of women who experience lack of bodily integrity as a capability deprivation. This is crucial, as bodily integrity is an important freedom in its own right as well as a means to further freedoms and economic opportunities."[208]

In relation to women's access to family planning information and services in humanitarian emergencies, the state is expected to put in place laws, policies and institutions which enhance women's capabilities. This is crucial as bodily integrity is an important freedom in its own right as well as a means to further other freedoms and economic opportunities.[209] Nussbaum reiterates that through the capabilities approach, it is expected that the government, through its social policies, is ultimately responsible for delivering the 'social bases of these capabilities.[210] The significance of women's bodily health in humanitarian emergencies cannot be overemphasised. Women in humanitarian emergencies face unique experiences which require reinforcement of their right to health. It is incumbent upon the government to ensure women access family planning information and services to respect, protect and fulfil their human rights.

Another central capability, as presented by the capabilities approach, is life. Life is the backbone for the exercise of other rights. General Comment No. 22 recognises that the right to sexual and reproductive health is indivisible from and

[206] Nussbaum (1999)235.

[207] Sithole (2020)39.

[208] Pyles L 'The capabilities approach and violence against women: Implications for social development' (2008) International Social Work, 51, 31–38.

[209] Pyles (2008)36.

[210] Nussbaum (2000)81.

interdependent with other human rights.[211]The exercise of reproductive rights, including the rights to life, to health, to decide freely on the number and spacing of one's children, to privacy and confidentiality, to access information and exercise informed consent, and to be free from violence against women and torture or ill-treatment, is essential to ensuring that rural women can achieve substantive equality and overcome discrimination.[212] Making family planning information and services accessible for women affected by humanitarian emergencies ensures that they are able to live to the end of human life of normal length and that they do not die prematurely before their lives are diminished as to be not worth living.[213] This study notes that the denial or lack of emergency obstetric care services for women in humanitarian emergencies often leads to maternal mortality and morbidity, which violates the right to life.[214]

Nussbaum's definition of practical reason includes one's ability to formulate a conception of the good and to critically contemplate the planning of one's life, which entails the protection of the liberty of conscience and religious observance.[215] Nussbaum argues that practical reason is a capability of significance and stands out as a deliberation about what it would be best to do in particular situations and with reference to one's life.[216] Practical reasoning guides the act of choice that determines which element of the objective capability set will be actualized. In other words, practical reasoning is the activation factor between a hypothetic capability and an achieved functioning.[217]

[211] General Comment No.22 para 10

[212] Centre For Reproductive Rights (2013)1.

[213] Nussbaum (1999)235.

[214] See General Comment No.22 para 10.

[215] Nussbaum (1999)235.

[216] Nussbaum (1999)236.

[217] Austin A 'Turning capabilities into functionings: Practical reason as an activation factor' (2018)1-19.

Sen emphasises the importance of practical reason in the capabilities approach in his discussion on agency.[218] Practical reason is significant to this study because it plays a central role in women's capability to live a good life. For women in humanitarian emergencies, guaranteed access to family planning information and services is an advancement towards reproductive self-determination which plays a central role in women's empowerment. The dimensions of practical reason are directly related to women's freedom and autonomy over their bodies as personal and private territory, over which every woman should have legal power and the capacity to take independent decisions.[219] Relatedly, the Committee on the Elimination of All Forms of Discrimination Against Women provides for the elimination of discrimination against women in marital and family relations as well as reproductive self-determination and equality.[220]

2.1.7 The dignity version of the capabilities approach

The concept of dignity plays a foundational role in more recent versions of Nussbaum's capabilities approach.[221] The dignity version of the capabilities approach by Nussbaum is a political project aimed at constructinga partial conception of justice compatible with political liberalism. Political liberalism creates the space for free and equal citizens to pursue their ends and allows individuals to apply capabilities as they grasp them from their standpoint or worldview.[222] The advantage of the dignity view is that it is a universal standard that can be applied crossculturally, taking into account the local conditions and yet independent of an essentialist depiction of a human being.

[218] Sen's discussion of agency looks at agency freedom as the freedom to achieve whatever the person as a responsible agent decides that he or she should achieve. See Sen(1985b) 186-204.

[219] Sithole (2020)40.

[220] CEDAW Committee, *Gen. Recommendation No. 21* para 22; Articles 12 and 16. CEDAW Committee, *Concluding Observations: Niger*, paras. 33-34, U.N. Doc. CEDAW/C/NER/CO/2 (2007)

[221] Nussbaum (2006)161.

[222] Kleist (2009)8.

The capabilities approach is tied to the global recognition of women's right to dignity. Respect for a person's dignity calls for recognising one's inherent worth as an equal human being.[223] Women's right to dignity is provided for in the Maputo Protocol.[224] In its preamble, CEDAW notes the significance of dignity and talks to the violation of human dignity as an impediment to the inclusion of women on equal terms with men in their onutries' political, social, economic and cultural life. This study observes that a breach of women's dignity is an affront to their capabilities in particular and to human development in general. This is so because control over reproduction and sexuality is an essential element of human dignity, both as a precondition for women to exercise their other rights and fulfil basic needs and as an end.[225] Dignity is indispensable to women's right to make meaningful and autonomous decisions about their lives and health.

Nussbaum asserts her conception of dignity as a political doctrine about basic entitlements.[226] She articulates the need for political liberalism as a framework for the capabilities approach, arguing that as political beings, human beings are worthy of respect and dignity.[227] Political liberalism allows people to pursue their conception of good and political goals, including ensuring liberal commitments to fundamental equal civil and political rights.[228] Liberalism, in this context, looks at the extent of well-being as a priority for the individual over the group. This study envisages utilising this approach to evaluate if women are accorded dignity and equality as stressed in global policy and human rights instruments.

[223] Durojaye E, Nkatha Murungi L 'The African Women's protocol and sexual rights' (2014)892 International Journal of Human rights.

[224] Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) Article 4 African Union; 2003

[225] Durojaye Nkatha (2014) 893.

[226] Nussbaum (2006)155.

[227] Nussbaum 'Political animals: Luck, love and dignity (1998)274.

[228] Kleist (2009)25.

The right to make fundamental personal decisions without interference from the state is a key aspect of human dignity.[229] Issues of family planning information and services belong to the woman's personal and private domain ; thus, the dignity component of the capabilities approach is preferred in analysing reproductive health, which inherently addresses relational processes of sexuality and reproduction while valuing the well-being of individual women.[230]

The dignity version of the capabilities approach is rooted in the list of ten central capabilities that every human being must be given the opportunity to fulfil in order to say that their life is truly dignified.[231] Nussbaum argues that every state must give its citizens an adequate threshold level of these central capabilities.[232] If the threshold standard cannot be secured, a state is not entirely just. The dignity version,a theory of justice, is preferred and forms a basis for determining a decent social minimum in various areas.[233]The dignity component of the capabilities approach is useful in assessing if the policy and institutional framework supports a threshold level of capabilities for women to access family planning information and services in humanitarian emergencies.

The importance of assessing policy and institutions to the right to health, especially in connection with sexual and reproductive health, cannot be overemphasised. It is incumbent upon the state to ensure that laws, practices and policies do not lead to human rights violations. It is argued that laws, policies and practices determine who has access to the benefits of SRHR services, the quality of SRHR services people will receive, and how SRHR systems are structured and governed.[234]The notion of an adequate threshold level of central capabilities ties into the underlying social

[229] Dixon, Nussbaum 'Abortion, dignity and a capability approach' (2011)2.

[230] Dejong J 'Capabilities, reproductive health and well-being' (2006)14-15.

[231] Kleist (2009)9.

[232] Nussbaum (2000) 1-312.

[233] Nussbaum (2000)75.

[234] Durojaye et al (*eds*) (2021)1-269.

determinants of women's reproductive health,forming the discussion in the next section.

2.1.8 The capabilities approach and underlying social determinants to women's reproductive health

Krieger interprets social determinants of women's reproductive health as social factors affecting people's ability to control their lives.[235] The capabilities approach calls for improving women's well-being and development through an evaluation of the impact of policy on people's lives.[236] It asks whether people are being healthy and whether the resources necessary for this capability, such as clean water, access to medical doctors, protection from infections and diseases, and basic knowledge of health issues, are present. It also checks whether people are well fed and whether the conditions for this capability, such as sufficient food supplies and entitlements, are met. Furthermore, it asks whether people have access to a high-quality education, to actual political participation, to community activities which support them to cope with struggles in daily life and which foster real friendships, to religions that console them and can give them peace of mind.[237] These questions encompass the full well-being of the human being, especially for women in humanitarian settings who suffer a double disaster.[238]

The combined interaction of internal and external factors makes up a person's capability.[239] These include a person's internal endowments, such as biology, knowledge and skills,and the external environment, including social, material and environmental factors. Nussbaum refers to internal factors as internal powers of a person which result from being trained and educated to realise her innate human

[235] Barreda L R et al 'Health assessment and the capability approach' (2019).

[236] Robeyns (2003)7.

[237] Robeyns (2003)7.

[238] My emphasis on women being impacted by pre-existing conditions and then disaster.

[239] Venkatapuram S, Chiappero-Martinetti E 'The capability approach: A framework for population studies' (2014)709.

capabilities.[240] Internal factors are further described as sufficient conditions for exercising one's requisite functions.[241] The fusion of internal capabilities and suitable external conditions for exercising functioning results in what Nussbaum terms combined capabilities.[242] To buttress this reasoning, Sithole quotes Price and Hawkins, who argue that sexual and reproductive behaviour is not just an individual decision-making process because a combination of social networks, religious background and affiliation, as well as political environment, shape an individual's behaviour.[243] As an example, for women to regulate their fertility, it is determined by their biological endowments, knowledge and skills to learn about and access fertility regulation technologies as well as the external availability of such technologies. These social and physical conditions allow access to such technologies.[244] Women require access to such conditions, even in humanitarian emergencies, to at least advance towards a certain dimension to a decent and dignified life. Thus, the capabilities approach works as a framework recognising that well-being is multi-dimensional and that women's development requires synergies across various spheres.

The right to the highest attainable standard of health includes the absence of disease and infirmity and the right to the provision of preventive, curative and palliative health care but also extends to the underlying determinants of health.[245] These include access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, safe and healthy working conditions and environment, health-related education and information, and effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health.[246] The nature of

[240] Austin (2018)5.

[241] Nussbaum (1999)238.

[242] Nussbaum (1999)237.

[243] Sithole (2020)41.

[244] Venkatapuram (2014)709.

[245] WHO 'Constituition of the World Health Organisation' (1948)1.

[246] See General Comment 14 CESCR, General Comment 22(7).

these social determinants is conveyed in laws and policies that curtail individuals' choices concerning their sexual and reproductive health. It is up to the government to fulfil sufficient guarantees of a wholesome set of social determinants for women in humanitarian settings, for these are intricately linked to the enjoyment of family planning information and services.

The capabilities approach offers a perspective for understanding and measuring poverty and designing public policies and development programs.[247] Sen defines poverty as a deprivation of basic capabilities rather than merely low income.[248] He further posits that poverty can make one helpless prey in violating other kinds of freedom.[249] Chipinge and Chimanimani rural districts, which are the focus areas of this study, are characterised by high levels of poverty as enunciated by the Zimbabwe Poverty Atlas.[250] Rural women are more likely to experience poverty and less likely to have formal education or paid employment. At the same time, many also face language barriers, which can result in multiple impediments to accessing reproductive health services.[251] Nussbaum posits that when poverty combines with gender inequality, the result is an acute failure of central human capabilities.[252] Poverty impedeswomen's access to family planning information and services, and one can justifiably assume that the effects are worsened during humanitarian emergencies. The CEDAW Committee has observed that poverty, income inequality, systemic discrimination and marginalization are all social determinants of sexual and reproductive health and impact the enjoyment of reproductive rights.[253]

[247] Venkatapuram (2014)717.

[248] Sen (1999)20.

[249] Sen (1999)8.

[250] UNICEF, World Bank 'Zimbabwe Poverty Atlas' (2015) 20-22.

[251] Centre For Reproductive Rights (2013)3.

[252] Nussbaum (2000)3.

[253] General Comment No. 22 para 8.

According to Sen, the capabilities approach explains that possession of income or commodities does not necessarily translate into welfare, as this depends on personal and social characteristics. Monetary conditions are, therefore, just one of the factors needed to enhance well-being.[254] Sen's contribution represents an important development in the theorisation of poverty because it considers that for one to achieve certain functions in life or a certain level of well-being, it is due tomarket and non-market variables. According to Wells, the causes of poverty include the interaction of physiological, environmental, economic, social, and political factors.[255] The capabilities approach acknowledges that the realisation of sexual and reproductive health and rights is tied to social determinants. Women who do not possess a level of education, who do not have access to reproductive health information and who do not have access to health centres due to long distances and difficult terrain are likely to be disproportionately affected by humanitarian disasters.

It is critical to note that the capabilities approach does not rank social determinants of health but calls for their recognition as an integrated and mutually interdependent whole. Rooted in state responsibility, its application secures women's health during humanitarian emergencies to ensure they do not fall through the cracks in government and civil society programming. The capabilities approach provides a framework for promoting core essential human rights expressed as social determinants of the right to health.

2.1.9 The capabilities approach and women's agency

The capabilities approach is a people-centred approach which puts human agency at the centre of the stage.[256] Agency refers to the various ways in which people act and exercise their choice to attain value in their states of being, this includes the

[254] Sen (1999).

[255] Wells (2013)1.

[256] Alkire S 'The capability approach and human development' (2005) University of Oxford Poverty and Human Development Initiative.

achievement of goals.[257] Women's agency does not occur to women in a vacuum but is exercisable through a complement of resource allocation.[258] Resources and agency together make up women's capabilities as enunciated by the capabilities approach. The crucial role of social opportunities is to expand the realm of human agency and freedom, both as an end and as a means of further expansion of freedom. The notion of agency, as expressed in the capabilities approach, is a reminder not to view individuals and their opportunities in isolated terms. A person's options depends largely on relations with others and what the state and other institutions provide.

What the state and other institutions do to enhance women's options and agency is particularly significant for this study. In simple terms, Nussbaum's capabilities approach focuses on the state's obligation to promote the capabilities of its citizens.[259] Thus in the context of this study, it is imperative that the state puts in place laws, policies, programmes and institutions that are attentive to women's circumstances and enhance women's agency during humanitarian emergencies. State obligations related to women's reproductive health rights will be discussed in greater detail in the study.

2.1.10 The capabilities approach and gender equality

Human dignity is usually violated on the grounds of sex, and often women's unequal treatment is manifest with respect to employment, bodily safety and integrity, basic nutrition and health care, education and political voice. Nussbaum argues that women's hardships as a result of inequality are due to their being women.[260] The main point feminists have stressed about gender inequality is that it is not an individual matter but is deeply ingrained in the structure of societies.

[257] Dixon, Nussbaum (2011)133.

[258] Kabeer N 'Gender Equality and women's empowerment: A critical analysis of the third Millennium Goal' (2005)14.

[259] Nussbaum (2000) 1-312.

[260] Nussbaum (1999)227.

Gender inequality is built into the organization of marriage and families, work and the economy, politics, religions, the arts and other cultural productions. Therefore, making women and men equal, necessitates social and not individual solutions.[261]

While the capabilities approach focuses on economic frameworks, poverty and development, its linkages with gender equality and the dignity of rural women in exercising their right to family planning information and services in humanitarian emergencies are essential to this study. The term gender is often referred to as the social construction of roles for men and women.[262] One notes that in times of crisis, gender inequality inhibits women's enjoyment of family planning information and services because it undervalues their potential to equal opportunities such as those given to their male counterparts.

In clarifying the meaning of gender equality, Durojaye postulates that whereas the assumption is that men are strong, powerful, clothed with aggression and are breadwinners, women are often perceived as weak, soft, subordinate, docile, destined to be home keepers.[263] The gender-allocated roles are often grounded in the cultural and sociological beliefs of the people. Gender stereotypes have also led to the erroneous belief that women are meant to be seen and not heard. This has worsened differential treatment between men and women, thus entrenching the low status of women in many African societies.[264] Discrimination[265] and stereotypes are still imported into humanitarian settings as women are associated with being

[261] Lorber J 'The variety of feminisms and their contribution to gender equality' (1997)8.

[262] Durojaye E 'A gendered analysis of Section 48(2)(d) of the Zimbabwean Constitution of 2013' (2017)2.

[263] Durojaye E (2017)2.

[264] Durojaye (2017)2.

[265] "Any 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." See Article 2 of Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

passive recipients of disaster, a view which negatively affects the perception of their capabilities. The capabilities approach provides an evaluative framework, which considers women's capability sets or key functionings such as being healthy, well nourished, safe, heard or have a livelihood.[266]

The many differences between men and women are partly derived from gender power relations and the social, economic and political positions that women hold on the broader society.[267] For example, a study done in Chipinge, Zimbabwe,[268] found that a common explanation for women's differential health status is their inferior standing within the prevailing patriarchal structures in most of Africa. Further, the study reveals that the needs and desires of rural women are not considered important, and that women are not expected to express themselves or participate in sexual decision-making.[269]

The list of ten central capabilities, presented by Nussbaum, aims to elevate women to an equal place in the world.[270] The capabilities approach becomes an outlet through which women can take part in areas where traditionally male domination is the norm, thus ensuring gender equality. With this approach, stakeholders in the disaster management continuum are directed to advance gender equality by ensuring women's access to family planning information and services in humanitarian emergencies. This aligns with CESCR General Comment No. 22, which affirms that gender equality requires that the health needs of women, different from those of men, be taken into account and appropriate services provided for women in accordance with their life cycles.[271] A study conducted by Chitongo on the gendered effects of climate change in the Cyclone Idai hit areas of Chipinge and Chimanimani districts underscores the importance of gender equality.

[266] Alkire S 'Using the capability approach Prospective and evaluative analyses' (2008)2.

[267] Riswan M 'Gender equality and vulnerability of women in the rural economy' (2018)63.

[268] Duffy (2005)24.

[269] Watts (1998).

[270] Ashaq L 'Nussbaum on gender equality: The capabilities approach' 43-47.

[271] General Comment No.22 para 25.

Gender inequality predominantly impacts negatively on women and girls, as men tend to have more decision-making power and control over resources than women. Because of this, efforts to advance gender equality must focus primarily on improving the situation and status of women and girls in their societies. For example, specific actions may be taken to ensure women's views and priorities are adequately and directly heard in disaster management committees.[272]

Thus in a humanitarian emergency, gender equality would entail setting benchmarks for reported disaster-related gender-disaggregated data, data collection around sexual and reproductive health and rights of women and adolescents and data analysis from a gender equality perspective.[273] This resonates with CEDAW's call for states to ensure equality of men and women in all realms of life, including legislation, education, employment, healthcare, social life, marriage and family life.[274]

The Constitution of Zimbabwe, as the supreme law of the land, has gender equality[275] as one of its founding values, provides for gender balance,[276] equality and non-discrimination[277] and specifically provides for the rights of women.[278] It has been noted that although the Constitution is gender-responsive, one major challenge is the inconsistencies and conflicts in legal and policy frameworks that are created by the gender-blind spots in the laws and policies to the interlocking systems of power that impact women and girls throughout their life-cycle across

[272] Chitongo et al 'Gendered impacts of climate change in Africa: The case of Cyclone Idai, Chimanimani Zimbabwe, March 2019 (2019)37.

[273] ATHENA 'What women want: A transformative framework for women, girls and gender equality in the context of HIV and sexual and reproductive health and rights' (2017)6.

[274] Articles 10-13 of CEDAW.

[275] Constitution of Zimbabwe Amendment 20 Act 2013 Section 3(1)(g).

[276] Constitution of Zimbabwe Section 17.

[277] Constitution of Zimbabwe Section 56.

[278] Constitution of Zimbabwe Section 80.

age, gender, and disability, among other forms of social stratification.[279] This study observes that gender blind spots in laws,[280] policies and institutions that respond to disaster pose as barriers to women's exercise of reproductive self-determination.[281] Nussbaum highlights that women face hardships caused by their being women, and in many cases, laws and institutions construct or perpetuate these inequalities.[282] When applied to humanitarian emergencies, the capabilities approach is key in denoting the inequalities and intersecting forms of discrimination that characterise the lives of rural women.

2.1.11 The capabilities approach and women's autonomy

The topic of women's autonomy over their bodies has been contested since a long time ago. Numerous cultures and religions decline women the freedom of choice regarding whether, how and what to do with their bodies.[283] The right to health is composed of both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive health, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.[284] Nussbaum's capabilities approach is key to women's right to access family planning information

[279] Spotlight Initiative Country Programme Document Zimbabwe (2018)13.

[280] Gender-blindness refers to lack of awareness of distinctions of gender. See Ayesha M Imam, Fatou Sow and Amina Mama (eds) 'Engendering African social sciences (1997)2.

[281] Centre For Reproductive Rights (2013)3.

[282] Nussbaum (1999)227.

[283] Durojaye et al(eds) (2021)69.

[284] 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 para 8)*, 11 August 2000, E/C.12/2000/4, available at*: https://www.refworld.org/docid/4538838d0.html* (accessed 17 August 2021).

and services because its commitment to comprehensive autonomy requires women to develop skills necessary to make meaningful choices.

The notion of autonomy is key to women's right to access family planning information and services in humanitarian emergencies. Autonomy is defined as the right of a woman to make decisions concerning her fertility and sexuality free of coercion and violence.[285] Autonomy is intimately and intrinsically connected with many fundamental human rights, such as liberty, dignity, privacy, security, and bodily integrity.[286] Moreover, women have equal standing before the law and full legal capacity as provided by Article 15 of CEDAW.[287]

Choice is the bedrock of family planning, and improving women's reproductive health involves empowering them to have control over their sexual lives. To be denied a choice is to be disempowered. To note is that some choices have greater significance than others in terms of their consequences on people's lives.[288] Choosing one's desired type of family planning services and when to utilise them is one of the strategic life choices a woman can make. Possessing capabilities reflects a person's freedom to choose between different ways of living.[289] However, in Zimbabwe, women's lack of economic security and opportunity has been identified as creating dependencies that make them unable to exercise choice within their sexual relationships.[290] Shalev has observed that women's health, in general, and their sexual and reproductive health, in particular, are determined by their access to health services and their status in society.[291] The capabilities approach focuses on human development and state support of women's autonomy which are intricately linked to their capacity to sustain gains in their well–being even during

[285] Shalev (1998)6.

[286] Shalev (1998)6.

[287] CEDAW Article 15

[288] Kabeer (2005)14.

[289] Sen (2003)3.

[290] Watts et al (1998)64.

[291] Shalev (1998)2.

humanitarian emergencies. The illumination of autonomy by the capabilities approach is in women's well-being and survival as well as for women's broader socio-economic development goals.

2.1.12 Capabilities as political rights

Political liberties have central importance in the well-being of human beings.[292]Traditional political rights and liberties have been pivotal to the international human rights movement in humanitarian emergencies.[293] Nussbaum argues that the best way of thinking about human rights is to view them as combined capabilities.[294] Combined capabilities cover the terrain covered by first-generation rights (civil and political rights), second-generation rights (economic, social and cultural rights) and provide philosophical underpinnings for fundamental constitutional principles. Nussbaum argues that her version of the capabilities approach, by centralising the idea of human choice and freedom, entails strong protection for these traditional rights and liberties.[295] Sen argues that political rights are important not only for the fulfilment of needs but also for the formulation of needs.[296] Sen's version elaborates that an analysis of development treats the freedom of individuals as basic building blocks.[297] In advancing capabilities as political rights, General Comment No. 22 provides that the right to sexual reproductive health is intimately connected to civil and political rights underpinning individuals'physical and mental integrity and autonomy.[298]

Sen pays particular attention to the expansion of the capabilities of people to

[292] Nussbaum (2000)96.

[293] Nussbaum (1999)238.

[294] Nussbaum (2000)98.

[295] Nussbaum (1999)238.

[296] Sen (1994)38.

[297] Sen (2000)18.

[298] General Comment No. 22:10.

lead the kind of lives they value and have reason to value. In advancing this argument, Sen expounds that public policy can enhance capabilities and the public's direction can be complemented by the public's effective use of participatory capabilities.[299] Possessing freedom to do things one has reason to value is significant for the person's overall freedom and in fostering one's opportunity to have valuable outcomes.[300] Freedom is crucial in women's access to family planning information and services as a principal determinant of individual initiative and social effectiveness. Cyclone Idai saw women internally displaced into camps where they could help themselves and act as change agents and influencers by standing up for other women to claim their reproductive rights. This would make a difference because Chatiza, as cited earlier in his study of the Cyclone aftermath, observed male domination in key disaster response structures. This posed a risk of overlooking and failing to respond to women's and girls' specific needs.[301] Given such a scenario, an illumination of the capabilities approach ensures that women are cushioned from human rights violations and maladministration[302] through law and practice in humanitarian emergencies.

Shalev's description of human rights is that they aspire to full participation, equal membership and active involvement in society.[303] Following the incremental global recognition of sexual and reproductive health and rights, this research views capabilities as human rights. The capabilities approach provides a benchmark for women's political participation in reproductive healthcare matters. Women's political participation is one of the indicators considered essential to achieving gender equality and women's empowerment.[304] Tamale and Onyango reiterate that

[299] Sen (2000)18.

[300] Sen (2000)18.

[301] Chatiza (2019)10.

[302] The right to administrative justice is provided for in the Constitution of Zimbabwe in Section 68 which provides that 1) Every person has a right to administrative conduct that is lawful, prompt, efficient, reasonable, proportionate, impartial and both substantively and procedurally fair.

[303] Shalev (1998)14.

[304] Kabeer (2005)13.

women's rights are human rights and that the struggle for human capabilities is not just a theoretical construct but a way of life,[305] meaning practical steps should be taken to ensure women have lived capabilities. Recognition of capabilities as rights would entail the institutionalisation of gender-responsive budgeting in the disaster-related legal and policy frameworks. It means including rural women in decision-making structures in the national budget process and cycle to ensure resources are allocated towards family planning information and services in humanitarian emergencies.

The capabilities approach by Nussbaum is appropriate for this study as it was developed for women in developing countries in mind. The approach yields a form of universalism that is sensitive to pluralism and cultural difference[306] therefore, applicable to inform an analysis of women's access to family planning information and services in humanitarian emergencies in the Zimbabwean context. Nussbaum acknowledges that generally, women lack essential support for leading lives that are fully human, and this lack of support is frequently caused by their being women.[307] The capability approach is envisaged as helpful to evaluate whether being a woman in rural Chipinge, and Chimanimani precludes one from enjoying family planning information and services.

2.1.13 Limitations of the capabilities approach

Despite its relevance in informing this study, the capabilities approach has limitations. Kleist criticises the flourishing version because most people can not live up to its standards which calls their quality of life and humanness into question.[308]

[305] Oloka-Onyango, J Tamale S 'The personal is political or why women's rights are indeed human rights' An African perspective on international feminism' (1995) 691- 692.

[306] Nussbaum (2000)7.

[307] Nussbaum (2000)4.

[308] Kleist (2009)8.

Robeyns argues that Sen's capability approach does not prescribe a list of functionings that should be considered constitutive of a person's well-being. Therefore, every evaluative exercise using the capability framework will require an additional selection of the functionings.[309] Gasper emphasises that on one hand Sen declines, for carefully considered reasons, to present or even discuss a list of central capabilities as a path to thinking further beyond choice utility-freedom frameworks. On the other hand, through that exercise, Nussbaum conveys and stimulates a richer picture of aspects of being human.[310] Robeyns[311] criticises Nussbaum's viewpoint that the capabilities approach comes in only two modes, that is, comparative quality of life assessment and a theory of justice. Robeyns argues this position's incorrectness as not all capability analysis modes can be reduced to these two modes. For Fredman, the capabilities approach operates at a level of minima and tends to emphasise personal choice too much.[312]

Fredman is concerned that Nussbaum's approach makes it clear that the capabilities approach is a basic minimum and not concerned with the above minimum distribution.[313] Instead, the approach asks what basic minimum justice requires and utilises the concept of a threshold but does not comment on what justice requires us to do about inequalities over the threshold.[314] Fredman further argues that the emphasis on choice in the capabilities approach goes too far. Sen's normative framework places the individual's ability to do or be what she has reason to value as its highest value. The risk of this argument is in focusing too much attention on

[309] Robeyns (2003)35 See Also Nussbaum (1988) (2003).

[310] Gasper D, 'Is Sen' s capability approach adequate basis for considering human development' (2002)23.

[311] Robeyns (2003)35.

[312] Fredman F 'Engendering socio-economic rights' (2010) SAHRJ University of Oxford Legal Research paper series 424.

[313] Fredman (2009(424.

[314] Fredman (2009)424.

what individuals can achieve, giving the impression that the only function of positive duties is to facilitate the ability of individuals to realise their own goals.[315]

Central to Sen's view is the choosing, reasoning individual, but with little further specified content of being human. It is further contended that a way of life is more than a set of private choices; personality and identity have a psychic and social grounding.[316] The capabilities approach by Sen has been criticised for being individualistic in that it assesses states of affairs only concerning the properties of individuals.

Critics have argued that the capabilities perspective is an evaluative framework,not a theory.[317] Sen defends that the capabilities approach is a theory of justice in a broad sense. He considers that the capabilities approach provides a way to address questions regarding how to enhance justice and eliminating injustice. He further stresses that justice is concerned with human lives rather than just the performance of institutions.[318] The approach by Sen has been criticised for its empirical application. However, Sen proposes that there is some nervousness in facing a valuation problem involving heterogeneous objects, such as the evaluation of capabilities and functionings. Further, capabilities are diverse and non-commensurable because measuring their 'values' in a common unit is problematic. Although Sen states that capabilities are non-commensurable, this does not imply that the approach is not operationalizable.[319]

The researcher notes that despite the criticism against Nussbaum and Sen, the capabilities approach is elaborative in its stance on the realisation of women's rights

[315] Fredman (2009)425.

[316] Gasper (2002) 20.

[317] Mendoza C D C 'Analysing educational transitions in upper secondary and higher education in Mexico. An empirical application of the capability approach and sociological perspectives on inequalities in education' (2017)23.

[318] Mendoza (2017(23.

[319] Mendoza (2017)23.

through capability sponsorship by the state in law and practice. The study finds that a consideration of the capabilities approach would shorten the gap between the *de jure* (legal) protection of women's reproductive rights and the *de facto* (actual) situation. Furthermore, through the capabilities approach, state institutions that nurture women's political participation are expected to ensure women's voices are heard across all platforms and their needs prioritised, including during humanitarian emergencies.

The nexus between human rights principles and the capabilities approach provides a dimension of engendering women's reproductive healthcare needs in humanitarian emergency management. Further, the emphasis on women's capabilities in human development by Nussbaum[320] is in tandem with securing a benchmark for improving women's status in humanitarian emergencies. That state responsibility should encompass securing a minimum threshold of capabilities for women's access to family planning information and services during humanitarian emergencies cannot be downplayed. Amollo buttresses this point and speaks on the emphasis on the capabilities approach and its imperative to improve women's material conditions. This resonates with the state's duty to progressively ensure the realisation of women's socio-economic rights within available resources.[321]

2.2 CONCLUSION

This chapter demonstrated the significance of the capabilities approach and radical African feminism in addressing women's right to access family planning information and services in humanitarian emergencies, with specific reference to a detailed discussion of four of the ten capabilities, namely, bodily health, life, practical reason and bodily integrity which are particularly relevant to this study. It further demonstrated how the capabilities approach is a thread that weaves into the

[320] Nussbaum (2000) further developed the capabilities framework with a particular focus on women's capabilities in developing countries.

[321] Amollo (2011)112.

social determinants of women's reproductive health, agency and autonomy, gender equality and political rights.

The chapter argued that the capabilities approach is an opportunity to eradicate gender inequalities and discrimination to realise women's empowerment through reproductive self-determination, agency and autonomy. The chapter discussed agency as a means of women's empowerment, advancing the struggle for women's participation and representation into the arena of strategic presence in reproductive health decision-making. In addition, the chapter elaborated that although women are different from men, they are not inferior and highlighted the importance of ensuring that male dominance is not institutionalised. Finally, the chapter advocated for substantive equality between men and women,the reshaping of power relations and the transformation of law and practice from the perpetuation of inequalities. The next chapter discusses the international, regional and national legal and policy provisions which advance women's right to access family planning information and services in humanitarian emergencies.

CHAPTER 3: INTERNATIONAL AND REGIONAL NORMS AND STANDARDS ON WOMEN'S ACCESS TO FAMILY PLANNING SERVICES.

3.1 INTRODUCTION

The preceding chapter examined how the capabilities approach and radical African feminism inform women's right to access family planning information and services during humanitarian emergencies. This chapter explores the international and regional norms and standards set for women to access family planning information and services in humanitarian emergencies.

The chapter provides a historical perspective on the development of sexual and reproductive health and rights through the women's rights and population movement in the international arena. In addition, the chapter discusses the emergence of women's reproductive health through provisions of International Conferences, programmes, and policies. Through these events, it was recognised that individuals have a basic human right and freedom to determine freely and responsibly when to have children, the spacing of their children and a right to adequate education and information in this respect.[322]

Women's reproductive rights provisions emanating from relevant international and regional treaties and monitoring bodies are discussed in this chapter. Moreover, the international and regional Special Procedures mandate in developing of reproductive health norms and standards is also articulated in this chapter.

It has been recognised that reproductive rights rest on the acknowledgement of the basic rights of all couples and individuals' responsibility and freedom to decide the number, spacing and timing of their children and to have the information and means

[322] International Conference on Human Rights in Tehran, 1968.

to do so. In addition, 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.[323] Deriving from these standards, this chapter discusses key elements of women's reproductive health, namely the right to health, family planning, lifeequality and non-discrimination, and the right to reproductive health information. Although not exhaustive, these elements comprise conditions that affect women's health, dignity, capabilities, and well-being in humanitarian emergencies.

3.1.1 A historical perspective of the development of reproductive health in international law

This section traces the historical evolution of reproductive health rights internationally through the women's and population movements.[324] Tracing the historical development of the right to reproductive health is important in understanding its modern-day conception. The construction of reproductive rights as human rights has been referred to as a 'schizophrenic history' since it is spilt into these two movements.[325] Retracing the historical development of women's reproductive rights enables this study to clarify the normative content of reproductive rights, explain the scope of state obligations, and elaborate on human rights monitoring and accountability for violations during humanitarian emergencies. This chapter is foundational for the next chapter, which discusses state obligations emanating from the international and regional norms and standards on women's reproductive health rights.

[323] ICPD (1994) para 7:3.

[324] Mattar L D 'Legal recognition of sexual rights – a comparative analysis with reproductive rights' (2008) *International Journal of Human Rights Year 5 Number 8 São Paulo*.

[325] Freedman LP & Isaacs SL 'Human Rights and Reproductive Choice' (1993) *Studies in Family Planning, Volume 24, Number 1* 18-30.

3.1.2 Evolution of reproductive health through the population movement

The population movement was based on the neo-Malthusian theory advanced by Thomas Malthus in the late 18th century. The population movement predicted that the world would self-destruct if the population growth curve were not reversed.[326] For nearly half a century, the neo-Malthusian movement sought to make fertility reduction an important international policy objective.[327] Fertility control and population reduction were achieved through contraception such as the pill and Intrauterine Devices (IUDs).[328]

The Malthusian League, headed by activists such as Charles Bradlaugh and Annie Besant, was formed in London, England, in 1877 and promoted the use of contraception to limit family size[329]. The League led to more tolerance when it came to contraception and family planning in Great Britain in the 20th Century.[330]In his later revised theory version, Malthus introduced moral restraint as an additional form of population check. The theory advanced that moral restraint from sexual intercourse would result from the postponement of the age of marriage conditional to pre-marital sexual abstinence. Malthus posits that the expansion of resources led to an increase in population growth. When the population grew beyond capacity by available resources, it was reduced by the 'preventive check' in the form of an intentional reduction of fertility and the 'positive check' through natural means such as malnutrition, disease, war, and famine.[331] Although Malthus opposed contraception, surprisingly, his work illuminated the birth control and eugenics movements[332].

