

“I NEVER THOUGHT I COULD GET HEALED FROM THIS”

BARRIERS TO TREATMENT AND HUMAN RIGHTS ABUSES AGAINST
WOMEN AND GIRLS WITH OBSTETRIC FISTULA IN ZIMBABWE

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Cover photo: HARARE, ZIMBABWE - JANUARY 14: Pregnant mothers wait for Midwife Angeless Kanzara, whose trading name is 'Mbuya Machona', to tend to them on January 14, 2021 in Harare, Zimbabwe. Zimbabwe's healthcare system is overwhelmed with the coronavirus pandemic after a severe economic crisis stripped the country into hyperinflation and poverty. © Tafadzwa Ufumeli via Getty Images

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GLOSSARY

TERM	DESCRIPTION
CHILDBIRTH RELATED INCONTINENCE	A pervasive form of maternal morbidity, which typically causes urinary leakage, affecting “one of three new mothers” ¹
CHILD MARRIAGE	Marriage in which at least one of the parties is under the age of 18. ² This terminology, as used in this report, recognizes the importance that legal ages of consent for marriage are above 18, as confirmed by Zimbabwe’s Constitutional Court (2016), ³ recognizing the obligations of the African Charter on the Rights and Welfare of the Child, ⁴ and the Convention on the Elimination of All Forms of Discrimination against Women to prohibit child marriage. ⁵
MATERNAL MORBIDITY	“[A]ny health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s wellbeing” (Maternal Morbidity Working Group) ⁶
MATERNAL MORTALITY	“The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (the World Health Organization) ⁷
OBSTETRIC FISTULA	an abnormal connection between the vagina, rectum and/or bladder which may develop after prolonged and obstructed labour and lead to continuous urinary or faecal incontinence. A hole between the urinary bladder and the vagina is regarded as vesicovaginal fistula whereas a hole between the rectum and the vagina is known as rectovaginal fistula ⁸

1 Brubaker L. Postpartum urinary incontinence. *BMJ*. 2002;324(7348):1227–1228. doi:10.1136/bmj.324.7348.1227
www.ncbi.nlm.nih.gov/pmc/articles/PMC1123200/

2 A/HRC/26/22, para 3 www.un.org/ga/search/view_doc.asp?symbol=A/HRC/26/22; Joint general recommendation/General Comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices CEDAW/C/GC/31-CRC/C/GC/18, 2014 (hereafter CEDAW and CRC Committees joint General Comment No. 31 and No. 18), para. 20.

3 Judgment No. CCZ 12/2015 Const. Application No. 79/14 *Loveness Mudzuru and Another v. Minister of Justice, Legal & Parliamentary Affairs and Others* (hereafter *Loveness Mudzuru and Another v. Minister of Justice and Others*) 2016

4 African Charter on the Rights and Welfare of the Child, Article 21 (2) which states that: “Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.”

5 UN Convention on the Elimination of All Forms of Discrimination against Women, Article 16(2). The Constitutional Court of Zimbabwe in *Loveness Mudzuru and Another v. Minister of Justice and Others* has clarified that when read with Article 1 of the UN Convention on the Rights of the Child, this prohibits marriages where one party is under the age of 18.

6 Firoz et al. Measuring maternal health: focus on maternal morbidity, *Bulletin of the World Health Organization* 2013;91:794-796. doi: <http://dx.doi.org/10.2471/BLT.13.117564> www.who.int/bulletin/volumes/91/10/13-117564/en/

7 World Health Organisation, Health statistics and information systems, www.who.int/healthinfo/statistics/indmaternalmortality/en/

⁸Tunçalp Ö, Tripathi V, Landry E, Stanton CK, Ahmed S. Measuring the incidence and prevalence of obstetric fistula: approaches, needs and recommendations. *Bulletin of the World Health Organization*. 2015 Jan 1;93(1):60-2 doi: 10.2471/BLT.14.141473 <https://www.who.int/bulletin/volumes/93/1/14-141473/en/>

RECTOVAGINAL FISTULAS (RVF)	A hole between the “intestine and vagina” resulting in “loss of gas and faeces from the vagina”. ⁹
SKILLED BIRTH ATTENDANT	Health care personnel “who can provide effective, uninterrupted and quality care” who are qualified and competent maternal and new-born health professionals, ¹⁰ and are “educated, trained and regulated to national and international standards” and working in “an enabling environment comprising the six building blocks of the health system” (the World Health Organization). ¹¹
TRADITIONAL BIRTH ATTENDANT	“A person who assists the mother during childbirth and who initially acquired their skills by attending births themselves or through an apprenticeship to other TBAs” (the World Health Organization) ¹²
TRADITIONAL LEADER	Someone who is recognized, in terms of the customary law, institutions and structures of a traditional community, to hold a leadership position. In Zimbabwe, traditional leaders so recognized perform important roles in the public life and governance of communities.
VESICOVAGINAL FISTULA (VVF)	A hole “between the bladder and the vagina that allows the continuous involuntary discharge of urine” ¹³

9 Reichert M, Schwandner T, Hecker A, et al. Surgical Approach for Repair of Rectovaginal Fistula by Modified Martius Flap. Geburtshilfe Frauenheilkd. 2014;74(10):923–927. doi:10.1055/s-0034-1383149 www.ncbi.nlm.nih.gov/pmc/articles/PMC4210382/

10 Categories of MNH competencies listed include: “1. Scope of knowledge 2. Scope of practice 3. Pre-pregnancy and antenatal care 4. Intrapartum care 5. Postpartum and postnatal care 6. Newborn care 7. Care related to loss or termination 8. Leadership All competent MNH professionals in a team provide evidence based, human-rights-based, quality, socio culturally sensitive and dignified care to women, newborns and their families.” Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPAWHO/RHR/18.14 © World Health Organization 2018 page 2, Box2.

11 Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPAWHO/RHR/18.14 © World Health Organization 2018

12 WHO recommendation on partnership with Traditional Birth Attendants (TBAs) 31 May 2015

<https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-partnership-traditional-birth-attendants-tbas>
13 Reichert M, Schwandner T, Hecker A, et al. Surgical Approach for Repair of Rectovaginal Fistula by Modified Martius Flap. Geburtshilfe Frauenheilkd. 2014;74(10):923–927. doi:10.1055/s-0034-1383149 www.ncbi.nlm.nih.gov/pmc/articles/PMC4210382/

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1. EXECUTIVE SUMMARY

“It’s been three years now, I can’t wear underwear, urine is always leaking. I have developed sores on my genitals that aren’t healing because of the moisture. I dread going out in public. The last time I went to a gathering, people distanced themselves from me because of the bad smell, it repelled them. I’m confined to this house so I can bathe each time I soil myself. My entire family believes I was cursed, they say no one has ever had a disease like mine before.”

Nyaradzai, a 19-year-old woman from Mashonaland West Province, Zimbabwe.

OBSTETRIC FISTULA: A DEVASTATING CONDITION THAT IS PREVENTABLE AND TREATABLE

Based on desktop research and qualitative field research carried out in Zimbabwe between January 2018 and October 2020 this report focuses on women and girls in Zimbabwe who have experienced obstetric fistula while giving birth.

Described as the “most devastating birth injury” by both the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), obstetric fistula is an abnormal communication between the urinary tract or the gastrointestinal tract and the genital tract, produced by obstetric causes, typically prolonged and obstructed labour. Obstructed labour associated with obstetric fistula has been identified as a major cause of maternal mortality worldwide, and in as many as 90% of cases, women who experience obstetric fistula also suffer a still birth.

WHO has stated that obstetric fistula is preventable; by reducing the number of early and unplanned pregnancies, ending harmful practices (such as “child marriage”), and ensuring access to quality emergency obstetric care, especially access to caesarean sections. When access to quality treatment is available, obstetric fistula is also curable. With expert care, surgical success rates of treating obstetric fistula are as high as 92%.

OBSTETRIC FISTULA AFFECTS THE MOST MARGINALISED

Globally, obstetric fistula affects between 50,000 and 100,000 women every year, with low income countries in Africa and Asia bearing the highest burden. In Zimbabwe, the actual rate of obstetric fistula is not known, but given that the latest Multiple Indicator Cluster Survey from 2019 indicates that the country’s maternal mortality ratio is among the highest in the world it can be expected there is a devastating prevalence and incidence rate of obstetric fistula in the country.

The findings of this report indicate that the impact of obstetric fistula on both physical and mental health of women and girls is catastrophic. Often resulting in the continuous and uncontrollable leaking of urine and/or faeces, obstetric fistula can lead to life-changing stigmatisation, and has far reaching consequences on women and girls’ physical wellbeing, social and marital relationships, mental health, and economic capacity.

In 2015, repair of obstetric fistula was established as a public health intervention in Zimbabwe. Despite this, our research shows that access to maternal healthcare which could prevent obstetric fistula as well as treatment for obstetric fistula has remained limited for many women and girls in Zimbabwe. This has been largely due to the fact that obstetric fistula appears to affect the most marginalized members of the society: poor, young and often illiterate girls and women in remote regions of the country.