[326] Mattar (2008)67.

[327] Hodgson &Watkins (1997)470.

[328] Mattar (2008)67.

[329] Eddy N C 'The Malthusian League 1877-1927 (2017)

[330]The Malthusian League (1877-1927) available at *https://hpsrepository.asu.edu/handle/10776/11488* (accessed on 2 September 2021).

[331] Ashraf Q & Galor O 'Malthusian population dynamics: Theory and evidence' (2008)10.

[332] Sithole (2020)48.

The eugenics movement stemmed from the idea that government should control the process of human reproduction by adopting the concept of selective breeding in animals to human species. [333] The eugenics movement in the United States is largely unknown, but it had an impact on the world and has been said to have exhibited an abuse of the prestige of science and its devastating impact on history. Advanced by the likes of Plato, Charles Darwin and Galton, this phase supported positive eugenics aimed at encouraging those with good traits to reproduce. When positive eugenics did not achieve the desired results, practices of negative eugenics, such as forced sterilisation, took off. The eugenics movement prompted the sterilisation of several hundred thousand people during the Nazi era in Germany. It was also used to sterilise 60 000 people (mostly women) between the 1930s and 1970s in Sweden to reducing the number of children born with genetic diseases and disorders.[334] When the Nazis in Germany proposed their sterilisation programme, they justified it by referring to its success in the United States.[335]

In essence, the theory of population is classified into three propositions: (1) Population is necessarily limited by means of subsistence (2) Population invariably increases where the means of subsistence increase, unless prevented by some very powerful and obvious checks (3) These checks which keep the population on a level with the means of subsistence are all resolvable into moral restraint, vice, and misery.[336] The purpose of this phase was to reduce population and never be concerned about the women who were part of the reproductive chain. Significantly, Avilla argues that contraceptive methods, which could have been tools for female

[333]A paper by Schexnayde S 'Eugenics in the United States: The forgotten movement.' 2021.

[334] Kevles D J 'Eugenics and human rights' (1999)435.

[335] Farber A S 'US Scientists' role in the eugenics movement (1907-1939) A contemporary Biologist's perspective.' (2008)243-245.

[336] Dent J M 'An essay on the principle of population Thomas Malthus 1803 (14th Edition 1826)1-24.

liberation, were viewed as devices for controlling women.[337] Traits of male domination and control over women's bodies found in this movement are opposed by radical African feminism, which views them as tools which inhibit women's capabilities in the private and public sphere.

3.1.4 Evolution of sexual and reproductive health and rights through the women's movement

Unlike the population movement, the women's movement drew on reproduction as one of its central themes but focused differently on women's control of their bodies, their sexuality and their reproductive life.[338] This would require access to safe contraceptives and financial and social conditions that would make reproductive choices possible.[339] The women's movement was premised on the feminist slogan of the 1970s, namely 'our bodies, our choice.'[340] This study observes that the women's movement viewed women as holders of rights, people of power who can act on life's choices as advocated for by the capabilities approach. The dignity version of the capabilities approach, Nussbaum enunciated, reiterates that dignity manifests through practical reason, sociability, and bodily need.[341] Thus during humanitarian emergencies, women require not only living dignified lives but developing practical reasons to enable their active participation in claiming their reproductive rights, nourishment to meet their basic needs and opportunities to interact socially.

A discussion on the role of the women's movement in the development of reproductive rights would be incomplete without reference to Margaret Higgins

[337] Avilla MB 'Reproductive Rights: chaos and government action' in Corrêa S & Ávilla MB *Reproductive Rights and the female condition* (1989) 18.

[338] Mattar (2008)68.

[339] Government offices of Sweden (2014)4-5.

[340] Mattar (2008)68.

[341] Kleist (2009)30.

Sanger.[342] Sanger encouraged women to rebel against all forms of slavery, especially biological and highlighted that a woman should be the 'mistress of her own body'.[343]Sanger popularised women's access to contraception and reiterated that correct usage would enable families to better support, educate, and raise their children, thus, granting families better lives and well-being.[344] In the same vein, women's control over their bodies, as advocated for by Sanger, is tied to the basic tenets of the capabilities approach, which measures well-being by what one is able to do and whom one can become. In line with the capabilities approach, one's capability set is reflected in their ability to make significant decisions and choices; thus, a person's capability reflects the level of empowerment she is experiencing. Sanger supported and promoted birth control methods which gave women agency. The significance of the population movement to this study also lies in its calling for gender equality and women's empowerment, key aspects to women's enjoyment of reproductive rights during humanitarian emergencies.

The women's movement witnessed the legal recognition of reproductive freedom through litigation. In the landmark case of *Griswold v Connecticut*[345] , the United States Supreme Court struck down a state prohibition against the prescription, sale, or use of contraceptives, even for married couples. The Court held that the Constitution guarantees a 'right to privacy' when individuals decide about intimate, personal matters such as childbearing. The *United States v Vuitch*[346] case was the first on abortion to reach the United States Supreme Court. In this case, a doctor challenged the constitutionality of a District of Columbia law permitting abortion only to preserve a woman's life or health. The Court rejected the claim that the

[342]Margaret Sanger forged a birth control movement led by middle class women that was aimed at legalising access to contraception. She fashioned an ideology that neatly combined feminism, neo- Malthusianism and eugenics.

[343] Wardell D 'Margaret Sanger: Birth control's successful revolution (1980)739.

[344] Eberts C 'The Sanger Brand: The relationship of Margaret Sanger and the Pre-war Japanese birth control movement.'

[345] 381 US 479 (1965).

[346] 402 US 62(1971).

statute was unconstitutionally vague, concluding that health should be understood to include considerations of psychological as well as physical well-being. This case is an indication of the inter relatedness of reproductive health and other factors. One observes that the state's responsibility to realise women's rights to health, food and housing influences the attainment of their capabilities to attain reproductive health. Furthermore, the right to privacy is constitutive of a woman's well-being and dignity, critical components required to realise reproductive rights. Arguably, this thinking resonates with the capabilities approach, which aims to promote core essential human rights.

The case of *Eisenstadt v Baird*[347] established the right of unmarried individuals to obtain contraceptives. This case entrenched the freedom of choice in reproductive health without discrimination. *Roe v Wade*[348] challenged a Texas law prohibiting lifesaving abortions. The Supreme Court invalidated the law because it violated women's constitutional right to privacy. The Court elaborated that the right to privacy encompasses a woman's decision whether to terminate her pregnancy, thus entrenching women's reproductive autonomy, a basic tenet of radical African feminism.

In a controversial move, in 2021, the Supreme Court overturned its earlier decision in *Roe v Wade* in the case of *Dobbs v. Jackson Women's Health Organization*[349] and consequently reversed the *1992 Planned Parenthood of South-eastern Pa v Casey*.[350] The court's decision is far-reaching as it negatively affects women's autonomy and equality and devastates other rights. The recent decision is an affront to the notion of abortion being a fundamental right to privacy and individual liberty. Furthermore, this 2021 pronouncement is evidence of state interference with women's access to reproductive health, bodily autonomy and reproductive justice.

[347] 405 US 438 (1972).

[348] 410 US 113(1973).

[349] *Dobbs v. Jackson Women's Health Organization* No. 19-1392, 597 U.S. 215 (2022).

[350] *Planned Parenthood of South-eastern PA. v. Casey*, 505 U.S. 833 (1992).

In the case of *Doe v Bolton*[351] the Court overturned a Georgian law which prohibited abortions except when necessary to preserve a woman's life or health or in cases of foetal abnormality or rape. In addition, the law prescribed that the abortion be held in an accredited hospital and that apart from the woman, a hospital committee, two doctors and the woman's doctor give their approval. The Court found these requirements unconstitutional because they imposed too many restrictions and interfered with a woman's right to decide, in consultation with her doctor, to terminate her pregnancy. The Court upheld the right to privacy[352] and elaborated on one's freedom of choice and non-interference in reproductive matters by stating:

> "There is, of course, a sphere within which the individual may assert the supremacy of his own will and rightfully dispute the authority of any human government, especially of any free government existing under a written constitution, to interfere with the exercise of that will."[353]

The women's movement, therefore, set the tone in ensuring women are accorded control and freedom of choice over their bodies without discrimination, coercion, violence, and non-interference. Radical African feminism speaks to the women's movement because it recognises that the image of a woman is not a prerogative of a man and women are not inferior but worthy beings who are able to formulate and make decisions about their life's choices without male domination and consent hovering over them. Thus, reproductive rights are an empowerment tool which accords women's capabilities in a gendered society where women's health needs have been historically excluded or marginalised.[354]

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[351] 410 US 179(1973).

[352] The Court referred to *Griswold* and defined the right to privacy as 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 to bear or beget a child.

[353] *Doe v Bolton* para 105.

[354] Ngwena CG & Durojaye E 'Strengthening the protection of sexual and reproductive health and rights in the African region through human rights' (2014)6.

3.1.5 Emergence of women's reproductive rights through international conferences, programmes, and policies.

The International Conference on Family Planning Programs held in Geneva in 1965[355] was the first to show the impact of modern contraception on fertility trends in some Asian countries (South Korea, Taiwan) and to seek consensus on the issue.[356] The history of reproductive rights as human rights focused on reproductive autonomy exercised primarily by women and was first expressed at the International Conference on Human Rights held in Tehran (Iran) in 1968.[357] The Conference adopted a resolution marking the first time when population control was explicitly linked to advancing human rights.[358] The conference adopted the essence of reproductive rights as it affirmed the right to marry and found a family, that couples have the basic right to responsibly and freely decide on the number and spacing of their children and a right to adequate education and information. [359]

The Bucharest World Population Conference of 1974, which embraced a World Plan of Action, defended the idea that population growth was linked to a country's level of development.[360] The World Plan of Action served as a guide to action in the field of population for governments, non-governmental organisations, and international organisations. The Conference reaffirmed the right to reproductive

[355] See Seltzer J R 'Origins and Evolution of family planning programs' (2002)1. The International Conference on Family Planning Programs, held in Geneva, Switzerland, in 1965, included participants from 36 countries with representatives from government health ministries and representatives from private family planning organizations, bilateral assistance agencies, international organizations, and private foundations.

[356] Garenne M 'Family Planning' (2018)122.

[357] United Nations 'Final Act of the International Conference on Human Rights, Teheran' (1968)15 xviii.

[358] Pizzarossa (2018)3.

[359] United Nations 'Final Act of the International Conference on Human Rights, Teheran' (1968)15xviii

[360] United Nations World Population Conference (1974).

choice and widened its definition to include couples and individuals. The Conference called on states to ensure that population policies alignwith human rights and that regardless of all demographic goals, the rights of persons to determine in a free informed manner should be respected. In essence, it was affirmed that individual freedom and choice on family size and spacing override governmental interests in population control.[361]

Furthermore, Bucharest established that people should have the information, education and means to exercise their reproductive rights,[362] and this wording could be interpreted to cover a range of social and economic rights. The World Plan of Action called for family planning to be a part of a general health and welfare policy as it acknowledged that 'development is the best contraceptive.'[363] Through this Conference, this study observes the recognition of the interconnection between population policies and development. Furthermore, the equal status of men and women in the family and society was acknowledged as a factor in improving the quality of life and it should be realised in family planning.[364]Nussbaum's capabilities approach acknowledges the linkages between women's rights and development and that producing capabilities requires material and institutional support.[365] Thus during humanitarian emergencies, women's reproductive rights present themselves as entitlements to capabilities with material and social preconditions requiring government action. Perhaps this is the basis upon which the capabilities approach argues for material distribution as key to an flourishing human life.[366]

[361] Pizzarossa (2018)3.

[362] Mattar (2008)67.

[363] Government Offices of Sweden (2014)7.

[364]United Nations Population Division. 1974a. UN World Population Conference. 1974. World Population Plan of Action. (WPPA). Bucharest. E/CONF, 60/L. 55. New York: United Nations Population Division.

[365] Nussbaum 'Human rights and human capabilities' (2007)21.

[366] Nussbaum (2007)22.

In 1975 the Declaration of the First World Conference on International Women's Year[367] elaborated on the need for governments to realise the particular health needs of women of all ages in all situations. It widened the right of individuals and couples to decide freely the number and spacing of their children.[368] The Conference participants, predominantly women, notably successfully managed to include in the Declaration of the Conference the right to reproductive autonomy and provided for the right to reproductive choice grounded on the notion of bodily control and integrity.[369] The Conference reiterated the importance of investments in community health programmes, mobile units and educating and informing women of their basic rights.

Of significance is the realisation of the need to prioritise women's health in all situations, which is encompassing humanitarian emergencies. Therefore, one would also assume that during Cyclone Idai, an investment in community health programmes and mobile units would partly fulfil the provisions of the 1975 Declaration. Furthermore, the enhancement of women's agency, autonomy, bodily control, and integrity are enablers to their attainment of a decent minimum level of capabilities as advanced by the capabilities approach.

The International Conference on Population and Development, held in Mexico in 1984, [370] met as an appraisal on implementating the World Population Plan Of Action(WPPA) adopted in Bucharest ten years prior.[371] The conference acknowledged that an improvement in the status of women and an enhancement of their roles influence family size and life.[372] Access to family planning information was highlighted as a pre-requisite to maternal health and child health, individual

[367] United Nations General Assembly 'Implementation of the World Plan of Action' adopted by the world Conference of the International Women's Year, 12 December 1975, A/RES/

[368] United Nations 'Report of the World Conference of the International Women's Year' (1975)77.

[369] Mattar (2008)68.

[370] International Conference on Population Mexico 1984.

[371] United Nations 'Report on the International Conference on Population (1984)2.

[372] Report on the International Conference on Population (1984)3.

human rights and couples rights.[373] Mattar observes that the 1984 Conference's final document stuck to the same language adopted in Bucharest and also included the obligation of governments to make family planning programs universally available.[374]

Pizzarossa argues that the recommendation for further implementations of the WPPA undoubtedly reflects a human-rights-centered approach.[375] For example, recommendation 30 of the WPPA urges states not only to ensure that all couples and individuals have the right to determine the number and spacing of their children freely and responsibly but also that they receive the information, education, and means to do so. Moreover, Recommendation 31 demands that legislation and policies concerning the family and programs of incentives and disincentives should be neither coercive nor discriminatory and consistent with internationally recognized human rights.[376]

The 1993 World Conference on Human Rights in Vienna endorsed the indivisibility of all human rights. It urged states to guarantee the full and equal enjoyment by women of all human rights and the eradication of all forms of discrimination against women.[377] Resultantly, the Conference led to the adoption of the Vienna Declaration and Programme of Action, which recognised the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span. The Conference affirmed women's right to accessible and

[373] Report on the International Conference on Population (1984)8.

[374] Mattar (2008)68.

[375] Pizzarossa (2018)4.

[376] UN Second Conference on Population. 1984. Recommendations 30,31 for the Further Implementation of the World Population Plan of Action. Adopted in the World Population Conference Mexico (1984) 24-25 available at: *http://www.un.org/popin/icpd/conference/bkg/mexrecs.html* (accessed on 5 September 2021).

[377] UN General Assembly, *Vienna Declaration and Programme of Action*, 12 July 1993, A/CONF.157/23 available at: *https://www.refworld.org/docid/3ae6b39ec.*html (accessed 5 September 2021).

adequate health care, the widest range of family planning services, as well as equal access to education at all levels.[378] This Conference was a significant milestone in the history of women's health rights as Mattar observes that it invoked the sexuality of women for the first time.[379] In agreement, Durojaye and Murungi posit that prior to 1993, the focus was on reproductive health and rights rather than sexual health and rights. This was apparently due to the universal tendency to shy away from discussions relating to sexuality.[380]

One important consideration adopted at the Conference was the appointment of a Special Rapporteur on violence against women and all forms of sexual harassment and exploitation.[381] The United Nations Declaration on Elimination of Violence against Women of 1993, which specifically focused on eliminating physical, sexual and psychological violence against women, was a further consolidation of these developments. They brought to the fore the implicit recognition of sexual violence as a violation of human rights.[382]Such achievements cannot go unnoticed as violence against women is a major contributing factor in depriving women of their capabilities to lead healthy reproductive lives,[383] even during humanitarian emergencies.

The International Conference on Population and Development (ICPD) held in Cairo in 1994 became a turning point in the population and reproductive health rights agenda. The Conference signalled a move away from narrowly focused family planning programmes, placed women at the centre of an integrated approach to reproduction, and recognized that human rights have a crucial role to play in relation

[378] Paragraph 41 of the Vienna Declaration and Programme of Action of 1993.

[379] Mattar (2008)68.

[380] Durojaye E & Murungi L N 'The African Women's Protocol and sexual rights' (2014)882.

[381] Paragraph 40 of the Vienna Declaration and Programme of Action of 1993.

[382] Durojaye & Murungi (2014)882-883.

[383] Sithole (2020)52.

to sexual and reproductive health.[384] The ICPD led to a consensus that governmental population policies must be built on the cornerstones of human rights.[385] It is recognised as having brought a major shift in the thinking and approach to population issues, from pure population control through family planning to a much wider field, encompassing fertility control, and safe sex and pregnancy free from coercion, discrimination, and violence.[386]

The ICPD enshrined a precise definition of reproductive rights in the non-institutional framework[387] as follows:

> "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right 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 their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents."[388]

The ICPD thus adopted a twofold definition. On the one hand, it conceptualized reproductive rights based on all couples' ability to decide freely and responsibly the number, spacing and timing of their children and the ability to access the information and means to do so, and the right to realise the highest standard of sexual and reproductive health. On the other hand, it recognised that these rights embrace certain human rights already recognized in national laws, international

[384] United Nations General Assembly 'Special Rapporteur on the right to the enjoyment of the highest attainable standard of health' (2004)5 E/CN.4/2004/49.

[385] Pizzarossa (2018)6.

[386] Pizzarossa (2018)5-6.

[387] Pizzarossa (2018)6.

[388] ICPD Programme of Action (1994) paragraph 7:3.

laws and international human rights documents and other consensus documents.[389] So the ICPD linked the definition of reproductive rights to human rights as enshrined in binding instruments and referred to the indivisibility of human rights.

In 1995 the Fourth World Conference on Women adopted the Beijing Declaration and Programme for Action, which guaranteed women's equal access and equal treatment in education and health care and called for the enhancement of women's sexual and reproductive health and education.[390] The Conference acknowledged the gender disparities in women's and men's access to reproductive health education.[391] Health education translates to family planning information and knowledge about services specifically sensitive to the needs of women and girls, a crucial component needed during humanitarian emergencies. Beijing elaborated on women's rights as follows:

> "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."[392]

Mattar reiterates that Beijing reinforced decisional autonomy and incorporated sexual rights. Through Beijing, there was an illumination on the right of all women to preside over all aspects of their health and the realisation that their fertility is basic to their empowerment.[393] This resonates with the elements of radical African feminism, which aims to dismantle patriarchy through reproductive autonomy.

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[389] Pizzarossa (2018)6.

[390] United Nations 'Beijing Declaration and Platform for Action: The Fourth World Conference on Women' (1995) paragraph 30.

[391] Beijing Declaration and Platform for Action paragraph 74.

[392] Beijing Declaration and Platform for Action paragraph 96.

[393] Pizzarossa (2018)9.

In 2000 Millennium Development Goals (MDGs) came into being[394] as eight goals that the United Nations member states set out to achieve by the year 2015.[395] Target 5A aimed at a reduction of maternal mortality by three quarters and universal access to reproductive health[396] , which was negotiated for after seven years of deliberations. In meeting MDG 5 in Zimbabwe, the 2012 Population census reported a Maternal Mortality Rate (MMR) decline from 1069 deaths per 100 000 live births in 2002 to 526 deaths per 100 000 live births in 2012. Notably, maternal mortality was higher in rural areas than in urban areas.[397] In meeting Target 5B, which aimed to achieve universal access to reproductive health by 2015, one notes the disparity between urban and rural contraception uptake. Access to family planning services was reportedly higher in urban areas than rural areas.[398] Although there was reported overall progress as far as Zimbabwe's achievement of the MDGs Target 5 is concerned, the United Nations Millennium Development Goals Progress Report highlights that maternal mortality remains a significant challenge in Zimbabwe owing to inadequate maternal care, shortage of skilled personnel, obstetric care equipment, essential drugs and other supplies among other challenges.[399] This background of challenges presented itself to women's right to access family planning information and services during Cyclone Idai in Chipinge and Chimanimani districts in 2019.

[394] The Millennium Development Goals (MDGs) are eight international development goals to be achieved by 2015 addressing poverty, hunger, maternal and child mortality, communicable disease, education, gender inequality, environmental damage and the global partnership.

[395] World Health Organisation 'Millennium Development Goals' available at *https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs)* (accessed on 6 September 2021).

[396] Pizzarossa (2018)10-11.

[397] UNDP 'Zimbabwe Millennium Development Goals 2000-2015 Final Progress Report' (2016)103-110.

[398] UNDP (2016)103. Contraceptive use of any method, unmet need for family planning, the proportion of girls aged 15 -19 years who were married on in union, adolescent birth rate, the proportion of women aged 15-19 who had begun childbearing, were higher in rural areas as compared to urban areas.

[399] UNDP (2016)103-110.

After the expiry of the MDGs in 2015, the General Assembly adopted the 2030 Agenda for Sustainable Development including 17 SDGs. Sexual and reproductive health and rights were adopted among the key objectives of the Sustainable Development Goals (SDGs). Under SDG 3, governments agreed that by 2030 they would ensure healthy lives and promote health for all ages. Goal 3 Target 3.7 affirms commitment to ensuring universal access to sexual and reproductive healthcare services, including family planning, information, and education. Goal 5 seeks to achieve gender equality and empower all women and girls by 2030. The SDGS recognise humanitarian crises, gender inequalities, global health threats, natural disasters, conflict, violent extremism, and forced displacement as hindrances to sustainable development.[400] The SDGs identify the need for the empowerment of vulnerable groups whose needs are a priority of Agenda 2030. Among these are internally displaced persons and those affected by complex emergencies[401] into whose ambit the case study of Chipinge and Chimanimani district falls.

3.2 INTERNATIONAL AND REGIONAL HUMAN RIGHTS FRAMEWORK

Several human rights guarantees, such as the rights to life, health, equality and non-discrimination, and information are pertinent to women's access to family planning information and services during humanitarian emergencies. The discussion elaborates on these human rights standards as they are entrenched in the international and regional human rights framework through treaties, monitoring bodies' General Comments and General Recommendations.

[400] United Nations '2030 Agenda for sustainable development' A/RES/70/1 Declaration para 14.

[401] United Nations '2030 Agenda for sustainable development' A/RES/70/1 Declaration Paras 23-23.

The International and regional human rights treaties and instruments under discussion in this section are the Universal Declaration of Human Rights (UDHR), Convention on the Elimination of All Forms of discrimination Against Women (CEDAW) monitored by the Committee on the Elimination of Discrimination against Women (CEDAW), International Covenant on Civil and Political Rights (ICCPR) which is monitored for compliance and implementation by the Human Rights Committee. However, the International Covenant on Economic, Social and Cultural Rights (ICESCR) is the only United Nations human rights treaty which refrained from establishing a committee to monitor the implementation of the covenant.[402] The Committee on Economic, Social and Cultural Rights (CESCR) was instead established by United Nations Economic and Social Council (ECOSOC).[403] The CESCR carries out the monitoring functions of the treaty by examining state party reports[404] and issuance of responses to the reports in the form of concluding observations where the Committee outlines its concerns and makes suggestions and recommendations.

Regionally the African Charter on Human and People's Rights'(ACHPR) monitoring body is the African Commission on Human and People's Rights. The African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol or The African Women's Protocol) reaffirms African women's rights. The discussion below focuses on the elements of reproductive rights, namely health, family planning, equality and non-discrimination, reproductive information, and life.

While treaties are not legally binding unless they are consented to by state parties, the study notes that they have persuasive value, present best practice standards for countries to emulate and create non binding political commitment. There is a moral perspective created by states which sign to become parties to treaties. Signature to

[402] WHO factsheet 31 pages 3-4.

[403] ECOSOC Resolution 1985/17 of 28 May 1985.

[404] Article 16 ICESCR.

a treaty creates an obligation for a state party to act in good faith and refrain from acts which would derail the purpose of the treaty.[405]

3.3 KEY ELEMENTS OF REPRODUCTIVE RIGHTS

3.3.1 Health

The right to the highest attainable standard of physical and mental health, commonly referred to as the right to health, was first mentioned in the preamble to the Constitution of the World Health Organisation[406] and provided as:

> "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

It has been recognised that the right to health is an inclusive right that extends to underlying health determinants.[407] Article 25 of the UDHR provides for the right to health as part of the right to an adequate standard of living, including the right to special protection and assistance for women in motherhood. However, Sithole argues that Article 25 does not adequately address issues related to motherhood. This can be attributed to the fact that the UDHR is a wide framework of general human rights, and does not pay particular attention to a group of rights or people.[408] After adopting the UDHR, the Commission on Human Rights drafted the

[405] United Nations 2010 Treaty event 'Towards universal participation and impelementation Factsheet #5 ' available at *https://treaties.un.org/doc/source/events/2010/Press_kit/fact_sheet_5_english.pdf* (accessed 5 March 2024).

[406] UN General Assembly, *Entry into force of the constitution of the World Health Organization*, 17 November1947, A/RES/131, available at *https://www.refworld.org/docid/3b00f09554.html* (accessed 17 October 2021).

[407] WHO, OHCHR 'The right to health' Fact sheet 31.

[408] Sithole (2020)60-61.

International Covenant on Economic Social and Cultural Rights[409] (ICESCR) and the International Covenant on Civil and Political Rights[410] (ICCPR), making the International Bill of Rights.

The ICESCR broadly defines the right to health and recognises the right of everyone to the highest attainable standard of physical and mental health.[411] Article 12[412] lists some of the steps to be taken by state parties to make the right to reproductive health attainable, such as the reduction of stillbirths and infant mortality, ensuring the healthy development of children, improving environmental and industrial hygiene; the prevention, treatment and control of diseases, and access to medical care for all. Article 12 is reinforced by article 24(1)(f) of the Children's Convention, which requires States Parties to 'develop preventive health care, guidance for parents and family planning education and services.'[413] CEDAW also guarantees the right to health and obligates states to ensure women have access to healthcare services, including those related to family planning and appropriate services.[414]

In considering the normative content of the right to health in Article 12, the Committee on Economic, Social and Cultural Rights emphasizes that the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services, and conditions to achieve the highest attainable standard of

[409] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: *https://www.refworld.org/docid/3ae6b36c0.html* (accessed 9 September 2021).

[410] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, available at: *https://www.refworld.org/docid/3ae6b3aa0.html* (accessed 9 September 2021).

[411] Article 12(1) ICESCR.

[412] Article 12(1,2a-d) ICESCR.

[413] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at *https://www.refworld.org/docid/3ae6b38f0.html* (accessed 16 September 2021).

[414] Article 12 CEDAW.

health.[415] Sithole notes that although Article 12 does not sufficiently provide for women's reproductive rights, this inadequacy is cured by General Comments.[416] General Comment No.14[417] provides the right to health facilities, goods and services that can be read to cover family planning services. It provides as follows:

> "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level ;the provision of essential drugs; and appropriate mental health treatment and care."[418]

The CESCR has elaborated that the right to health includes a right to maternal, child and reproductive health and has requested states to improve maternal and reproductive health services, including access to family planning, pre- and post-natal care, and emergency obstetric care.[419] CESCR enjoins states to fulfil the right to health by ensuring a guarantee of its availability, acceptability, accessibility, and quality.[420] Dodzo and Mhloyi have observed that most Zimbabweans, 67%, live in rural areas where availability, accessibility and affordability are key issues affecting health utilization.[421] The state is obligated to do this and fulfil general,[422] specific[423]

[415] General Comment No. 14 paragraph 9.

[416] Sithole (2020)63.

[417] Office of the High Commissioner for Human Rights. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000.

[418] General Comment No. 14 paragraph 17.

[419] CESCR General Comment 14 paragraph 14.

[420] CESCR General Comment 14 paragraph 12.

[421] Dodzo KM &Mhloyi M (2017)2.

[422] General Comment No.14 paragraphs 30-33.

[423] General Comment No.14 paragraphs 33-37.

and international[424] state party obligations as elaborated in General Comment No.14.[425] The subject of state obligations forms the discussion in the next chapter.

Regionally, Article 16 of The African Charter on Human and People's Rights guarantees the right to health, stating that every individual has the right to enjoy the best attainable state of physical and mental health and obliging states to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[426] However, article 16 has been criticised for being too general and as not detailed as Article 12(2) of the ICESCR. Durojaye argues as follows:

> "More importantly, Article 16 of the African Charter fails to address issues, such as, maternal, and infant mortality, access to contraception and HIV/AIDS. In particular, these issues affect women more than men in Africa. Given that these are serious health issues that affect Africa more than other regions, it is a serious omission on the part of the drafters of the Charter, although one may argue that at the time the Charter was being finalised HIV/AIDS had not become a major challenge in the region. However, it is inexplicable that issues, such as, infant, and maternal mortality, which have always posed great challenges in the region, were not addressed in the Charter."[427]

This study notes that upon the realisation of this loophole, the African Commission devised curative provisions. The African Commission crafted guidelines on implementing economic, social, and cultural rights in the ACHPR. The guidelines provide elaborate provisions on the normative content of the right to health in

[424] General Comment No. 14 paragraphs 88-42.

[425] See General Comment No.14 paragraphs 30-45.

[426] Article 16 of the African Charter on Human and Peoples rights.

[427] Durojaye E 'The approaches of the African Commission to the right to health under the African Charter' (2013)397.

Article 16 ACHPR.[428] Furthermore, the same guidelines are specific to women's reproductive, maternal, and childcare rights. Article 14 of the African Women's Protocol buttresses these provisions as it contains broad and radical provisions relating to the sexual and health needs of African women and girls.[429] The African Women's Protocol and General Comments are historic and radical in the sense that they broke the silence on some contentious sexual and reproductive health issues that are often treated with kid gloves,[430] such as abortion and HIV. Durojaye substantiates this preceding statement by stating that the African Women's Protocol explicitly guarantees women's sexual and reproductive rights, provides that women should be protected from STIs, including HIV/AIDS, recognizes women and girls' rights to seek contraception services, and, it forbids marriage of a girl below eighteen years.[431] Furthermore, the provisions of Article 14 of the African Women's Protocol address some of the contemporary health challenges in Africa which still threaten women's reproductive rights during humanitarian emergencies.

Among significant developments to women's sexual and reproductive health rights is the clarification of provisions on the respect of people living with HIV or at risk of the epidemic who form part of women in humanitarian emergencies.[432] This is against evidence that women in Sub-Saharan Africa are at a disproportionate risk of HIV infection.[433] The African Women's Protocol recognises that the limitation of women's rights in the context of sexual and reproductive health increases the

[428]African Commission on Human and People's Rights 'Principles and Guidelines on the Implementation of economic, social and cultural rights in the African Charter on Human and People's Rights' pages 24-26 available at *https://achpr_instr_guide_draft_esc_rights_eng.pdf* (accessed on 14 September 2021).

[429]Durojaye E 'Realizing Access to Sexual Health Information and Services for Adolescents Through the Protocol to the African Charter on the Rights of Women' (2009)166.

[430] Durojaye eds (2021)5.

[431] Durojaye (2009)166.

[432] General Comment No.1 on Article 14(1)(d)(e) on the Protocol to The African Charter on Human and People's Rights on the rights of women in Africa available at *https://www.achpr.org/legalinstruments/detail?id=14* (accessed on 14 September 2021.

[433] General Comment No.1 paragraph 3.

likelihood of HIV exposure and transmission.[434] In line with the capabilities approach, the importance of bodily health for women in humanitarian emergencies cannot be overemphasised. It involves having good health including reproductive health, adequately nourished and shelter. These are necessary conditions pivotal for rural women's reproductive health who find themselves in more difficult circumstances when they encounter humanitarian emergencies. Furthermore, when a woman is healthy, she can exercise her independence and agency when making decisions about reproductive choices, thereby rewriting her own identity, a key aspect of radical African feminism.

3.3.2 Family Planning

Family planning is a key aspect of the right to the highest attainable physical and mental health standard.[435]At the International level, while the UDHR does not specifically provide for the right to family planning services, it provides for the right to a standard of living adequate for the health and well-being of individuals and their families. Additionally, motherhood and childhood are entitled to special care and assistance in the UDHR.[436] Men and women have the right to marry and find a family in terms of Article 16(1) of the UDHR, a demonstration that it anticipates the institution of the family.

CEDAW elaborates on women's right to family planning services by outlining state obligations relating to the need to guarantee appropriate services in connection with "pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[437] Of significance to this study is that CEDAW considers problems faced by rural

[434] General Comment No.1 paragraph 5.

[435]Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/66/254 (2011), paras. 44, 48. See also Inter- National Covenant on Economic, Social and Cultural Rights, Article 12.

[436] Article 25 (1) (2) UDHR.

[437] Article 12:2 CEDAW .

women and the need for access to adequate health facilities, including information, counselling, and services in family planning.[438]

CEDAW General Recommendation No.24 recognises access to health, specifically reproductive health, as a basic right.[439] Although there is no specific reference to women in humanitarian emergencies, the Committee requires that special attention be paid to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as "migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities."[440]

The interconnectedness of women's reproductive rights and other social determinants is articulated by the obligation on state parties to facilitate physical and economic access to productive resources, especially for rural women, and to ensure otherwise that the special nutritional needs of all women within their jurisdiction are met.[441] State obligations regarding women's reproductive health rights will be discussed in detail in the next chapter of this study.[442] It is essential that government and other stakeholders work together to ensure women have access to social determinants of health in humanitarian emergencies as this enhances their well-being and dignity, as elaborated on in the capabilities approach. This is based on the premise that access to social determinants of health works to improve women's access to their reproductive rights.

[438] CEDAW Articles 14:1,2(b) See also CEDAW Article 16(1)(e).

[439]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, chap. I, available at: *https://www.refworld.org/docid/453882a73.html* [accessed 7 September 2021).

[440] General Recommendation No. 24 paragraph 6.

[441] General Recommendation No.24 paragraph 7.

[442] Article 25 Convention on the rights of persons with disabilities.

This study observes that the timeous provision of women's family planning information and services is of utmost importance during humanitarian emergencies because of the vulnerabilities posed by loss of personal belongings and access to services. Therefore, General Recommendation No. 24, upon this basis, provides for the need for states to put in place measures to ensure women have expedient access to the range of services that are related to family planning as follows:

> "In their reports, States parties should state what measures they have taken to ensure timely access to the range of services that are related to family planning, in particular, and to sexual and reproductive health in general. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning."[443]

Women's right to family planning services in humanitarian emergencies can be derived from the fact that General Comment No.14 affirms equality, non-discrimination, the importance of women's health, prescribes integration of gender perspective in health policies[444] and provides for the right to treatment in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergencies.[445] Of significance to this study is that bodily autonomy, sexual and reproductive freedom, freedom from interference, freedom from torture and non-consensual medical treatment and experimentation are recognised as freedoms which constitute the right to health, some of the components advocated for by the capabilities approach. Family planning is essential to ensuring substantive equality between men and women. The UN Working Group on the issue of discrimination against women in law and practice has stated that since only women can become pregnant, a lack of access to contraceptives is bound to affect their health disproportionately.[446] The right to a system of health protection which provides equality of opportunity for people to enjoy the highest

[443] General Recommendation No.24 paragraph 23.