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ZIMBABWEAN GOVERNMENT'S FAILURE TO PREVENT OBSTETRIC FISTULA AND HUMAN RIGHTS ABUSES

Amidst an ever-worsening economic situation in Zimbabwe, as well as the country's consistently low healthcare budget allocation, Amnesty International found that the government of Zimbabwe has failed to assign sufficient resources to the health sector, and despite declaring a policy of free maternal services, has not funded or operationalised relevant initiatives. The lack of ambulances and high fuel prices, further compounds delays that women and girls experience reaching and receiving care at health facilities. The situation is urgent as the country weathers the impact of the COVID-19 crisis and barriers to maternal health services are increasing.

Amnesty International also found that various economic and cultural challenges undermined women's agency to make decisions on where to give birth. A preference for home births was influenced by traditional practices and/or the costs associated with giving birth in health facilities, limiting women's access to quality intra-partum care. However, in some cases, home births were found to expose pregnant women and girls to dangerous health complications and violence. This report documents serious abuse that may amount to torture and ill-treatment of women and girls committed by private individuals, during labour at home. Women and girls were left with life changing injuries and often hospitalised for weeks or months and faced astronomical bills as a result. The government of Zimbabwe has an obligation to investigate these cases.

DISCRIMINATION, ISOLATION AND ECONOMIC VULNERABILITY

The report further indicates that the lack of information about the causes and treatment of obstetric fistula increased women's risk of discrimination and abuse within their families and communities. Most women had lived for years with obstetric fistula, or undiagnosed conditions of incontinence related to childbirth, with many thinking they were the only person with the condition. The fear of stigma and discrimination because of their health status led most women to try and keep their condition hidden and they all faced isolation and enormous barriers to health information and treatment for obstetric fistula.

In most cases, women were also unable to work, and were thus pushed further into poverty because of their maternal injuries. Their health status also increased the risk of domestic violence, including economic abandonment. Without financial assistance and support, it is impossible for most women to afford the essential health commodities needed to bath, wash clothes, and prevent blisters and sores.

POSITIVE PUBLIC HEALTH INTERVENTIONS OVERSHADOWED BY COVID-19

The Ministry of Health and Child Care Fistula Programme provides a positive start for a national information campaign and the treatment of people with obstetric fistula. Women who have received surgery for fistula expressed a desire to be "ambassadors" and work with community members to provide information and help change attitudes. As participants at Amnesty International's community drama and dialogues stressed, "we must teach each other that it [obstetric fistula] is curable". Raising awareness about the causes and treatment of obstetric fistula can assist in dispelling myths and superstition that women with obstetric fistula have been bewitched. However, despite the success of the Ministry of Health and Child Care Fistula Programme in providing surgical repair for obstetric fistula, promotion of the program has yet to reach all health facilities, throughout the country.

The advent of the COVID-19 pandemic has adversely affected programming for obstetric fistula in Zimbabwe. The fragile gains registered in previous years have been progressively reversed, as evidence has shown that lockdowns and aggressive state responses have further decreased the impact of the Ministry of Health and Child Care Fistula Programme. A study published in April 2021 by Chimamisse *et al.* noted that because of restrictions imposed due to the pandemic, only 25 women had repair surgery in 2020, compared to 313 in 2019.

CONCLUSION AND RECOMMENDATIONS

Ultimately, the prevalence and incidence of obstetric fistula in a country are indicators of the failure of a health system to deliver accessible, timely and appropriate maternal care to women and girls, violating the rights to health of such persons. This report finds that the experiences of fistula patients in Zimbabwe indicate a failure of the Zimbabwean government to uphold sexual and reproductive health rights and the rights to equality and privacy and to be free from torture and other ill-treatment of women and girls in the country, in direct violation of various commitments it has under international and regional law as well as its own Constitution.

In holding the government of Zimbabwe to these obligations, Amnesty International recommends that the government should urgently increase efforts to prevent obstetric fistula, as well as increase efforts to identify and treat women with maternal morbidities, including obstetric fistula, by adequately funding and

operationalising a comprehensive public maternal health care policy; ensuring such policy is in line with the international standards of availability, accessibility, acceptability and quality. Importantly, the policy must be contextualized to the COVID-19 crisis. The government of Zimbabwe is also encouraged to take immediate action against any acts of violence and ill-treatment inflicted on women during childbirth and ensure that neither third parties nor harmful social or traditional practices interfere with women and girls' rights to sexual and reproductive health, including enacting legislation to prohibit child marriage.

The international community is strongly encouraged to provide technical and financial support for these initiatives.

2. METHODOLOGY

This report is based on desktop research and qualitative field research carried out in Zimbabwe between January 2018 and October 2020 and focuses on women and girls in Zimbabwe who have experienced obstetric fistula while giving birth.

Background research included individual interviews, authorised visits to Chinhoyi Provincial Hospital¹⁴, focus group discussions and community dialogues. Participants of group discussions reached over 170 people, including traditional and religious leaders, traditional birth attendants and community members.¹⁵ Community dialogues included the use of drama performance about obstetric fistula to facilitate the identification of barriers to health services.¹⁶ Amnesty International researchers interviewed 15 women who self-reported incontinence related to childbirth injuries, and 11 women who had been formally diagnosed with obstetric fistula and who had been living with the condition for between 3 to 44 years.

In September and October 2020, researchers interviewed 25 healthcare workers in Bulawayo, Harare and Chinhoyi. These practitioners included nurses, doctors, clinical directors, medical superintendents, and midwives. Although we received permission to interview patients, we did not see any patients during the 2020 visits due to COVID-19 restrictions. In addition, Amnesty International researchers visited Zimbabwe five times¹⁷ to meet with senior government officials working in the Ministry of Health and Child Care, medical experts¹⁸ and key staff working in NGOs and inter-governmental institutions to gain policy and programmatic information and establish the context relating to maternal health and obstetric fistula in the country.

The interviews were conducted using semi-structured open-ended questions to allow the researchers to capture women's narrative accounts. The questions were not medical per se but focused on the experiences of labour and the underlying social dynamics and contexts in which health services are delivered and accessed.¹⁹ The primary research was supported by desktop research, which included a comprehensive literature review, drawing from medical and sociological peer-reviewed literature, government policy and budget documents.

Amnesty International researchers visited six provinces in Zimbabwe: Harare, Bulawayo, Mashonaland West, Mashonaland East, Manicaland and Masvingo. Research sites were selected to ensure a mix of rural, peri-

14 Permission was granted by the Hospital Superintendent on 18 July 2018. Further permission granted by Permanent Secretary in Ministry of Health and Child Care on 3 March 2020

15 These included two focus group discussions, in July 2018, one with 12 Traditional Birth Assistants in Mashonaland East Province and one in Manicaland Province with eight women who had given birth in the last 24 months. Three Community Dialogues took place in November 2018.

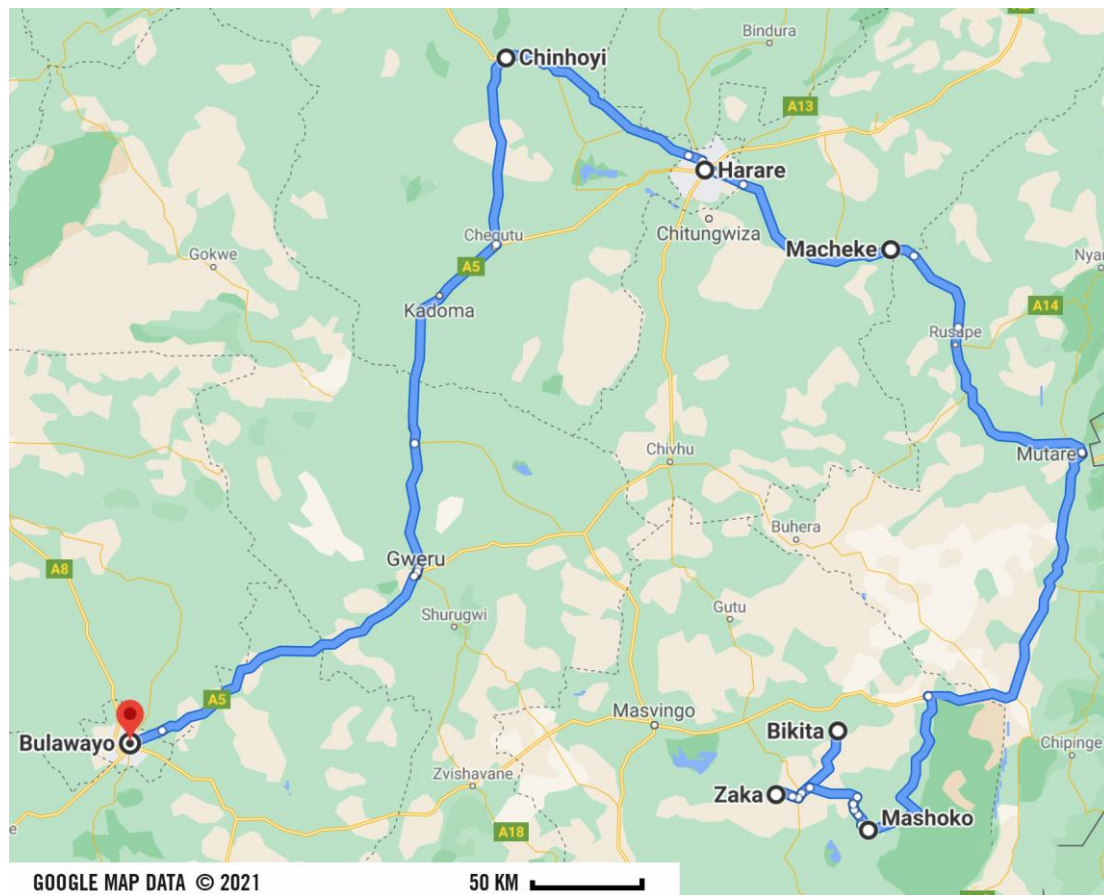
16 Drama is a well-recognised tool for supporting community-based research and for providing a safer-space to engage with difficult subjects, see further Meghna Guhathakurta, Theatre in Participatory Action Research: Experiences from Bangladesh, The SAGE Handbook of Action Research, <http://dx.doi.org/10.4135/9781848607934>, noting it has been found effective for accessing communities and issues which are "missing", "in terms of their absence in mainstream development agendas." at page 501 and Ditte Tofteng and Mia Husted, Theatre and action research: How drama can empower action research processes in the field of Unemployment, Action Research 9(1) 27–41 (2011).