[444] General Comment No.14 paragraph 20.

[445] General Comment No.14 paragraph 16.

[446] A/HRC/32/44 (2016), para. 23.

attainable level of health is recognised as an entitlement which forms part of the right to health. One can observe that the broad interpretation given to the right to health by General Comment No.14 can be employed to cover the ambit of women affected by humanitarian emergencies as it seeks to enhance their capabilities and recognise their equal standing in claiming access to family planning services.

The Convention on the Rights of Persons with Disabilities[447] in Article 11 calls on states to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and natural disasters. The right of women to access family planning information and services is inferred from a guarantee on reproductive rights of persons with disabilities provided as follows:

> "The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised and the means necessary to enable them to exercise these rights are provided."[448]

The Committee on the Rights of Persons with Disabilities stressed that all women with disabilities must be able to exercise their legal capacity by making their own decisions with support on medical or therapeutic treatment when desired, including on decisions to do with retaining fertility, reproductive autonomy, and the right to choose the number and spacing of children.[449]

[447] UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106, available at: *https://www.refworld.org/docid/45f973632.html* (accessed 7 September 2021).

[448] Article 23(1)(b) Convention on the rights of persons with disabilities.

[449] OHCHR Submission of petition ADI/ADPF 5581 on 'Denial of abortion services and the prohibition of torture and cruel, inhuman and degrading treatment' To Honourable Madame Justice Ministra Cármen Lúcia by Mandates of the Working Group on the issue of discrimination against women in law and in practice; the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, the Special Rapporteur on the right of everyone to the

Article 16 of the African Charter on Human and People's Rights (ACHPR) provides the right to enjoy the best attainable physical and mental health state. The wording of the ACHPR is vague and general as it does not specifically provide for women's family planning services or speak to humanitarian emergencies. As argued by Durojaye, Article 16 does not refer to underlying determinants of health such as a healthy environment, water and sanitation and prevention, treatment, and control of the epidemic.[450] These underlying determinants are crucial in fulfillingwomen's well-being and ensuring they live a life worthy of dignity as enunciated by the capabilities approach. The African Women's Protocol tends to be more specific as it provides for women's right to health and reproductive rights, specifically the right to control their fertility,[451] to decide on whether to have children, their number and spacing,[452] to choose any method of contraception,[453] to self-protection and protection against sexually transmitted infections including HIV- AIDS,[454] the right to be informed of one's health status and that of their partner particularly if affected by STIs including HIV-AIDS[455] and the right to family planning education.[456] Furthermore, Article 14 enjoins states to provide adequate, affordable and accessible health services, including information and communication programmes, especially to women in rural areas.[457]

enjoyment of the highest attainable standard of physical and mental health; Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on violence against women, its causes and consequences available on *https://www.ohchr.org/Documents/Issues/Women/WG/AmicusBrazil.pdf* (accessed on 12 September 2021).

[450] Durojaye E 'The approaches of the African Commission to the right to health under the African Charter' (2013)397.

[451] Article 14 (1) (a).

[452] Article (14) (1)(b).

[453] Article (14) (1)(c).

[454] Article (14) (1)(d).

[455] Article (14) (1) (e).

[456] Article (14) (1)(f).

[457] Article (14) (2) (a-c).

Given the patriarchal nature of most African societies, guaranteeing women the right to choose a method of contraception, number and spacing of their children is empowering and will enable themto assert their sexual health and rights.[458] As enunciated by the capabilities approach, women's empowerment is committed to comprehensive autonomy, which requires women to develop the necessary skill set to make meaningful choices free of coercion and violence. Radical African feminism also recognises and is supportive of the ability of a woman to make life's strategic decisions free from male domination or under 'pressure' from the family, community, and society.

3.3.3 Equality and non-discrimination

The Universal Declaration of Human Rights proclaims the equal entitlements of women and men to the rights contained in it without distinction of any kind.[459] One observes that the UDHR is premised on the inherent human dignity and equality of human beings, pivotal principles in realising women's gender equality and empowerment, even in humanitarian emergencies.

CEDAW provides for equality and non-discrimination in access to healthcare and services, including those related to family planning.[460] Article 16 of CEDAW sets the obligation for all state parties to take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and, in particular, to ensure, on the basis of equality of men and women, 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.[461] CEDAW General Recommendation No.24 provides an analysis of the key elements of Article 12 CEDAW and provides for women's right

[458] Durojaye & Murungi (2014)888.

[459] Article 2 UDHR.

[460] Article 12:1 CEDAW

[461] Mattar (2008)68.

not to be discriminated against in the field of healthcare and unequivocally reaffirms equality between men and women to healthcare services, including those related to family planning.[462]

CESCR General Comment No. 14 entrenches non-discrimination in the access to healthcare and recognises that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.[463] CESCR General Comment No.14 specifically singles out women's right to health and the requirement to remove all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.[464] Bodily health is part of the central capabilities enunciated by the capabilities approach and is an essential aspect of well-being.

Cook reiterates that women's right to control their fertility through the prohibition of all forms of discrimination may therefore be a fundamental key that opens women's capacity to enjoy other human rights and to achieve the physical, mental, and social well-being that is the essence of health.[465] One notes that the opening of one's capacity results from the promotion of practical reason, an ingredient of the capabilities approach. Thus, in humanitarian emergencies, General Comment No. 14 enjoins states to ensure reproductive healthcare is availed to affected populations.

CESCR General Comment No. 22 is pivotal to this study as it speaks specifically on the right to non-discrimination in the context of sexual and reproductive health.[466] It speaks to substantive equality, which entails that the distinct sexual and reproductive health needs of particular groups, as well as any barriers that particular

[462] General Recommendation No. 24 paragraph 8

[463] CESCR General Comment No.14 paragraph 18.

[464] General Comment No.14 paragraph 21.

[465] Cook R J 'Women's health and human rights' (1994)39.

[466] General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights EC.12/GC 22 2 May 2016.

groups may face, be addressed.[467] Substantive equality is a precondition to women's self-determination. Furthermore, radical African feminism opposes women's differential health status and inferior standing within the patriarchal structures found in most of Africa. This is reflected in allowing women a voice in sexual decision-making in the private sphere and their effective participation and decision-making in public matters that have a bearing on addressing their needs during humanitarian emergencies.

Alyne v Brazil[468] was the pioneer case on maternal mortality to be decided by an international human rights body. The significance of this landmark case is in articulating the recognition of women's rights to safe motherhood and access to quality maternal healthcare without discrimination. CEDAW Committee held Brazil accountable for violating CEDAW Article 1 on discrimination against women as read with General Recommendation 24 on women and health, General Recommendation 28 (related to CEDAW Article 2) and CEDAW Article 12 on access to health. CEDAW Committee found that failure to provide maternal health services that meet the specific, distinctive health needs and interests of women constitutes not only a violation of CEDAW Article 12(2) but also discrimination against women.[469] This case demonstrates the existence of discrimination against especially women from the most vulnerable sectors of society, especially women of African descent.[470] This study observes that the differential impact on women's reproductive rights due to lack of access to quality, timely and appropriate maternal health services amounts to discrimination and negatively impacts their right to life.

In the case of *L.C v Peru*[471] CEDAW Committee reiterated that a state party has an obligation under CEDAW Article 12 to eliminate discrimination in thehealthcare

[467] General Comment No.22 paragraph 24.

[468] Committee on the Elimination of Discrimination Against Women (CEDAW) 49th Session 2011 Communication/C/49/D/17/2008 para 7.6.

[469] CEDAW Committee Communication/C/49/D/17/2008 para 7.6.

[470] CEDAW Committee Communication/C/49/D/17/2008 para 7.6.

[471] CEDAW 50th Session Communication No. 22/09 para 8.11.

field to ensure equality between men and women and ensure access to health services, including those related to family planning. Furthermore, it was stated that *L.C* was a victim of exclusions and restrictions in relation to access to health services based on gender stereotype that portrays a woman's reproductive capacity as a duty and not as a right. One observes that *L. C* was discriminated against because she was a woman who sought an abortion and was denied this right on time and had to go through a forty-two-day delay by a hospital medical board and a twenty-day wait for the hospital director to respond to her request for an abortion. During humanitarian emergencies, failure to provide women with legal protection for their reproductive rights as provided to men constitutes discrimination. Failure to avail of timeous conditions, including professional medical assistance that gives women access to abortion and other services of choice, is detrimental to their mental and physical health.

CESCR General Comment No. 22 establishes the co-relation between women's reproductive health autonomy and their right to make meaningful decisions about their life and health.[472] This General Comment recognises legal, procedural, practical, and social barriers that inhibit access to various sexual and reproductive health facilities, services, goods and information. Thus, one can assume that in rural Zimbabwe, the patriarchal role of men solely as heads of households and breadwinners and women as passive victims is carried into the context of humanitarian emergencies. Furthermore, gender-based stereotypes, assumptions and expectations related to women being the subordinates of men and their role being sole caregivers and mothers are identified as obstacles to substantive gender equality, including the equal right to sexual and reproductive health hence the need to modify or eliminate them.[473]

CESCR General Comment No. 22 provides that prisoners, refugees, stateless persons, asylum seekers and undocumented migrants are groups whose additional vulnerability needs specific prioritisation to ensure their access to sexual and

[472] General Comment No 22. Paragraph 25.

[473] General Comment No.22 paragraphs 25-28.

reproductive information, goods, and healthcare. However, women in humanitarian emergencies do not fall into the mentioned categories provided for as far as intersectional and multiple discrimination[474] in the context of sexual and reproductive health is concerned.

The International Covenant on Civil and Political Rights[475] was adopted to provide equal enjoyment of civil and political rights between men and women.[476] The In its CCPR General Comment No.28,[477] the Human Rights Committee obligates states to ensure equal enjoyment of rights without discrimination.[478] Additionally, having regard to Article 4 of the ICCPR, the equal enjoyment of human rights by women in a state of public emergency is provided for in CCPR General Comment No. 28.[479] Furthermore, the recognition of the vulnerability of women during internal and international conflict situations could lead to the assumption that women in humanitarian emergencies as a related group are equally entitled to state protection from rape, abduction and other forms of gender-based violence.[480] Of significance

[474] General Comment NO.22 paragraphs 30-31 identifies that poor woman, persons with disabilities, migrants, indigenous or other ethnic minorities, may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health. As identified by the Committee, groups such as, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and people living with HIV/AIDS are more likely to experience multiple discrimination. Trafficked and sexually exploited women, girls and boys are subject to violence, coercion and discrimination in their everyday lives, with their sexual and reproductive health at great risk. Also, women and girls living in conflict situations are disproportionately exposed to a high risk of violation of their rights, including through systematic rape, sexual slavery, forced pregnancy and forced sterilization.

[475] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999 (entered into force 23 March 1976) [*ICCPR*].

[476]Article 3 ICCPR.

[477]UN Human Rights Committee (HRC), *CCPR General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, 29 March 2000, CCPR/C/21/Rev.1/Add.10, available at: *https://www.refworld.org/docid/45139c9b4.html* (accessed 12 September 2021).

[478] General Comment No. 28 paragraph 4.

[479] General Comment No.28 paragraph 7.

[480] General Comment No.28 paragraph 8.

is that the Human Rights Committee acknowledges that the unequal exercise of rights by women is grounded in tradition, culture, including religious attitudes.[481] Relatedly, radical African feminism is pertinent to this study because of its quest to challenge not only male dominance like other feminisms but goes further to resist the oppression of women based on African culture, tradition and ethnicity.

Article 26 of the International Covenant on Civil and Political Rights (UN 1966) guarantees equal rights before the law and freedom from discrimination. Moreover, the Human Rights Council, in its General Comment 28[482] 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.[483] In *Nahlik v Austria*[484] the Human Rights Committee explains that articles 2 and 26 of the ICCPR obligates states to ensure that all individuals within its territory and subject to its jurisdiction are free from discrimination, and state parties through their courts are under an obligation to protect individuals against discrimination, whether this occurs within the public or private sphere.

General Comment No. 2 on Article 14 of the African Women's Protocol[485] interprets provisions of Article 14 of the Protocol, which guarantee women's rights to fertility control, contraception, family planning education and abortion. Ngwena argues that the adoption of General Comment No. 2 signals the continuation of a new trend in the history of the African Commission whereby equality between the

[481] General Comment No.28 paragraph 5.

[482] General Comment No.28 paragraph 12.

[483] Durojaye E 'Between rhetoric and reality: the relevance of substantive equality approach to addressing gender inequality in Mozambique' (2017)36.

[484] Communication No 608/1995. 22 July 1996. CCPR/C/57/D/608/1995.

[485] 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 available at *https://www.achpr.org/legalinstruments/detail?id=13* (accessed on 13 September 2021).

sexes and elimination of all forms of discrimination against women is given priority.[486]

Article 18(3) of the ACHPR enjoins states to ensure non-discrimination against women and calls for protecting women's and children's rights. In addition, article 2 of the African Women's Protocol calls explicitly for states to eliminate all forms of discrimination against women in the region. The Protocol broadly defines discrimination as follows:

> "Any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment, or the exercise by women, regardless of their mental status, of human rights and fundamental freedoms in all spheres of life. "[487]

Under the ACHPR, Article 2 provides for everyone's right to equality before the law and non-discrimination on grounds such as gender, religion, political beliefs, or another status, thus offering protection to women around reproductive health. Article 3 similarly guarantees every individual the right to equality and equal protection of the law. The African Commission on Human and Peoples' Rights in *Purohit and Moore v The Gambia* has stated as follows:

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

[486] Ngwena CG, Brookman- Amissah & Skuster P 'Advancing women's reproductive health in Africa' (2015)2.

[487] Article 2 African Women's Protocol.

Eliminating discriminatory laws and practices that impact women's ability to access family planning services during humanitarian emergencies is constitutive of the progressive realisation of economic, social and cultural rights. It contributes to securing a dignified life of well-being. This resonates with radical African feminism, which calls for substantive equality by examiningthe actual economic, social conditions in which women inhabit and requires government to take positive measures, including the allocation of resources, to eliminate conditions that perpetuate inequality. Furthermore, ensuring equality and non-discrimination in women's access to family planning services during humanitarian emergencies amounts to securing a certain threshold of the ten central capabilities of the capabilities approach.

3.3.4 Right to reproductive information

The vitality of the acquisition of education and information in women's access to reproductive health cannot be overemphasised. The UDHR provides for the right of women and men to marry and find a family[488] and access to information.[489] Although it does not specify women's reproductive rights or encompass women in humanitarian emergencies, a reading of entitlements of the right to health reveals that when health is provided, it should meet guarantees to maternal, child and reproductive health, equal and timely access to health services, provision of health-related education and information, participation of the population in health-related decision making at the national and community levels.[490] Access to information equips women with better practical reason, a central capability of the capabilities approach. Nussbaum argues that the core idea is that a human being should be able to shape her own life rather than be pushed passively by the world.[491]

[488] Article 16 UDHR.

[489] Article 19 UDHR.

[490] WHO, OHCHR 'The right to health' Fact sheet 31 pages 3-4.

[491] Nussbaum M 'Women and equality: The capabilities approach' (1999)234.

At the global level, the right to information is protected by the ICCPR.[492] Women's right to access specific educational information, including information and advice on family planning, is provided for in Article 10 of CEDAW.[493] The connection between the right to information and maternal health is elaborated by the CEDAW Committee, which has stated that low access to family planning services and information heightens women's and ,adolescent girls' susceptibility to maternal mortality.[494] CESCR General Comment No. 22 recommends that statesrepeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or groups to sexual and reproductive health facilities, services, goods and information.[495] In addition, CEDAW Article 10 specifies that women's right to education includes access to specific educational information to help ensure families' health and well-being, including information and advice on family planning. In the same vein, Durojaye argues that a strong correlation exists between adolescent girls' literacy and SRHR.[496] Literacy facilitates access to SRHR information and can help to reduce early pregnancies, STIs, HIV and early marriage, especially in rural areas where adolescent-friendly services are not easily accessible.[497] CEDAW General Recommendation No.24 recommends that states should prioritise the prevention of unwanted pregnancy through family planning and sex education.[498]

In the case of *I.V v Bolivia*[499] , the Inter-American Court of Human Rights considered that the right of access to information and informed consent are essential

[492] Article 19(2) ICCPR.

[493] Article 10(h) CEDAW .

[494] Concluding Observations of the Human Rights Committee on Kenya, para 14 UN Doc CCPR/Co/83 KEN (2005)

[495] General Comment No. 22 paragraph 49(a).

[496] Durojaye E 'Access to contraception for adolescents in Africa: A human rights challenge' (2011) 44(1) *Comparative and International Law Journal of Southern Africa* 1–29; Government of Zimbabwe *Demographic Health Survey* (2015) 76.

[497] Maziwisa (2021)70.

[498] CEDAW General Recommendation 24 (1999) on women and health, para. 31(c).

[499] *I.V v Bolivia* Case 12.655/2016.

instruments to ensure other rights such as personal integrity, autonomy, sexual and reproductive health, the right to decide freely on maternity and to raise a family, as well as to give free and informed consent to any measure that may affect one's reproductive capacity and that these are all interrelated rights.[500] The court elaborated on the right to access to information as a right of a patient to receive comprehensible information to enable her to make free well-informed decisions, on the most intimate aspects of her health, body and personality and the corresponding duty of the state to obtain her consent prior to any health procedure.[501] The Inter-American Court of Human Rights held Bolivia responsible for the forced sterilisation of a Peruvian refugee. Furthermore, Bolivia was found internationally responsible for the violation of the rights to personal integrity, personal freedom, dignity, private and family life, access to information and founding a family.[502] Nussbaum's capabilities approach points out that human beings deserve human dignity and respect from laws and social institutions.

In order to protect women and girls from health risks associated with unsafe abortions, the Human Rights Committee urges state parties to ensure access to quality and evidence-based information and education about sexual and reproductive health.[503] Additionally, the Committee on the Rights of the Child has explained that family planning services should be situated within comprehensive sexual and reproductive and health services and should encompass sexuality education, including counselling.[504] However, this is against the background of the

[500] *I.V v Bolivia* (2016) Page 36.

[501] *I.V v Bolivia* (2016) Page 36

[502] See the Inter-American Court of human rights judgement in the case of *I.V v Bolivia* (2016)1-131: Preliminary objections, reparations and costs available at *https://www.corteidh.or.cr/docs/casos/articulos/seriec_329_ing.pdf* Accessed on 17 September 2021.

[503] General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights on the right to life para 8.

[504] General comment No. 15 (2013) on the right of the child to the highest attainable standard of health para 69.

reality of adolescent sexual activity, as enunciated by Justice Amy Tsanga in the Zimbabwean case of *Masuku*.[505] The Judge in the Masuku case noted that ignoring the reality of consensual sex among teenagers and adopting a formalist approach to the crime consequently results in a punitive sentence, a criminal record and stigmatisation of a teenager as an offender.[506]

Cook reiterates that the role of information is to contribute to the individual's liberty to choose whether or not to accept a proposed form of management. She further elaborates that information for the exercise of choice normally includes a fair description of the form of management proposed, fair descriptions of alternatives to what is proposed, the known outcomes of each management option, the risks associated with each option and the likely effect of each form of management on the individual's lifestyle.[507] The right to informed choice in health services, self-help and preventive health care is related to rights to education and literacy information and freedom of thought and association.[508] Therefore, Zimbabwe, as a state party to CEDAW and ICESCR, must eliminate any barriers that inhibit women's access to family planning information.

Regionally the right to general information linked to freedom of expression is guaranteed by the African Charter in Article 9(1). However, there is silence on the specific provision of reproductive health information, or education save to say reproductive information is inferred from health rights in Article 16, as well as adequate and affordable reproductive services in Article 14 of the ACHPR. Article 14 of the African Women's Protocol enjoins state parties to ensure the provision of adequate, affordable, and accessible health services, including information, education, and communication programmes to women, especially those in rural areas. This study argues that failure to provide women and girls access to reproductive health information in humanitarian emergencies increases chances of

[505] ZWHHC (2015) 106, CRB B467/14 (High Court of Zimbabwe).

[506] ZWHHC (2015)107.

[507] Cook (1994)25-26.

[508] Cook (1994)25.

maternal mortality and disability and constitutes a violation of already stated interrelated rights.

Articles 14(1) (e-g) entails the provision of comprehensive information and family planning education. The right to be informed of one's status and that of their partner capacitates women to make decisions based on informed consent. Furthermore, Articles 14(1) (d) (e) oblige states to respect, promote, protect and fulfil women's rights in the context of HIV,[509] an important consideration during humanitarian emergencies. Ultimately, what is important is that access to reproductive health information capacitates a woman to lead the kind of life she would like to lead, do what she wants to do and be the person she wants to be, as affirmed by the capabilities approach.

3.3.5 Right to life

Although originally, the International Covenant on Civil and Political Rights ICCPR was adopted to protect and promote 'civil and political rights' such as the right to life, the right to be free from arbitrary detention and torture, the right to free expression, it has provisions that General Comments have elaborated to include protection of women's reproductive rights.[510] ICCPR provides for the right to life[511] , which has been clarified by the Human Rights Committee[512] General Comment

[509] Durojaye (2013)413.

[510] Sithole (2020)61.

[511] Article 6 ICCPR.

[512]OHCHR 'Human Rights Committee' available at *https://www.ohchr.org/en/hrbodies/ccpr/pages/ccprindex.aspx* (accessed on 12 September 2021. The Human Rights Committee is the body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights by its State parties.

No. 36[513] as a supreme right which has crucial importance for individuals and society as a whole and whose adequate protection is the prerequisite for the enjoyment of all other human rights.[514] The leading case of *Alyne v Brazil* [515] marks the first decision of an international treaty body holding a government accountable for a preventable maternal death.[516] The case is instrumental in recognising women's right to safe motherhood, access to essential health services without discrimination and the right to life itself. *Alyne v Brazil* concerned the death of a rural indigenous Afro-Brazilian woman during childbirth due to a lack of quality and timely maternal healthcare. Apart from extinguishing the life out of women, preventable maternal mortality is a form and an indicator of discrimination against women, for it deprives them of their right to live a healthy life on the basis of equality with men.[517] The capabilities approach lists life as one of the central capabilities used to assess quality-of-life.

The CEDAW Committee established that the right to life is violated whenever women are denied access to quality healthcare services because 'the lack of appropriate maternal health services has a differential impact on women's right to life.'[518] *Alyne*'s case, by extension, enjoins states to ensure women in humanitarian emergencies have timely access to quality health services during pregnancy and delivery to guarantee the right to life. Thus, during Cyclone Idai, this would entail

[513]UN Human Rights Committee (HRC), *General comment no. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35, available at: *https://www.refworld.org/docid/5e5e75e04.html* (accessed 17 October 2021).

[514]UN Human Rights Committee (HRC), *General comment no. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35, available at: *https://www.refworld.org/docid/5e5e75e04.html* (accessed 12 September 2021).

[515] CEDAW Committee Communication No. 17/2008.

[516] Cook R 'Human Rights and maternal health: Exploring the effectiveness of the *Alyne* decision' (2013)103.

[517] Centre for Reproductive Health 'Alyne v. Brazil' available *at https://reproductiverights.org/wp-content/uploads/2018/08/LAC_Alyne_Factsheet.pd* (accessed on 17 September 2021).

[518] CEDAW Committee Communication No. 17/2008 paragraph 7:6.

the timeous deployment of skilled health professionals, pre-natal and post-natal facilities and medicine as referral systems would have likely been destroyed.

The Human Rights Committee has interpreted existing global human rights standards to guarantee a women's right to safe and legal abortion, under certain circumstances, as entailing guaranteed rights to equality, non-discrimination, life, liberty, security of the person and the highest attainable standard of health.[519] Human Rights Committee General Comment No. 36 has called on state parties to ensure that measures designed to regulate voluntary terminations of pregnancy must not result in violation of the right to life as follows:

> "Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives."[520]

CEDAW Committee has stated that maternal mortality due to unsafe abortion is a violation of women's right to life. It is widely acknowledged that in countries in which abortion is restricted by law, women seek abortions clandestinely, often under conditions that are medically unsafe and, therefore life-threatening.[521] Criminalizing abortions encourages adolescent girls to resort to unsafe abortions in the event of unwanted pregnancies or contraceptive failure.[522] State parties have a positive duty to protect young people's right to life and from 'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.'[523] Article 9 (1) ICCPR, read with Article 19 UNCRC, shows that lack of access to contraception-related information, education

[519]Obadina I 'Addressing maternal mortality through decriminalizing abortion in Nigeria Asking the 'woman question' in Durojaye E et al (*eds*) 'Advancing sexual and reproductive health and rights in Africa: constraints and opportunities' (2021)39-40.

[520] General Comment No. 36 paragraph 8

[521] Centre for Reproductive Rights 'Safe and Legal Abortion is a woman's right' (2011)1.

[522] Maziwisa (2021)70.

[523] IPPF 'Understanding young people's right to decide. Why it is important to develop capacities for autonomous decision making' (2012)8.

and services and denial of abortion violate adolescent girls' rights to liberty and security of the person.[524]

Special Procedures of the Human Rights Council reiterate that treaty jurisprudence indicates that denying women access to abortion in certain circumstances can result in violations of the rights to health and privacy. They have also raised concerns about the enjoyment of the right to life for women who are denied safe abortion services and may put their lives at risk.[525]Furthermore, restrictions on abortion rights constitute a violation of the notion of bodily integrity as per the capabilities approach. In its Concluding Observations to Kyrgyzstan, the CRC Committee expressed concern at the high and increasing rate of teenage pregnancies and the consequently high rates of abortions among girls under 18. The Committee noted that several factors, including limited availability of contraceptives, poor reproductive health education and the requirements of parental consent, have resulted in an increasing number of illegal abortions among girls.[526]

The landmark case of *K.L v Peru*[527] concerned a 17-year-old whose pregnancy complications exposed her to a life-threatening risk. When she decided to terminate her pregnancy due to a lack of clear regulations, she was denied that request. She suffered severe depression as a result. The Human Rights Committee found that in denying her the choice to abort, *Peru* had violated a range of her rights as an adolescent under national as well as several provisions of the ICCPR, including, among others, provisions on to the right to be free from cruel, inhumane, and

[524]Kangaude G & Skelton A 'Decriminalizing adolescent sex: A rights-based assessment of age of consent laws in Eastern and Southern Africa' (2018) available at *https://journals.sagepub.com/doi/full/10.1177/2158244018806036* (accessed on 16 September 2021).

[525] OHCHR petition number ADI/ADPF 5581 by mandate holders to Honourable Madame Justice Ministra Cármen Lúcia.

[526] United Nations Committee on the Rights of the Child, *Concluding Observations: Kyrgyzstan*, 24th Session, Para. 45 UN Doc. CRC/C/15/Add.127 (2000).

[527] CCPR/C/85/D/1153/2003.

degrading treatment (Article 7), privacy (Article 17), and special measures of protection for minors (Article 24). The CEDAW Committee has also urged Zimbabwe to liberalize and decriminalize abortion, considering its contribution to maternal mortality, as they violate the right to life of most of the victims.[528] The outcome of the landmark case relates to reproductive health and rights of not only women in Peru but worldwide. Zimbabwe, as a state party to the ICCPR and other related treaties, has an obligation to ensure that rural women and girls have access to safe, legal, and effective abortions, even in humanitarian emergencies, to preserve life. A restriction on choices is a restriction on capabilities as well as the central issue of choice, as raised by radical African feminism.

Ngwena argues that one of the consequences of unmet contraception needs is a commensurately high rate of unintended pregnancies, including adolescent pregnancies. Women and girls with unintended pregnancies resort to unsafe abortion resulting in a higher rate of maternal mortality and morbidity.[529] An estimated 6.2 million women have unsafe abortions in the African region. Women from sub-Saharan Africa constitute the highest incidence of deaths at 62 per cent (29,000) from unsafe abortion.[530] Upon this realisation, the African Women's Protocol is an important milestone as the first human rights treaty to recognize abortion as a discrete and substantive human right expressly.[531] In the same vein, Durojaye and Murungi state as follows:

> "For the first time in the history of any human rights instruments, the Protocol contains provisions relating to the sexual and reproductive health

[528] Obadina I 'Addressing maternal mortality through decriminalising abortion in Nigeria' in Durojaye et al (eds) 'Advancing sexual and reproductive health and rights in Africa' (2021)39-40.

[529] Ngwena (2014)2.

[530] World Health Organization 'Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008' (2011) 27.

[531] Ngwena (2014)2.

and rights of women, protects women's rights in the context of HIV, and allows for abortion on limited grounds."[532]

Nabaneh argues that General Comment No. 2 is critical for ensuring access to safe and timely legal abortion.[533] General comment No. 2 obligates State Parties to ensure that relevant legislation guarantees are in place to ensure that no woman is forced to undergo an abortion, emphasizing that the use of family planning/contraception and safe abortion services by women should be done with their own informed and voluntary consent. [534] Nabaneh posits that, in particular, the African Commission sends a clear message to African states that permit conscientious objection to abortion that they must establish and implement effective regulatory framework so as to guarantee that such refusals do not undermine women's access to legal abortion services.[535] Although Article 14(2) of the African Women's Protocol appears to undo Article 14(1) by specifying abortion on limited grounds,[536] it imposes an obligation on Zimbabwe as a member state to provide for safe abortion during humanitarian emergencies in order to preserve life.

Although the African Women's Protocol is a regional instrument, its potential is highly significant as it goes beyond the African continent.[537]It affirms women's reproductive choice and autonomy to make sexual and reproductive decisions, right to family planning education and services, and right to abortion when pregnancy results from a sexual assault, incest, rape or when a pregnant woman's life is in

[532] Durojaye E & Murungi LN 'The African Women's Protocol and sexual rights' (2014)881.

[533] Nabaneh S 'Abortion and conscientious objection in South Africa: The need for regulation' in Durojaye et al (eds) 'Advancing sexual and reproductive health and rights in Africa' (2021)21

[534] 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 47.

[535] Nabaneh (2021)21.

[536] Gonese -Manjonjo T & Durojaye E 'Lessons from litigating for sexual and reproductive health and rights in Southern Africa' in Durojaye et al (eds) 'Advancing sexual and reproductive health and rights in Africa' (2021)195.

[537] Durojaye & Murungi (2014)886.

imminent danger.[538] General Comment No. 3 on the ACHPR on the right to life as recognised in Article 4 of the ACHPR affirms the positive obligations of states to prevent loss of life in the context of SRHR. Similarly, Article 4 of the African Women's Protocol and Articles 5 and 30 of the African Charter on the Rights and Welfare of the Child (ACRWC) protect the right to life. Considering the linkage between unsafe abortions and high mortality rates, restrictive laws that leave women no choice but to resort to unsafe abortion procedures violate women's right to life. Removal of barriers which interfere with women's access to life-saving family planning services during humanitarian emergencies fulfils respect for their right to preventable maternal mortality, integrity, and dignity. Living to the end of a human life without dying prematurely or having one's life unnecessarily reduced to be not worth living is the foremost central capability as posited by the capabilities approach.[539] This study observes that a guarantee of the right to life is a precursor to exercising other central human capabilities which gives a woman a dignified life.

3.3.6 International and regional special procedures mandate

One important mechanism in the United Nations is the Human Rights Council, an inter-governmental body responsible for strengthening the promotion and protection of human rights around the globe and addressing situations of human rights violations and making recommendations on them.[540] The Human Rights Council was created by the United Nations General Assembly on 15 March 2006 by resolution 60/251. The Human Rights Council works through procedures and mechanisms.

Of importance in Human Rights Council is the United Nations Special Procedures established by the former Commission on Human Rights and now assumed by the

[538] See Articles 14(1)(2).

[539] Nussbaum (2000)78.

[540] United Nations OHCHR 'Welcome to the Human Rights Council' available at *https://www.ohchr.org/EN/HRBodies/HRC/Pages/AboutCouncil.aspx* accessed on 9 September 2021.

Council. Special Procedures Special rapporteurs, special representatives, independent experts and working groups monitor, examine, advise, and publicly report on thematic issues or human rights situations in specific countries.[541] In 2020 the Human Rights Council adopted by consensus a resolution titled 'Promoting, Protecting and Respecting Women's and Girls' full enjoyment of human rights in humanitarian situations. The Human Rights Council added a voice to the recognition of women in humanitarian emergencies' reproductive rights as follows:

> "All women and girls in humanitarian settings urgently need sexual and reproductive health care and services. The provision of sexual and reproductive health information and services is a crucial component of rehabilitation and reparations for victims and survivors and should not be overlooked."[542]

Of particular relevance to SRHR are the Special Rapporteur on the Right of Everyone to Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Special Rapporteur on Violence against Women, Its Causes and Consequences. Their reports provide valuable guidance on the application of various rights to individual cases.[543] In her report, The Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, she calls for state party commitment to ensuring universal access to sexual and reproductive health care and universal health coverage. Synergies between the right to health and underlying social determinants

[541] United Nations OHCHR.

[542] Centre for reproductive health 'Centre applauds UN's adoption of landmark resolution on women and girls' rights in humanitarian settings. Available at' *https://reproductiverights.org/center-applauds-uns-adoption-of-landmark-resolution-on-womens-and-girls-human-rights-in-humanitarian-situations/ (* accessed on 9 September 2021).

[543] Southern African Litigation Centre (SALC) 'Dismantling the gender gap: Litigating cases involving violations of sexual and reproductive health' (2013)22.

are spelt out in the Special Rapporteur report.[544] Related to this study, the correlation between the right to health and women's family planning services is articulated in paragraph 17 of the 2016 Special Rapporteur's report as follows:

> "The right to health requires health-care goods, services and facilities be available in adequate numbers; financially and geographically accessible, as well as accessible on the basis of non-discrimination; acceptable, that is, respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements; and of good quality. "[545]

Humanitarian emergencies are likely to aggravate women's vulnerability to ill health.This juxtaposed with the concern raised for women in conflict situations as expressed in the Special Rapporteur's 2013 report to the General Assembly, whose focus is on the right to health in conflict situations.[546] This study notes that during crises, poor health outcomes among women are attributed to a lack of availability of quality reproductive and maternal care, such as family planning, emergency obstetric services, and pre-and post-natal care. In addition, special procedures acknowledge that mass displacement, breakdown of community and family networks, and institutional collapse may create a vacuum in which women and young girls are vulnerable to sexual violence. This has seen recognition of women's right to psychosocial counselling during traumatic experiences which impact their reproductive rights.[547] This underscores the right to well-being as propounded by the capabilities approach.

[544] United Nations General Assembly 'Report of the Special Rapporteur on the right to the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2016)4-5 submitted in accordance with Human Rights Council Resolutions 6/29 24/6.

[545] Report of the Special Rapporteur on the right to the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2016)6.

[546] United Nations General Assembly 'Report of the special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2013) submitted in accordance with Human Rights Council resolutions 6/29 and 15/22.

[547] Special Rapporteur report (2013)14-15 Paragraph 45.

Regionally, The Special Rapporteur on the Rights of Women in Africa (SRRWA) is an important subsidiary mechanism created by the African Commission on Human and People's Rights.[548] What necessitated the establishment of this mechanism in Africa was the need to address deep cultural practices and the patriarchal nature of African societies, which tended to relegate women's rights to the background and treated them as second-class citizens who were confined to the role of child bearers.[549] The redress of women's subordinate category is aligned with radical African feminism, which seeks to eliminate male privilege and domination, which results in discrimination against women in private and public life. Male domination, if allowed to permeate to humanitarian emergencies, forms the root of oppression, inequality, and injustice and curtails women's access to reproductive rights, thus constituting a violation of human rights.