17 January, July, October–November 2018, August 2019, September–October 2020

18 Amnesty International met with two medical experts on maternal health, one in South Africa and one in Zimbabwe and an expert fistula surgeon. In addition, meetings were held with six obstetrician/ gynaecologists with experience of working in the public sector in Zimbabwe and a further two doctors who were responsible for managing health facilities. All doctors have requested to remain anonymous in this report.

19 Questions related to: access to antenatal care, maternal services and post-natal care, access to emergency obstetric care, participant's experiences during labour, the realities of living with obstetric fistula / maternal morbidity, access to information and access to surgical repair.

urban and urban contexts and to reflect disparities in performance indicators related to maternal health outcomes.²⁰ Masvingo province was identified by the Ministry of Health and Child Care as a site with a potential high prevalence of obstetric fistula.²¹ Site selection included remote communities around Mutare, Marange and Masvingo, in areas with very limited infrastructure.



Interview data was analysed on a thematic basis for commonalities and according to themes relevant to maternal morbidity and the right to health, the right to gender equality and the right to be free from ill-treatment.²² While the research is not intended to be statistically significant, the individual stories highlight systemic challenges. The findings have been contextualised with reference to the broader literature and demographic data, which support the wider application of the report's findings.

Amnesty International wrote to Zimbabwe's Ministry of Health and Child Care and the Ministry of Women Affairs, Gender and Community Development on 5 November 2019 to share the initial findings of the report and to request further information regarding the key findings.

Amnesty International expresses deep gratitude to the women and their relatives who agreed to share their difficult accounts, and to the communities who participated in this research. The organisation is grateful for the efforts of the Eastern Arts Ensemble drama group for creating and performing a drama around obstetric fistula and their dedication to sharing information about the condition. Amnesty International wishes to acknowledge the inspirational work of the doctors, nurses and health care professionals who are working with the Ministry of Health and Child Care and partners to provide access to treatment for women with obstetric fistula in Zimbabwe.

20 "Manicaland province has the worst health outcomes for children in the country, with one in 10 dying before the age of five". See www.usaid.gov/zimbabwe/press-releases/june-13-2018-united-states-launches-25-million-program-improve-health.

21 The Ministry of Health and Child Care's Obstetric Fistula program initiated a satellite surgical repair program in at Masvingo hospital in October 2018.

22 See for example, OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27.

3. OBSTETRIC FISTULA: A HIDDEN AND AVOIDABLE TRAGEDY

“Giving birth is hard, it can leave you with a disability – women are living with a condition that is unspeakable.”

Woman with obstetric fistula.²³

Obstetric fistula is considered the “most devastating” maternal morbidity,²⁴ as it occurs after the trauma of an obstructed labour and results in continued incontinence of urine and/or faeces.²⁵ In as many as 90 percent of cases, women who experience obstetric fistula also suffer a still birth.²⁶

Obstetric fistula is a medical term for a hole that develops between the vagina and the bladder and/or rectum and is caused by prolonged pressure on those tissues during an obstructed labour.²⁷ While in most cases labour takes less than 24 hours, an obstructed labour can take several days, putting women’s lives and health at risk.²⁸

23 Interview with “Chenai*” 18 July 2018.

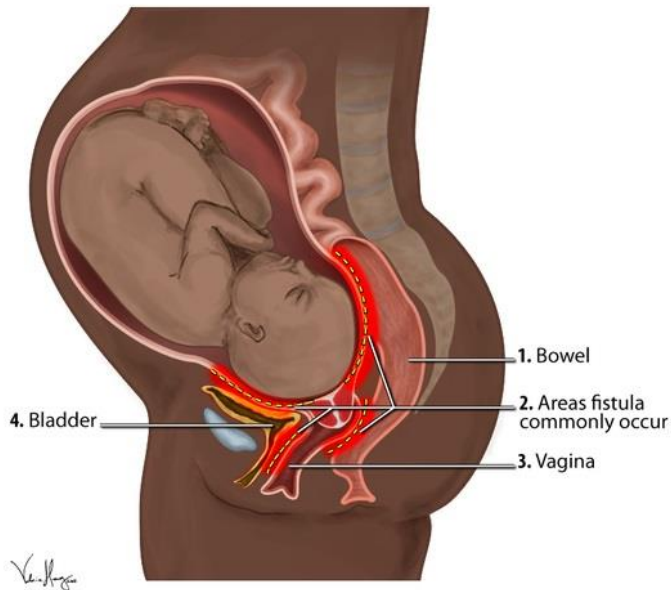
24 Ahmed et al. Double burden of tragedy: stillbirth and obstetric fistula. The Lancet Global Health, Comment Vol. Issue 2, PE80-E82, February 01, 2016 [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00290-9/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00290-9/fulltext)

25 Carmen Dolea and Carla AbouZahr, Global burden of obstructed labour in the year 2000 Evidence and Information for Policy (EIP), World Health Organization, Geneva, July 2003 page 11 http://cdrwww.who.int/healthinfo/statistics/bod_obstructedlabour.pdf

26 Saifuddin Ahmed, Erin Anastasi and Laura Laski, “Double burden of tragedy: stillbirth and obstetric fistula”, The Lancet Global Health, vol. 4, No. 2 February 01, 2016, [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00290-9/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00290-9/fulltext)

27 L Lewis Wall, Overcoming phase 1 delays: the critical component of obstetric fistula prevention programs in resource-poor countries, BMC Pregnancy and Childbirth 2012, 12:68. Wall www.biomedcentral.com/1471-2393/12/68 Page 2/13

28 Wall L et al. The obstetric vesicovaginal fistula in the developing world. Obstet Gynecol Surv. 2005; 60: S3-S51; Carmen Dolea1 and Carla AbouZahr, Global burden of obstructed labour in the year 2000 Evidence and Information for Policy (EIP), World Health Organization, Geneva, July 2003.



According to the World Health Organisation (WHO), obstetric fistula can be prevented by reducing the number of early and unplanned pregnancies, by ending harmful practices, such as child marriage, and ensuring access to quality emergency obstetric care, especially caesarean section.³⁰ Globally, obstetric fistula has been almost entirely eradicated in high income countries where there is access to quality obstetric care, yet more than two million women in low income countries, like Zimbabwe, are living with obstetric fistula, and UNFPA estimate “50,000 to 100,000 new cases develop each year.”³¹ In such contexts, women and girls who are the most marginalised are at the highest risk for obstetric fistula.³²

Senior health officials in Zimbabwe have estimated as many as 50 women and girls suffer pregnancy related morbidities - including obstetric fistula - every day.³³ While Zimbabwe’s maternal mortality rate dropped to 462 per 100,000 live births from the previous 651 per 100,000 live births recorded in 2014, the latest Multiple Indicator Cluster Survey³⁴ from 2019 indicates that the country’s maternal mortality ratio (MMR) is among the highest in the world.³⁵ Experts working with the WHO describe maternal deaths as “the tip of the iceberg” in relation to poor maternal health outcomes.³⁶ Modelling used by the WHO indicates that generally, the number of maternal injuries, or ‘morbidities’ may be up to 30 times higher than the number of maternal

²⁹ <https://commons.wikimedia.org/w/index.php?curid=37812735>

³⁰ World Health Organization, 10 facts on obstetric fistula, available at www.who.int/features/factfiles/obstetric_fistula/en/ accessed 19 September 2019.