Key to this study are resolutions which concern access to life-saving medications in the context of HIV[550] and the need for African governments to adopt a right-based approach to maternal mortality.[551] These resolutions are of significance to the reproductive rights of women in humanitarian emergencies, particularly in Zimbabwe, where women continue to die during childbirth due to a lack of access to quality health services[552] Furthermore, Resolution 283 of the ACHPR on the situation of women and children in armed conflict[553] speaks to the situation of women in humanitarian emergencies. In line with this resolution, states are called

[548] Durojaye E The special rapporteur on the rights of women in Africa (SRRWA) 2007-2015' (2018)1.

[549] Durojaye (2018)1.

[550] ACHPR/Res.141 (XXXXIIII) 08: Resolution on access to health and needed medicines in Africa.

[551] ACHPR/Res.135XXXXIV (08135) Resolution on maternal mortality in Africa.

[552] UNFPA Zimbabwe 'Sexual and reproductive health' available *https://zimbabwe.unfpa.org/en.topics/sexual-reproductive-health-5 (*accessed on 18 September 2021). Maternal mortality in Zimbabwe currently stands at 614 deaths per 100,000 live births, one of the highest maternal mortality rates worldwide.

[553] African Commission on Human and People's rights Resolution on the situation of women and children in armed conflict ACHPR/Res.283 (LV)2014 available *htpps://achpr.org/sessions/resolutions?id+=330* (accessed on 7 November 2021).

to uphold women's rights and ensure that survivors of armed conflict receive affordable and accessible healthcare services, including sexual and reproductive health. Although Resolution 283 is focused on women and children in armed conflict, the circumstances pertaining to such crisis situations resemble that of any other humanitarian emergency. What is striking about this resolution is that it is comprehensive in providing for pertinent issues key to women's rights. It calls for the ratification of key instruments and the effective implementation of the African Charter on the Rights and Welfare of the Child, The African Women's Protocol, the Convention on the Elimination of All Forms of Discrimination against Women as well as other regional and international human rights instruments that protect women and children's rights.

Zimbabwe has one of the highest HIV prevalences where women are disproportionately affected by HIV compared to men.[554] The SRRWA's jurisprudence goes beyond addressing the scientific reasons for women's death during childbirth to raising attention to issues such as the low status of women and socio-cultural reasons which have a bearing in aggravating maternal death in Africa.[555] A significant regional mechanism for women's reproductive rights is the Committee on the Protection of the Rights of People Living With HIV (PLHIV) and those at Risk, Vulnerable to and Affected by HIV.[556] Among other duties, this Committee is mandated to engage state parties around their obligations to respect, protect and fulfil the rights of people living with HIV and those at risk. This mechanism could prove helpful in conscientizing the government of Zimbabwe of its responsibilities towards women living with HIV who were affected by Cyclone

[554] 'HIV and AIDS in Zimbabwe' available *at https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe* (accessed on 18 September 2021).

[555] Durojaye (2018)3.

[556] The Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV was established by the African Commission on Human and Peoples' Rights with the adoption of Resolution 163 at the 47th Ordinary Session held in Banjul, The Gambia in May 2010. Available at *https://www.achpr.org/specialmechanisms/detail?id=15* (accessed on 22 October 2021).

Idai and raising awareness on their family planning and other reproductive needs. Since 1995, The African Commission has introduced special procedures because of the urgency of some human rights issues. In addition, the Special Rapporteur on Human Rights defenders in Africa was introduced on the initiative of civil society to design appropriate strategies for human rights challenges on the continent.[557]

Although its focus is on the human rights of human rights defenders, the body's input is crucial to inform the African Commission on creating synergies in the response to women's reproductive rights needs in humanitarian emergencies in Africa. Furthermore, the mechanism represents human rights defenders who might be providers of response in humanitarian situations such as Cyclones and hence its ability to collaborate with humanitarian agencies, state actors, and National Human Rights Institutions among key stakeholders who have a bearing on ensuring women's access family planning services as a matter of priority during humanitarian emergencies.

This study observes that women accorded their reproductive rights have a high probability of living fulfilled lives and achieving well– as posited by the capabilities approach. This is important for human development and focuses on the expansion of real freedoms that accumulate due to good health. Health is central to poverty reduction, and development becomes a precursor to the realisation of poverty alleviation, gender equality and women's development as postulated by the capabilities approach. Furthermore, the relegation of obligatory motherhood through reproductive autonomy and agency becomes foundational to the enjoyment of other human rights as enunciated by radical African feminism. Of particular significance to this study is that the Special procedures mandate pays special attention to the reproductive rights of groups in vulnerable and marginalised situations and applies a gender perspective.

[557] African Commission on Human and People's Rights 'Report on the implementation of the mandate of the special rapporteur on human rights defenders in Africa of the African commission on human and peoples' rights' 52nd Ordinary session (2012)6-7.

3.4 CONCLUSION

This chapter presented the historical development of women's reproductive rights emanating from the women's and population movements. Through the evolution of reproductive rights, women were affirmed as beings with the power to control and make decisions concerning their bodies, sexuality and reproductive life. This historical development of reproductive rights provides an insight into the tenets of the capabilities approach as well as radical African feminism from how women-built confidence to speak out on their issues.

The chapter also demonstrated that women's well-being is directly related to empowerment and development. The chapter demonstrated that the provision of tailored family planning services for women in humanitarian settings fulfils substantive equality as called for by radical African feminism. An analysis of case law in the chapter is particularly important for the recognition of women's rights to safe motherhood and access to quality essential health services without discrimination.

The chapter noted that the realisation of women's family planning rights in emergencies accords their dignity as advocated for by the capabilities approach. It further enhances their capabilities, thus empowering them to claim their rights in the face of violation. The Chapter traced the evolution of women's reproductive rights through international conferences, programmes, and policies. Key elements of reproductive health, namely the rights to health, life, family planning, equality and non-discrimination, and reproductive information, were expounded. In addition, the chapter discussed the significance of the international and regional Special procedures mandate in developing norms and standards to protect and promote women's reproductive rights.

An analysis of international and regional treaties demonstrated that while some do not specifically provide for reproductive rights and services in humanitarianemergencies, their broad provisions can be interpreted to cover

women's access to family planning information and services. The next chapter discusses Zimbabwe's laws, policies and programmes and their adequacy and consistency in fulfilling state obligations emanating from international and regional norms and standards on women's reproductive rights.

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CHAPTER 4: AN ANALYSIS OF ZIMBABWE'S LAWS, POLICIES AND PROGRAMMES ON WOMEN'S FAMILY INFORMATION AND SERVICES

4.1 INTRODUCTION

The previous chapter discussed the international and regional norms and standards on women's access to family planning services during humanitarian emergencies. This Chapter seeks to answer the question: Are Zimbabwe's laws, policies, and programmes adequate and in compliance with its international obligations to advance women's reproductive rights particularly family planning services during humanitarian emergencies.?

When answering the question posed for this chapter, one does so with the awareness that Zimbabwe has ratified and domesticated relevant provisions of international and regional treaties which guarantee women's reproductive rights through its Constitution and other laws. Domestication entails incorporation of provisions of a treaty into the laws of a country to give it force of law in that jurisdiction.[558] Domestication matters to a country because it enhances the chances of citizens getting practical benefits from treaties. Legal codification of international human rights standards into domestic law is pivotal for ensuring the respect, protection and fulfilment of accessing reproductive healthcare.[559] Legal codification can be done through a dualism or monist approach. These two approaches elaborate on how international law becomes part of the domestic law of a country. Zimbabwe endorses the dualist approach which entails that international law does not automatically become part of domestic law unless it has been incorporated. Incorporation means that a state gives consent for a particular legal norm to become part of its law.[560] One notes that dualism affords local institutions control over the scope and ambit of their obligations at international law and allows domestic scrutiny before international law is subscribed to.

[558] UNDP 'Accelerating the Ratification, Domestication, and Implementation of African Union Treaties Project April 2021 – March 2023

[559] Sithole (2021)97.

[560] Thilakarathna K & Jayarathna N 'Theories involved in recognising and implementing international law in domestic contexts'(2021)83.

Through an interrogation of Zimbabwe's laws, policies and programmes for their adequacy to advance women's family planning services during humanitarian emergencies, the chapter further exposes the legal and practical challenges that women encounter in accessing family planning services.

This chapter discusses state obligations, the concept of 'minimum core' and the notion of 'progressive realisation'. It is important to elaborate on these aspects because they lay a yardstick with regard to the normative content useful for the evaluation of state adherence to international and regional norms and standards, which are spelt out in Chapter 3. Such a discussion gives an impetus to an assessment of whether Zimbabwe, through law and in practice, is in compliance with its obligations to ensure women's access to reproductive services during humanitarian emergencies.

International human rights law imposes three levels or types of obligations: the obligations to respect, protect and fulfil human rights.[561] Relatedly, a discussion on state obligations in this chapter would be incomplete if one does not elaborate on the essential elements of the right to sexual and reproductive health, namely accessibility, acceptability, affordability, availability and quality. The next section focuses on a discussion of state obligations.

4.2 State Obligations

States' responsibility to implement human rights arises from the 'tripartite tripology' introduced by Henry Shue and developed by Asbjørn Eide, who acted as the UN's Special Rapporteur for Food during the early 1980s. State responsibility for human rights can be examined at three levels: the obligation to respect, the obligation to protect and the obligation to fulfil human rights. The state's role has been referred to as 'double faced' as it must, on the one hand, respect human rights constraints and limitations and, on the other hand, is obliged to be active in its role

[561] Shue H 'Basic Rights: Subsistence, Affluence and U.S. Foreign Policy'2nd Ed (1980) 52.

as the protector and provider.[562] Shue argues that all rights impose obligations on states, firstly, to avoid depriving citizens of existing enjoyment of rights, secondly, to protect them from violations of their rights by third parties and thirdly, to aid the deprived.[563]

Throughout the United Nations Charter, there is an elaborate language of state responsibility in terms of international and social cooperation, reiterated in Articles 55 and 56.[564] Articles 2 and 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) buttress the basis for state obligations in relation to economic, social and cultural rights. The Limburg Principles discuss the nature and scope of state obligations, clarify the need for state parties' good faith in fulfilling the ICESCR obligations and their accountability and compliance under the Covenant.[565] Elaborating on state obligations towards economic, social, and cultural rights, the Maastricht Guidelines provide as follows:

> "It is no longer taken for granted that the realization of economic, social, and cultural rights depends significantly on action by the state, although, as a matter of international law, the state remains ultimately responsible for guaranteeing the realization of these rights."[566]

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has clarified that states have clear obligations under current human rights standards to ensure respect for and

[562] United Nations Economic and Social Council: Report on the right to adequate food as a human right submitted by Special Rapporteur Mr Asbjørn Eide E/CN/4.Sub. 2/1987/23 (1987)15 para 70.

[563] Shue H (1980) 52.

[564] United Nations Charter available on *https://treaties.un.org/doc/Publication/CTC/uncharter.pdf (Accessed on 26 February 2022).*

[565] UN Commission on Human Rights, Note verbale dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ("Limburg Principles"), 8 January 1987, E/CN.4/1987/17, available at: *https://www.refworld.org/docid/48abd5790.html* (accessed 13 February 2022) 7-10.

[566] Maastricht Guidelines on violations of economic, social, and cultural rights (1997) para 2.

protection and fulfilment of sexual and reproductive health rights even during the COVID-19 pandemic.[567] Significant to this study is that the Special Rapporteur demonstrates that even during humanitarian crises, states are not exempt from their duties towards women's reproductive rights. CESCR General Comment No 22, and CESCR General Comment No. 14 provide general and specific legal obligations towards protecting, respecting, and fulfilling sexual and reproductive health rights.

4.2.1 Obligation to respect

The obligation to respect requires that the state, all its organs and agents, refrain from doing anything that violates the integrity of the individual or infringes on her or his freedom.[568] In the context of this study, the obligation to respect requires that:

> "States refrain from direct or indirect interference with women's exercise of reproductive rights including through reforming laws that impede the right to sexual and reproductive health, for example 'laws criminalizing abortion, non-disclosure of HIV status, exposure to and transmission of HIV, consensual sexual activities between adults and transgender identity or expression."[569]

The CEDAW Committee has recognised that during the Covid pandemic period, sexual and reproductive health and rights are an essential service to which states have a clear obligation to respect.[570] In the same vein, respect for women's access to family planning services is of utmost importance during other humanitarian

[567] UN Human Rights Council, Report of The Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health 76th Session (2021) paras 22, 23.

[568] Eide A (1987)14.

[569] Report of The Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health 76th Session (2021) para 22.

[570] Report of The Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health 76th Session (2021) para 23.

emergencies.[571] CESCR General Comment No. 22 states that the obligation to respect entails that there be no restrictions on the right of individuals to access information about sexual and reproductive health as it is likely to fuel stigma and discrimination.[572] The African Commission on Human and People's Rights' interpretation is that the state has to respect the freedom of individuals and people to use all of the resources at their disposal to meet their economic, social and cultural needs and obligations.[573] Thus when disaster struck in Chipinge and Chimanimani districts, it is expected that the government of Zimbabwe timeously allocate emergency funding to meet women's family planning services needs in terms of its obligations since family planning is identified as an essential service.

Furthermore, in the context of humanitarian emergencies, the state is obliged to ensure that all branches of government involved in humanitarian response (legislative, executive, and judicial) at all levels (national, regional, and local), as well as all organs of state, do not violate economic, social, and cultural rights. One can argue that a common aspect of radical African feminism is the belief that strategies can be formulated to make the world a better place for women's needs in any context. States can achieve this through meeting their obligation to respect in relation to reproductive health.

[571]Barriers to access sexual and reproductive health and rights include third-party authorization requirements, such as parental, spousal and judicial authorization requirements for access to sexual and reproductive health services and information, including for abortion and contraception; biased counselling and mandatory waiting periods for divorce, remarriage or access to abortion services; mandatory HIV testing; and the exclusion of particular sexual and reproductive health services from public funding or foreign assistance funds.

[572] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 22 paras 40-41.

[573] African Commission on Human and People's rights 'Principles and guidelines on the implementation of economic, social, and cultural rights in the African Charter on Human and Peoples' Rights '(2010) 11 paras 5-6 available *at https://www.achpr.org/public/Document/file/English/achpr_instr_guide_draft_esc_rights_eng.pdf* (Accessed on 16 November 2021).

Respect for women's reproductive rights during humanitarian emergencies ensures that women have access to substantial freedoms which enable them to access information, opportunities and ultimately, an improvement in the quality of life as envisaged by the capabilities approach. Thus, in line with the capabilities approach, the obligation to respect entails that the state ought to refrain from interference with women's personal reproductive choices and decisions concerning their bodies during humanitarian emergencies. This resonates with the notion of the dignity version of the capabilities approach, which calls for a respect of the inherent worth of a human being.

4.2.2 Obligation to protect

The obligation to protect entails that states must put in place measures to prevent third parties from directly or indirectly interfering with the enjoyment of the right to sexual and reproductive health.[574] States are responsible for ensuring equal access to health care and health-related services provided by third parties; ensuring that the "availability, accessibility, acceptability and quality" of health facilities, goods and services are not threatened by the privatisation of health services; ensuring there is state control of the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals are endowed with appropriate standards of education, skill and ethical codes of conduct.[575]

Of particular significance to this study is that through the obligation to protect, CESCR General Comment No.14 places a duty on states to eradicate harmful social and traditional practices that interfere with women's access to pre-natal and post-

[574] CESCR General Comment No. 22 (2016) para 42.

[575] 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)*, 11 August 2000, E/C.12/2000/4, (2000) para 35. available at: *https://www.refworld.org/docid/4538838d0.html* (accessed 12 February 2022).

natal care and family planning.[576] This study considers harmful practices as those that are perpetrated by third parties against women and girls. The capabilities approach raises an important dimension of capabilities being an interaction of internal and external factors. This study argues that the state has an obligation to protect women's reproductive rights through regulation of external factors which may violate access during humanitarian emergencies. Thus, the state is obligated to ensure the deconstruction of patriarchy and challenge third-party ideologies that suffocate women's access to their rights.

In 2019 it was reported that because of the prevalence of membership to the Apostolic sect in Mutare, Chipinge and Chimanimani, the Cyclone hit districts, there were fears of an increase in child marriages.[577] In 2021 the world was confronted by a story of a 14-year-old girl bride who, having been married off to a 26-year-old Hatirarame Momberume by her parents, died in childbirth at a church shrine because of her family's Apostolic church beliefs which refuse women access to healthcare services other than the services of their church birth attendants offered at shrines. Failure to prosecute this case and ensure justice prevails violates the obligation to protect women and girls from third parties' interference with their reproductive rights. Furthermore, failure by the state to decisively deal with such cases is tantamount to upholding the patriarchal beliefs of the apostolic sect, which view women as a group whose decisions can only be made and validated by men, entrenching women's inferiority.

What makes men who lead Apostolic churches in Zimbabwe dictate to women where to access reproductive services is the evil the state should strive to deal with when prosecuting cases before them. Judgements should spell out state obligations to protect women and girls from such situations. One notes that one major challenge with participation in faith and religion is voluntary, and the state can only regulate

[576] CESCR General Comment No.14 (2000) para 35.

[577] CARE (2019)10. The report states that the Apostolic sect are known for practicing child marriages. Girls' vulnerability was heightened because of disruption of the school system.

what is presented especially in the courts, otherwise, most of what happens in private persists undetected.

Child marriage is a form of violence and discrimination against women.[578] The persistence of child marriages in Africa has resulted in the Joint General Comment on ending child marriage[579] which is inspired by the interrelatedness of women's and children's rights. Article 6 of the Maputo Protocol and Article 21(2) of the African Children's Charter prohibit child marriage. Radical African feminism, which informs this study represents voices that take a stand against all forms of violence against women and girls.

4.2.3 Obligation to fulfil

The obligation to fulfil has been described as the most proactive of the three obligations, requiring states to adopt measures to fully realise the right to sexual and reproductive health.[580] As an example, in order to fulfil reproductive rights, a state must adopt a National Health Policy encompassing public and private sectors, ensure equal access to social determinants of the right to health, ensure that public health institutions provide sexual and reproductive health services, ensure that there are qualified and sufficiently trained medical personnel and that there is adequate public health infrastructure among others.[581] The hardships encountered by rural

[578]UNOHCHR 'Child and forced marriage, including in humanitarian settings' available at *https://www.ohchr.org/en/women/child-and-forced-marriage-including-humanitarian-settings* (accessed on 12 May 2023.), see also Girls not brides ' Why is child marriage a form of violence against women and girls?' available at *https://www.girlsnotbrides.org/articles/why-is-child-marriage-a-form-of-violence-against-women-and-girls/ (*accessed on 12 May 2023).

[579] Joint General Comment of the African Commission on Human and People's rights and the African Committee of experts on the rights and welfare of the child (ACERWC) on ending child marriage.

[580] Report of The Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health 76th Session (2021) para22.

[581] UN Office of the High Commissioner for Human Rights (OHCHR), *Fact Sheet No. 31, The Right to Health*, (2008) 27 available at: *https://www.refworld.org/docid/48625a742.html* (accessed 12 February 2022)

women in accessing family planning services are recognised in the formulation of CESCR General Comment No. 14 provisions as follows:

> "Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas."[582]

Pertinent to this study is that the obligation to fulfil encompasses the need to prioritise and give tailored attention to the rights of vulnerable groups in social and economic development.[583] This is an acknowledgement that although women are affected by the same health conditions as men, they experience them differently. In the African context, the prevalence of poverty and economic dependence by women see them as individuals of limited power and decision-making capacity hence lack of influence on social realities which impact their health.[584] In such instances, this study invokes CESCR General Comment No. 14 provisions which stipulate that the state obligation to fulfil entails that the state provides a specific right (in this case, the right to health) contained in the ICESCR when women are unable to for reasons beyond their control, to realize that right themselves by the means at their disposal. In such instances, the state is required to ensure that access to family planning services is maintained and restored even during and after humanitarian emergencies.[585]

In line with Sen's version of the capabilities approach, women who are economically dependent are constrained in terms of freedom. Thus, even during humanitarian emergencies, women of low economic status may not possess significant reproductive self-determination. This is because what they can achieve is influenced by economic opportunities, political liberties, social powers, and the enabling conditions of good health, basic education and the encouragement and

[582] CESCR General Comment No. 14 (2000) para 36.

[583] African Commission Principles and Guidelines on the implementation of economic, social, and cultural rights in the African Charter on Human and People's rights (2010)12.

[584] UN Office of the High Commissioner for Human Rights (OHCHR), *Fact Sheet No. 31, The Right to Health*, (2008)12.

[585] CESCR General Comment 14 (2000) para 37.

cultivation of initiatives[586] which may be limited in their context. The notion of economic agency, as explained by Nussbaum in the capabilities approach,opens up other possibilities for women and gives them self-worth and a sense of personal realisation.[587]

The obligation to fulfil requires evidence of results, hence states should be able to show the outcomes of their actions, not just their intentions. The obligation can be discussed in relation to the Zimbabwean case of *Mudzuru & Another v. Ministry of Justice, Legal & Parliamentary Affairs (N.O.) & Others*. The court held that the effect of Section 78(1) and 81(1) is that the right to enter into a marriage and to found a family is a preserve for a person who has attained 18 years of age and legally delayed for a person who has not attained 18 years of age. The court confirmed the inconsistency and invalidity of Section 22(1) of the Marriages Act with Section 78(1) of the Constitution for providing that a girl who has attained 16 years of age could marry. This case demonstrates that the government has a duty to strengthen its efforts for full and timely constitutional alignment of women's legislative agenda in order to harmonise legislation with the Constitution. It is well known that laws are interpreted by humans who design them, and there is no reason to cause delays that tramp reproductive justice. In order to meet this obligation, the state is supposed to allocate sufficient human, budgetary and other relevant resource allocation towards programmes, awareness campaigns, legislative reform, law and policy implementation and training aimed at ending child marriage.[588]

In the case of Kawenda v Minister of Justice, Legal and Parliamentary Affairs and 2 Others[589] appellants approached the Constitutional Court seeking a declaration of unconstitutionality of the criminal law which governs the age of consent in

[586] Amollo (2014)184.

[587] Nussbaum (1999)230.

[588] Para 45 Joint General Comment of the African Commission on Human and People's rights and the African Committee of experts on the rights and welfare of the child (ACERWC) on ending child marriage available at *https://achpr.org/public/Document/file/English/joint_gc_acerwc_achpr_ending_child_marriage_eng.pdf* (accessed on 10 December 2022).

[589] CCZ 11/21.

Zimbabwe. The court made reference to the *Mudzuru* case, which outlawed child marriage. The court found that the criminal law failed to protect all children between 16 and 18 from sexual exploitation and contradicted Section 81(1)(e) of the Constitution. The definition of a young person in Section 61 Criminal Codification Reform Act (Chapter 9:23 was found unconstitutional. Similarly, sections 70, 76, 83, and 86 were declared unconstitutional, and the Minister of Justice, Legal and Parliamentary Affairs was given 12 months to enact a law that protects all children from sexual exploitation in line with Section 81(1)(e) of the Constitution of Zimbabwe. The judge in the *Kawenda* case gave the government a timeframe of 12 months within which to enact laws to protect children who might be below 18 but above 16 years of age from sexual exploitation, thus directing them to fulfil their obligation through creating legislation. Since the 2013 Constitutional enactment, it had to be the court to remind the government to take such an important step. The state obligation to enact and enforce laws is reiterated in relation to the eradication of Violence Against Women (VAW) by the Special Rapporteur on the Rights of Women in Africa (SRRWA) in line with Article 4(2) of the African Charter.[590]

In its Concluding Observation of Norway, the Committee on the Elimination of Discrimination Against Women requested information on the steps Norway has taken to review its climate change and energy policies and others to ensure that they take into account the negative effects on women's rights.[591] The state duty to fulfil women's reproductive rights through positive action has been underscored by the CEDAW Committee in its Concluding observations to the Philippines and includes the elimination of the root causes of child marriages, vulnerability of women to the impact of disasters, harmonisation of laws with the CEDAW and the Magna Carta of Women.[592] The CEDAW Committee has also recommended that Indonesia

[590] Hon. Commissioner Janet Ramatoulie Sallah-Njie, Inter Session Activity report of the71st Ordinary Session of the African Commission on Human and Peoples' Rights (21 April –13 May) para 30.

[591] CEDAW 'Concluding observations on the 9th Periodic report on Norway' CEDAW/C/NOR/CO/9.

[592] CEDAW 'Concluding observations on the combined seventh and eighth periodic reports of the Philippines' CEDAW/C/PHL/CO/7-8. Throughout the Concluding observations there is

ensures women and girls have effective access to sexual and reproductive health and rights information and services, including for rural populations, through adoption of concrete time frames for repealing, adopting or enacting legislation which advances gender equality as well as women's sexual and reproductive health and rights.[593]

Advancing gender equality through legislation to ensure women's equal access to reproductive services at all times is in line with the capabilities approach's call for one's freedom, a principal factor towards one's initiative and social effectiveness. Further, in terms of the capabilities approach, the obligation to fulfil involves securing a threshold of central capabilities through assessing legal, policy and institutional adherence to fulfilling women's capabilities.

In its Concluding observations of Malawi, the African Commission recommends that in terms of Articles 5 and 6 concerning the elimination of harmful practices and marriage, the state party should employ practical and effective legal, policy and programmatic measures to end early, child and forced marriage.[594] Furthermore, the government of Malawi is directed to provide an update on the status of the Termination of Pregnancy Bill and reasons for the delay in its progression into a law. These recommendations are given to ensure compliance with its obligations to fulfil Article 14 of the African Women's Protocol. Moreover, eliminating harmful practices and child marriages resonates with the notion of substantive equality embedded in radical African feminism, which stands for remedying socio-cultural disadvantages imposed on women manifest through such suffocating practices.

recommendations for positive government action towards the legislative agenda and other actions towards the advancement of women's rights, including for women with disabilities.

[593] CEDAW 'Concluding observations on the eighth periodic report of Indonesia' CEDAW C/IDN/CO/8.

[594] See African Commission on Human and People's Rights 'Concluding Observations and Recommendations of the Initial and Combined Periodic Report of the Republic of Malawi on the Implementation of the African Charter on Human and Peoples' Rights' 70th Ordinary Session of the African Commission on Human and Peoples' Rights (2015-2019) 82-83.

4.3 Essential elements of sexual and reproductive rights

The Committee on Economic, Social and Cultural Rights (CESCR) has developed a framework of essential elements of the right to sexual and reproductive health. These are availability, accessibility, acceptability and quality.[595] These standards are useful in identifying potential barriers to access to reproductive health services in humanitarian settings.

4.3.1 Availability

Availability entails that an adequate number of functioning health-care facilities, services, goods, and programmes should be put in place to provide individuals with the fullest possible range of sexual and reproductive healthcare.[596] Thus, availability ensures the social determinants of the right to sexual and reproductive health are adequately provided. These include safe and potable drinking water and adequate sanitation facilities, hospitals, and clinics. The significance of social determinants to women's health is a recurring argument in this study because they provide equality of opportunity for women to enjoy the highest attainable standard of health. Addressing the broader social determinants of health will improve access to health services. In addition, reducing poverty and income inequalities has the effect of enhancing access to reproductive health.[597]

Examining the context in which reproductive rights are provided is an opportunity to challenge the unequal distribution of resources and power, which manifests itself in social determinants of the right to health. In elaborating on the issue of social determinants, the World Health Organisation (WHO) has highlighted that social justice is a matter of life and death, it affects the way people live, their consequent

[595] See CESCR General Comment No.22 Part 111 A paras 11-21.
[596] See General Comment No. 22 paras 12-14.
[597] Evans, D B et al 'Universal health coverage and universal access. *Bulletin of the World Health Organization, 91* (8) (2013) 546 - 546A. Available at: *http://www.who.int/bulletin/volumes/91/8/13-125450* (accessed on 12 February 2022 World Health Organization.

chance of illness, and their risk of premature death.[598] Thus, the availability of women's family planning services is determined by other equally important factors embedded in other existing human rights. Furthermore, social determinants of sexual and reproductive health determine whether women can live a dignified life, a recurring thread in this thesis in alignment with the capabilities approach.

Availability of family planning services involves the availability of trained medical and professional personnel and skilled providers who can dispense the full range of sexual and reproductive healthcare services. Further, skilled personnel must be complemented by a range of essential medicines in public and private institutions and within a reasonable geographical reach.[599] CESCR General Comment No. 22 has clarified that the right to sexual and reproductive health encompasses a set of freedoms and entitlements and has elaborated that entitlements include among others; the availability of trained medical and professional personnel and skilled providers, as well as the right to evidence-based information on all aspects of sexual and reproductive health. One argues that the situation, gathered by Maziwisa during her study in rural Zimbabwe, constitutes a violation of women and girls' sexual and reproductive health and rights. She summarises the situation as follows:

> "There is a shortage of qualified doctors, specialists, and nurses in rural areas. In Matabeleland North, nurses conceded that they are trained in primary health care, but only have basic training in family planning methods during their preservice training, and they sometimes do not know how to administer family planning methods such as 'Jadelle' insertion and removal. The lack of knowledge by health workers is passed on to the rural women they serve, who are given inadequate or incomplete information. Healthcare workers do not explain the full range of available family planning methods and their side effects."[600]

[598] World Health Organisation 'Closing the gap in a generation: Health equity though action on the social determinants of health' (2008) 1-206.

[599] CESCR General Comment No. 22 paras 12-14. See also CESCR General Comment No. 14 para 12(a).

[600] Maziwisa M R in Durojaye E (eds) 'Advancing Sexual and Reproductive health and rights in Africa: Constraints and Opportunities' (2021)68

The availability of reproductive services enables women to access the necessary functionings and capabilities to live a near-normal life, even during humanitarian emergencies. According to the capabilities approach, this can be achieved through access to material and non-material needs such as food, adequate housing, water and sanitation. Therefore, availability in humanitarian emergencies is related to the fulfilment of Nussbaum's list of central capabilities making women a bearer of value and an end to themselves.[601]

4.3.2 Accessibility

Access is the cornerstone of the quality of family planning programmes.[602] CESCR General Comment No. 22, paragraph 15, states that accessibility means that health facilities, goods, information, and services related to sexual and reproductive health care should be within reach to all individuals and groups without discrimination and free from barriers. At entry-level, access to contraceptives is a function of the availability of contraceptive commodities at service delivery points. Contraceptive supply systems in the public health system are the government's responsibility, as they must purchase and distribute commodities that allow potential users to access them.[603]Furthermore, accessibility includes physical accessibility, affordability, and information accessibility.[604] Of significance is that the capabilities approach focuses on developing countries and the urgent needs of women in that context to secure a threshold of a list of key entitlements as a requisite of a life worthy of human dignity. Thus, ensuring accessibility of family planning services during

[601] Nussbaum (2000)70-101.

[602] Zulu T 'Covid-19 and access to reproductive health rights for women in higher education institutions in South Africa (2021)55.

[603] J Welsh et al 'Access to modern contraception' (2006) 20 Best Practice & Research Clinical Obstetrics & Gynaecology (2006) 325.

[604] See also CESCR General Comment No.14 para 12(b).

humanitarian emergencies in Zimbabwe expands women's choices and fulfils combined capabilities as enunciated by the capabilities approach.

4.3.3 Physical accessibility

Physical accessibility implies that health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.[605] The African Commission, in its resolution on access to medicines, urges African governments to ensure the availability, accessibility, acceptability, and quality access of everyone to medicines.[606] It has been noted that when discussing accessibility, it is of significance to consider that women living with HIV (WLHIV) in Southern Africa face specific obstacles in accessing SRHR due to their HIV status.[607] It is also important to note that disabled women are on the receiving end of most deprivations and should be targeted to ensure the physical accessibility of SRHR during humanitarian emergencies. In rural Zimbabwe, access to health care is often impeded by long distances and travel times to access healthcare centres, the availability of financial resources to pay for services, and the availability of drugs and skilled personnel. In these rural areas, women, in some instances, have to walk between 10 and 50 kilometres to access the nearest health facility.[608] Rural Chipinge and Chimanimani are characterised by steep slopes, mountainous ranges and deep valleys, and the onset of Cyclone Idai saw most roads being impassable. Chatiza, in his observations after the 2019 Cyclone Idai hit, gives an eyewitness account of the state of the roads as follows:

> "Roads and bridges in Chimanimani and Chipinge were severely damaged, rendering some areas inaccessible for at least two weeks. The damage

[605] CESCR General Comment No. 14 para 12(b).

[606] ACHPR '141 Resolution on access to health and needed medicines in Africa ACHPR Res 141 (XXXXIV) 08 available at *https://www.achpr.org/sessions/resolutions?id=212 (*accessed on 5 February 2022).

[607] Southern African Litigation Centre (SALC) 'Dismantling the gender gap: Litigating cases involving violations of sexual and reproductive health (2013)4.

[608] Mangundu M et al 'Accessibility of rural healthcare in Zimbabwe: The perspective of nurses and healthcare users' (2020)1-7.

> included soaked roadbeds, cracked roads, and landslides making roads impassable, washed-away culverts, and damaged bridges and bridge approaches. A city engineer observed that the damage was exacerbated by the fact that some of the roads had not been graded since the 1980s; they were poorly maintained, with some culverts and drains completely silted and 'forgotten' with overgrown trees encroaching onto roads; and roads were made of inadequate materials, especially gravel."[609]

CARE, an organisation involved in humanitarian assistance during the 2019 Cyclone, observed that most communities[610] travelled long distances and multiple times to access assistance as most assistance was being provided at ward centres,[611] affecting people from the furthest village. Due to impassable roads and flooded rivers, pregnant women faced challenges in accessing healthcare centres, thereby resorting to home births with untrained birth attendants, thus increasing the risk of birth complications and potentially jeopardising aftercare of the mother and child.[612] Zimbabwe can take steps towards universal health coverage through prioritisation and substantially increasing health financing to make it accessible.[613] Access to reproductive health in emergencies is intertwined with one's quality of life and ability to function in fulfilment of their broad capabilities, which are pertinent aspects of the capabilities approach.

4.3.4 Information Accessibility

[609] Chatiza K (2019)13.

[610] CARE conducted a Rapid Gender Analysis in Chipinge, Chimanimani, Buhera and Mutare rural districts.

[611] In Zimbabwe, a ward is a sub district policy space, made up of a village assembly whose boundary coincides with that of a traditional village. See Jaap de Visser, Steytler N & Machingauta N (eds) in 'Local Government Reform in Zimbabwe: A policy dialogue' Community Law Centre (2010)15.

[612] CARE (2019)3.

[613] Evans D B et al (2013)546-546A.

Closely linked to the attainment of other rights is the right to reproductive information. It has already been alluded to in this thesis that women cannot access rights they do not know about. For them to make informed decisions about safe and reliable contraceptive measures and other reproductive issues, women and girls in humanitarian settings are entitled to have adequate, accurate information about contraceptive measures and their use and guaranteed access to sex education and family planning services as provided for in article 10(h) of the CEDAW.[614] Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities). However, having personal health data treated confidentially does not impair the right.[615] Reproductive health information accessibility is elaborated on in CESCR General Comment No. 14, paragraphs 18 and 19. Adolescents are also entitled to receive reproductive information as it has been noted that although they are generally a healthy population group, they are prone to risky behaviour, sexual violence, and exploitation.[616] Moreso, in humanitarian settings where social systems have been disrupted, their sexual and reproductive rights are dependent on appropriate and accurate reproductive health information, in line with the United Nations Convention on the Rights of the Child (UNCRC) Article 24.

Article 14 of the African Women's Protocol refers to the state's obligation to ensure adequate, affordable, and accessible health services, including information, education, and communication programmes for women, especially those in rural areas.[617] This is particularly important for rural women and girls with limited access to digital services and connectivity on common media platforms. In addition, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has with reference to Covid 19 as

[614] See also CEDAW General Recommendation No. 21 on Equality in Marriage and Family Relations' Thirteenth Session, General Assembly Report Supplement 38 (A/49/38) para 1.