³¹ World Health Organization, 10 facts on obstetric fistula, available at www.who.int/features/factfiles/obstetric_fistula/en/ accessed 19 September 2019.

³² UNFPA Zimbabwe, Restoring “Hope, healing, and dignity” for women living with fistula requires all our commitment, 23 May 2017, <http://zimbabwe.unfpa.org/en/news/restoring-hope-healing-and-dignity%E2%80%9D-women-living-fistula-requires-all-our-commitment-0>; see also WHO, 10 facts on obstetric fistula, January 2018, www.who.int/features/factfiles/obstetric_fistula/en/.

³³ Maheu-Giroux M, Filippi V, Maulet N, et al. Risk factors for vaginal fistula symptoms in Sub-Saharan Africa: a pooled analysis of national household survey data. BMC Pregnancy and Childbirth. 2016; 16:82. doi:10.1186/s12884-016-0871-6; UN General Assembly Resolution Intensification of efforts to end obstetric fistula 16 November 2016, A/C.3/71/L.16/Rev.1 page 2/8;

³⁴ Firoz et al. Measuring maternal health: focus on maternal morbidity, Bulletin of the World Health Organization 2013;91:794-796. doi: <http://dx.doi.org/10.2471/BLT.13.117564> www.who.int/bulletin/volumes/91/10/13-117564/en/

³⁵ See the latest MICS Survey by UNICEF here: https://mics-surveys-prod.s3.amazonaws.com/MICS6/Eastern%20and%20Southern%20Africa/Zimbabwe/2019/Survey%20findings/Zimbabwe%202019%20MICS%20Survey%20Findings%20Report-31012020_English.pdf

³⁶ Latest official figures: Zimbabwe Voluntary National Review (VNR) of SDGs for the High-Level Political Forum Summary of Key Messages <https://sustainabledevelopment.un.org/content/documents/14894Zimbabwe.pdf>

³⁷ Firoz et al. Measuring maternal health: focus on maternal morbidity, Bulletin of the World Health Organization 2013;91:794-796. www.who.int/bulletin/volumes/91/10/13-117564/en/

deaths.³⁷ Given Zimbabwe's high rate of maternal mortality, it can be expected that there is a devastating prevalence and incidence rate of obstetric fistula in the country.³⁸

Further, the COVID-19 pandemic has caused an increase in poor maternal outcomes as routine services aimed at saving lives such as antenatal and postnatal care were disrupted³⁹. Zimbabwe has been under an indefinite lockdown since 16 May 2020⁴⁰ and during lockdown, the country recorded a marked decrease in the utilisation of maternity services thus making pregnant women even more vulnerable⁴¹.

Natsai's⁴² life changed dramatically when she suffered an obstetric fistula while giving birth to her first child.



NATSAI'S EXPERIENCE

Natsai⁴³ was just 16 when she experienced a traumatic labour that left her with urine and faecal incontinence. Natsai had left school in the first year of secondary school aged 15, to get married, and she became pregnant soon after.⁴⁴ She was living with her husband and his family, who as members of an Apostolic sect that preaches against formal medicine, decided she should give birth at home.

Natsai had a long and complicated labour. She explained that over three days she experienced "extreme pain", spreading to her legs and her back. Her husband's family refused her pleas to be taken to hospital. Eventually, Natsai's husband called her parents, who hired a car and rushed her to the clinic three kilometres away. The clinic was unable to provide emergency obstetric care and transferred Natsai to Mutare Provincial Hospital. Natsai does not know why help was unavailable in Mutare, which as a provincial hospital, should have had the necessary equipment and doctors to help her. But she was transferred again, this time to Parirenyatwa General Hospital in Harare, where she was given a caesarean-section. It was too late. Her baby had died, and Natsai's injuries were so severe that she needed to stay in hospital for six weeks.

Natsai described the shattering experience of discovering her incontinence. While in hospital, she realised she was leaking urine and stools when she stood up. The hospital staff explained that a hole had formed in her body during labour. They told her that she needed to go home to heal, then return to hospital later to be "fixed".

Natsai's home is over 260km from Harare.⁴⁵ The journey costs more than US\$12 and may take several hours in public transport.⁴⁶ Natsai was not working and was financially dependent on her husband's family. For a woman in poverty, who is terrified of leaking urine or stools in public, the journey back to the hospital represented a distressing ordeal.

But Natsai was hopeful and had the support of her husband, who accompanied her back to Harare for the surgery. But when she arrived at the hospital, she was told she could not be treated because she was under 18 and she needed her parents to sign the consent form. Her parents gave their consent over the phone, but it was not accepted. Natsai went home and never returned.

37 Modelling cited by the World Health Organization indicates approximately 30 maternal morbidities occur for every maternal death. See: Tabassum Firoz et. Al. Measuring maternal health: focus on maternal morbidity, Bulletin of the World Health Organization 2013;91:794-796, citing Ashford L. Hidden suffering: disabilities from pregnancy and childbirth in less developed countries. Population Reference Bureau; 2002. <http://www.prb.org/pdf/hiddensufferingeng.pdf> [accessed 24 June 2013] and Reichenheim ME, Zylbersztajn F, Moraes CL, Lobato G. Severe acute obstetric morbidity (near-miss): a review of the relative use of its diagnostic indicators. Arch Gynecol Obstet 2009; 280: 337-43.

38 Tabassum Firoz et. Al. Measuring maternal health: focus on maternal morbidity, Bulletin of the World Health Organization 2013;91:794-796, citing Ashford L. Hidden suffering: disabilities from pregnancy and childbirth in less developed countries. Population Reference Bureau; 2002. www.prb.org/pdf/hiddensufferingeng.pdf [accessed 24 June 2013] and Reichenheim ME, Zylbersztajn F, Moraes CL, Lobato G. Severe acute obstetric morbidity (near-miss): a review of the relative use of its diagnostic indicators. Arch Gynecol Obstet 2009; 280: 337-43.

39 Murewanhema G, Nyakanda MI, Madziyire MG. Restoring and maintaining robust maternity services in the COVID-19 era: a public health dilemma in Zimbabwe. Pan Afr Med J. 2020;37(Suppl 1):32. Published 2020 Nov 8. doi:10.11604/pamj.supp.2020.37.32.26798

40 Zimbabwe extends coronavirus lockdown 'indefinitely', 17 May 2020, Aljazeera See: <https://www.aljazeera.com/news/2020/5/17/zimbabwe-extends-coronavirus-lockdown-indefinitely>

41 Murewanhema G, Nyakanda MI, Madziyire MG. Restoring and maintaining robust maternity services in the COVID-19 era: a public health dilemma in Zimbabwe. Pan Afr Med J. 2020;37(Suppl 1):32. Published 2020 Nov 8. doi:10.11604/pamj.supp.2020.37.32.26798

42 Pseudonyms are used in this report to protect and respect the privacy of interviewees. A pseudonym is denoted by an asterisk (*) after the name where it is first used in the report.

43 Interview with Patient 3 Natsai, 19 July 2018 Visit and interviews at hospital in Chinhoyi.

44 She was 16 when she went into labour in 2014, and was living with her husband, aged 22 and his family.

45 Natsai is from Manicaland Province.

46 Cost estimated in 2019

Natsai tried seeking help closer to home, visiting the local clinic and Mutare Provincial Hospital, but her family's savings and resources⁴⁷ had already been wiped out by an astronomical hospital bill of \$1400 for the caesarean-section and weeks spent recovering in hospital. Natsai's incontinence prevents her from working and she was unable to find the money for the fistula surgery, which was estimated to cost over \$300.

For 11 years Natsai thought she was the only person with such a condition. Now she considers herself to be fortunate. She has been part of the Ministry of Health and Child Care's obstetric fistula program. When Natsai spoke to Amnesty International researchers, she had received two surgeries and hoped another procedure would finally end her incontinence.

In nearly all cases, the only treatment for obstetric fistula is to surgically close the hole between the vagina and the bladder and/or rectum.⁴⁸ With expert care, surgical success rates of treating obstetric fistula are as high as 90%.⁴⁹ The government of Zimbabwe has taken commendable steps to increase access to treatment for women and girls who have suffered an obstetric fistula.⁵⁰ Since 2013, the Ministry of Health and Child Care in Zimbabwe, with support from UNFPA, Women and Health Alliance International (WAHA) and partners, has provided access to surgical fistula repair. The program has focused on "providing obstetric fistula services at selected hospitals", with quarterly Obstetric Fistula Camps for affected women taking place at Chinhoyi Provincial Hospital since 2015.⁵¹ The program provides specialised surgical training to doctors in Zimbabwe to perform fistula corrective operations, and a doctor involved estimated surgical success rates had increased from 40% to 90% as a result.⁵² The program also covers patients' transport, food and accommodation costs. A UNFPA Policy Brief reports that as of November 2018 over 500 women and girls had undergone surgery for free.⁵³ However, this number is likely to represent only a small proportion of the total number of women and girls with obstetric fistula in Zimbabwe. The Fistula Foundation estimate that globally, for every one person who receives treatment for obstetric fistula, over 50 others "go without".⁵⁴

While recognising the important efforts of the Ministry of Health and Child Care and partners to increase access to obstetric fistula treatment, major challenges remain. Senior officials in the Ministry say it has been difficult to recruit enough doctors to the program, and nationally, only a few hospitals have sufficient theatre equipment or staffing capacity to offer treatment.⁵⁵ The limited capacity to provide surgical treatment has resulted in a reluctance to promote the Obstetric Fistula Camps, as government officials noted they feared being inundated with requests.⁵⁶ Amnesty International found most people interviewed for this report lacked information about how obstetric fistula can be prevented and repaired, and few people outside of Harare knew that the government had a program to repair injuries from obstetric fistula. The current state of affairs not only denies the right to health but perpetuates the data vacuum on the prevalence of obstetric fistula at the national level, in turn contributing towards the 'invisibility' of the condition as an urgent public health priority.

Without access to health information and services, women with obstetric fistula are left without hope. The cases documented in this report illustrate how experiencing an obstetric fistula leads to serious physical and mental health challenges and social disadvantages. For many women and girls with an obstetric fistula in Zimbabwe, their injuries lead to stigmatisation and ill treatment from husbands, family and community members. Many women with the condition are living in isolation. The report further highlights how obstetric fistula can push women deeper into poverty. Having an obstetric fistula makes it difficult to work and brings high costs associated with seeking help from health facilities and for hygiene commodities for self-care.

47 Natsai's husband sold his potato crop, her parents used all their savings.

48 Worldwide Fistula Fund <https://worldwidefistulafund.org/what-is-fistula.aspx>

49 Bengtson et al. Identifying Patients with Vesicovaginal Fistula at High Risk of Urinary Incontinence After Surgery, *Obstetrics & Gynaecology*: November 2016 - Volume 128 - Issue 5 - p 945-953 doi: 10.1097/AOG.0000000000001687

50 Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020) , August 2015,

www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf page 33

51 Investing in Sexual and Reproductive Health and Rights Policy Brief, UNFPA December 2018,

[https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Policy%20Brief%20-](https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Policy%20Brief%20-%20Investing%20in%20Sexual%20and%20Reproductive%20Health%20and%20Rights.pdf)

[%20Investing%20in%20Sexual%20and%20Reproductive%20Health%20and%20Rights.pdf](https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Policy%20Brief%20-%20Investing%20in%20Sexual%20and%20Reproductive%20Health%20and%20Rights.pdf)

52 Interview with Senior Doctor, 18 July 2018.

53 Investing in Sexual and Reproductive Health and Rights Policy Brief, UNFPA December 2018,

[https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Policy%20Brief%20-](https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Policy%20Brief%20-%20Investing%20in%20Sexual%20and%20Reproductive%20Health%20and%20Rights.pdf)

[%20Investing%20in%20Sexual%20and%20Reproductive%20Health%20and%20Rights.pdf](https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Policy%20Brief%20-%20Investing%20in%20Sexual%20and%20Reproductive%20Health%20and%20Rights.pdf)

54 Fistula Foundation www.fistulafoundation.org/what-is-fistula/

55 Amnesty International meeting with Senior Official in Ministry of Health and Child Care 2 November 2018

56 Note above

“But it doesn’t have to be this way – fistula is both treatable and preventable.”⁵⁷

Many women who had experienced obstetric fistula told Amnesty International they want to help other women and girls, by sharing information on safer delivery and letting others with the condition know they are not alone, and that treatment is available.

This report aims to raise awareness of the human rights impact of obstetric fistula and by doing so, contribute to the efforts of the Ministry of Health and Child Care and partners in preventing obstetric fistula and expanding access to treatment.

3.1 AN UNFOLDING MATERNAL HEALTH CRISIS IN ZIMBABWE

3.1.1 MOPPING THE FLOOR WITH THE TAP RUNNING

The government’s efforts to increase access to treatment for obstetric fistula risk being totally undermined, unless there is simultaneous action to prevent new cases occurring. However, the escalating political and financial crisis since 2018 and the emergence of COVID-19 have jeopardised Zimbabwe’s health system and undermined the fragile progress the country has made in improving maternal health outcomes over the past decade.

Zimbabwe’s maternal mortality ratio (MMR) peaked in 2010 at 960 deaths per 100,000 live births - a steep rise from the rate of 283 in 1994⁵⁸ - as political and economic instability in Zimbabwe during the period 2000-2010 escalated household poverty levels⁵⁹ and undermined the public health system.⁶⁰ Government spending on health per capita declined dramatically over the period, from the highest levels in sub-Saharan Africa at “US\$42 in 1991...to just under US\$6 in 2009.”⁶¹ Analysis by Zimbabwe’s development partners indicates that by 2011 “maternal and child health were the most underfunded programmes in the health sector.”⁶² Health spending improved to US\$57 per person in 2017, but was estimated to have sharply declined to US\$21 in 2020, which puts the gains made by the country over the years at risk⁶³.

Since 2011, fragile gains have been made in relation to maternal health outcomes, with the assistance of international development partners.⁶⁴ The country’s maternal mortality ratio declined to 462 per 100,000 live births in 2019.⁶⁵ Key interventions have increased access to contraception,⁶⁶ skilled birth attendants,⁶⁷ and antenatal and postnatal care.⁶⁸ However, Zimbabwe’s development partners have emphasised that the

⁵⁷ Royal College of Obstetricians and Gynecologists <https://www.rcog.org.uk/en/global-network/global-health-advocacy/obstetric-fistula/>

⁵⁸ UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Maternal Health.

⁵⁹ Ministry of Health and Child Care, Neonatal, Maternal and Newborn Health Road Map 2007-2015 (hereafter NMNH Road Map 2007-2015), which also notes the period witnessed spiralling inflation rates and a shortage of foreign currency, collapse of the agricultural sector, massive unemployment, and widespread civil unrest.

⁶⁰ NMNH Road Map 2007-2015, which further cites the HIV and AIDS pandemic, soaring inflation rates and a shortage of foreign currency, shortages of medical supplies, drugs and equipment, and an exodus of skilled medical professionals.

⁶¹ Ministry of Health and Child Care, Health Development Fund, ‘Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020)’ at page 1, www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf

⁶² Ministry of Health and Child Care, Health Development Fund, ‘Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020)’ at page X, www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf

⁶³ 2020 Health Budget Brief, Zimbabwe, UNICEF see: <https://www.unicef.org/esa/media/6501/file/UNICEF-Zimbabwe-2020-Health-Budget-Brief.pdf>

⁶⁴ Zimbabwe Voluntary National Review (VNR) of SDGs for the High-Level Political Forum July 2017.

<https://sustainabledevelopment.un.org/content/documents/15866Zimbabwe.pdf>

⁶⁵ Zimbabwe Voluntary National Review (VNR) of SDGs for the High Level Political Forum Summary of Key Messages

<https://sustainabledevelopment.un.org/content/documents/14894Zimbabwe.pdf>; UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Maternal Health - 43% decline in MMR since 2010, from 960 to 651.

⁶⁶ Ministry of Health and Child Care, Zimbabwe National Family Planning Costed Implementation Plan 2016 – 2020; Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMMA) country report on Zimbabwe

www.carmma.org/champion/public-zimbabwe; in July 2017 the Zimbabwe Ministry of Health and Child Care announced the country had reached a contraceptive prevalence rate of 67%; <http://healthtimes.co.zw/2017/07/15/zim-meets-global-family-planning-target/>

⁶⁷ Zimbabwe Demographic and Health Survey 2015 noting an increase to 78% of births in 2015 up from 66% 2010-11, page 145.

<https://dhsprogram.com/pubs/pdf/FR322/FR322.pdf>

⁶⁸ UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Maternal Health.

<https://zimbabwe.unfpa.org/en/publications/zdhs-2015-key-findings-maternal-health>

country's prospects of improving health outcomes rely on the country's "economic recovery and political stability",⁶⁹ – conditions which remain elusive.