[615] UN Office of the High Commissioner for Human Rights (OHCHR), *Fact Sheet No. 31, The Right to Health*, June (2008)4 available at: *https://www.refworld.org/docid/48625a742.html* (accessed 13 February 2022)

[616]OHCHR, WHO Factsheet 31 (2008)15.

[617] African Women's Protocol Article 14(2) (a).

a humanitarian emergency, called for digital health innovation.[618] This refers to diverse information and communications technologies used in health systems, ranging from mobile applications to health management information systems.[619] In essence, technologies should assist and meet the specific needs of diverse populations by providing access to information and services to people who might otherwise face barriers.

Maziwisa has documented stigmatisation and scrutiny in accessing public family planning services by adolescents in her study. Reportedly, in rural Zimbabwe, nurses yell, decline to provide contraception services, and ridicule adolescents seeking reproductive services or if they contract STIs or fall pregnant.[620] Adolescents find it difficult and uncomfortable to access family planning information and services without privacy and fear that someone might report them to their parents. These actions transgress the dignity version of the capabilities approach and are a violation of international human rights.[621] Furthermore, one of the core aspects of the right to health is the duty of governments to provide health information, including methods of preventing and controlling illnesses.[622] Access to reproductive information influences one's choices in line with the central capability of practical reason as advocated for by the capabilities approach.

During the Cyclone Idai period, for women to participate in reproductive health decisionmaking in the disaster management continuum, they ought to have had exposure to such knowledge, thus enabling them to pursue a life that is truly human on the basis of the capabilities approach. Kabeer states that access to education

[618] United Nations General Assembly 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic' A/76/172 paras 65-67.

[619] Report of The Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health 76th Session (2021)21/25.

[620] Maziwisa (2021)68.

[621] Article 12 ICESCR, Article 18(3) Maputo Protocol.

[622]CESCR General Comment No 14 para 44(d).

capacitates a woman to deal with the outside world, including government officials and other service providers, and enables her to question the subordinate status.[623]

4.3.5 Acceptability

All facilities, goods, information, and services related to sexual and reproductive health must be considerate of the culture of individuals, minorities, peoples, and communities and sensitive to gender, age, disability, sexual diversity, and life-cycle requirements. However, this cannot be used to justify the refusal to provide tailored facilities, goods, information, and services to specific groups.[624] Acceptability also entails people's willingness to seek services. Acceptability is low when patients have a negative attitude towards services because they perceive them to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider inhibit them from seeking services.[625] Acceptability means that policies and interventions must be acceptable in terms of medical ethics and the culture of individuals' life cycle requirements, sensitive and designed to improve the lives of those targeted.[626] Thus addressing disrespectful or abusive treatment given during the dispensing of reproductive services to women and adolescents is, in a way guarding the acceptability and quality of services. In humanitarian emergencies, substantive equality requires tailored interventions that address women's reproductive health needs in a fashion acceptable and sensitive to their context. Moreover, radical African feminism, which informs this study as grounded in substantive equality, requires the elimination of socio-cultural practices and stigma that trivialise women's issues.

4.3.6 Quality

[623] Kabeer (2005)17.

[624] CESCR General Comment No. 22 para 20. See also General Comment No.14 para 12(c).

[625] Evans, D B et al (2013) 546 - 546A.

[626] UNFPA 'Elevating rights and choices for all: Guidance note for applying a human rights-based approach in programming' (2020(22.

Health facilities, goods and services must be of acceptable quality, meaning they must be scientifically and medically appropriate and up to date. Related to information accessibility, failure to incorporate technological advancements and innovations in the provision of sexual and reproductive services jeopardises the quality of care.[627] Quality is also denoted in the skills and specialisations health practitioners who dispense SRHR possess. In instances where there is a shortage of skilled manpower that puts pressure on scant resources, where services lack privacy and are provided by personnel who have inadequate and incomplete information, there is a compromise on quality. The World Health Organisation states that in the poorest and those countries experiencing brain-drain losses, adequate numbers of appropriately skilled health workers at the local level are fundamental to extending universal health coverage and improving the quality of care.[628] Thus even the provision of reproductive health services by humanitarian organisations in the context of emergencies must be in line with the Paris agreement, which emphasizes that the quality of aid must be improved.[629]

The right to health has been interpreted to include the concept of informed consent. Article 12 of CEDAW, which includes the right to quality healthcare, includes voluntary and informed consent as provided for under CEDAW General Recommendation No. 24. The General Recommendation states that quality healthcare services under article 12(1) of CEDAW entail an obligation that States provide acceptable services, which make realisable women's informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.[630] In essence, the capabilities approach assigns an urgent task to government and public policy to ensure an improvement in the quality of life

[627] CESCR General Comment No.22 para 21.

[628] OHCHR, WHO Factsheet 31 (2008) 8.

[629] The Paris Agreement was adopted on 12 December 2015 at the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate change held in Paris from 30 November to 13 December 2015.

[630] SALC (2013)36.

manifesting in quality reproductive health services as defined by people's capabilities.[631]

During the 2019 Cyclone Idai in Chipinge and Chimanimani, poor preparedness affected the quality of the humanitarian response.[632] The Ministry of Health and Child Care, the lead government agency in health response, recorded low daily completeness due to inadequate software and airtime, affecting the type of services they were able to deliver to disaster-affected populations.[633] Thus during humanitarian emergencies, if the quality of family planning services is poor, it violates women's well-being and the threshold of central capabilities set out by the capabilities approach.

4.3.7 Affordability (Economic Accessibility)

CESCR General Comment No. 14 states that in the provision of health services, health facilities, goods, and services must be affordable to all and based on the principle of equity.[634] In line with the progressive provisions of the African Women's Protocol, General Comments call for affordable, comprehensive and quality procedures, evidence-based technologies and services for the medical monitoring of one's sexual and reproductive health.[635] In addition, essential goods

[631] Amollo R 'Advancing a feminist capabilities approach to HIV and AIDS in Sub Saharan Africa' in Ngwena C & Durojaye E *(eds) in '*Strengthening the protection of sexual and reproductive health and rights in the African region through human rights' (2014)185.

[632] Chatiza (2019)10 paints a picture of Zimbabwe's disaster management and particularly a health sector riddled with resource constraints, low institutional coherence, lack of access to robust data on disaster risk, inadequacies in information and communications technology and inadequate financial and logistical capacity in key disaster response institutions among other challenges which fed into the quality of the health delivery sector during Cyclone Idai response.

[633] Government of Zimbabwe and WHO (2019) Situation Report on Cyclone Idai. Issue 0015, 15 April 2019 available at *https://reliefweb.int/report/zimbabwe/situation-report-cyclone-idai-issue-012* (accessed on 11 December 2022).

[634] CESCR General Comment No. 14 para 12(b)

[635] General Comment No 2 on Article 14 1(d) and (e) of the Protocol on the African Charter on the rights of women in Africa para 40.

and services, including those relating to underlying social determinants of reproductive health, must be provided at no cost[636] , especially in situations of humanitarian emergencies where affordability falls away due to vulnerability.

During Cyclone Idai, it was documented that access to reproductive services was affected by cost as women in Ward 23 of Chipinge district could not pay the fee of $5(RTGS).[637] Their economic status was worsened by the disruptive effects of Cyclone Idai on their sources of livelihood as income-generating garden and poultry projects were washed away by the heavy rains thus, income at the household level was severely constrained.[638] Under normal circumstances, affordability would entail a measure of people's ability to pay for family planning and information services without financial hardship.[639] In the Zimbabwean context, this requires one to consider indirect costs such as transport costs. It has been highlighted that women are confronted with inhibitive long distances and consequently high transport costs, worsened in rural areas where the means of transport is not easily available. Economic accessibility thus exposes the intersection between women's socio-economic status and their capability to control their reproductive choices. Affordability can enhance women's capabilities and their ability to function in the context of humanitarian emergencies in line with the capabilities approach. Thus, according to Sen's capabilities version, women's capacity to develop is tied to their functioning, which depends on how easily they can afford lifesaving reproductive services.

4.4. Progressive realisation and minimum core obligations

[636] CESCR General Comment No. 22 para 17.

[637] RTGS known as Real Time Gross settlement abbreviated as the ZWL (Zimbabwean dollar) was the only official currency from June 2019 to March 2020 after which foreign currencies were allowed for trade in the country again.

[638] See CARE 'Rapid Gender Analysis' (2019)8.

[639] Evans, D B et al (2013) 546 - 546A.

General state obligations prescribe that states must take steps to the maximum of their available resources to progressively and fully achieve sexual and reproductive health and rights.[640] This means socio-economic rights can only be realised over time, and progress towards full realisation depends on resource availability. This position was reached after the realisation that states may be constrained in terms of resources, when meeting their human rights obligations. However, progressive realisation does not relinquish the state of its obligations on the basis of insufficient resources but entails expeditious and effective movement towards the full realisation of the highest attainable standard of sexual and reproductive health.[641] Therefore, the provisions indicate a degree of flexibility by states in implementing socio-economic rights. The state must take deliberate, concrete, and targeted steps using all appropriate means, such as the adoption of legislative and budgetary measures to make realisable women's family planning services even during humanitarian emergencies.[642] The concept of progressive realisation was discussed in the case of *New Clicks South Africa v Minister of Health, where the* Supreme Court of Appeal (SCA) stated as follows:

> "This section guarantees the right of access to health care services and enjoins the state to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of [this right].' The right to health care services includes the right of access to medicines that are affordable. The state has an obligation to promote access to medicines that are affordable."[643]

[640] ICESCR General Comment No. 22 para 33.

[641] ICESCR General Comment No.3 The Nature of State Parties 'Obligations on Article 2 para 1 of the Covenant E/1991/23 para 11.

[642] CESCR General Comment No.3 para 9 states that realization over time, or progressively, is foreseen under the Covenant and should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social, and cultural rights.

[643] CCT 59/04 para 514.

In the *New Clicks South Africa case*, it was noted that in promoting access to medicines, private player interests must be balanced and yield to public interests and that the duty to take steps is, therefore, an immediate one [644] and can be implemented individually and through economic and technical international assistance and cooperation. It implies that the state must take steps towards progressive realisation within a reasonably short time.[645] Where immediate steps towards the realisation of socio-economic rights cannot be taken, the court, in the case of *Grootboom,* stated that the state must still take steps to achieve the goal of the socio-economic right.[646] Thus in the context of women's access to family planning services during Cyclone Idai, this study prefers Chenwi's argument for attentiveness to and prioritisation of women's reproductive needs as follows:

> "…progressive realisation requires that special measures for vulnerable and disadvantaged groups need to be put in place. States are required to do more than abstain from taking measures that might have a negative impact on the enjoyment of their rights. The obligation on the state is to take positive action to reduce structural inequality and to give appropriate preferential treatment to vulnerable and marginalised groups. Positive action includes specially tailored measures or additional resource allocation for these groups."[647]

When Cyclone Idai struck, family planning services were already being provided around Zimbabwe, and in such instances, Liebenberg argues for the state's obligation to ensure the improvement and quality of services to which people have access.[648] Additionally, she argues that the state must ensure everyone has access to essential levels of goods and services known as the 'minimum core', which can

[644] CESCR General Comment No.3 para 13.

[645] See Chenwi L 'Unpacking "progressive realisation", its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliance' (2013)745.

[646] Government of The Republic of South Africa v Grootboom & Others (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).

[647] Chenwi (2013)746.

[648] Liebenberg 'The interpretation of socio-economic rights' (2003)41.

be improved gradually over time. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights give regard to the minimum core concept as part of state obligations to ensure respect for minimum subsistence rights regardless of the level of economic development. [649]Furthermore, CESCR General Comment No. 14 provides for the concept of minimum core obligation for states to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.[650] Minimum core obligations of reproductive healthcare encompass non-discrimination when dispensing services for marginalised populations as well as ensuring the availability of social determinants of the right to health.[651] It is upon this basis that Yacoob J, in *Grootboom's* case, states that:

> "Minimum core obligation is determined generally by having regard to the needs of the most vulnerable group that is entitled to the protection of the right in question. It is in this context that the concept of minimum core obligation must be understood in international law."[652]

In addition, Forman argues that CESCR General Comment No.14 is a watershed moment for core obligations under the right to health as it sets parameters on what constitutes 'essential' aspects of the right to health as a baseline of protection

[649] Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights' E/CN.4/1987/17 (hereafter Limburg Principles) paras 25 and 28.

[650] CESCR General Comment No. 14 paras 43, 44, See also CESCR General Comment No. 22 para 49.

[651] CESCR General Comment No.14 paras 43, 44. In General Comment No. 14, the committee interprets core obligations under the right to health to include "(1) ensuring non-discriminatory access to health facilities, goods, and services, especially for vulnerable and marginalized people; (2) ensuring access to food, basic shelter, housing, sanitation, and water; (3) providing essential drugs as defined by WHO; (4) ensuring the equitable distribution of health facilities, goods, and services and (5) adopting a national public health strategy and plan of action addressing the concerns of the entire population, devised through a participatory process that pays particular attention to vulnerable and marginalized groups."

[652] Grootboom case para 31.

regardless of any given country's shortage of national resources or international assistance.[653]

Thus, during humanitarian emergencies, the minimum core concept can be applied to determine if women have access to the essential levels of reproductive healthcare since they are one of the vulnerable groups entitled to international legal protection. Failure to satisfy women's access to the minimum essential levels of family planning services is thus a violation of economic, social, and cultural rights, irrespective of the resources Zimbabwe possesses or any other factors or difficulties the country faces.[654] The minimum core concept as it was conceived by the Committee on Economic, Social and Cultural Rights, resonates with the bare social minimum of what respect for human dignity requires in the capabilities approach. Women's access to a minimum threshold level of each capability hinges on their socio-economic standing and a gendered perspective in humanitarian response. Therefore, access to a minimum threshold of reproductive services as per the capabilities approach contributes to women's improved capabilities, dignity and well-being in humanitarian emergencies. The next section descends to the Zimbabwean context in analysing laws, policies and programmes on women's reproductive rights.

4.5 ZIMBABWE'S LAWS, POLICIES AND PROGRAMMES ON WOMEN'S REPRODUCTIVE HEALTH RIGHTS

This section examines the regulatory framework for sexual and reproductive health and rights of women in Zimbabwe, specifically access to family planning services during humanitarian emergencies.

[653] Forman L et al 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage' (2016)28.

[654] See Maastricht Guidelines, para.9.

4.5:1The Constitution of Zimbabwe and reproductive rights

Section 76(1) of the Constitution of Zimbabwe provides as follows

> "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."

The Constitution of Zimbabwe provides access to basic healthcare services, including reproductive healthcare services, without specifying the right to health orbasic healthcare services.[655] People Living with HIV (PLHIV) are accorded access to primary health care services in Section 76(2). Sithole argues that inclusion of the right to have access to reproductive health services in the Constitution translates to Zimbabwe entrenching into domestic law rules which enable it to abide by its treaty obligations under Article 12 of the ICESCR, Article 12 of CEDAW and Article 14 of the African Women's Protocol.[656] In essence, Zimbabwe has domesticated and entrenched provisions which obligate it to protect, promote and respect women's reproductive health rights. By enacting reproductive rights, Zimbabwe recognises women as right holders and pillars of development as expected by the capabilities approach.

Section 76(1)(4) provides for the progressive realisation of the rights to basic health services, including reproductive health care services, within the ambit of the state taking 'reasonable and other measures' to fulfil the right to health. Comparing this provision with Article 24 (3) UNCRC, which requires the state to take 'all effective and appropriate measures,' section 76 of the Constitution appears not watertight. However, Section 29(1) of the National Objectives to the Constitution of Zimbabwe

[655] Section 76 Constitution of Zimbabwe.
[656] Sithole (2021)94.

commendably requires the state to take 'all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.' Section 80 of the Constitution of Zimbabwe provides for women's rights and is a basis for prioritisation of women's rights during humanitarian emergencies. This study observes that the provisions on the progressive realisation of socio-economic rights, specifically, access to reproductive healthcare contain gender blind spots and inconsistencies. One notes that one of the barriers to adolescents' access to reproductive health in humanitarian emergencies is 'consent confusion' in Zimbabwe's legal framework. The Constitution of Zimbabwe provides that anyone who has reached the age of 18 has the right to find a family,[657] while Criminal law provides that young persons can consent to sexual activities under the age of 16.[658] The limited access to sexual and reproductive health services to persons above 16 years of age is often linked to the age of sexual consent, which in Zimbabwe is set at 16 by the Criminal Law (Codification and Reform) Act.[659] The effect is that a person under 16 years of age cannot legally consent to sexual intercourse, but on the other hand, the law does not penalise consensual sex between children aged 12 to 16 years. So, because a child under 16 cannot legally consent to sexual intercourse at law, it is assumed that they do not need access to reproductive health care services, thereby prejudicing children who are sexually active at such ages.

The reality of consensual sex among teenagers is spelt out by Tsanga J in the *Masuku case,*[660] where the accused was convicted of contravening Section 70 of the Criminal Law Codification and Reform Act (Chapter 09:23) which criminalises having sexual intercourse with a young person. The circumstances of the case pertain to a couple comprised of a sex-experimenting boyfriend aged 17 and a girlfriend who was 15 years of age. Justice Tsanga stated that while common perpetrators of the crime of sex with a young person under Section 70 are usually

[657] Section 78 Constitution of Zimbabwe.

[658] Section 70 Criminal Law (Codification and Reform) Act Chapter 9:23

[659] S 70 Criminal Law (Codification and Reform) Act Chapter 9:23

[660] S v Masuku ZW HHC 106-15 page 2 available at *https://media.zimlii.org/files/judgments/zwhhc/2015/106/2015-zwhhc-106.pdf* (accessed on 23 February 2022

male adults, adolescent boys over the age of 16 who may still be regarded as children in terms of s 81(1) of the Constitution because they are below 18 years of age often find themselves among perpetrators. The Judge highlighted that ignoring the reality of teenage consensual sexual activity amounts to adopting a formalistic approach to the crime, resulting in an unnecessary punitive sentence, a criminal record and stigmatisation as a sex offender.[661]

The Spotlight Initiative has noted that the law in Zimbabwe has a singular or narrow approach to women's and girls' lives and often compartmentalises them.[662] In the context of Cyclone Idai, there is a need to consider the intersectionality which characterises the rural disasteraffected women and the difficulties imposed by the catastrophe of humanitarian emergencies. An inclusion of gendered special and temporary measures for humanitarian emergencies would level the unequal and inequitable ground from where women start when seeking to claim their reproductive rights during humanitarian emergencies (bearing in mind that among rural women are women and girls with disabilities, women living with HIV, older women, and rural women from impoverished settlements).

Women's dignity is an essential element and integral to their reproductive rights. The capabilities approach advocates for a life worthy of the dignity of a human being and provide the philosophical underpinnings for what constitutes the bare minimum of what respect for human dignity requires. The Constitution of Zimbabwe in Section 51 provides the right to human dignity to which every woman and man in any humanitarian context is entitled. After all, reproductive rights rest on the right to attain the highest attainable standard of reproductive health, which entails the right to privacy, confidentiality, respect, and informed consent, which are imperative to achieve dignity. Dignity enables women to make choices about their sexuality and bodies.

[661] *S v Masuku* ZW HHC 106-15).

[662] Spotlight Initiative 'Country Programme Document Zimbabwe' (2018)13 available at *https://spotlightinitiative.org/sites/default/files/publication/Spotlight_Annual_Report_July_2017-March_2018.pdf (accessed on 16 February 2022).*

The Constitution of Zimbabwe provides for the right to bodily and psychological integrity, which includes freedom from violence against women, the right to make decisions concerning reproduction and the right not to be subjected to medical or scientific experiments, or the extraction or use of their bodily tissue, without their informed consent.[663] Significant is that bodily health and bodily integrity are elements of the central human functional capabilities, as spelt out by Nussbaum in the capabilities approach.[664] Psychological integrity is tied to the central human capabilities of emotions and practical reason. So, women should be able to make reproductive decisions during humanitarian emergencies without influence from third parties.

Section 62(1) of the Constitution of Zimbabwe guarantees the right to information from anyone (including the state) to exercise or protect a right. As has been noted already, women cannot claim rights they do not know about, hence access to reproductive information is integral in their access and enjoyment of the right to health. CEDAW Committee General Recommendation No. 21 demonstrates the linkage between access to information and women's ability to make informed decisions regarding their sexuality.[665] Article 13(1) of the Convention on the Rights of the Child (CRC) guarantees young people the right to seek, receive and impart information and ideas of all kinds.

The African Women's Protocol in Article 12(2) enjoins states to promote literacy among women and girls, a provision which one can interpret to include reproductive rights education. Additionally, Article 14(f) of the African Women's Protocol provides for women's right to family planning education.[666] ACHPR General Comment No. 2 enjoins states to provide complete and accurate information which is vital for the respect, promotion, protection and enjoyment of health, ensure

[663] Section 52(a)-(c) Constitution of Zimbabwe.

[664] Nussbaum (2000)78.

[665]Committee on CEDAW General Recommendation 21 on Equality in Marriage and Family Relations' Thirteenth Session, General Assembly Report Supplement 38 (A/49/38) pars 1-1.

[666] For further reference on women's right to reproductive information see also Articles 10(h),16(1)(e) CEDAW, Article 23(1) CRPD, Article 9 African Charter on Human and People's Rights.

training or upgrading of service providers so that they are capacitated with full, accurate family planning information,[667]ensure availability, accessibility, acceptability, reliability of reproductive information, ensure that competent institutions can dispense tailored reproductive information to different population groups, including women and girls with disabilities. [668] In General Comment No.2, the right to reproductive information is a recurring precursor to the enjoyment of other rights, and this means that when women are well-informed, they can make better choices about all other aspects of their lives. Furthermore, the African Commission stresses the importance of family planning information, education, and safe abortion to women and girls. The content must be rights-based and informed by clinical findings in line with the Maputo Plan of Action and Articles 2 and 5 of the African Women's Protocol.[669]

The cited provisions are proof that Zimbabwe has a wide scope through which it can ensure that during humanitarian emergencies, it rolls out measures to ensure the availability, accessibility, acceptability, reliability and quality of family planning information, especially for women and girls in rural areas who are already affected by limited access to digital devices and data.[670] SDGs Target 3:7 on health requires that by 2030 the government should have ensured universal access to sexual and reproductive health care services, including family planning, information, and

[667] ACHPR 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 (para 28).

[668] ACHPR General Comment No. 2 on Article 1 and 4.1 (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 (para 28).

[669] ACHPR General Comment No. 2 on Article 1 and 4.1 (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 (para 51).

[670] Maziwisa (2021) 68.

education. Access to reproductive information is imperative in achieving gender equality and women's empowerment in the fulfilment of SDGs Target 5:6.[671]

The ICPD Programme of Action provides that governments should uphold the sexual and reproductive rights of persons with disabilities and eliminate all forms of discrimination they may face. This is particularly important during humanitarian emergencies where women with disabilities face additional obstacles and are likely to be forgotten. The European Court of Human Rights *Open Door case* held that any attempt by a state to hinder access to sexual health information would amount to a violation of the right to information. The case could provide ample guidance to Zimbabwe in its upholding of international law obligations relating to ensuring women are able to access reproductive health information.[672]

Religion is not without controversy[673] and has been defined in Zimbabwe in the case of *Dzvova v Minister of Education and Culture and Others.*[674] In order to understand the interplay between religion and human rights, it is significance that this study refers to Mutangi, who comprehensively describes the state and spiritual values and practices of indigenous Africans in Zimbabwe.[675] Mutangi submits that one of the areas of concern is child marriages attributed to religious beliefs and

[671] See also ICPD Programme of Action para 5:5 as it refers to equality of men and women in health services and specifically states that "Governments should take effective action to eliminate all forms of coercion and discrimination in policies and practice. Para 6:30 provides that governments should uphold the SRH rights of persons with disabilities and eliminate all forms of discrimination that people with disabilities may face.

[672] *Open Door and Dublin Well Woman v. Ireland*, 64/1991/316/387-388, Council of Europe: European Court of Human Rights, available at: *https://www.refworld.org/cases,ECHR,3ae6b7020.html* [accessed 8 March 2023]

[673] United States v Ballard 322 US 78 (1944) 86-7 (quoting Justice Douglas).

[674]Case SC 26/07 (2007) ZNSC.

[675] Mutangi T 'Religion, law and human rights in Zimbabwe' (2008)537.

poverty.[676] Although Mutangi carried out his study in 2008, Sithole, in her study in the Hwange district a decade later, captures an escalation of the problematic impact of religious aspects on rural women's access to and perception of reproductive rights. She delivers on how women from the Apostolic sect fail to access reproductive services because religious beliefs prohibit them from seeking medical help.[677] Additionally, due to their Catholic beliefs, some faith-based health institutions limit rural women's access to family planning services such as contraception and abortion when they deny them attention and refer them to the already insufficiently equipped government hospitals.[678] Denying women access to family planning services on religious grounds interferes with their reproductive self-determination and agency, depriving them of truly human functioning as advocated by the capabilities approach.[679] In her capabilities approach, Nussbaum also speaks to how when given broad latitude to determine a woman's quality of life, religion interferes with her human capabilities and threatens not only her dignity and equality but also health, the wherewithal to live and bodily integrity.[680]

The Constitution of Zimbabwe gives parents, and guardians of minor children an upper hand and determination on their children's moral and religious upbringing provided such determination does not contravene children's rights.[681] While this provision is with good intentions, it has been open to abuse, particularly by some parents and guardians. The issue of interference with one' reproductive rights through the claws of religion applies to adolescents and adult women. The effect on younger people has been child marriages, denial of access to modern reproductive health care due to religious doctrine and poor maternal and newborn health

[676] Mutangi (2008)537 writes that that poor families often 'sell off' girl children in consideration of generous payment in the form of lobola or any other payment in kind. This customary practice is called 'kuzvarira.' Further he talks of solemnisation of marriage between minor girls and elderly men, especially in the African Apostolic churches, which also practise polygamy.

[677] Sithole (2021)134.

[678] Sithole(2021)134.

[679] See Nussbaum (2000)87-101.

[680] Nussbaum (2000)186.

[681] Section 60(3).

outcomes, especially among Apostolic religious groups.[682] The double-edged sword of child marriage and religious interference in one's reproductive agency has been detailed in the media in Zimbabwe. In 2020 the media reported incidents surrounding the death of 14-year-old *Anna Machaya*, who reportedly died from complications she experienced during childbirth at a 'Marange Apostolic church[683] shrine in rural Manicaland province in the Eastern part of Zimbabwe.[684] The Marange Apostolic sect is known for its shared values of collectivism, authoritarianism, polygamy and patriarchy.[685] The Machaya case, which shocked the global community, compelled the United Nations to speak out against child marriages[686] and urged the government of Zimbabwe to act. This is particularly

[682] See 'Zimbabwe: Engage religious group in fight for SRHR' available at *genderlinks.org.za/news/zimbabwe-engage-religious-groups-in-fight-for-srhr/* accessed on 28 December 2021.

[683] The Johanne Marange Apostolic church also known as the Apostolic church of Johanne Maranke was founded in 1912 by Muchabaya Momberume and is most known as a white garments church. Available at *https://www.theafricangourmet.com/2019/12/making-of-african-apostolic-church-of.html* accessed on 28 December 2021

[684] Anna Machaya was a 14-year-old girl who was dropped out of school by her parents and married off to a male adult namely Hatirarami Momberume aged 26. According to their community standards, Momberume was viewed as rich, and his marrying of Anna Machaya was expected to bring food on the table for the Machaya family. After the death of Anna, the family pledged to replace her with a 9-year-old girl bride to Momberume. The media went to narrate how this case is a microcosm of the predicament that many young girls face in some religious sects in Zimbabwe and that it is believed that the Apostolic sect is the biggest culprit of this problem. See The Standard 'Child Brides: Machaya saga opens Pandora's Box' available at *https://thestandard.newsday.co.zw/2021/08/22/child-brides-machaya-saga-opens-pandoras-box/* (accessed on 28 December 2021) See also *https://www.zimbabwevoice.com/2021/08/14/shocking-truth-about-death-of-14-year-old-memory-machaya-at-johanne-marange-shrine/*

[685] Chikwature W & Oyedele V 'Polygamy and academic achievement: A case of Johane Marange Apostolic sect' (2016)26.

[686] CNN 'UN Condemns Zimbabwean child marriages as girl dies after giving birth' available at *https://edition.cnn.com/2021/08/09/africa/zimbabwe -child-bride-death-intl/index.html* accessed on 28 December 2021.

because Zimbabwe set the legal age of marriage at 18 years through the 2016 landmark judgement of *Mudzuru & Anor v Ministry of Justice, Legal & Parliamentary Affairs N.O. & Ors*) and committed to eradicating child marriages.[687] Further to that, Section 80(3) of the Constitution of Zimbabwe outlaws all laws, customs, traditions, and cultural practices that infringe the rights of women conferred by the same Constitution. To this study, the call by the United Nations on government action speaks volumes to Zimbabwe's violation of women and girls' reproductive rights and a range of other related rights (including both civil liberties and socio-economic rights), chief among them is life and preventable maternal mortality. To this end, radical African feminism calls out the institutionalisation of male dominance through elimination of conditions which perpetuate inequalities and discrimination against women. The CEDAW Committee has, through Concluding Observations, repeated its concern on the issue of child marriages in Zimbabwe, and although it has recommended specific action, the scourge has persisted.[688]

4.6 LEGISLATIVE FRAMEWORK

4.6.1 Civil Protection Act Chapter 10:06

The Civil Protection Unit Act was established to provide for civil protection services, including the establishment of a fund to finance civil protection during times of disaster as follows:

> "An Act to establish an organisation provide for the operation of civil protection services, in times of disaster, to provide for the establishment of a

[687] (2016) ZWCC 12.

(2016) ZWCC 12.

ding Observations on Zimbabwe by the CEDAW Committee Fifty first session CEDAW/C/ZWE/CO/2-5, 2020, Concluding Observations on Zimbabwe by the CEDAW Committee on the sixth periodic report of Zimbabwe CEDAW/C/ZWE/CO/6.

fund to finance civil protection and to provide for matters connected with or incidental to the foregoing: [689]

The Act is guided by the provisions of the Constitution, which provides for the right to basic health care services, which includes reproductive health care services and, in addition, health services as follows:

> "1) The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.
> (2) The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution.
> (3) The State must take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease."[690]

The Civil Protection Act mandates the Civil Protection Officer to maintain specified stocks of water, fuel, food or medical supplies for use during the state of disaster.[691] However, there are no specific provisions relating to the gender mainstreaming of specific services or the specification of minimum reproductive health services to be provided during disasters of varied dimensions. The 2022 Universal Periodic Review (UPR) Working Group recommends that Zimbabwe improve the rights of women and girls by ensuring access to health and reproductive rights information and HIV.[692] In addition, Zimbabwe is urged to strengthen efforts to ensure comprehensive gender responsive and disability-inclusive approaches to developing and implementing climate change and disaster risk reduction policies.

[689] Civil Protection Unit Act Chapter 10:06 Part X.

[690] Constitution of Zimbabwe Amendment Act 20/2013 Section 29(1-3)

[691] Civil Protection Unit Act Chapter 10:06 Section 22(1) (b).

[692] Human Rights Council Working Group on the Universal Periodic Review 40th Session Draft Chronological list of Recommendations to Zimbabwe. See Recommendations by Eswatini, Fiji, Iceland, and Mozambique available at *https://uprmeetings.ohchr.org/Sessions/40session/Pages/Zimbabwe.aspx* (accessed on 30 January 2022).

It is upon this basis that this study advocates for a Civil Protection Unit Act, which is gender responsive and comprehensively provides for women's reproductive health services during humanitarian emergencies. The capabilities approach advocates that the law pays special attention to women's problems and provides constitutional principles that exude respect for human dignity.

One of the aims of this chapter is to interrogate if Zimbabwe's laws, policies, and programmes are adequate and in compliance with international obligations to advance women's reproductive rights during humanitarian emergencies. In so doing, the chapter analyses laws, policies, and programmes which advance women's reproductive health in Zimbabwe. The Public Health Act[693] provides that the state has an obligation to ensure the provision of basic, accessible, and adequate health services throughout Zimbabwe. In addition, the Public Health Act cites important Constitutional Provisions such as providing basic, accessible, and adequate health services, respect for fundamental human rights and freedoms, and the right to healthcare, among others. Reproductive health care is entrenched in the right of access to healthcare in line with international and regional norms and standards. These provisions are missing from the specific recognition of reproductive rights during humanitarian emergencies, given that there should not be an uninterrupted supply of such lifesaving services.

Articulated in the Public Health Act is providing and coordinating health and medical services during public health emergencies. What is commendable is that the Public Health Act attaches significance to the provision of water by the responsible local authority as a social determinant of health.[694] For example, during Cyclone Idai, it was observed that in Chipinge and Chimanimani districts, the unavailability of water at some of the affected clinics and the inaccessibility of

[693]Public Health Act 15:17.

[694] Public Health Act Section (86)(1)

health institutions led to an increase in home births, putting pregnant women at the risk of maternal mortality.[695]

It has been recognised that maternal mortality is due to the 'three delays model', which encompasses delays in accessing appropriate medical help for an obstetric emergency, delays in reaching an appropriate facility, and delays in receiving adequate care when a facility is reached.[696] Shortages of or unavailability of water supplies to facilitate access to adequate care when a health facility is reached is thus a violation of reproductive rights.

Section 44(1) of the Public Health Act provides that

> "A user has the right to participate in any decision affecting his or her personal health and treatment. (2) If the informed consent of the user is given by a person other than the user, such person must, if possible, consult the user before giving the required consent. (3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed after the provision of the health service in question."

In this regard, the law underscores women's reproductive rights decision-making through participation. This speaks to amplifying women's voices in their access to family planning services during humanitarian emergencies. The Special Rapporteur on the right to the highest attainable standard of health has reiterated that

[695] See United Nations General Assembly 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' 61st session A/61/338 (2006)7.

[695] See United Nations General Assembly 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' 61st session A/61/338 (2006)7

[695] See generally CEDAW.

[695] See Nussbaum (2000)80.

[695] CARE (2019)8.

[696] See United Nations General Assembly 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' 61st session A/61/338 (2006)7.

participation in health-related decision-making processes is one of the underlying determinants of the right to health.[697] Women's participation in private and public life on equal terms with men in matters that affect their lives is one of the core objectives of international instruments like CEDAW.[698]

This study argues for women's participation at all levels of decision-making in the disaster management continuum, especially where their reproductive health matters are decided. Women's participation in reproductive health matters is tied to their decision-making and choice rights, as provided in Article 14 of the African Women's Protocol. Nussbaum identifies an ability to control one's environment through effective participation in choices that govern one's life as one of life's central capabilities and a precursor to development.[699] The participation of Zimbabwean rural women who experience poverty, and face difficulties in accessing health and social services in decision-making processes at the community level has been called for by the CEDAW Committee in its treaty body recommendations.[700]

In its defence of feminism in Africa, Radical African feminism, which informs this study rejects male dominance and patriarchy and identifies them as drivers of women's structural disadvantage in patriarchal societies.[701] During Cyclone Idai, male dominance was reported in key decision-making positions in both traditional and elected positions. This adversely affected women's voices and their presence in reproductive health decision platforms. One might argue that in those instances, it is assumed women found decisions being made for them by their male counterparts which might not have appreciated what to prioritise when it came to women's reproductive needs. CARE, an organisation which was on the ground during Cyclone Idai in 2019, states as follows:

[697] Special Rapporteur Report (2006)7.

[698] See generally CEDAW.

[699] See Nussbaum (2000)80.

[700] See Concluding Observations of the Committee on the Elimination of Discrimination against Women on Zimbabwe CEDAW/C/ZWE/CO/2-5 51st session (2012)9.