In March 2019, the Finance Minister failed to secure US\$1.2 billion in emergency loans from South Africa,⁷⁰ necessary to bolster economic growth and infrastructure investment. Meanwhile, the inflation rate has increased enormously since October 2018.⁷¹ Inflation rates spiralled further to reach 75.86% by April 2019⁷² with annual inflation soaring to 176%.⁷³ In August 2019, the Finance Minister announced the government would no longer report inflation figures.⁷⁴ However, a month later, the IMF reported the country had the "highest inflation rate in the world", at 300 per cent.⁷⁵

Compounding Zimbabwe's challenges, the country has also faced extreme climate events and humanitarian crises. Having barely recovered from the regional drought of 2017, and a state of emergency in response to a cholera outbreak in 2018,⁷⁶ remote parts of the country were ravaged by Cyclone Idai in 2019.⁷⁷ Foreign direct investment remains low. Lloyds Bank highlight the country's "precarious food and health situation" as one of four "weak spots" hindering foreign direct investment.⁷⁸ The World Food Programme warned over a third of the population would face food insecurity at the peak of the lean season in 2019, estimating that "63% of people live below the poverty line."⁷⁹ Women and girls in Zimbabwe are also disproportionately affected and bear the brunt of these recurrent shocks. Unemployment rates have been consistently high among women and young people, who also struggle to find money for school fees and health services.⁸⁰

3.2 HEALTH SYSTEM CHALLENGES

In general, countries with higher rates of obstetric fistula often have under-resourced and inequitable health systems.⁸¹ Despite the urgent need to strengthen the health system and improve maternal health outcomes, the government of Zimbabwe has consistently failed to assign sufficient funding to the health sector.⁸² The allocation to health in the 2020 budget represented just 10% of the total national budget,⁸³ a minor increase

69 Health Development Fund Programme Document 2015 at page 5.

<https://www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf>

70 No SA bailout for Zim after Ramaphosa visit, FinNews, 12 March 2019, www.fin24.com/Economy/Africa/no-sa-bailout-for-zim-after-ramaphosa-visit-20190312

71 African Development Bank Group, ZIMBABWE ECONOMIC BRIEF February 2019

www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Monthly_Bulletin_February_2019.pdf

72 "The annual inflation rate in Zimbabwe soared to 75.86% in April 2019" <https://tradingeconomics.com/zimbabwe/inflation-cpi>

73 Shingai Nyoka, Zimbabwe after Mugabe: The country where pensions have disappeared, BBC News, 13 August 2019:

www.bbc.com/news/world-africa-49317593

74 Ray Ndllovu and Godfrey Marawanyika, 'Once Famed for Hyperinflation, Zimbabwe Suspends Inflation Data', Bloomberg 1 August 2019, www.bloomberg.com/news/articles/2019-08-01/once-famed-for-hyperinflation-zimbabwe-suspends-inflation-data.

75 Chris Muronzi, 'IMF: Zimbabwe has the highest inflation rate in the world', Al Jazeera, 27 September 2019,

www.aljazeera.com/ajimpact/imf-zimbabwe-highest-inflation-rate-world-190927004536305.html

And in July 2020, Zimstats <https://businessstech.co.za/news/trending/408053/zimbabwes-inflation-rate-hits-785-55/>

76 www.theguardian.com/global-development/2018/sep/12/zimbabwe-state-of-emergency-cholera-outbreak-claims-20-lives

77 Zimbabwe Voluntary National Review (VNR) of SDGs for the High Level Political Forum July 2017 notes that "Of the 6.3 million children in Zimbabwe, 78 per cent (4.8million) live in consumption poverty and 26 per cent (1.6 million) live in extreme/food poverty", page 7 and that the "El Nino-induced drought of 2015/16 which left over 4 million people food insecure, 51 per cent of whom are women", page 10 and that "Endemic poverty afflicts the majority of youths and women in rural areas and in the informal economy where they work with little or no incomes" page 20.

78 Lloyds highlight the following factors as "hindering foreign investment in Zimbabwe": "economic and financial situation hit by a long period of hyperinflation; shortage of cash; under-investment in infrastructures (especially energy infrastructure); precarious food and health situation: the majority of the population depends on international aid; AIDS prevalence rate among the highest in Africa and in the world."

79 World Food Programme www.wfp.org/countries/zimbabwe and noting "In 2019, nearly 5.3 million people face food insecurity at the peak of the lean season".

80 According to the Zimbabwe Vulnerability Assessment Committee, "at least 63% of the children experienced being turned away for non-payment of school fees." Zimbabwe Vulnerability Assessment Committee (ZimVAC) 2017 Rural Livelihoods Assessment Report. According to the HRC Working Group UPR, National report on Zimbabwe, the participation rate for girls at upper secondary level remains at 44%, at para. 53.

81 UN Report of the Secretary-General, Intensifying efforts to end obstetric fistula, 2016 ref: A/71/306 para 8.

82 Amnesty International's report, Lost without knowledge 2018, notes "Despite calls from UN agencies and human rights treaty bodies that Zimbabwe substantially increase budget allocations in the areas of health, education and social services to adequate levels, Zimbabwe's budget allocations have remained below the 2001 Abuja Declaration, where governments committed to allocating at least 15% of their annual budget to the improvement of the health sector. The budget allocation to health has been declining since a 'high' of 10.9% in 2012 and in 2017 represents 8.2% of the total national budget, compared to the Sub Saharan Africa average of 11.3%." at page 13, citing: CRC/C/ZWE/CO/2 para 59 (b) and para 15(a) at page 50; Government of Zimbabwe National Health Strategy (2009-2013); UN Issue Paper Series, Paper 1 2013; CRC Committee Concluding Observations Zimbabwe para 15(a); Abuja Declaration on HIV/AIDS, Tuberculosis, and other related infectious diseases, www.un.org/ga/aids/pdf/abuja_declaration.pdf; Community Working Group on Health (CWGH) Post Budget Analysis – Health Sector Allocations 2017.

83 The 2020 National Budget Speech "Gearing for Higher Productivity, Growth and Job Creation" Presented to the Parliament of Zimbabwe on November 14, 2019 by the Hon. Prof. Mthuli Ncube Minister of Finance & Economic Development, http://www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&download=234:2020-national-budget-speech&id=54:2020-budget&Itemid=787

from 9.3% the previous year. The government has repeatedly failed to heed recommendations from UN Human Rights Treaty Bodies, and the Committee of the Rights of the Child (CRC Committee) in 2016 to “Substantially increase allocations in the areas of health, education and social services to adequate levels”.⁸⁴ Allocations have never reached 15% of the annual budget, despite Zimbabwe’s commitments to fund health at this level, under the 2001 Abuja Declaration.⁸⁵ While Zimbabwe’s 2019 budget was billed as one of austerity,⁸⁶ civil society analysis stressed the disproportionate impact on people living in poverty.⁸⁷ The Community Working Group on Health (CWGH) have analysed the long-term underinvestment as a “clear sign of lack of political commitment in addressing problems in the health sector”.⁸⁸

The government’s inadequate public spending in the health sector has meant that the costs of health services are disproportionately paid for by the poor,⁸⁹ as people who are ill and in need of care have to rely on high levels of “out of pocket” payments.⁹⁰ Soaring inflation has further increased these costs, at a time when nearly two thirds of the population live below the poverty line.⁹¹ In addition to already expensive fees for medical consultations and tests,⁹² patients are reportedly required to pay for medicines, sterile equipment and fuel for ambulances.⁹³ Such costs can range from tens to hundreds of dollars and are out of reach for the majority of people in Zimbabwe, with potentially devastating impact for pregnant people.

Zimbabwe is heavily reliant on international assistance to fund maternal health programs. Since 2011, the Health Transition Fund and a joint UN initiative, the H4+,⁹⁴ have driven significant initiatives including the training of midwives, the running costs of 1500 rural health facilities and helped improve the “availability of essential drugs, vaccines and commodities”.⁹⁵ Over one hundred Maternity Waiting Homes (MWHs) have been built across the country.⁹⁶

Since 2011, the government has also committed to provide free maternal and child health services at all public health facilities.⁹⁷ While this initiative was initially also funded through the Health Transition Fund,⁹⁸ many local authority clinics have continued to charge fees, citing the funding shortfalls from national government.⁹⁹ In one example from June 2019, the Harare City Council was reported as raising maternity fees at local government clinics to ZW\$120 (US\$22.20), and consultation fees to ZW\$50 (US\$9.20).¹⁰⁰ Women and girls who are unable to pay the clinic fees for maternal health care, go directly to public hospitals to give birth.¹⁰¹ As these hospitals fall under the administration of the national government,

84 CRC Committee Concluding Observations to Zimbabwe 2016 para 15(a), ref: CRC/C/ZWE/CO/2

85 Abuja Declaration on HIV/AIDS, Tuberculosis, and other related infectious diseases, www.un.org/ga/aids/pdf/abuja_declaration.pdf,

86 The 2019 National Budget Statement, was entitled: “Austerity for Prosperity”, 2019 National Budget Statement Presented to the Parliament of Zimbabwe On Thursday, November 22, 2018 By Hon. Prof. Mthuli Ncube Minister of Finance and Economic Development.