[701] See Dosekun (2007)46.

> "The Cyclone Idai period was characterised by low female representation and participation in disaster management meetings. Women's participation in these meetings was limited due to their engagement in family care, and the social-cultural norms that prevail in the area, especially in Chipinge. In some areas in Chipinge, women were not encouraged to speak in public forums. Women reported that most of the meetings were being held at the village Head's homestead. In Chipinge, the CARE assessment team heard that women had not been given an opportunity to air their concerns as men had taken precedence during the crisis period, reverting to old practices."[702]

The situation described above is an affront to gender equality and other specific and elaborate women's rights as provided by the Constitution of Zimbabwe in line with international and regional frameworks.[703]

Termination of pregnancy in Zimbabwe is constitutional within the limits set by the Termination of Pregnancy Act.[704] Termination of pregnancy is allowed in circumstances where there is a physical health risk to the mother, where the physical and mental health of the foetus is at risk and where pregnancy is because of unlawful intercourse such as rape or incest. During humanitarian emergencies, women and men suffer from mental health issues because of disaster-induced shock and loss. Some survivors of the Cyclone reported being haunted by the screams and sights of people they were unable to save during the floods.[705] It has been recorded that because of humanitarian crises, survivors experience a range of mental disorders, including depression, post-traumatic stress disorder, suicidal ideation,

[702] CARE (2019)9, See also Chatiza (2019)10.

[703] The Constitution of Zimbabwe provides for gender equality in Section 3(1) (g), for equality and non-discrimination in Section 56 and, full equality of dignity and participation of women and women in all spheres of life in Section 80.

[704] Termination of Pregnancy Act Chapter. 15:10

[705] Médecins Sans Frontiers (MSF) 'Mental Health: Treating psychological trauma after Cyclone Idai' available at *https://blogs.msf.org/bloggers/elizabeth/mental-health-treating-psychological-trauma-after-cyclone-idai* (accessed on 1 January 2022).

and other forms of self-harm are also common among survivors.[706] So during humanitarian emergencies, if a woman chooses to terminate her pregnancy due to mental stress, the restrictive legal requirements in the country's abortion law impede her reproductive rights as the law only makes reference to termination where there is a physical health risk to the mother, and the mental health ground is provided for only in relation to the foetus.[707] This violates Article 14(2) (c) of the African Women's Protocol which provides that states should ensure that abortion is provided in cases continued pregnancy is a danger to the physical and mental health of the mother or the life of the mother or foetus among other grounds.

Radical African feminism calls for the creation of spaces for women to participate in societal management. One argues that this should include airing their voices during law-making processes to erode legal restrictions rooted in patriarchy and a misunderstanding of what women go through.

Although Zimbabwe legally provides for abortion[708] under limited circumstances, access is difficult and rare in practice. Legal and administrative barriers, stigma among both women and service providers and fear of social repercussions, inhibit women's access to abortion services. [709]In the *Mapingure case*, a woman was forced to carry the pregnancy to full term after she had been gang raped, thereby being denied her right to choose whether to carry the baby in her body. *Mapingure* met administrative hurdles which precluded her from accessing abortion services on time, resulting in the birth of a child she did not

[706] Article by Potyaraj J 'Mental health, psychosocial support for women in the wake of crisis' available at *https://reliefweb.int/report/world/mental-health-psychosocial- support-women-wake-crisis* (accessed on 1 January 2022).

[707] See Section 4 Termination of Pregnancy Act.

[708] Abortion is the termination of pregnancy which can be spontaneous also known as miscarriage, or intentional or induced.

[709] Sully EA et al 'Abortion in Zimbabwe: A national study of the incidence of induced abortion, unintended pregnancy and post-abortion care in 2016' (2018)2.

want.[710] In making its determination, the court had judicial notice of the significance of international human rights instruments relating to women's sexual and reproductive health and rights. It is commendable that the court took cognisance of the elimination of discrimination against women, elimination of violence against women and state obligations thereof, women's right of choice to family and to decide on the size of family, the progressive notion of the state obligation to facilitate an abortion for women under the African Women's Protocol in cases of sexual assault, rape and incest.

The case revealed the reality of the intersection between institutions, policy and misogyny manifest through maladministration[711] inflicted by the Zimbabwe Republic police and medical practitioners and their transgression on women's reproductive rights. The court brings out a dimension of the reality of government institutions that fail women every day through administrative blunders, thus trivialising and violating their reproductive rights.[712] This case has a bearing on the obligations of the state through its institutions when it comes to the advancement of women's access to sexual and reproductive health and rights in humanitarian emergencies as it demonstrates the far-reaching life complications which result from downplaying the vitality of SRHRon the right to life, women's well-being and other human rights. The case enjoins the state in eliminating violence against women and ensuring access to justice for survivors through enforcing their claims against administrative laws, policies, procedures, and practices that impede

[710] The police failed in their duty to assist Mapingure to access timely services to prevent pregnancy as she was informed that she could only get an order to allow her abortion after the case had been concluded at trial.

[711] The Constitution of Zimbabwe provides for the right to administrative justice in Section 68 which a right to lawful, prompt, efficient, reasonable, proportionate, impartial, procedurally and substantively fair administrative conduct by public officials.

[712] Mapingure SC 22/14 pages 20-21. The police failed to attend at the hospital on time to ensure the pregnancy was terminated, the matron failed to take reasonable steps to terminate the pregnancy, the doctor failed in his mandate to avert the pregnancy, the magistrate and prosecutors failed to act timeously to ensure a certificate of termination of the pregnancy was issued.

women's access to family planning violate the woman's right to life non-discrimination and health in that they deprive her of her decision-making power.[713]

Denial of abortion, when a woman requires it, interferes with their sexual and reproductive self-determination and constitutes cruel, inhuman or degrading treatment.[714] When women are denied abortion services, they may resort to unsafe methods which endanger their lives. Denying victims of rape, such as Mapingure abortion services and forcing them to become mothers compounds the injuries suffered.[715] The Human Rights Committee has stated that restrictive abortion laws, lack of access to reproductive health services, including emergency obstetric services, and high maternal mortality rates may violate the right to life.[716] The Human Rights Committee has expressed concern over severe abortion laws in El Salvador, especially considering the detrimental effects of clandestine abortions on women's lives, health, and well-being.[717] General Comment No. 36 enjoins states to ensure that women and girls are able to access safe and legal abortion.[718] General Comment No. 3 on the African Charter on Human and People's Rights elaborates on the right to life as the fulcrum of all other rights as provided for in Article 4 of

[713] IPPFAR 'Reproductive rights and sexual and reproductive health' in The State of African Women (2018)230.

[714] Human Rights Council 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' Juan E. Méndez A/HRC/22/53 para 46.

[715] Mavundla S & Ngwena C 'Access to legal abortion for rape as a reproductive health right: A commentary on the abortion regimes of Swaziland and Ethiopia' Ngwena C & Durojaye E (eds) in 'Strengthening the protection of sexual and reproductive health and rights in the African region through human rights' (2014)62.

[716] The right to life as provided for in Article 6(1) ICCPR, Article 10 CRPD, Article 4 African Charter on Human and People's Rights, and Article 4 of the African Women's Protocol.

[717] See Concluding Observations of the Human Rights Committee: El Salvador 78th Session U.N. Doc. CCPR/ CO/78/SLV (2003) at para14, See Also General Comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life (CCPR/C/GC/36 para 8.

[718] Human Rights Committee General Comment No. 36 on the right to life.

the ACHPR and the extent of state obligations thereof.[719] Similarly, Articles 5 and 30 of the African Charter on the Rights and Welfare of the Child protect the right to life.

Ngwena and Durojaye state that a human right to reproductive health means little if women with unwanted pregnancies are implicitly forced to either become mothers or resort to unsafe abortion due to the criminalisation of abortion or the inaccessibility of safe abortion services.[720] Reducing levels of unsafe abortion is one of the overarching goals of the African Union Commission.[721]The Criminal Law Codification and Reform Act in Zimbabwe criminalises termination of pregnancy outside the provided grounds cited in the Termination of Pregnancy Act. The Criminal Law Codification and Reform Act in Section 60(1) provides as follows:

> "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. (2) It shall be a defence to a charge of unlawful termination of pregnancy for the accused to prove that (a) the termination of the pregnancy occurred in the course of a "Caesarean section", that is, while delivering a foetus through the incised abdomen and womb of the mother in accordance with medically recognised procedures; or (b) the pregnancy in question was terminated in accordance with the Termination of Pregnancy Act [Chapter 15:10]."

[719] General Comment No.3 of the African Charter on Human and People's Rights (The right to life) Article 4.

[720] Ngwena C & Durojaye E 'Strengthening the protection of sexual and reproductive health through human rights in the African region: an introduction' (2014).267.

[721] The Maputo Plan of Action of the Continental Policy Framework for the Operationalisation of Sexual and Reproductive Health and Rights has been the most significant policy initiative to come from the African Union (AU) 2016-2030 pages 1-24.

Compelling women to carry pregnancies they do not want interferes with their autonomy, disqualifying them of their life accounts, experiences and, ultimately, their agency through a discriminatory and infantilising paternalism grounded in patriarchy. This is simply because patriarchy views women as procreative instruments and not as human beings with moral agency[722] , which is what radical African feminism frowns upon. In the same vein, the capabilities approach calls for the individual recognition of women's capabilities, and that women should not be treated as supporters of the ends of others rather than as ends in their rights, women are capable of deciding on what to do with their bodies.

Furthermore, women survivors of humanitarian emergencies already bear the trauma of the catastrophe, why deny them requested abortion and further inflict pain on them and expose them to maternal mortality and disability? Denying survivors of humanitarian emergencies access to safe abortion services must be understood as a form of violence against women because it puts their health and lives in danger, just as it is perceived for victims of rape.[723] The following section contains an analysis of the policy framework on women's reproductive rights in Zimbabwe.

4.7 POLICY FRAMEWORK IN ZIMBABWE

The policies presented in this section are those currently in use in Zimbabwe but have outlived their time since most have reached their expiry dates. The country awaits the promulgation of new policies on sexual and reproductive health and rights since the ones cited in this study expired either in 2020 or in 2021. The expired ones are The Zimbabwe National Family Planning Strategy 2016-2020, National Adolescent Sexual Reproductive Health Strategy 2016-2020, National Health Strategy 2016-2020, The Extended Zimbabwe National HIV and Aids Strategic Plan (ZNASP3) (2015-2020), and the National Climate Policy (2017). The National Development Strategy (NDS) 1 (2020- 2025) is also analysed in this

[722] Ngwena & Durojaye (2014)7.

[723] Mavundla & Ngwena (2014)62.

section. The Policies and Strategies outlined in this section are administered and implemented by different state institutions and agencies. Zimbabwe's obligations in advancencingwomen's family planning services during humanitarian emergencies are tied to how state institutions fare in crafting gendered policies adequate for humanitarian emergency contexts and how in practice, through implementation, they address the needs of rural women during humanitarian emergencies.

4.7.1 The Zimbabwe National Family Planning Strategy (2016-2020)

The Zimbabwe National Family Planning Strategy (2016-2020), a product of the Ministry of Health and Child Care, incorporates a human rights-based approach to ensuring quality, comprehensive and integrated family planning and related SRHR service delivery in Zimbabwe.[724] The policy recognises family planning as one of the important interventions aimed at reducing maternal and neonatal morbidity and mortality.[725] Rural women, young people, those living with HIV and disabled women are guaranteed improved availability and access to quality integrated and related SRHR services. Consequently, in terms of this Strategy, women in humanitarian emergencies who are located in hard-to-reach areas because of displacement are entitled to equitable family planning services. The specific recognition of rural women and these stated groups is attentive to the substantive equality of radical African feminism, which strives to achieve equality of opportunity for those groups affected by socio-cultural inequalities and context. One notes that in line with the capabilities approach, the Strategy aims at ensuring women's dignity and well-being by recognising their right to access family planning rights, goods and services at all times.

4.7.2 National Adolescent Sexual Reproductive Health Strategy (2016- 2020)

[724] National Family Planning Strategy (2016-2020).

[725] National Family Planning Strategy (2016-2020)10.

The National Adolescent Sexual Reproductive Health Strategy (National ASRHR Strategy) is the second of such a kind, following the first one promulgated for 2010-2015 and falls under the Ministry of Health and Child Care purview. The Strategy was formulated as an acknowledgement of the sexual and reproductive health and rights challenges which confront adolescents in the absence of a guiding framework. The rationale of the policy is to reduce morbidity and mortality associated with sexual and reproductive health activity among adolescents and young people.[726] The African Women's Protocol, in its definition of women, incorporates persons of the female gender, including girls; hence this Strategy document is in line with international and regional obligations towards adolescents' SRHR. Furthermore, General Comment No. 4 on the Convention on the Rights of the Child (CRC)[727] recognises that adolescence is a period of dynamic transition into adulthood, raises awareness of the sexual and reproductive health rights of adolescence and clarifies state obligations in that regard. Hence the formulation of strategies and policies for adolescent reproductive health is commendable and in line with Article 13(1) of the Convention on the Rights of the Child.

Articles 17 and 24 of the Convention on the Rights of the Child obligate states to ensure access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs) among others. [728] The Special Rapporteur on Torture has articulated the importance of access to reproductive information and highlighted that it is imperative to a woman's exercise of reproductive autonomy, her rights to health and physical integrity.[729] One notes that these guarantees are essential to adolescent girls during humanitarian emergencies as they improve their well-being capacitate them with

[726] National Adolescent Sexual Reproductive Health Strategy (2016-2020).

[727] General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the child CRC/GC/2003/4, available at: *https://www.refworld.org/docid/4538834f0.html* (accessed 9 January 2022).

[728] General Comment No. 4 (2003) Adolescent Health and Development in the Context of the Convention on the Rights of the para 24.

[729] Centre For Reproductive Rights '(2013) 4.

agency and enhance their capabilities through restoring dignity in line with the capabilities approach.

The National Adolescent Sexual Reproductive Health Strategy (2016-2020) acknowledges the risk of teenage pregnancies on rural adolescents compared to their urban counterparts as well as the prevalence of child marriages in rural areas.[730]The National ASRH Strategy amplifies the need to target the underlying causes of impediments to adolescents' access to SRHR, which equally affect adult women.

One notes that women's economic status and their social environment have a bearing on their access to reproductive rights. This is why the Strategy suggests that in order to address the identified obstacles to women's access to SRHR, there is a need to address the underlying causes through mentoring and economic empowerment, livelihoods and skills development, and promotion of educational opportunities to strengthen the enabling environment women and girls thrive in.[731] Adolescents' reproductive health needs in humanitarian settings are not specifically provided for, and one would have to widen the provision on under-saved and vulnerable adolescents and young people living in informal settings in order to accommodate such a context[732]

Notable is that the Strategy is alive to the inconsistency in the Zimbabwean legal and policy framework already alluded to in this study. Whereas the Constitution provides 18 years as the marriageable age for both boys and girls, the Marriages

[730] National Adolescent Sexual and Reproductive Health Rights Strategy page 4. Furthermore, the theory of change identifies poverty, lack of access to ASRHR information, inadequate and irrelevant service delivery, inadequate policy and regulatory framework, as the major drivers for challenges of ASRHR challenges facing adolescents and young people in Zimbabwe. See page 14.

[731] National Adolescent and Youth Sexual and Reproductive Health Strategy (2016-2020)5.

[732] The Strategy refers to under saved and vulnerable adolescents and young people as those who are at high risk lacking adequate care and protection. This includes orphans and street children, adolescents with disabilities, adolescents with HIV and AIDS, adolescents living in informal settlements, adolescents with disability, in the labour market, sexually exploited, adolescents living below the poverty datum line.

Act Chapter 5:11 provides for a marriage of an adolescent between 16 and 18 with the consent of a guardian or a Judge of the High Court in the absence of a guardian or with Ministerial consent for a girl aged below 16 years. Moreover, the Customary Marriages Act Chapter 5:07 does not specify the minimum age of marriage, thus leaving a loophole which allows the practice of child marriages to continue.[733]

Although adolescent family planning services are not specifically contextualised to humanitarian emergencies, Zimbabwe has made strides in addressing their reproductive health rights through a comprehensive SRHR package which targets the most vulnerable and epitomises gender mainstreaming in service provision.[734] However, the 2020 CEDAW Committee Concluding Observations on Zimbabwe have bemoaned the long delays by Zimbabwe in amending subsidiary legislation to the Constitution.[735] CEDAW Committee General Recommendation No.28 under Article 2 of CEDAW recommends that Zimbabwe amends or repeals without delay sex discriminatory provisions, including those on marriage, property and the legal minimum age of marriage, in order to align them with the Constitution and CEDAW.

This study argues that unjustifiably long delays in ensuring a conducive legal and policy environment for the enjoyment of adolescents' and women's rights is in itself a violation of their human rights. Legal reform is a priority under radical African feminism to correct disadvantages and under the capabilities approach to make health services more responsive to women's needs.

4.7.3 National Health Strategy 2016 – 2020

The National Health Strategy 2016-2020 expresses the vision of the Ministry of Health and Child Care to have the highest possible level of health and quality of

[733] National Adolescent Sexual and Reproductive Health Rights Strategy page 5.

[734] National Adolescent Sexual and Reproductive Health Rights Strategy page 31

[735] CEDAW Committee Concluding Observations on the sixth periodic report of Zimbabwe CEDAW/C/ZWE/CO/6 paras 9-10.

life for all its citizens.[736] Its primary focus is expressed in its main goals: Goal 1: to strengthen priority health programmes, Goal 2: to improve service delivery platforms and entities and Goal 3: to improve the enabling environment for service delivery. Under Goal 1 Priority 3, the focus is on the reduction in maternal mortality ratio, women and adolescents' reproductive health and an acknowledgement of rural and urban discrepancies in service provision.[737]

Significantly to the context of humanitarian emergencies is that the National Health Strategy, in its Goal 1 Priority 4, makes provision for public health surveillance and disaster preparedness and response. Priority is given to strengthening environmental health services and early detection of disease outbreaks and man-made disasters. This study argues that although commendable, these provisions are not enough. Lack of specificity on the prioritisation of reproductive services and mention of only man-made and the exclusion of natural disasters in Goal 1 Priority 4 areas weakens the National health strategy given the propensity of Zimbabwe to experience pandemics, epidemics, and natural disasters[738]

It is commendable that the National Health Strategy seeks to address gender mainstreaming and specifically targets women and young girls to improve gender equity and community participation at all levels.[739] This is in line with the basic tenets of the capabilities approach, which stresses women's effective participation as constituting truly human functioning and giving an impetus to lives worthy of human dignity .[740] Furthermore, The National Health Strategy aims to improve several outcomes related to priority health interventions, including in the areas of

[736] Zimbabwe National Health Strategy (2016-2020) page 35.

[737] Zimbabwe National Health Strategy (2016-2020) xi.

[738] See Bonga W G 'Poverty and pandemic response in Zimbabwe' (2020)1-9. Bonga looks at how for decades Zimbabwe has been experiencing an economic and humanitarian crisis as well as macroeconomic stability. The article details how challenges of persistent poverty in the country has continued to affect women and young people. The article traces the history of pandemics internationally and in Zimbabwe and how government of Zimbabwe has responded to previous pandemics, epidemics and natural disasters up to the time of the Covid 19 pandemic in 2020.

[739] National Health Strategy (2016-2020) xii.

[740] Nussbaum M 'Feminism and International Development' (20120 33.

reproductive, maternal, new-born, child and adolescent health; communicable diseases (Human Immunodeficiency Virus - HIV, Tuberculosis (TB); and creation of an enabling environment for the delivery of quality services through appropriate policy and regulatory frameworks, reduction of financial barriers, improved procurement and supply of health products and equipment, and improved infrastructures, amongst other things.[741] This is ambitious but in line with international and regional norms and standards.[742]

The acknowledgement by the National Health Strategy of the national budgetary allocation for health's failure to meet the Abuja Declaration threshold reflectsa government alive to its obligations and shortcomings.[743]The promulgation of the National Health Strategy, which provides for family planning services, is a stride towards the fulfilment of the state's core obligations provided for in international law as stated in General Comment No. 22 as follows.

> "To adopt and implement a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health, which is devised, periodically reviewed and monitored through a participatory and transparent process, disaggregated by prohibited ground of discrimination."[744]

4.7.4 National Development Strategy 1 (2020-2025)

[741] National Health Strategy page 2.

[742] See Article 12 ICESCR, Article 14 African Women's Protocol, Article 16 CEDAW, CESCR General Comment No. 22 para 49(c), CESCR General Comment No. 14 paras 34-37.

[743] See National Health Strategy (2016-2020) 52. In terms of The Abuja Declaration, In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector available *https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf (*accessed on 15 January 2022.

[744] See CESCR General Comment No. 22 para 49(b).

The National Development Strategy 1 (NDS1), whose theme is 'Towards a prosperous and empowered upper middle-income society by 2030', is a 5-year development plan being implemented under the country's vision 2030.[745] The Ministry of Finance and Economic Development is the custodian of NDS1 which replaced the Transitional Stabilisation Programme from October 2018 to December 2020. Pillar 3 of the NDS1 focuses on health and well-being.[746] The programme document integrates the 17 SDGs within 14 national priorities. NDS1 does not explicitly address reproductive health rights, so one assumes that it can be read in the right to health, been defined at the international level as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[747] However, NDS1 identifies increased water, sanitation and a healthy environment as key strategies or outcomes of the right to health and well-being. This is in line with CEDAW General Recommendation 24, which requires that state parties should facilitate rural women's access to physical and economic productive resources and take steps to ensure their nutritional needs are met.[748]

Given the background of humanitarian emergencies in Zimbabwe, NDS1 entrenches the need to strengthen disaster management as a critical strategy. If such an outcome is buttressed with how to address reproductive rights in general and family planning services in particular during disasters, it would be a major stride in the Zimbabwean context. It is of significance to note that NDS1 amplifies the protection of human rights and freedoms under the Governance priority and provides for human rights as a priority area. Under this provision, National Human Rights Institutions (NHRIs) such as the Zimbabwe Gender Commission[749] and the

[745]United Nations 2021-2025 National Development Strategy (NDS1) available *https://zimbabwe.un.org/en/153007-2021-2025-national-development-strategy-nds-i* (accessed on 8 March 2023).

[746] United Nations 'National Development Strategy 1' (2020)162-169.

[747] See the WHO definition of health as cited in this study.

[748] CEDAW General Recommendation No. 24 para 7.

[749] The Zimbabwe Gender Commission is established in terms of Section 245 of the Constitution of Zimbabwe Amendment No. 20 Act 2013 and operationalised in terms of the Zimbabwe Gender Commission Act Chapter 10:31.

Zimbabwe Human Rights Commission[750] need their capacities to be strengthened so that they deliver on their mandates, chiefly the advancement of human rights and good governance. One notes that these NHRIs have a role in educating the citizens of Zimbabwe on their sexual and reproductive rights, considering complaints related to SRHR violations,investigating alleged violations and providing redress. Such mechanisms would provide remedies for women whose reproductive health rights are violated during humanitarian emergencies. Moreover, both the (ZGC) and the (ZHRC) have thematic working groups which focus on women's rights and are mandated to monitor the upholding of women's family planning services even during humanitarian emergencies.

NDS1 prioritises gender mainstreaming and contains strategies and deliverables for gender mainstreaming in the development agenda. One of the key strategies is to ensure the entrenchment of gender-sensitive policies and legislation, among others. This is a notable consideration taking into cognisance that the laws and policies in this section have to be updated with gender-tailored solutions to women's challenges in accessing family planning services during humanitarian emergencies. Notably, this aligns with the capabilities approach, which advocates for tailored interventions as a basis for development.

4.7.5 Extended Zimbabwe National HIV and Aids Strategic Plan (ZNASP3) (2015-2020)

It has been realised that Africa carries the world's burden of sexual and reproductive ill health.[751] Lack of access to sexual and reproductive health remains a challenge

[750] The Zimbabwe Human Rights Commission is established in terms of Section 242 of the Constitution of Zimbabwe Amendment No. 20 Act 2013 and operationalised by the Zimbabwe Human Rights Commission Act Chapter 10:30.

[751]'Global burden of diseases in Sub Saharan Africa' available at https://www.medicalacademic.co.za/news/global-burden-of-diseases-in-sub-saharan-africa/ (accessed on 19 December 2022).

for most Africans.[752] The Extended Zimbabwe National HIV and AIDs Strategic Plan's main goal is to improve the well-being and health of all population groups through universal access to HIV prevention, treatment, and care and support services. It also recognises gender mainstreaming as an approach that informs responses across all result areas.[753]

The African Women's Protocol is the first internationally legally binding instrument to recognise the intersection between women's human rights and HIV. General Comment 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 provides for women's right to self-protection and to be protected against STIs including HIV/ AIDs and the right to be informed of one's status and that of their partner if affected with STIs and HIV/AIDS.

Women and girls are identified as groups that are likely to be at substantial risk of HIV infection and require a targeted response to HIV/AIDS. This is commendable for women in humanitarian emergencies as they experience disproportionate burdens and risk factors, increasing their vulnerability to HIV/AIDS. HIV prevalence among young women of 20-24 years is recorded at 2, 78 times greater than their male counterparts.[754] Rural women often experience violations of their reproductive rights more than other women; hence the strategic plan ought to be specific on how women living with HIV are to be targeted and prioritised on access to family planning services in such settings. The African Women's Protocol articulates state obligations to guarantee rural women adequate, affordable and accessible health services.[755] The Strategy identifies several gaps and challenges to Zimbabwe's response to HIV/AIDS but does not articulate the challenges posed by

[752] Report of the Commission on women's health in the African Region 'The health status of women in the African Region' (2007) 35 available at *https://www.afro.who.int/sites/default/files/2017-06/report-of-the-commission-on-womens-health-in-the-african-region---chapter-3.pdf* (accessed on 13 February 2022).

[753] The Extended Zimbabwe National HIV and AIDs Strategic Plan (2015-2020) page 10

[754] The Extended Zimbabwe National HIV and AIDs Strategic Plan (2015-2020) page 26.

[755] See African Women's Protocol Article 14(2) (a).

humanitarian emergencies and the possible interventions to ensure populations living with HIV/AIDS are still able to access SRHR in such contexts. Thus, one identifies that there is a weak policy environment when it comes to specifically addressing women's access to family planning services during humanitarian emergencies.

In terms of General Comment 1, states have an overall obligation to create an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected.[756] One notes that this provision extends to elements of reproductive rights, namely access to reproductive information,[757] equality and non-discrimination,[758] life,[759] dignity,[760] health,[761] self-determination, privacy[762] and the right to be free from all forms of violence.[763] The constituent elements of reproductive health enable women and adolescents to make informed decisions and are instrumental in their reproductive self-determination. Reproductive rights are at the core of human rights and essential to achieving substantive equality. So in policy analysis, it is of importance to note that substantive equality requires not only Zimbabwe to rubberstamp its obligations by crafting laws and policies that are seemingly gender sensitive but it requires states to be accountable for the effectiveness of those laws and policies in improving women's equality to men in

[756] General Comment 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 para 10.

[757] Article 14(2) (a) African Women Protocol extends this right to especially women in rural areas.

[758] Article 18 African Charter on Human and People's Rights calls on state parties to eliminate discrimination against women and ensure protection of women's rights in accordance with international conventions and declarations, Article 2 CEDAW.

[759] Article 4 African Women's Protocol.

[760] Article 3 African Women's Protocol.

[761] Article 14 African Women's Protocol.

[762] See Generally the African Women's Protocol.

[763] See also African Platform for Action (Fifth African Regional Conference on Women) 1994, Dakar Declaration of 1994 and the Beijing Platform for Action of 1995.

accessing human rights.[764] Furthermore, one notes that laws and policies are ineffective if not complemented by adequate budgetary allocations and human and technical resources to ensure implementation for the intended beneficiaries.[765] Sen's version of the capabilities approach values the availability of resources, for they are core to an evaluation of the capability relationship and notably on how well life is going.

4.7.6 National Climate Policy 2017

The National Climate Policy[766] is housed in the Ministry of Environment, Water and Climate and aims to address unfolding challenges brought by climate change. The Policy acknowledges the Paris Agreement, which considers the rights of indigenous peoples, local communities, migrants, children, persons with disabilities and people in vulnerable situations, their right to development as well as gender equality and women's empowerment.[767] Although the Policy includes a gender component for the health sector to understand the impact of climate change on women, children, youth and persons with disabilities,[768] the CEDAW Committee has expressed its concern about the disproportionately adverse effects of Cyclones and Floods in Zimbabwe and the information gap on the National Climate Change Response Strategy of 2014 and the lack of clarity on the inclusion of women's voices and participation.[769] The CEDAW Committee acknowledges that the crisis exacerbates pre-existing gender inequalities and compound intersecting forms of

[764] Centre For Reproductive rights (2013)2.

[765] See CEDAW Committee Concluding Observations on the sixth periodic report of Zimbabwe CEDAW/C/ZWE/CO/2020/6 para 19.

[766]Zimbabwe National Climate Policy available at *http://www.climatechange.org.zw/sites/default/files/National%20Climate%20Policy.pdf.* (accessed on 23 January 2022).

[767] National Climate Policy (2017)2.

[768] National Climate Policy (2017)6.

[769] CEDAW Committee Concluding Observations on Zimbabwe CEDAW/C/ZWE/CO/ 2020 paras 47-48.

discrimination against women with disabilities, internally displaced and living in rural[770] areas, thus demonstrating the severity of burdens, risks and impacts on women in humanitarian emergencies.

In the context of climate change, states have a duty to ensure equality and non-discrimination, women's participation and empowerment, access to information, and access to justice[771] , which are essential in ensuring that all interventions, including the provision of family planning services, are done in tandem with the CEDAW. General Recommendation No. 37 provides that apart from having gender-responsive Climate Change Policies, monitoring and budgeting activities should be fully integrated within health services and systems and spell out how the sexual and reproductive health rights of women will be met during disaster periods.[772]

One way of denoting Zimbabwe's compliance with its international and regional obligations through laws, policies and programmes and institutions towards advancing women's reproductive rights is to look at the international and regional human rights mechanisms' assessments on Zimbabwe. For example, the 2020 Concluding Observations on Zimbabwe by the Committee on CEDAW has indicated that while these institutions exist at law, one crippling factor confronting them is inadequate human, technical and financial resources to enable them to carry out their mandates effectively.[773] In Sens's version of the capabilities approach, resources and utilities are a means to an end, that is, a person's ability to do certain things.[774]

[770] CEDAW General Recommendation No 37 on Gender Related Dimensions of disaster risk reduction in the context of climate change CEDAW /C/GC/37.

[771] CEDAW General Recommendation No.37 Paras 25-27.

[772] CEDAW General Recommendation No. 37 paras 65-67.

[773] CEDAW Committee Concluding Observations on Zimbabwe CEDAW/C/ZWE/CO/ 2020 paras 19-22.

[774] Barreda LR et al (2019)20.

As of 2020, a year after the March 2019 Cyclone Idai, it was noted with concern that Zimbabwe was still confronted by high costs of healthcare beyond what citizens could afford, shortage of drugs and supplies in maternity clinics, limited reproductive health information, shortage of trained midwives and health professionals and a constant high maternal mortality rate and emphasis on the plight of those living in rural areas among a myriad of challenges.[775] The theoretical underpinnings of this study assist in evaluating whether Zimbabwe's laws and policies on family planning advance the well-being and dignity of women during humanitarian emergencies. Additionally, radical African feminism assists in an assessment of whether Zimbabwean women are empowered through laws, policies and programmes to access family planning services free from male dominance.

4.8 CONCLUSION

This chapter analysed Zimbabwe's laws, policies and programmes on women's family planning services and elaborated on the typology of international human rights obligations imposed on states. The chapter discussed accessibility, acceptability, affordability, availability, and quality in the context of the provision of women's family planning services during Cyclone Idai.

This chapter demonstrated how women's access to life-saving reproductive health rights is a precursor to gender equality and empowerment. The chapter investigated how the capabilities approach and radical African feminism speak to current laws, policies and programmes regarding women's access to reproductive health in emergencies. Legal and practical hurdles were observed regarding women's capabilities to attain reproductive health services in crisis settings .

Notably, while the Constitution, subsidiary legislation, policy and programme documents contain commendable provisions on reproductive health, their

[775] CEDAW Committee Concluding Observations on Zimbabwe CEDAW/C/ZWE/CO/ 2020 para 39(a).

inadequacy is in that they do not specifically provide for women's access to reproductive services in the context of humanitarian emergencies. In addition, there is a general lack of prioritisation of women and adolescents' reproductive rights in the said documents. The study utilised Concluding Observations, the Universal Periodic Review and the African human rights system and noted Zimbabwe's shortcomings in its obligations towards women's reproductive health.

CHAPTER 5. ENSURING ACCESS TO REPRODUCTIVE HEALTH SERVICES FOR WOMEN DURING HUMANITARIAN EMERGENCIES: LESSONS FROM PHILLIPINES AND ETHIOPIA.

5.1 INTRODUCTION

The preceding chapter analysed the laws, policies and programmes available in Zimbabwe in relation to women's access to reproductive rights during humanitarian emergencies. The analysis exposed legal and practical inhibitions faced by women in accessing family planning information and services in the context of humanitarian emergencies.

The study has highlighted weaknesses in Zimbabwe's legal, policy and programmatic environment, inadequate to ensure that women access family planning services during humanitarian emergencies. Given this state of affairs, this chapter seeks to draw lessons from the Philippines and Ethiopia, which have made progress in advancing women's reproductive health services through their experiences with humanitarian emergencies. Furthermore, the Philippines and Ethiopia have made strides through their legal and policy frameworks, which are in some respects attentive to women's reproductive health services during emergencies.

The Philippines and Ethiopia are on different continents, namely the Asia Pacific and Africa, respectively and experience disasters of entirely different dimensions. Philippines have been prone to several natural disasters which fall in the same category as Cyclone Idai. Ethiopia offers lessons from an African perspective when addressing women's reproductive rights in the context of armed conflict. One notes that for Zimbabwe to learn from the complex circumstances of women from Ethiopia is what radical African feminism aligns with by tackling the needs and experiences of continental African women.

Lessons drawn from the two countries combined include, among others, robust and adaptive gender-responsive institutions, specificity in legal and policy provisions

on women's reproductive rights during disasters, legally binding provisions on disaster finance, community and women's participation in the disaster management continuum, provisions on tailored psychosocial support to distressed disaster-affected populations, adolescent reproductive health legal recognition and multi-sectoral composition of disaster response institutions. Lessons are drawn from not all but just relevant key legal, policy and programmatic frameworks from these two countries. The next section briefly provides, the background around the propensity of humanitarian emergencies in Philippines and Ethiopia.

5.2. DISASTER RISK PROFILES OF PHILIPPINES AND ETHIOPIA

5.2.1 Disasters risk profile of Philippines

Philippines has been struck by many catastrophic storms and other natural and man-made disasters because of its geographic location in the typhoon belt and ring of fire between the Eurasian and Pacific tectonic plates.[776] The country is prone to cyclones, floods, earthquakes and landslides and ranked third among all the countries with the highest risks worldwide.[777] Almost sixty per cent of the country's total land is exposed to natural hazards, while 74% of the population is highly vulnerable to disasters.[778] According to the United Nations Office for Disaster Risk Reduction (UNISDR)[779], women are more exposed to disaster risks than men and face higher mortality and morbidity rates. A study on the effects of disasters on economically challenged women in the Philippines observed that during disasters, the delivery of prenatal care decreases, thus heightening the high risk of pregnancies

[776] UNDRR 'Disaster risk reduction in the Philippines Status report' (2019)6.

[777] World Economic Forum 'World Global risks report' (2018) available at *https://www3.weforum.org/docs/WEF_GRR18_Report.pdf* (accessed on 11 March 2022)

[778] Mangahas T L S et al 'Economically Challenged Women in Disaster Risk Management: Toward a Resilient Filipino Community' (2018)43.

[779] United Nations International Strategy for disaster reduction (2007) available at *https://www.unisdr.org/files/547_gendergoodpractices.pdf Accessed on 10 June 2022.*

and poor maternal and foetal outcomes.[780] In addition, women's reproductive roles of pregnancy and childbirth make them particularly vulnerable to disasters, thus making reproductive health services for expectant and nursing mothers, particularly critical.[781] In 2022 following Typhoon Odette (Rai) in Philippines, UNFPA called for urgent sexual and reproductive health interventions because pregnant women faced life-threatening complications due to lack of access to delivery and emergency obstetric care, loss of access to family planning services exposing them to unintended pregnancies and sexual violence.[782]

5.2.3 Disaster risk profile of Ethiopia

Ethiopia is the second most populous country in Sub-Saharan Africa, whose increased climate variability is associated with the ElNiño Southern Oscillation (ENSO), which exposes the country to floods, earthquakes and droughts.[783] Additionally, humanitarian needs in Ethiopia are driven by the escalation of conflict-induced displacement in the Tigray region, which began in November 2020. The conflict has seen a heightened demand for maternal and newborn health services, family planning as well as gender-based violence prevention and response

[780] Mangahas et al (2018)44.

[781] See Generally 'Women and Girls in disasters' available at *https://disasterphilanthropy.org/resources/women-and-girls-in-disasters/* (accessed on 10 June 2022).

[782] See 'UNFPA Philippines calls for urgent donations for women and young girls affected by Typhoon Odette (Rai)' available at *https://reliefweb.int/report/philippines/unfpa-philippines-calls-urgent-donations-women-and-young-girls-affected-typhoon* (accessed on 10 June 2022). It was reported that as a result of this typhoon 4 million women and girls of reproductive age in 13 provinces were affected. Of these, an estimated 162,000 were believed to be pregnant, of whom 24,000 were likely to experience complications. An estimated 470,000 women living in the affected areas reportedly had an unmet need for family planning information and services, including contraceptives.

[783] Irish Aid 'Ethiopia country climate risk assessment report' (2018)5.

services.[784] In March 2022, UNFPA estimated that 25,9 million people in Ethiopia needed humanitarian aid due to intercommunal conflicts, climate shocks and disease outbreaks coupled with the socio-economic impact brought by covid 19 pandemic. Among those affected, over 100 000 were pregnant and lactating women, thus bringing to the fore the plight of women to access reproductive services during humanitarian emergencies.[785]

5.2.4 Rights and obligations arising from humanitarian emergencies

International law provides that governments are responsible for taking care of victims of humanitarian emergencies through the initiation, organisation, coordination and implementation of humanitarian assistance.[786] Protecting the lives and dignity of women in humanitarian emergencies enhances their capabilities to enjoy reproductive self-determination in line with the capabilities approach. CEDAW Committee General Recommendation No.37 provides guidelines onimplementingstate party obligations relating to disaster risk reduction and climate change under CEDAW.[787] National legal systems should provide the main regulatory framework to ensure the protection of women's reproductive needs in the wake of humanitarian emergencies. CESCR General Comment No. 22 provides that states have the duty to craft laws, policies and ensure institutional arrangements

[784]UNFPA 'Ethiopia Humanitarian emergency' available at *https://www.unfpa.org/data/emergencies/ethiopia-humanitarian-emergency* (accessed on 10 June 2022.

[785] UNFPA 'Ethiopia Humanitarian response Situation report March 2022' (2022)1-6.

[786] United Nations General Assembly 'Resolution on Strengthening the effectiveness and coordination of international urban search and rescue assistance.' 57th session A/RES/57/150.

[787] United Nations Committee on The Elimination of All Forms of Discrimination Against Women See General Recommendation No. 37 on the gender related dimensions of disaster risk reduction in the context of climate change.

and social practices which advance the enjoyment of women's sexual and reproductive health and rights.[788]

Regionally, The African Commission lays down women's right to the highest attainable health standard, including sexual and reproductive health and rights.[789] Although the aforementioned General Comment focuses on women's right to self-protection and to be protected from HIV infection, it stipulates the state's overall obligation to create an enabling, supportive, legal and social environment that empowers women to realise their reproductive rights.[790] Furthermore, state parties are obliged to guarantee substantive equality between men and women by providing healthcare services, including sexual and reproductive health and mental and psychological services.[791] The next section singles out key pieces of legislation, policies and programmes from the Philippines and Ethiopia that guide the Zimbabwean context.

5.3. PHILIPPINES' LAWS, POLICIES AND PROGRAMMES ON WOMEN'S FAMILY PLANNING SERVICES DURING HUMANITARIAN EMERGENCIES

5.3.1 The Constitution of the Republic of Philippines

In Philippines, the Constitution provides for the protection and promotion of the right to health and adoption of a comprehensive approach to essential goods and

[788] CESCR General Comment No.22- paras 33 -64.

[789] African Commission on Human and People's Rights General Comment on Article 14 (1)(d)(e) on the Protocol to the African Charter on Human and People's Rights on the rights of women in Africa para 5.

[790] The General Comments speak to women's right to self-protection and to be protected from HIV through the legal, policy and social environment facilitated by the state.

[791] CEDAW General Recommendation No.37 para 65.

services[792] Priority is given to the special needs of the elderly, sick, the underprivileged, disabled, women and children.[793] In its Declaration of state policies, the Philippines Constitution acknowledges the sanctity of family life as a basic and autonomous social institution which shall be strengthened and protected by the state.[794] The Constitution of Zimbabwe in Section 76 (1) (4) provides access to basic health services, including reproductive health, and this obligates the state to protect, promote and respect women's reproductive rights. The right to found a family is entrenched[795] thus, one argues that, by extension, the freedom of adults to consent to marriage is recognised, and the dignity to reproduce is acknowledged.

5.3.2 SUBSIDIARY LEGISLATION PROVISIONS ON WOMEN'S REPRODUCTIVE RIGHTS IN PHILIPPINES

5.3.3 Philippines' Magna Carta of Women

The Philippines Magna Carta of Women[796] singles out women affected by disasters, calamities and other crises and entrenches their right to a comprehensive package of rights, goods and services. A comprehensive health package addresses the causes of women's mortality and morbidity and respects women's religious convictions, thus mirrors some of the important principles underpinning CEDAW[797] , the Paris Agreement under the United Nations Framework Convention on Climate Change

[792] Section 15 Constitution of the Republic of Philippines.

[793] Article 4 Section 1(c) Phillipines Republic Act No.9994 (Expanded Senior Citizens Act of 2010).

[794] Section 12 1987 Constitution of The Republic of Philippines.

[795] Section 78 Constitution of Zimbabwe provides that anyone who has attained the age of 18 has the right to found a family and that no one should be compelled to marry against their will.

[796] The Magna Carta of Women Republic Act RA 9710.

[797] See Article 12 (1) CEDAW which prescribes the elimination of discrimination in the field of health and provides for equality in the access to healthcare services including those related to family planning.

and the Conference of the Parties.[798] Furthermore, CEDAW General Recommendation No.37 reiterates the need for state parties to ensure that sexual and reproductive health services are made available, accessible, acceptable and of good quality, even in the context of disasters.[799]

Progressively, there is recognition of the need for immediate humanitarian assistance soon after a disaster, including addressing the particular reproductive and psychosocial needs of women, the need for allocation of resources, and the protection of women from sexual and gender-based violence, among others.[800] In this regard, the law pays special attention to women affected by humanitarian emergencies and prescribes gender-responsive reproductive health, which is missing in the Zimbabwean context. Moreover, reproductive rights and the freedom to make choices are some of the basic tenets of radical African feminism which inform this study. Relatedly, the recognition given to women's reproductive rights is in tandem with the capabilities approach, which affirms broader issues like bodily health, autonomy, human dignity and agency.

Chapter 3 of the Magna Carta of Women provides for state duties related to women's human rights in general, such acknowledgement is much needed during emergencies. Section 10 provides for the rights to security and protection of women affected by a range of disasters in all phases of relief, recovery, rehabilitation and construction efforts. The acknowledgement of women's right to comprehensive health services in Section 17 of the Magna Carta is pertinent, especially for women in humanitarian settings whose lives would have been disrupted, experienced loss and trauma and require a restoration of dignity. Furthermore, women in

[798] United Nations Climate Change Paris Agreement (2015) 2 available at *https://unfccc.int/process/conferences/pastconferences/paris-climate-change-conference-november-2015/paris-agreement* (accessed on 17 April 2022).

[799] United Nations Committee on the elimination of all forms of discrimination against women General Recommendation No.37 on the gender related dimensions of disaster risk reduction in the context of climate change (2018) para 65.

[800] Section 10 The Magna Carta of Women.

emergencies require protection from sexual and gender-based violence. Dignity is a fundamental feature of women's capabilities and well-being as it enables them to engage the world and make significant decisions.

The Magna Carta of Women in Philippines represents the epitome of the prioritisation of women's access to reproductive health services during humanitarian emergencies. This key piece of legislation has a gendered interwoven disaster management lens which obliges the state to ensure that 'special' efforts are made to include women's participation and representation in decision-making and policy-making processes in planning and management in government and private entities.[801] Women's full participation in matters which affect them is emphasised in their involvement in the planning and management of relief operations. One notes that this tallies with the capabilities approach, which recognises women's health as a precursor to their ability to function and, most importantly, participate in development processes which affect them. Furthermore, radical African feminism also calls for the disbanding of the social domination of women by men through women's effective representation in private and public life.

In line with international standards, a broad range of key state institutions in Philippines' disaster management framework are mandated to observe the Minimum Initial Service Package (MISP) for Reproductive health in relief operations.[802] Furthermore, one notes that the law is specific to family planning service needs of specific groups of women, such as those with disabilities, lactating mothers, pregnant women, senior citizens, and mothers with dependent children.[803] This demonstrates that the crafters of the Magna Carta for Women in Philippines were clear that women in humanitarian emergencies are not a homogeneous group but have different experiences and diverse needs, although they are found in one humanitarian emergency context.

[801]Section 11 Magna Carta of Women Section.

[802] Section 12(B)(2) Magna Carta of Women.

[803] Section 12(B) (3-4) Magna Carta of Women 12(B) (3-4).

Tailor-made provisions for specific women's reproductive needs during humanitarian emergencies in the Magna Carta resonate with the notion of substantive equality found in Article 18 of the CEDAW and as enumerated in the African Women's Protocol.[804] Social inclusion through prioritisation of women's reproductive needs in emergencies tallies with substantive equality which requires attention to context, intersectionality, dignity and aims at gender justice. Radical African feminism's pursuit of substantive equality, seeks transformation by focusing on women's situations.[805]

Section 13(B)(3) of the Magna Carta of Women articulates the prioritisation of social determinants for sexual and reproductive health rights.[806] Timely, adequate and culturally sensitive provision of relief goods and services such as food, water, sanitary packs, psychosocial support, livelihood, education and comprehensive health services, including implementation of the MISP for sexual and reproductive health at the early stage of the crisis is prescribed in Section 13(B)(3) of the Magna Carta for Women. Addressing women's access to social determinants of SRHR in humanitarian emergencies equates to addressing the underlying drivers of inequality and advancement towards health equity.[807] This is a valuable lesson to Zimbabwe to ensure the legal provision of social determinants of health during emergencies, as it does not currently provide for a minimum threshold of reproductive services or supporting social determinants to be made accessible to women during disasters.[808] Arguably, one's living conditions are a necessary ingredient to their overall well-being and in assessing of whether they are living a life truly worth living as per the capabilities approach.

[804] Stefiszyn K 'Adolescent girls, HIV and state obligations under the African Women's Protocol' in Ngwena C &Durojaye E *(eds*) in 'Strengthening the protection of sexual and reproductive health and rights in the African region through human rights' (2014)158-159.

[805] Dosekun S 'Defending feminism in Africa' (2007)

[806] See also generally Section 12(B) (1-4).

[807] WHO 'Closing the gap in a generation: Health Equity through action on the social determinants of health' (2008) 155.

[808] Social determinants to health are spelt out in CESCR General Comment No. 22 with reference to CESCR General Comment No. 14.

The Magna Carta of Women in Philippines specifies the significance of family planning services provision. Section 17(1-11) contains all-encompassing provisions relating to women's right to maternal care, promotion of breastfeeding, ethical, legal, safe and effective methods of family planning, youth sexuality education, among other elements. Notably, the law recognises the significance of the management, treatment and intervention of mental health problems of women and girls, a critical element of a comprehensive reproductive health package, especially for women affected by humanitarian disasters.[809] One argues that the attainment of well-being by women in humanitarian settings is partly achievable through mental health support services as outlined in the Magna Carta of Women. Legal cushioning of the adversity of disasters on women in order to preserve their dignity and well-being is a stride towards the laid down approach of the capabilities approach, a lesson for Zimbabwe.

5.3.4 Law on Responsible Parenthood and Reproductive Health Act 2012 of Philippines

The Law on Responsible Parenthood and Reproductive Health Act 2012 of Philippines speaks to the provision of mobile healthcare services aimed at the delivery of healthcare goods and services with appropriate transport suited to the terrain and aimed to reach the less privileged,[810] thus reaching out to disaster-affected women. This can be emulated in Zimbabwe in the event of infrastructural damage to health care service centres and possibly the road or rail networks, as has been experienced during Cyclone Idai.

The Law on Parenthood and Reproductive Health of 2012 pertains to the requirement for private and non-governmental reproductive health service providers to provide at least 48 hours of annual free reproductive health services ranging from reproductive information dissemination to free medical

[809] Section 17(a)(11) Magna Carta of Women.
[810] See Section 13 Responsible Parenthood and Reproductive Health Act of 2012.

services to indigent and low-income patients who include adolescents.[811] Pertinently, this speaks to a corporate social responsibility perspective that renders private specialised reproductive health services mobilizable and accessible to women during humanitarian emergencies, a key lesson to Zimbabwe.

5.3.5 Philippines' Climate Change Act /10174/2011

In Philippines, The Climate Change Act/ 10174/2011 promulgates disaster management implementation structures with the creation of the Climate Change Commission (CCC), a broadly constituted structure.[812] Additionally, The Disaster Risk Management Act (2010) constitutes a National Disaster Risk Reduction and Management Council (NDRRMC)[813] composed of multi-disciplinary stakeholders. Zimbabwe may find it useful to borrow this setup and set up multiple structures to tackle specific disaster-related concerns. Currently, all disaster burdens are on the shoulders of The National Civil Protection Committee,[814] a national organ housed under the Ministry of Local Government, Public Works and National Housing.[815] However, the Zimbabwean legislative framework does not assign a clear mandate and responsibilities to the National Civil Protection Committee for the prioritisation of women's reproductive services during disasters. One notes that Philippines's disaster management institutions are coordinated at law in the advancement of specific groups' needs during emergencies. Furthermore, community involvement takes centre stage in disaster management,[816] ensuring different groups' voices are expressed. Arguably, this could be linked to the capabilities approach, which recognises individual human dignity through practical reason.

[811] See Section 17.

[812] Philippines Climate Change Act Republic Act 10174 Section 4.

[813] Section 5 Disaster Risk Reduction and Management Act.

[814] Section 4(2) (a-h) Civil Protection Act Chapter 10:06.

[815] Section 4 Civil Protection Act Chapter 10:06.

[816] Section 25 Philippines Climate Change Act 10174.

The 2015 Third International Conference on Financing for Development, committed countries to mainstream women's empowerment into financing andimplored countries to undertake legislative and administrative reforms to give women equal rights and promote gender-responsive budgeting and tracking, among other steps.[817] The African Regional strategy for disaster risk reduction calls for the establishment of strengthened dedicated public funding for disaster reduction through special funds by African governments.[818]This study argues for the formalisation of disaster funds in the legal framework with specific provisions on funding women's reproductive services in the context of humanitarian emergencies. This is echoed throughout CEDAW General Recommendation No 37[819] and The Sendai Framework for Disaster Risk Reduction.[820] In Philippines the Climate Change Act 10174 provides for climate finance[821] and a People's Survival fund[822] , among whose other functions is general health funding.[823] In Zimbabwe, the Civil Protection Act (Chapter 10:06) establishes a National Civil Protection fund financed by the central government[824] which is silent on funding women's reproductive health services. Additionally, the law has to provide institutional oversight of disaster management resources because of high-risk exposure to corruption.[825] Zimbabwe has to reconstitute a functional, funded disaster

[817] United Nations 'Third International Conference on Financing for Development 13-16 July 2015 A/CONF/.227/L.

[818] African Regional Strategy for disaster risk reduction 3:3:3.

[819] Committee on the Elimination of all forms of Discrimination Against Women
General recommendation No. 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change CEDAW/C/GC/37 paras 67,68b,

[820] United Nations General Assembly 'Sendai Framework for Disaster Risk Reduction 2015-2030' A/RES/69/283 para 27(i).

[821] Sections 3e, 4&5 Philippines' Climate Change Act.

[822] See Section 18 Philippines' Climate Change Act.

[823] See Section 20(a) Philippines' Climate Change Act.

[824] Sections 29-37 Civil Protection Chapter 10:06.

[825] Transparency International Zimbabwe 'Corruption Risk Assessment in the Management & Distribution of Social Protection Initiatives & Humanitarian Aid in Zimbabwe. A Case Study of Cyclone Idai & the Cholera Response' available at

management fund with allocations for women's reproductive health services in humanitarian emergencies.

5.3.6 PHILIPPINES' POLICY FRAMEWORK

5.3.6.1 Philippines National Climate Change Strategy

Key to this study are two policies, namely the National Climate Change Strategy and the National Framework Strategy on Climate Change. The National Climate Strategy is expressed through The National Climate Change Action Plan (NCCAP) (2011-2028). The Action Plan aims to build adaptive capacities of women and men [826] emphasising the differentiated impacts of climate change on men and women,[827] thus emphasise on their different needs. Significantly, the (NCCAP) recognises equitable differentiated responsibility and attentiveness to equal and equitable protection of the less privileged, women, children and other vulnerable and disadvantaged sectors.[828] The Action plan pays attention to the importance of providing skilled health personnel, climate change-responsive social determinants to health,[829] and pivotal in the provision of reproductive health services in emergencies.

5.3.6.2 National Framework Strategy on Climate Change 2010-2022

https://www.tizim.org/sdm_downloads/corruption-risk-assessment-in-management-distribution-of-social-protection-initiatives-humanitarian-aid-in-zimbabwe (accessed on 9 May 2023).

[826] Philippines National Climate Change Action Plan 2011-2028 page 5.

[827] See Articles 1(a), 1(h), 3, 4.

[828] Philippines National Climate Change Action Plan 2011-2028 Page 4.

[829] See pages 87, The provision of food security, water sufficiency, ecological and environmental stability, human security, climate friendly industries and services, sustainable energy and knowledge and capacity development are priorities in the NCCAP, See page 6 NCCAP.

The National Framework Strategy on Climate Change speaks to equal and equitable protection of people experiencing poverty, women, children and other vulnerable and disadvantaged sectors during humanitarian emergencies.[830] The Strategy is alive to the need for a robust resilient climate change infrastructure[831] to make the dispensation of reproductive goods and services effective and efficient. Additionally, the Strategy is alive to the impact of climate change disasters on the health of the affected populations[832] and advocates for a climate-responsive health sector[833] which, in the context of this study, should prioritise women and girls' reproductive rights in humanitarian emergencies. The two policies reflect gendered institutional response during emergencies, signalling commitment towards women's reproductive health. This is in line with the capabilities approach, which regards health as a necessary precondition for a well-lived life.

5.3.7 LESSONS FROM KEY PHILIPPINES' PROGRAMMES

5.3.7.1 Philippines National Family Planning Program

Philippines reproductive health policy aims to provide universal access to reproductive health services while using the Philippines National Family Planning Programme (PNFPP) as a flagship initiative. Impliedly men and women have an equal right to medically safe, legal, non-abortifacient, effective, and culturally acceptable modern Family Planning (FP) methods.[834] Responsible parenthood, birth spacing, respect for life and informed child spacing are some of the National

[830] Article 2:8 National Framework strategy on Climate Change 2010-2022.

[831] See Article 5:2:4 National Framework on Climate Change 2010-2022.

[832] National Framework Strategy on Climate Change 2010-2022 page 18

[833] Article 9:5 National Framework strategy on Climate Change 2010-2022.

[834] Republic of Philippines Department of Health See 'National Family Planning Program' available at *https://doh.gov.ph/family-planning* (accessed on 9 April 2022).

Family Planning Programme's guiding principles.[835] The Program also provides adolescent health and youth development programs and general family planning methods for both men and women. Significantly, the Family Planning Program aims to design and implement innovative strategies to address socio-economic barriers to the enjoyment of reproductive rights of poor couples.

Zimbabwe has various initiatives aimed at fulfilling family planning needs administered by the Ministry of Health and Child Care[836] and the Zimbabwe National Family Planning Council[837] , but there is no specificity as to humanitarian emergency-tailored interventions. The capabilities approach is vital to assess women's reproductive needs in humanitarian emergencies to gauge if the available family planning services led to the attainment of individual freedom and agency and, ultimately, a life of well-being. Radical African feminism criticises patriarchal institutions which fail to reflect gender equality through the provision of gender-sensitive and contextually relevant services while allowing men to dominate.

5.3.7.2 Philippines National Development Plan 2017-2022

One of the objectives of The National Development Plan is to promote a long and healthy life for Filipino citizens through quality and affordable universal health care expressed through reproductive health and family planning programs.[838] The Plan calls for the improvement of the socio-economic conditions of poor women in urban areas and Geographically Isolated and Disadvantaged Areas (GIDAs), including indigenous women. Recognising the inherent vulnerabilities of women, children,

[835] Republic of the Philippines Department of Health 'National Family Planning Program' available at *https://doh.gov.ph/family-planning?msclkid=f43b75c7cf8411ec9579018aaf2fa40a* (accessed on 9 May 2022).

[836] Ministry of Health and Child Care Zimbabwe available at www.mohcc.gov.zw (accessed on 12 May 2022).

[837] Zimbabwe National Family Planning Council available at *https://www.znfpc.org.zw* (accessed on 12 May 2022).

[838] Philippines National Development Plan 2017-2022 page 10.

the elderly and persons with disabilities, the National Development Plan speaks of the need to put in place policies and programs to ensure their well-being in the context of natural and human-induced hazards. This provision is important to cushion women's sexual and reproductive health needs during humanitarian emergencies. By so doing, this resonates with the capabilities approach, which elaborates that human well-being and capability is achieved through the fulfilment of human rights such as access to good health and longevity (SDG2) which one may further break down into sexual and reproductive rights, food and nourishment (SDG2), gender equality (SDG5), access to clean water and basic sanitation (SDG6) among others.

The National Development Plan is a living document alive to the disruptions caused by emergencies when it comes to the implementation of routine and normal health programs and underscores the need to ensure health care for people with special needs, among who are indigenous persons, persons with disabilities, and those in the Geographically Isolated and Disadvantaged Area (GIDA) and disaster-prone areas (including where-women are) is prioritised.[839] By so doing, the National Development Plan churns out substantive equality as promoted by the CEDAW. It entails targeted women's access to family planning services during humanitarian emergencies by going past an understanding of equality for everyone but recognising differences among groups of people.

In Zimbabwe, the National Development Strategy 1 (NDS1) (2020-2025) in Pillar 3 focuses on health and well-being but does not specifically provide for reproductive health.[840] Philippines provides lessons for Zimbabwe and other jurisdictions because it incorporates international norms in the domestic framework. In particular, the Philippine National Development Plan 2017-2022 is specific to being founded upon the Sustainable Development Goals (SDGs) and the

[839]National Development Plan page140 There is also an acknowledgement that floods, earthquakes and pandemics to the provision of safe water, sanitation and health care services.

[840] National Development Strategy 1 (2021-2025) available *at www.zimtreasury.gov.zw* (accessed on 12 May 2022).

Sendai Framework for Disaster Risk Reduction and United Nations Framework Convention on Climate Change commitments. The international framework is thus used to monitor and evaluate the effectiveness of local CC and DRRM actions.

5.3.7.3 Philippine Plan for Gender Responsive Development 1995-2025

The Philippine Plan for Gender Responsive Development (PPGD) is the main vehicle for implementing the government's commitments to women's empowerment and gender equality emanating from the Fourth World Conference on Women[841] The PPGD spells out the need to incorporate gender perspectives in all phases of policy and program formulation and implementation.

The PPGD articulates various initiatives meant to ensure women attain their right to family planning expressed through Maternal Health Care, breastfeeding, nutrition, National AIDS/STD Prevention and Control Program, Breast and cervical cancer control programmes, among others.[842] In its goals and objectives of the women's health sector, the PPGD elaborates on the need to give priority to women's health, related programs and services to women marginalised by poverty, indigenous women, and those living under difficult circumstances, among them, those affected by disasters.[843] This would guarantee that in the context of humanitarian emergencies, women and girls are able to access and enjoy sexual reproductive health services.

[841] Philippine Plan for Gender Responsive Development 1995-2025 Executive Order No. 273.

[842] Philippines' other programs to improve women's health are Phippine Health Development project, Urban health and nutrition project, Women's health and safe motherhood program pages 65-66.

[843]Philippines Plan for Gender Responsive development Article pages 75-76.

5.4 ETHIOPIA LAWS, POLICIES AND PROGRAMMES ON WOMEN'S FAMILY PLANNING SERVICES DURING HUMANITARIAN EMERGENCIES

5.4.1 Constitution of the Federal Democratic Republic of Ethiopia

The Constitution provides for the protection and promotion of the working population's health, welfare and living standards.[844] Although there is no direct provision relating to women's reproductive services during humanitarian emergencies, Article 89(3) obliges the state to take measures to avert natural and man-made disasters and, in the event of disasters, to provide timeous assistance to the affected populations. Further, health, access to the public, education, clean water, housing, food and social security are guaranteed in Article 90 of the same Constitution. One argues that Article 90 is an acknowledgement that social factors influence people's abilities to exert control over their lives, as posited by the capabilities approach.

Gender equality for women to participate in economic and social development endeavours is expressed in Article 89(7). Notably, radical African feminism calls for the breaking down traditional gender-ascribed roles to allow women's participation in public. The right to marry and find a family is provided for in Article 34. Article 35(1) sets out the equal rights of women with men to reproductive health. In that regard, gender equality as an intrinsic value allows women capabilities towards the attainment of a well-lived life as per the capabilities approach.

Women's right to access family planning education, information and capacity, as well as the right to be protected from pregnancy and child birth-related harm[845] is provisioned in the Constitution. Article 35(a) recognises women's right to full consultation in the formulation of national development policies, design and

[844] Article 89(8) Constitution of the Federal Democratic Republic of Ethiopia.

[845] Article 35(9) Constitution of the Federal Democratic Republic of Ethiopia.

execution of projects which affect them, implying women's right to air their voices in the disaster management continuum. The state is obliged to set aside ever-increasing resources towards public health, education and other social services[846] , even during conflict periods. Radical African feminists view war as an aspect of male dominance because men's security lies in armies and weapons arsenals while African countries suffer military expenditure. On this basis, Amina Mama challenges governments to define security in terms of bodily integrity and freedom of women from abuse and exploitation during conflict.[847]

5.4.2 Subsidiary legislation provisions on women's reproductive rights in Ethiopia

5.4.2.1 Health Policy of the transitional government of Ethiopia 1993

In its general objectives, the Health Policy emphasises intersectional collaboration to enrich and intensify the concept of family planning.[848] Article 10(1-9) provides for, among other services, family health services which encompasses assuring adequate maternal health care,[849] and intensifying family planning.[850] One of the priorities of the policy is to give special attention to the health needs of women and children and victims of natural and man-made disasters[851] , which can be read to include women's reproductive health needs. Specificity to groups affected by disasters in policy documents is a key lesson to Zimbabwe. Radical African feminism pays attention to the effect of conflict on African women, for it results in violence against women and brings out the central feature of women's oppression.

[846] See Article 41 Constitution of the Federal Democratic Republic of Ethiopia.

[847] African Studies Association 'Feminists we love: Professor Amina Mama' available at *https://africanstudies.org/coordinate-organizations/october-2014/feminists-we-love-professor-amina-mama* (accessed on 12 May 2023).

[848] Article 3(3:1) Health policy of the Transitional Government of Ethiopia 1993.

[849] Article 10:1

[850] Article 10:2

[851] See Clauses 8:1 & 8:4.

5.4.2.2 National Policy of Ethiopian Women

In order to eliminate the gender gap (discrimination) and to enhance women's participation in all spheres of life, Ethiopia formulated a women's National Policy in 1993. The National policy of Ethiopian women advocates for the active participation of women in the political, social and economic spheres on an equal basis with men.[852] As one of the strategies for the implementation of the policy, the government is obliged to facilitate women's easy access to basic healthcare facilities and traditional and modern family planning methods. Furthermore, there is an acknowledgement in strategy 10 of the implementation of the policy that women who are impacted by disasters must be given aid promptly[853] , thereby prioritising their needs which include SRHR services.

5.4.2.3 Health sector transformation plans 11 2020/2021- 2024-2025

Ethiopia's Health Sector Transformation Plan (HSTP11) is the health sector's strategic plan from 2020-2025. The prevalence of natural and man-made shocks and stresses in Ethiopia is acknowledged in the strategy, including the 2020 covid 19 pandemic. That women and children are disproportionately affected by disasters isspelt out, with 1.2 million women and girls needing family planning and maternal health services during humanitarian emergencies.[854]

Article 3:3:2 provides for reproductive, maternal, neonatal child, adolescent, and youth health and specifies family planning services as an integral component of women's health.[855] The Health sector transformation plans score successes and challenges in achieving reproductive, maternal, neonatal, child, adolescent and youth health. The strategy is realistic and alive to the gender disparities in achieving

[852] Section 2:1 (Contents of policy) National Policy on Ethiopian Women

[853] Strategy 10 National Policy on Ethiopian Women.

[854] Health Sector Transformation Plan 11 2020-2025.

[855] See Article 3:3:2:1 Health Sector Transformation Plan 2020-2025.

women's health. It identifies them as limited enforcement of laws and policies on the rights of women and girls, limited health sector capacity in ensuring gender-responsive services and limited capacity for providing comprehensive, multisectoral services to survivors of sexual GBV.[856]

In the context of humanitarian emergencies, one notes that there are challenges confronting access. To remedy the identified socio-economic disparities, the Health Sector Transformative Plan advocates for equitable access to health services by women, youth, children, the uneducated, the poor, and people with disabilities.[857] This clause would ensure that women in humanitarian emergencies are able to access high levels of health outcomes and essential health services. Furthermore, in line with humanitarian contexts, there is provision for improving public health emergency and disaster management through timeous intervention in order to improve the well-being of the affected. This is in line with the capabilities approach, which calls for an overall improvement of women through equipping them with capabilities and functioning.

5.4.2.4 National Policy andStrategy on disaster risk management 1993

Ethiopia's National Policy and Strategy on disaster risk management aim at reducing disaster risks through the establishment of a comprehensive and coordinated disaster risk management system in the context of sustainable development.[858] As one of its strategies, it identifies the need to provide free emergency relief assistance and recovery and rehabilitation assistance to pregnant and lactating women, among other groups, thus being alive to women's reproductive requirements.[859] In outlining cross-cutting issues during disasters, women, children, the elderly and people with disabilities are recognised as the most

[856] Article 3:4:3 Health Sector Transformation plan.

[857] Article 4:6:1:10.

[858] Article 2:3:1 National policy and strategy on disaster risk management 1993.

[859] Article 3:2:8 National policy and strategy on disaster risk management 1993.

vulnerable to the impact of disaster. Therefore, risk management is called on to pay special attention to their needs, which inevitably include lifesaving reproductive health services.[860] This elaborate and targeted approach is a key lesson to Zimbabwe.

5.4.2.5 Programs on women's SRHR in Ethiopia during the Tigray Crisis

During the Tigray Crisis in 2021, UNFPA reported that of the people in need, 1 300 000 were women of reproductive age, 117846 were pregnant, 624 000 were adolescent girls aged 10-19 years, and 13 0934 births were expected every month.[861] Reportedly mobile van outreach services delivered reproductive services, including targeted SRH/GBV key messages in conflict-affected areas to women during the Tigray humanitarian crisis. Article 14 of CEDAW requires that state parties ensure that women have access to adequate healthcare facilities, including information, counselling and services in family planning. In line with this provision, SRHR/GBV awareness sessions were conducted in Internally Displaced Persons (IDP) camps in Mekelle, Tigray.[862]

In March 2022, in response to the Tigray conflict, Ethiopia demonstrated that it aligns with international standards of SRHR humanitarian response as in Northern Ethiopia, 99 healthcare providers were trained in the Minimum Initial Service Package (MISP) and other elements of SRHR.[863] Reportedly 11628 conflict-affected individuals received midwifery services, and 44140 received SRHR awareness sessions in different health facilities across Ethiopia.[864] The reported work done by UNFPA and the World Health Organisation (WHO)[865] and other

[860] Article 3:10 National policy and strategy on disaster risk management 1993.

[861] UNFPA 'UNFPA Ethiopia Response to the Tigray crisis' Situation report' (2021)4.

[862] UNFPA (2021)7.

[863] UNFPA Ethiopia Humanitarian Response Situation report' ((2022)2.

[864] UNFPA 'Ethiopia Humanitarian response Situation Report' (2022)2.

[865] WHO as the Global Health Cluster lead see WHO 'Crisis in Northern Ethiopia' available at *https://www.who.int/emergencies/situations/crisis-in-tigray-ethiopia* (accessed on 12 June 2022.

humanitarian organisations is a clear demonstration of coordinated efforts stemming from laws, policies and programs facilitated by the government of Ethiopia to enable women's access to reproductive services during humanitarian emergencies, which could be emulated in Zimbabwe's disaster response.[866] However, Ethiopia still faces serious challenges related to access to reproductive health because, by its nature, war results in a shortage in service providers, skills flight, damage to infrastructure and facilities, disruption of supply chains, and reversing the gains brought through laws, policies and programmes.

5.5 CONCLUSION

Key lessons and guidance were drawn from natural disaster management in Philippines, and the armed conflict in Ethiopia in order to ameliorate women's access to reproductive services during humanitarian emergencies. The chapter discussed a formalised approach to women's reproductive services, tailored psychosocial support, and provisions relating to disaster finance, among others. Furthermore, key lessons were spelt out around the Minimum initial service package, the entrenchment of a comprehensive health package, mobile health services and addressing social determinants in SRHR for Zimbabwe to emulate. The significance of women's participation in key decision-making around reproductive rights in emergencies is also spelt out in the chapter as an enhancement of their capabilities.

The chapter recommends a disaster management framework rooted in international and regional norms and standards that advance women's reproductive rights through instruments such as CEDAW, African Women's Protocol, CEDAW Committee and African Commission General Comments, among others. The next chapter presents recommendations for a general statute on disaster risk management

[866] For a better understanding of the coordination and support provided to government of Ethiopia by humanitarian organisations, see UNFPA led responses in partnership with the Regional Health bureau available at *https://www.unfpa.org/resources/ethiopia-humanitarian-response-situation-report-22-march-2022*

in Zimbabwe, with a dedicated chapter on women's access to reproductive services during humanitarian emergencies/disasters.

CHAPTER 6: PROPOSAL FOR A DISASTER RISK MANAGEMENT ACT FOR ZIMBABWE.