87 Prosper Chitambara, Making sense of the 2019 budget, Zimbabwe Independent, 30 November 2019, noting the budget allocation for the Ministry of Defense increased, to 7%: ZIMCODD Analysis of the 2019 National Budget A social and Economic Justice Perspective.

88 Community Working Group on Health (CWGH), Press Release, 4 December 2018 Recurrent doctors’ strikes mirrors lack of political commitment to address sticking issues www.cwgh.co.zw/wp-content/uploads/2018/12/CWGH-Statement-on-the-Doctors-Strike-4-December-2018-2.pdf; see also Daily News, Health budget slated as ‘grossly inadequate’ Helen Kadirire 30 November 2018.

89 Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality,(2012) ref: A/HRC/21/22, para 46.

90 Ministry of Health and Child Care, National Health Strategy for Zimbabwe 2016-2020. See:

https://zdrh.uz.ac.zw/xmlui/bitstream/handle/123456789/703/National_Health_Strategy_for_Zimbabwe_2016-2020.pdf?sequence=1&isAllowed=y

91 World Food Programme, noting “In 2019, nearly 5.3 million people face food insecurity at the peak of the lean season”, www.wfp.org/countries/zimbabwe

92 ‘Soaring health costs: Poor caught in death trap’, Zimbabwe Independent, 10 June 2017,

www.theindependent.co.zw/2017/06/16/soaring-health-costs-poor-caught-death-trap/

93 News 24, ‘In Zimbabwe, hospitals battle with Mugabe’s legacy’ 10 September 2019, www.news24.com/Africa/Zimbabwe/in-zimbabwe-hospitals-battle-with-mugabes-legacy-20190910

94 H4+ is “a joint UN initiative with UNICEF, WHO, UN Women and UNAIDs coordinated by UNFPA” Government of Zimbabwe, Ministry of Health and Child Welfare Harare, Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020) at 3, available at: www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf

95 Government of Zimbabwe, Ministry of Health and Child Welfare Harare, Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020) at 3.

96 Maternity Waiting Homes (MWH) are shelters where pregnant people can stay in close proximity to a health facility during the late stages of pregnancy and have been implemented in Zimbabwe as a way to alleviate transport challenges. The government recommends women in rural areas should stay in a MWH “for 3 weeks before and three days after delivery to increase their access to skilled birth attendance”, according to the government’s reports, “68% Government rural hospitals and 63% Government district hospitals having obstetric waiting homes.” Government of Zimbabwe, Ministry of Health and Child Welfare Harare, Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020) at pages 3,14 and 18

97 UNICEF www.unicef.org/infobycountry/zimbabwe_61823.html; CARMMA Updates Maternal Death Rates Fall in Zimbabwe by 36 Percent 12 February 2015, <http://carmma.org/update/maternal-death-rates-fall-zimbabwe-36-percent>

98 Amnesty International’s 2018 research further confirmed that the 2011 policy was not fully implemented and fees for maternal health services were charged in public health facilities run by local authorities and municipalities; Amnesty International, Lost Without Knowledge 2018. UNICEF www.unicef.org/infobycountry/zimbabwe_61823.html; CARMMA Updates Maternal Death Rates Fall in Zimbabwe by 36 Percent 12 February 2015, <http://carmma.org/update/maternal-death-rates-fall-zimbabwe-36-percent>

99 Harare hikes maternity fees, Newsday, 18 July 2019, www.newsday.co.zw/2019/07/harare-hikes-maternity-fees/

100 Harare hikes maternity fees, Newsday, 18 July 2019, www.newsday.co.zw/2019/07/harare-hikes-maternity-fees/

101 Harare hikes maternity fees, Newsday, 18 July 2019, www.newsday.co.zw/2019/07/harare-hikes-maternity-fees/

maternity fees are waived. However, in 2019, hospital maternity units became severely overburdened, and were described as so full, women and their new-born babies were forced to sleep on the floor.¹⁰² The hospitals are referral centres, which should only be dealing with complicated deliveries. Delays providing caesarean operations have also been highlighted, resulting in avoidable maternal and neo-natal deaths.¹⁰³ Senior doctors at Parirenyatwa Hospital in Harare met with the then Minister for Health and Child Care, Obadiah Moyo, in March 2019, to urge additional resources. A Doctor in the maternity unit pleaded for support, explaining “I come to work to certify dead (baby) bodies, that’s not why I am here”.¹⁰⁴

UNICEF stressed that globally, “[m]ore preventable deaths occur from low-quality health care than from lack of access”¹⁰⁵ and similarly, in Zimbabwe, reports indicate that nearly all “maternal deaths are occurring at health facilities”.¹⁰⁶ Such outcomes suggest a systematic failure to meet sufficient standards of good quality, respectful and timely care.¹⁰⁷ Health facilities in Zimbabwe remain under resourced, with shortages of emergency obstetric care provision and a lack of skilled health care workers.¹⁰⁸ Significant disparities in maternal health outcomes have been reported between rural and urban contexts and between provinces.¹⁰⁹

Reports also indicate that the burden on public hospitals is increasing as patients flock from private facilities, due to exponential increases in hospital fees (over 100%)¹¹⁰ and premiums for private medical insurance schemes (between 50% and 400%).¹¹¹ The cost of delivery in a private health facility in 2019 was reported at between US\$300-US\$1000.¹¹² In 2021, the cost was reported at between US\$150-US\$1200¹¹³.

Zimbabwe’s health system has also been affected by the ongoing economic and political crisis in other ways. Nurses and doctors have protested low pay and dire working conditions, with strike action in 2018 and throughout 2019 related to the lack of foreign currency and reduced wages, “severe shortages of medicines... dilapidated infrastructure and obsolete medical equipment.”¹¹⁴ Doctors have reported being unable to operate due to dysfunctional surgical theatres, with elective operations in April 2019 down 80% from the same period in 2018 for this reason.¹¹⁵ Civil society groups have documented a dramatic decline in health standards at hospitals,¹¹⁶ and doctors have testified to patients dying due to drug and equipment shortages.¹¹⁷ The CWGH also emphasise a crisis in emergency care, with ambulances being unstaffed and unroadworthy.¹¹⁸ The picture remains equally dire at the primary health care level, with civil society groups

102 Free maternity services require solid funding, Zimbabwean Situation, 23 October 2018: www.zimbabwean-situation.com/news/free-maternity-services-require-solid-funding/

103 Zimbabwe doctors say patients dying due to drug, equipment shortages, Reuters, 13 March 2019: www.reuters.com/article/us-zimbabwe-doctors/zimbabwe-doctors-say-patients-dying-due-to-drug-equipment-shortages-idUSKBN1QU2EX

104 Doctors in Zimbabwe 'sending patients away to die' as drug shortages bite, The Guardian, 14 March 2019: www.theguardian.com/global-development/2019/mar/14/doctors-strike-zimbabwe-sending-patients-away-to-die-drug-shortages

105 UNICEF Quality of care, available: www.unicef.org/health/quality-care

106 Community Working Group on Health, 'Heads should roll at Parirenyatwa', 6 November 2019 www.cwgh.co.zw/heads-should-roll-at-parirenyatwa/; reporting the maternal “death of a woman during labour at hospital in Harare amid allegations that she was left unattended for too long” citing that 92 percent of maternal deaths in the country occur at health facilities;

107 Community Working Group on Health, 'Heads should roll at Parirenyatwa', 6 November 2019 www.cwgh.co.zw/heads-should-roll-at-parirenyatwa/; Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page 280, noting cases of negligence and non-attendance during visits to health facilities, including “two cases of non-attendance to patients by doctors and nurses which led to death of a pregnant woman at hospital in Chiredzi.”; Margaret E Kruk et al., Quality of basic maternal care functions in health facilities of five African countries: an analysis of national health system surveys, *Lancet Glob Health* 2016; 4: e845–55, noting efforts to increase quality of care have recommended governments in “Low-income and middle-income countries should systematically assess and improve the quality of delivery care in health facilities to accelerate reduction of maternal and newborn deaths.”

108 Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page 280.