6.1 INTRODUCTION

Chapter four and five analysed Zimbabwe, Phillipines and Ethiopia's laws, policies and programs and their significance in the advancement of women's reproductive needs during humanitarian emergencies. Chapter four particularly exposes that the Civil Protection Act Chapter 10:06 (lead statute in the disaster management legal framework) is outdated and inadequate to respond to disaster-affected populations' needs. Based on that premise, this chapter six proposes that Zimbabwe crafts a Disaster Risk Management Act herein interchangeably referred to as the 'proposed statute' or the 'model law' or 'proposed law.'

The chapter does not develop a Disaster Risk Management Act, it simply proposes that the statute dedicates a section on SRHR during humanitarian emergencies meant to champion women's access to reproductive rights and services. Of significance is that while this study focuses on the case of Cyclone Idai in the Chipinge and Chimanimani districts of Zimbabwe, the recommendations proposed herein are meant to advance women's access to reproductive services in any humanitarian emergency context. The study, therefore, seeks to ameliorate the earlier identified dearth in literature in an effort to address the question of women's access to reproductive rights in the face of contemporary phenomena such as the COVID-19 pandemic and conflict situations. The proposed statute has to draw from international and regional norms and standards and guidelines from a myriad of sources.

The model law will utilise international instruments on disasters and humanitarian assistance, United Nations and other formally adopted intergovernmental principles and guidelines on humanitarian emergency management, particularly the

Humanitarian Charter Minimum standards as set out in the Sphere handbook,[867] The Inter-Agency Working Group (IAWG) field Manual on reproductive health in crises,[868] Special Rapporteur reports, General Comments, General Recommendations and major international and regional norms and standards relating to women's SRHR. Furthermore, as identified in the previous chapter, best practice provisions from other jurisdictions are recommended to form part of Zimbabwe's model law.

Currently, Zimbabwe's disaster management legal framework does not specifically address the reproductive concerns of women and girls in disaster settings. This presents a gap, especially since a re-emergence of pandemics and disasters has marked Zimbabwe.[869] It is hoped that the recommendations raised in this chapter will form part of future proposed legal reform in order to ameliorate the circumstances women find themselves in during humanitarian emergencies as far as their SRHR are concerned. Furthermore, this chapter seeks to provide practical guidance and improve the capacity of humanitarian response stakeholders in dispensing gendered reproductive services during humanitarian emergencies. The proposed model law acts as a legally binding accountability mechanism for the government. The proposed statute should improve indigenous women's effective participation in the disaster management cycle.

[867] The Humanitarian Charter available at *https://spherestandards.org/wp-content/uploads/2018/07/the-humanitarian-charter.pdf* (accessed on 9 August 2022).

[868] IAWG is an international coalition of organisations and individuals working collectively to advance sexual and reproductive health and rights in humanitarian settings available at *https://iawg.ne* (accessed on 9 August 2022).

[869] Bonga (2020)1-8.

6.2 Fundamental principles relating to the provision of reproductive services in humanitarian emergencies

CEDAW Committee General Recommendation No. 37 contains key cross-cutting principles which should guide state parties in drafting legislation, policies, plans of action, programmes, budgets and other measures on gender-related dimensions of disaster risk reduction.[870] General Recommendation No.37 prescribes gender responsiveness, a human rights-based approach, accountability and access to justice[871] as some of the general principles drawn from the CEDAW guide in disaster risk reduction and climate change contexts. Arguably one is alive to the significance of the intersectionality of identity categories of women in Africa and how they shape their experiences in the emergency context. The next sections spell out important principles which should form part of the section dedicated to SRHR during humanitarian emergencies, which aims to guarantee women's reproductive goods and services in any humanitarian emergency context.

6.2.1 A human rights-based approach

A Human Rights-Based Approach (HRBA) as a broad-based principle is recommended to guide the proposed dedicated section on SRHR in the proposed statute. A rights-based approach utilises international human rights norms and standards to address the needs of disaster-affected populations.[872] An HRBA entails transparency, accountability, participation, non-discrimination and capacity

[870] CEDAW General Recommendation No. 37 (2018) on the gender related dimensions of disaster risk reduction in a changing climate available at *https://documents-dds-ny.un.org/doc/UNDOC/GEN/N18/068/98/PDF/N1806898.pdf?OpenElement* (accessed on 3 September 2022).

[871] General Recommendation No. 37 on the gender dimensions of disaster risk reduction paras 25-38.

[872] IAWG Field Manual (2018).

development[873] during humanitarian response. Since the HRBA entails respect for human dignity, it aligns with Nussbaum's capabilities approach version, which is the philosophical underpinning for an account of basic constitutional principles that should be respected and implemented by the governments of all nations as a bare minimum of what respect for human dignity requires.[874] Akey recommendation by CEDAW General Recommendation No. 37 is that state parties should ensure that policies, legislation, plans, programmes, budgets and other activities relating to disaster risk reduction and climate change embrace an HRBA.[875]

In terms of the Inter-Agency Standing Committee (IASC) guidelines, an HRBA forms the basis of humanitarian action grounded in universal principles such as human dignity and non-discrimination, as well as a set of universally accepted human rights.[876] This study recommends that disaster-affected populations be treated as rights holders instead of being portrayed as passive recipients of humanitarian aid characterised by victimhood and dependency. On the whole, a human rights-based approach embraces basic tenets of both the capabilities approach and radical African feminism. This thesis argues that an analysis of the ten central capabilities reflects elements of intrinsic human rights.

6.2.2 Gender responsiveness

The United Nations recognises that gender-responsive climate action refers to the meaningful, informed and effective participation of women and girls from diverse backgrounds in relevant decision-making processes of climate-related disasters.[877]

[873] A call to a human rights-based approach to humanitarian assistance for Haiti 1-3 available at *https://ccrjustice.org/files/100114_HaitiAid_Statement_FINAL.pdf* (accessed on 19 July 2022).

[874] Nussbaum (2000)5.

[875] CEDAW General Recommendation No. 37 on gender related dimensions of disaster risk reduction (2018)7.

[876] IASC 'Operational Guidelines on the protection of persons in situations of natural disasters' (2011)2.

[877] UNOHCHR 'Gender Responsive climate action' available at *https://previous.ohchr.org/EN/Issues/HRAndClimateChange/Pages/GenderResponsiveClimateAction.aspx* (accessed on 6 March 2023).

The proposed law should be premised on gender responsiveness and anchored on the CEDAW committee's recommendations to Zimbabwe on the backdrop of Cyclone Idai in 2019. The CEDAW Committee urged the government of Zimbabwe to assess and address the impact of Cyclone Idai on women and girls and ensure that a gender perspective is integrated in developing and implementing policies and programmes on disaster risk reduction and climate change.[878]Provisions rooted in gender responsiveness drawn from decisions made by the United Nations Framework Convention on Climate Change (UNFCCC) and the Paris Climate Agreement must not be omitted from the proposed law. Arguably, gender responsiveness speaks to the capabilities approach's call for personalised support and tailored interventions for people to achieve worthwhile goals.

Provisions to include in the model law should address women and girls' entitlement to age-appropriate specific sexuality educational information including that which pertains to family planning in line with CEDAW.[879] Additionally, the capabilities approach, the provisions relating to gender responsiveness should be aimed at achieving women's well-being and upholding their dignity during humanitarian emergencies.

The Sendai Framework for Disaster Risk Reduction states that a gender, disability, and cultural perspective in disaster risk reduction should be included in all policies and practices.[880] Thus in its guiding principles, the model law on disaster risk management in Zimbabwe could benefit from this provision. Furthermore, programmes of action, budgets, and strategies should be coordinated for gender responsiveness across sectors.[881]

[878] See CEDAW Concluding Observations on the 6th periodic report of Zimbabwe (2020) paras 47-48.

[879] Article 10(h)CEDAW.

[880] Sendai Framework on disaster risk re/4duction para 19(d).

[881] General Recommendation No.37 para 41.

Section 13 of Philippines' Magna Carta of women provisions should be considered in drafting a proposed statute on disaster risk management in Zimbabwe. Particularity on the gender sensitivity and gender responsiveness of specific varied groups of women is one major strength of the Philippines' legal and policy framework. It provides for women affected by disasters, calamities and other crises. Furthermore, the Philippines National Climate Change Action Plan advocates for gender-responsive, climate-smart policies, plans, and budgets[882] , which equip women with capabilities as they form a basis for women to demand their rights.

6.2.3 Gender Equality

One of the cornerstone principles which should form the backbone of any legal or policy document which advances women's rights and empowerment is the principle of gender equality.[883] Gender equality is expressed in SDG Goal 5 which aims to achieve equality between men and women. CEDAW recommends that the development of legislation in member states should embody the principle of equality of men and women and ensure its practical realisation.[884]Gender inequalities in disaster risk reduction reflect the gender inequalities in society.

The development of a law anchored on gender equality is echoed in Article 12, CEDAW, as an essential component of women's access to SRHR health care services, including those relating to family planning services as well as mental and psychological services. This study is informed by radical African feminism, rooted in substantive equality, which should be considered when formulating a disaster risk management statute in Zimbabwe. It entails that African women's particular

[882] Philippines National Climate Change Action Plan 2011-2028 page 10.

[883] Gender equality in the context of this study means equal enjoyment of reproductive rights, goods, services, opportunities by women, men, girls and boys. Gender equity entails reproductive rights, goods, services and opportunities are dispensed according to women, men, boys' and girls' specific needs.

[884] Articles 2,3 CEDAW.

context and lived realities be considered when crafting a law and that there be equality of opportunity.

6.2.4 Non-discrimination

The principle of non-discrimination, as reflected in CEDAW, aims to ensure that on the basis of equality with men, women access family planning services.[885] On this basis, rural women and those with disabilities[886] should not face limitations in accessing reproductive services.[887] Additionally, measures need to be outlined for women living with HIV to access lifesaving reproductive services and to protect them against gender inequality and discrimination due to their status. The dignity version of the capabilities approach expounds on dignity as central to capabilities, and therefore, women living with HIV ought to be treated with dignity to live a "truly human life."[888]

6.2.5 Mental health and psychological support in humanitarian emergency settings

Humanitarian emergency settings are characterised by heightened stress levels among the affected populations. The minimum standards of humanitarian response require the provision of psycho-social support for those who are distressed, including referral to mental health services when necessary.[889] These services should extend to survivors of sexual violence, staff and volunteers providing services in these settings as they also suffer stress and trauma. In line with radical African feminism, CEDAW[890] requires state parties to ensure substantive equality in the provision of healthcare services, including sexual and reproductive health and

[885] See Article 12 CEDAW.

[886] Sphere Handbook page 14

[887] See Article 14(1)(b) CEDAW. See also Articles 12,13.

[888]According to Nussbaum, a person who is unable to realise all central capabilities is not living a 'truly human life.'

[889] Sphere handbook (2018)189.

[890] See Article 12 CEDAW.

mental and psychological health services. Further, the model law should be guided by the IASC provisions on the integration and coordination of mental health and psychosocial support services.[891] Psychological well-being alignswith the capabilities approach and the broader scheme of women's well-being.

6.2.6 Minimum initial service package (MISP)

The *MISP* is an international, non-negotiable health standard within the sphere standards for humanitarian response, which should be reflected in Zimbabwe's model law on disaster risk management. The entrenchment of the *MISP* in the proposed law should be complemented by provisions on the training of humanitarian response agencies' staff on the component. In Ethiopia during the Tigray crisis, health personnel were trained on the *MISP*[892] and managed to dispense midwifery, counselling and other SRHR awareness sessions to disaster-affected populations. Philippines entrenches a comprehensive package of reproductive rights, goods and services in the Magna Carta of Women[893] and gives an elaborate definition of *MISP*.[894]

6.2.7 Women's participation in disaster management

The proposed disaster risk management law for Zimbabwe should contain provisions which relate to women's participation at every stage of disaster management. The Sendai framework for disaster risk reduction cites women's participation as an integral component in the implementation of gender-

[891] Inter-Agency Standing Committee (IASC) Mental health and psychosocial support services in emergency settings (2012)13.

[892] UNFPA Ethiopia Humanitarian Response Situation report' ((2022)2.

[893] Section 10 The Magna Carta of Women.

[894] 13(Q) Definition of terms Magna Carta of Women.

sensitive disaster risk reduction policies.[895] In strengthening disaster risk governance, in its priorities for action, the Sendai Framework also advocates for the design and implementation of inclusive policies and safety nets that promote access to healthcare services which include maternal, newborn and child health, sexual and reproductive health, at a national level.[896] The proposed disaster risk management law should include adolescents' access to tailored and age-appropriate reproductive information and services. Furthermore, meaningful participation of young people in the design, implementation, monitoring and evaluation of programmes and policies should be spelt out in the proposed statute as provided in the IAWG field manual.[897]

6.2.8 Disaster finance

This study advocates for gender-responsive disaster finance. Frequently, the capacity to respond to climate change and any other disaster disproportionately affects women due to inequitable income and power structures.[898] It is recommended that the proposed law set aside and tracks the use and impact of disaster finance with gender responsiveness. Humanitarian response targeted at financing SRHR should also deliberately target women in rural areas disproportionately affected by a lack of realisation of human rights.[899] In terms of the Sphere standards, the provision of comprehensive sexual and reproductive healthcare in humanitarian settings involves upgrading existing services,adding missing services and enhancing the quality,[900] all factors requiring financial resourcing.

[895] Sendai Framework para 36(i)(a).

[896] Sendai Framework para 30(j).

[897] Inter-Agency Working Group (IAWG) on Reproductive health in crisis field manual page 223.

[898] Oxfam 'Making climate finance work for women: Voices from Polynesian and Micronesian communities' (2019)8.

[899] U.N. Secretary-General, *Improvement of the situation of women in rural areas, Rep, of the Secretary General*, paras. 2-4*,* U.N. Doc. A/62/202 (2007).

[900] Sphere handbook page 327.

6.2.9 Monitoring, evaluation and reporting

Monitoring and evaluation are key aspects of reproductive service delivery in humanitarian emergencies in line with the IAWG Field Manual on reproductive rights in humanitarian settings.[901] According to the Sphere handbook, monitoring and evaluation, accountability, and learning support timely, evidence-based management decisions in humanitarian response.[902] Monitoring and evaluation work to inform government decision-makers when their plans are not working and when circumstances have changed and provide information into decision-making in disaster management implementation mechanisms.[903] United Nations Framework Convention on climate change (UNFCCC)[904] recognises the integral position of monitoring and reporting for the gender responsiveness of policies, plans, strategies and actions.

The proposed law should, as part of its monitoring and evaluation, on the basis of disaggregated data, speak on the development of specific gender-responsive indicators and monitoring mechanisms to ensure the establishment of baselines in the measurement of progress on women's participation in disaster risk management initiatives which include making decisions on access to reproductive services in the crisis context as well as monitoring health policies and programmes' implementation.[905]

[901] Inter-Agency Field Manual on Reproductive health in humanitarian settings (2018)61.

[902] Sphere Handbook (2018)10.

[903] National Climate Change Action Plan, Philippines 2011-2028 page 48.

[904]UNFCCC 'Report on the Conference of the parties on its 25th session held in Madrid from 2-15 December (2019) FCCC/CP/2019/13/Ad available at *https://unfccc.int/sites/default/files/resource/cp2019_13a01_adv.pdf* (accessed on 9 July 2022).

[905] See also General Recommendation No.37 para 40(c).

6.3 CONCLUSION

The chapter proposed a disaster risk management law for Zimbabwe with a section focused on women's reproductive rights and services during humanitarian emergencies. In addition, the chapter proffered recommendations for specific elements of SRHR emanating from international best practices from the CEDAW Convention, Sphere Handbook, Inter-Agency Working Group on reproductive health in the crisis field manual, General Comments, General Recommendations, Special Rapporteur reports, provisions from other jurisdictions and other instruments among others to formulate part of the model law.

The chapter recommended that provisions of the disaster risk management statute be crafted to include a human rights-based approach, gender responsiveness, disaster finance, gender equality, non-discrimination, consideration for mental health and psychosocial support, a minimum initial service package (MISP), women's participation in disaster management, monitoring, evaluation and reporting.

CHAPTER SEVEN: OVERALL CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The researcher provides the study's overall findings, conclusions and recommendations in this chapter. The chapter summarises the challenges which impede women's access to family planning information and services during humanitarian emergencies in Zimbabwe. The chapter draws general conclusions on Zimbabwe's compliance with its obligations towards the advancement of women's right to access family planning information and services during humanitarian emergencies.

Conclusions and recommendations on Zimbabwe's laws, policies and programmes which advance family planning information and services during humanitarian emergencies are presented in this chapter. Moreover, conclusions are made on the judicial interpretation of women's reproductive health rights and lessons learnt from other jurisdictions. The chapter concludes with the opportunities and practicalities available for ensuring women's access to reproductive services during humanitarian emergencies. Based on the thesis findings, the chapter provides recommendations to the government, the Zimbabwe Gender Commission, the Zimbabwe Human Rights Commission, the Ministry of Health and Child Care, the Department of civil protection, the Judicial Services Commission and civil society on their different roles to ensure enhancement of women and girls' capabilities to access reproductive health during humanitarian emergencies.

7.1.1 Conclusions on challenges to women's access to family planning information and services during humanitarian emergencies.

The study revealed that before Cyclone Idai struck, Zimbabwe's health delivery sector was bedevilled by an economic crisis. However, key findings reveal that during Cyclone Idai, the operational context was characterised by

poor infrastructure, poor roads reach to health facilities, unavailability of trained personnel especially inadequate medical products, vaccines and technology, health financing, health information, and generally under-resourced health budget among other challenges. These and other challenges negatively affected the ability of the government and other stakeholders to adequately respond and provide for women and girls' access to family planning information and services during the humanitarian emergency.

A review of literature revealed that women did not have a stake in determining reproductive health service delivery outcomes because patriarchy hindered their participation. Relatedly, radical African feminism, which informs this study, calls for affirmative action in women's participation and tackles how power is distributed. The capabilities approach requires that women utilise their voices to explore their full potential by employing capabilities and functionings.

The study observed that child marriages rob girls of their childhood and adolescence and are an impediment to their reproductive decision-making and autonomy, even when they develop womanhood. The study, therefore, identifies human capabilities and well-being as enunciated by the capabilities approach as it identifies if people are living a dignified human life.

Results indicate that during the 2019 Cyclone Idai in Chipinge and Chimanimani districts, women's access to reproductive information and services was inhibited in terms of availability, accessibility and affordability.

The study found that the challenges for rural women were compounded owing to several factors such as an already existent inadequate family planning programme, service delivery pitfalls, impassable roads and poor telecommunications, an under-resourced family planning budget, lack of safe spaces for making SRHR accessible to women and girls during the disaster, lack of skilled health personnel, and negative attitudes to adolescent reproductive health by health workers among others.

7.1.2 Conclusions on Zimbabwe's laws, policies and programmes in advancing women's reproductive rights during humanitarian emergencies.

The study reviewed Zimbabwe's strides towards ensuring that rural women have access to reproductive health. The study found that Zimbabwe has commendable recognition of the right to reproductive health care in Section 76 of the Constitution. The study assessed the Civil Protection Act,[906] Zimbabwe's National family planning strategy,[907] National adolescent sexual reproductive health strategy 2016-2020,[908] National health strategy 2016-2020,[909] The extended Zimbabwe national HIV and Aids strategic plan (ZNASP3) (2015-2020),[910] National Climate Policy (2017),[911] and The National Development Strategy (NDS1) (2020- 2025). It was observed that while these laws and policies provide for equitable family planning, they do not elaborate on women's reproductive health and well-being during disaster periods.

In line with radical African feminism, the study argues that the configurations of power in Africa dictate that men usually create laws which cater for themselves and are not concerned with women's issues. This is evident in how Zimbabwe's laws and institutions exclude women's reproductive concerns.

The study found that Zimbabwe is not compliant with its obligation to respect, as manifest in the restrictive provisions which interfere with women's reproductive self-determination in matters relating to abortion rights. State interference tampers with women's dignity and ability to function and

[906] Civil Protection Act Chapter 10:06

[907] Zimbabwe national family planning strategy (2016-2020).

[908] National Adolescent sexual reproductive health strategy (2016-2020)

[909] National health strategy (2016-2020)

[910] The extended Zimbabwe national HIV and Aids strategic plan 2015-2020

[911] National Climate policy (2017).

exercise central capabilities in life, as elaborated in Nussbaum's version of the capabilities approach.

Utilising lessons learnt from Philippines, Ethiopia and key international instruments, the chapter developed guidelines to inform development of a law on disaster risk management which is alive to women's reproductive health needs.

7.1.3 Conclusions on Zimbabwe's programmes on family planning

The research notes that, commendably, Zimbabwe has established programmatic and institutional mechanisms for family planning information and services. However, the economic meltdown in the country has reversed these gains as the public health delivery system has deteriorated.[912] Furthermore, during Cyclone Idai, there was a lack of integration of services, and agencies lacked financial, technical and logistical capacities to respond to the disaster.[913] The Ministry of Health and Child Care's record-keeping was adversely affected by poor resourcing and being manned by inadequately skilled health personnel; hence one doubts it could respond adequately to the needs of disaster-affected populations.

In practice, Zimbabwe was found wanting in its obligation to make reproductive health resources and services available and accessible during Cyclone Idai. Sen's version of the capabilities approach reiterates that the use of resources lies in that for women to achieve substantive freedoms, they

[912] Newsday 'Devaluation and the deterioration of the health delivery system' available at *https://www.newsday.co.zw/2020/02/devaluation-and-the-sustainability-of-health-delivery-system-today (*accessed on 25 September 2022), see also Newsday 'Zim health system is in intensive care: How it got there' available at *https://www.newsday.co.zw/health/article/17151/zim-health-system-is-in-intensive-care-how-it-got-there* (accessed on 26 September 2022).

[913] Chatiza (2019)5.

have to be able to access resources. He further highlights the crucial role resources play in determining living conditions and the quality of life.[914]

7.1.4 Conclusions on judicial interpretation of women's reproductive rights in Zimbabwe

The study findings demonstrate that there is a dearth of jurisprudence in litigated cases around sexual and reproductive health and rights in Zimbabwe. This study commends the judiciary for the landmark *Mudzuru* judgement, thoroughly grounded in international and regional treaties as guiding tools to justice. However, the case did not expound much on the normative content of SRHR.

While the legal age of marriage is set at 18, the biggest challenge confronting Zimbabwe and perhaps the better part of Africa as a continent is how to enforce that age of marriage. The *Memory Machaya* case of a 14-year-old girl who died while giving birth is evidence that the scourge of child marriages persists. The circumstances around the case are revelatory of the inadequacies Zimbabwe has in clamping down on child marriages.

Mapingure, a case which pertains to restrictive abortion rights, exposes the state's failure to provide the rape survivor access to timeous abortion. The case demonstrated the reality of the intersection between institutions, policy, and misogyny manifested through maladministration.[915] The court is credited for clearly labouring on the dimension of the reality of government

[914] Sen A 'Development as freedom' (2000)14.

[915] The Constitution of Zimbabwe provides for the right to administrative justice in Section 68. The case demonstrated the maladministration inflicted by the Zimbabwe Republic police and medical practitioners and their transgression on women's reproductive rights.

institutions which fail women every day through administrative blunders, thus trivialising and violating their reproductive rights.[916]

The study utilised the *Masuku* case for its validity in acknowledging the reality of teenage sexual intercourse and in conscientizing the state and non-state actors to prioritise adolescents' access to SRHR during humanitarian emergency response. In overall, the cases are a demonstration that more work needs to be done by the courts in order to expound more jurisprudence on the subject of sexual and reproductive health and rights. This is in line with the capabilities approach, which recognises that while capabilities relate to the space to perform actions, how that space plays out is one's functioning.[917] For women to realise their capabilities during humanitarian emergencies, they have to beaware of their right to access family planning information and services and be able to stand in the courts and amplify their voices while fighting to defend their rights.

7.1.5 Conclusions on lessons learnt from other jurisdictions

The shortcomings of Zimbabwe's legal and policy framework, as presented in this study, necessitated that lessons be drawn from Philippines and Ethiopia due to their experiences in humanitarian emergency management. Key lessons for Zimbabwe include the adoption of provisions around: the Minimum Initial Service Package *(MISP)*, the entrenchment of a comprehensive health package, mobile health services and addressing social determinants in SRHR, women's participation in critical decisionmaking among others,

7.2 Principal Areas of Concern and Recommendations

[916] Mapingure SC 22/14 pages 20-21. The police failed to attend at the hospital on time to ensure the pregnancy was terminated, the matron failed to take reasonable steps to terminate the pregnancy, the doctor failed in his mandate to avert the pregnancy, the magistrate and prosecutors failed to act timeously to ensure a certificate of termination of the pregnancy was issued.

[917] Kleist (2009)7.

7.2.1 To the Government of Zimbabwe

The researcher recommends that the government of Zimbabwe prioritises the expeditious alignment of outstanding laws with the Constitution in furtherance of women's reproductive rights during humanitarian emergencies.

The study recommends that the government prioritises the allocation of resources towards women's reproductive health services in disasters. The Treasury arm of the government should allocate the Ministry of Health and Child Care adequate resources to enable them to respond to various health needs of disaster-affected populations. Government funding for health remains below the 15% commitment expected as per the Abuja Declaration.[918]

This study identified non-existent or weak institutional mechanisms as far as advancing women's reproductive rights during humanitarian emergencies. The study notes with concern the need to rethink institutional arrangements created by the 1989 Civil Protection Act through the proposed Disaster Risk Management Act.

Economic and social inequalities and traditionally entrenched gender roles make women subordinate to men. The study raised concern about male domination in key positions of the Cyclone Idai disaster management continuum. It is recommended that government increases the participation of women in development plans relating to disaster risk management through technical and financial support. In addition, reliable, cost-effective telephone, data and digital services should be extended to rural areas so as to enhance access to information by rural women and girls, including those living with disabilities, within the context of programmes relating to disaster risk reduction and climate change.

[918] The Abuja Declaration is the name of a 2001 pledge made by Heads of state and government of African Union countries to allocate at least 15% of their national budgets to the improvement of the health sector. See 'African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases' (2001)5 available at *https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf* (accessed on 30 September 2022).

The state should ensure the provision of family planning information, related goods and services within disaster preparedness and response, including access to emergency contraception, abortion services, post-exposure Prophylaxis for HIV, treatment for HIV, and prioritise reduction of maternal mortality through safe motherhood services in line with CEDAW General Recommendation No. 37.[919] Social determinants of sexual and reproductive health such as but not limited to food, shelter and clean portable water should be made accessible during humanitarian emergencies. Government should also have monitoring mechanisms to ensure women's access to reproductive goods and services during humanitarian emergencies complies with quality standards.

The study noted that lack of reproductive knowledge impedes women's capability to claim and enforce their rights in the face of violation. Furthermore, it becomes an affront to their ability to hold duty-bearers accountable for upholding international, regional and national human rights obligations. In order to achieve this, the government, through its various agencies, has to ensure constitutional and legal literacy on reproductive rights in general, family planning information and services in particular, as well as awareness raising on international and regional norms and standards. This can be done through the Ministry of Justice, Legal and Parliamentary Affairs' Department of Constitutional and Parliamentary Affairs[920] with funding from the Ministry of Finance and Economic Development.[921]

Overall, the health system must be strengthened for it to be able to cope with the burden of disaster preparedness and respond to the health needs of disaster-affected populations. Interventions towards women's SRHR needs must be evidence-based,

[919] CEDAW General Recommendation No. 37 on the gender related dimensions of disaster risk reduction para 68(d).

[920] Department of Constitutional and parliamentary affairs available at *https://justice.gov.zw/departments/constitutional-and-parliamentary-affairs/* (accessed on 26 September 2022).

[921] Ministry of finance and economic development available at *www.zimtreasury.gov.zw/?option=com_quix&view=page&id=8&Itemid=754* (accessed on 26 September 2022).

backed by robust research and development. Furthermore, reports on past epidemic outbreaks are indicative of the need for public health surveillance and a disaster preparedness and response programme.[922]

7.2.2 Civic Society

The task of ensuring the protection of human rights cannot be left to the government, the courts and Independent Commissions alone. Civic society has an enormous task to play, and in Zimbabwe, the *women's movement* has an appropriate mandate to advance women's rights even during humanitarian emergencies. The civic society represents a necessary component of democracy as it can hold the government accountable for failure to protect, promote and fulfil human rights through advocacy and litigation interventions.[923] Organisations such as the Zimbabwe Women Lawyers Association,[924] Women and Law in Southern Africa,[925] and Musasa Project[926] under the broader umbrella body, the Women's Coalition of Zimbabwe all have a duty to advance women's family planning information and services and, more importantly break the ice on women's plight during humanitarian emergency contexts. These organisations have a role to play in raising awareness around sexual and reproductive health and rights as they carry out lobbying and advocacy work on legal reform as well as provide public interest litigation services to women whose rights have been violated.

7.2.3 To Humanitarian agencies

[922] Zimbabwe Multi sectoral cholera elimination plan 2018-2028 available at *https://www.afro.who.int/sites/default/files/2021-09/ZIMBABWE-MULTI-SECTORALCHOLERA-ELIMINATION-PLAN_1.pdf* (accessed on 30 September 2022.

[923] Legal grounds: Reproductive and sexual rights in Sub Saharan African Courts (2017)1.

[924] Zimbabwe Women Lawyers Association available at *www.zwla.co.zw* (accessed on 1 October 2022).

[925] Women and Law in Southern Africa available at *https://www.wlsazim.co.zw* (accessed on 1 October 2022).

[926] Musasa Project available at https://musasa.co.zw

The researcher recommends that there be coordinated humanitarian response among state and non-state agencies during disasters. Staff dispensing SRHR services should uphold international guidelines and have undergone training in the dispensation of the Minimum initial service package (*MISP*) on reproductive health in crisis. The MISP is a conduit through which government can achieve the provision of the minimum threshold of the central capabilities as enunciated by the capabilities approach. In addition, the study recommends that humanitarian agencies uphold women's rights to autonomy, confidentiality, informed consent, non-discrimination and choice. Humanitarian agencies should aim to provide integrated services and mainstream disaster risk management across all sectors so as to give a holistic picture of common risks, effective data gathering and dissemination.

7.2.4 To the Zimbabwe Gender Commission

In line with its mandate and in relation to this study, it is recommended that the Zimbabwe Gender Commission carry out further research on the impact of disasters on rural women's access to SRHR and other socio-economic rights in fulfilment of its duty to research gender and social justice.[927] There is still a need for the ZGC and the Zimbabwe Human Rights Commission[928] to conduct individual and joint investigative studies on the level of women's access to SRHR during humanitarian emergencies, as well as carry out a situational analysis to enhance future interventions.[929] There is a need for both the ZHRC and the ZGC to offer evidence-based, sector-specific recommendations, backed by disaggregated data in order to effectively execute its mandate towards monitoring government ministries and

[927] Section 246(d) Constitution of Zimbabwe Amendment Act 20/2013.

[928] The Zimbabwe Human Rights Commission is an independent Commission established in terms of Section 242 of the Constitution of Zimbabwe and whose functions are elaborated in Section 243 of the Constitution.

[929] OXFAM ' Tens of thousands of people are still suffering one year on from Cyclone Idai' available at *https://www.oxfam.org.uk/media/press-releases/tens-of-thousands-of-people-are-still-suffering-one-year-on-from-cyclone-idai-oxfam* (accessed on 29 September 2022).

relevant stakeholders towards the advancement of gender equality and women's empowerment.

7.2.5 Ministry of Health and Child Care

There is a need for the Ministry of Health and Child Care (MOHCC) to rethink reproductive health service delivery, especially in the context of humanitarian emergencies. Therefore, the MOHCC has to demonstrate preparedness and capacity to deliver comprehensive, lifesaving reproductive health services through investment in modern technology and personnel trained in humanitarian response standards.

7.2.6 Ministry of Local Government, Public Works and National Housing

The study noted that the Department of Civil Protection Administers and Implements the Civil Protection Act Chapter 10:06 of 1989. This study has exposed weaknesses in the disaster management continuum to which the Department of Civil Protection is the lead agency. Backed by a weak legal and policy framework, the parent Ministry is recommended to advocate for legal and policy reform and constitutional alignment to enable the laws and policies under its ambit to conform with international and regional norms and standards on disaster risk reduction. Under the Inter-Ministerial Taskforce on Alignment of legislation, each Ministry is mandated to approach the IMT through the Attorney General's office with areas of the law that require alignment with the Constitution.[930] The Department of Civil Protection has to make a case for decentralising its operations and ensuring community participation characterised by gender and disability inclusion. Through its parent Ministry, the Department of Civil Protection, should present and lobby for revamping the current National Civil Protection Committee and other key structures under its wings.[931] Due to its outdatedness, the structure does not include

[930] Since the advent of a new Constitution in 2013, Zimbabwe has embarked on a Constitutional Alignment process. See *imt.gov.zw/category/news/* and *https://www.ca-lr.org*

[931] Section 4 Civil Protection Act Chapter 10:06.

key humanitarian agencies, which would ensure multi-sectoral coordination during disaster response.

7.2.7 To Judicial Service Commission

Courts are judicial mechanisms available for women to enforce their reproductive rights through. While other traditional institutions may work to address access to justice for women in the longer term, in practical terms, the disruption of life and services during a humanitarian emergency may not make such formal setups equitable for women and girls in distress, for it may mean waiting for normalcy for them to then access the said institutions. This study recommends that the proposed disaster risk management law includes provisions on response plans that provide for the deployment of mobile specialised reporting, investigative teams and courts in order to ensure expedient access to justice.[932] Section 85 of the Constitution of Zimbabwe promotes access to justice for women in humanitarian emergencies through the enforcement of fundamental human rights and freedoms by the courts through their granting of appropriate relief. The Judicial Service Commission should prioritise the training of judicial officers on women's rights, sexual and reproductive health and rights so as to enhance the quality of judgements in relevant cases.

7.3 Limitations and Recommendations for further study

The study was conducted using a desktop review which did not capture the voices of women and girls from the Cyclone-affected Chipinge and Chimanimani districts of Zimbabwe. Future studies are recommended to replicate this study while utilising the personal experiences of women and stakeholders who were affected by Cyclone Idai in 2019.

[932] See CEDAW General Recommendation No. 37 para 38(e).

This study focused on Chipinge and Chimanimani, the two districts hardest hit and affected by Cyclone Idai in Manicaland province and did not explore the situation from districts in other provinces of Zimbabwe. It is recommended that future studies cover other affected districts in Zimbabwe and cover other humanitarian emergencies to explore further women's experiences and reach definitive conclusions on their access to SRHR and other socio-economic rights in such contexts. There is scope for future studies around access to reproductive health during the Covid 19 era.

The study managed to bring to the fore adolescent girls' reproductive rights in the same vein as adult women's experiences. It is important that further studies focus specifically on adolescent SRHR and seek to draw comparisons with other jurisdictions in Africa and other continents.

Future studies should be preceded by a baseline survey or situational analysis in order to establish the extent of rural women's access to SRHR. This will inform future interventions around women's access to sexual and reproductive health and rights.

7.4 CONCLUSION

This study has demonstrated that women and girls are among those most affected by the effects of humanitarian emergencies. Women's health and well-being are disproportionately affected, yet disaster management law and public policy do not particularly focus on them. The study revealed that exclusion due to patriarchal social norms and customs, child marriages, restrictive abortion provisions, gender blind spots in laws and policies, among others, exacerbate women's obstacles to reproductive health during crises.

Drawing from a qualitative analysis, this study concludes that women's access to reproduction during humanitarian emergencies in Zimbabwe remains a pipedream for many. Results indicate that when Cyclone Idai hit, Zimbabwe had an ailing health delivery sector caused by, among other factors, an economic meltdown

which in turn triggered the high attrition rates of experienced health practitioners, reduced quality of service, limited access to essential drugs and supplies provision, poor water and sanitation access. It is imperative that these challenges be addressed in law and practice in order to improve the respect for women's rights.

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