109 Guzha, Bothwell Takaingofa et al. “Assessment of quality of obstetric care in Zimbabwe using the standard primipara.” *BMC pregnancy and childbirth* vol. 18,1 205. 4 Jun. 2018, doi:10.1186/s12884-018-1863-5

110 CWGH Desperate patients overwhelm public hospitals 13 May 2019, www.cwgh.co.zw/desperate-patients-overwhelm-public-hospitals/

111 Funding for Zim’s healthcare now dire, News Day, 29 May 2019 www.newsday.co.zw/2019/05/funding-for-zims-healthcare-now-dire/

112 Funding for Zim’s healthcare now dire, News Day, 29 May 2019 www.newsday.co.zw/2019/05/funding-for-zims-healthcare-now-dire/

113 Amnesty International Zimbabwe field research

114 Junior doctors are reported to earn \$329 a month, “despite many years of training and study” www.theguardian.com/global-development/2018/dec/31/zimbabwe-health-crisis-doctors-pay-strike; Junior doctors undertook strike action in March and December 2018, and senior doctors at hospital in Harare went on strike in March 2019. www.cwgh.co.zw/wp-content/uploads/2018/12/CWGH-Statement-on-the-Doctors-Strike-4-December-2018-2.pdf; The government fired thousands of nurses who went out on strike against low wages in April 2018 www.theguardian.com/world/2018/apr/18/zimbabwe-sacks-thousands-of-nurses-on-strike-for-better-pay

115 www.theguardian.com/global-development/2019/mar/14/doctors-strike-zimbabwe-sending-patients-away-to-die-drug-shortages

116 Community Working Group on Health, 'Horror tales of rot in public hospitals', 14 May 2019, www.cwgh.co.zw/horror-theses-of-rot-in-public-hospitals/

117 Doctors in Zimbabwe 'sending patients away to die' as drug shortages bite, The Guardian, 14 March 2019

www.theguardian.com/global-development/2019/mar/14/doctors-strike-zimbabwe-sending-patients-away-to-die-drug-shortages

118 Community Working Group on Health, Press Release, 4 December 2018 Recurrent doctors’ strikes mirrors lack of political commitment to address sticking issues www.cwgh.co.zw/wp-content/uploads/2018/12/CWGH-Statement-on-the-Doctors-Strike-4-December-2018-2.pdf

raising alarm at shortages of contraceptives¹¹⁹ and prescription of outdated anti-retroviral drugs.¹²⁰ The government has acknowledged challenges as including shortages of essential medicines and equipment and consumables, “[p]oor diet [and] [o]vercrowding”, industrial action and “[i]nadequate [i]nfrastructure” of ambulances and service vehicles.¹²¹ However, as of September 2019, only ZW\$712 million (US\$54 million) of the ZW\$1.67 billion (US\$127 million) allocated to Health in the national budget had been released, with the major spending going to employment costs.¹²²

A matron at one of the hospitals visited by Amnesty International confirmed these constraints when she said that “the hospital has intermittent shortages of maternal resources mainly due to procurement and supply chain issues. This is because procurement is conducted at a district level and locally, and this lengthens the process”. She also went on to say that the hospital has a huge shortage in human resources and that staff morale is low due to overwork.¹²³ A registered adult nurse at the same hospital also stated that nurses are “more overwhelmed and overworked” and that there was a shortage of resources in surgical wards which were needed for fistula surgery, such as special linen which is often hard to find.¹²⁴

Compounding matters, Zimbabwe’s health system has been stretched to the limits and worsened by COVID-19. COVID-19 has become a health, economic and social pandemic threatening the fragile gains Zimbabwe has made in reducing maternal mortality and morbidity in recent years. In the first three months of lockdown in 2020, 106 maternal deaths were recorded which far exceeded the numbers of recorded COVID-19 deaths.¹²⁵ As at around the same time Zimbabwe had only recorded four COVID-19 related deaths¹²⁶.

An inadequate state response to the pandemic further deepened the inequalities that most marginalized women and girls experience. Fearful that the public health system could be overwhelmed, in 2020 authorities imposed several measures that sought to redirect resources to the COVID-19 response. Some of these measures included reassigning equipment, turning hospital facilities into isolation centres, closure of non-emergency units and reassigning the limited health force to address the potential influx of COVID-19 patients.¹²⁷

WHO noted, “People, efforts, and medical supplies all shift to respond to the emergency. This often leads to the neglect of basic and regular essential health services. People with health problems unrelated to the epidemic find it harder to get access to health care services.”¹²⁸ In Zimbabwe, the net effect of restructuring the health care workforce and services was the cancellation of antenatal, childbirth and post-partum care for pregnant women and girls. Workforce shortages were also recorded as several skilled health workers were infected by the coronavirus in the process. Fortune Nyamande, the Zimbabwe Association of Doctors for Human Rights (ZADHR) chairperson, was quoted by the Standard Newspaper of 26 April 2020 as saying “both rural and urban expecting mothers were vulnerable to the coronavirus. Most hospitals are now delaying attending to patients with conditions such as diabetes and pregnant women as they give priority to coronavirus cases.”¹²⁹

As per its obligations under the right to health, the government of Zimbabwe has a core obligation to ensure the satisfaction of the minimum essential levels of the right to health. These core obligations include the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;¹³⁰ reproductive, maternal (prenatal as well as post-natal) and child health care;¹³¹ provision of appropriate training for health personnel, including education on health and human rights; and the adoption and implementation of a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health.¹³² The Committee on Economic, Social and Cultural rights has stressed that

119 Citizens Health Watch, Press Statement on Contraceptive shortage hits Matabeleland North province, 10 April 2019.

120 Zimbabwean patients on ARV treatment have to take expired medicines, Daily Maverick, 5 May 2019:

www.dailymaverick.co.za/article/2019-05-05-zimbabwean-patients-on-arv-treatment-have-to-take-expired-medicines/

121 Ministry of Finance and Economic Development, 2020 National Budget, Slide 23, 14 November 2019 available:

www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&id=54&Itemid=787

122 Ministry of Finance and Economic Development, 2020 Proposed Estimates of Expenditure, 14 November 2019, at page 214, www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&id=54&Itemid=787

123 Interview with Nurse at hospital in Mashoko, 01 October 2020

124 Interview with, Registered Adult Nurse at hospital in Mashoko on 01 October 2020

125 Zimbabwe records 106 Maternal Deaths, Daily News, 9 June 2020 See: <https://dailynews.co.zw/zimbabwe-records-106-maternal-deaths/>

126 Coronavirus - Zimbabwe: COVID-19 update, 19th June 2020, Africa News, 19 June 2020:

<https://www.africanews.com/2020/06/19/coronavirus-zimbabwe-covid-19-update-19th-june-2020/>

127 Gilbert M, Pullano G, Pinotti F et al. Preparedness and vulnerability of African countries against importations of COVID-19: a modelling study. *Lancet*. 2020; 395: 871-877

128 WHO, Managing epidemics: key facts about major deadly diseases, <https://www.who.int/emergencies/diseases/managing-epidemics/en/>, Date: May, 2018

129 All Africa, Coronavirus -Lockdown Puts Pregnant Women at Risk, 26 April 2020 <https://allafrica.com/stories/202004270656.html>

130 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12).

131 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12).

132 CESCR 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).

a State party cannot justify its non-compliance with these core obligations, which are non-derogable. It is notable that unlike the International Covenant on Civil and Political Rights (ICCPR), which makes provision for derogation of rights pursuant to a declared state of emergency, the International Covenant on Social Cultural and Rights (ICESCR) does not include a provision on derogations¹³³ thus core obligations in relation to health remain non-derogable during states of emergency caused by pandemics such as COVID-19. Despite these obligations, the challenges outlined above mean that women and girls continue to face serious barriers to access basic health care.

¹³³UN 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>
Also see OHCHR EMERGENCY MEASURES AND COVID-19: GUIDANCE
https://www.ohchr.org/Documents/Events/EmergencyMeasures_COVID19.pdf

4. FAILURE TO PREVENT OBSTETRIC FISTULA

“[M]ore than 75% of women with obstetric fistula have endured labour that lasted three days or more”

The Fistula Foundation¹³⁴

4.1 OBSTRUCTED LABOUR AND BARRIERS TO SKILLED OBSTETRIC CARE

Obstetric fistula can primarily be prevented by ensuring pregnant people have access to skilled birth assistance and emergency obstetric care.¹³⁵ The WHO links obstetric fistula directly to obstructed labour, which occurs when the foetus does not progress as it needs to along the birth canal.¹³⁶ Obstructed labour is a major cause of preventable maternal mortality and morbidity and is estimated to account for 8% of maternal deaths globally,¹³⁷ but as much as 70% of all maternal deaths in developing countries.¹³⁸ Skilled medical care, usually a caesarean delivery, is needed to prevent an obstructed labour from resulting in maternal death or obstetric fistula.¹³⁹

Although Zimbabwe's Ministry of Health and Child Care advises women to give birth in health facilities,¹⁴⁰ demographic data indicates that nearly one quarter (23%) of women give birth without skilled assistance.¹⁴¹ COVID-19 has worsened the situation. The Women's Coalition of Zimbabwe¹⁴² reports that they received reports of hospitals' unwillingness to attend to pregnant women due to inadequate personal protective equipment, compelling women to resort to home deliveries.

134 The Fistula Foundation, www.fistulafoundation.org/what-is-fistula/

135 WHO 10 Facts on Obstetric Fistula www.who.int/features/factfiles/obstetric_fistula/en/

136 “Labour is considered obstructed when the presenting part of the fetus cannot progress into the birth canal, despite strong uterine contractions.” Carla AbouZahr, Global burden of maternal death and disability, British Medical Bulletin, Volume 67, Issue 1, 1 December 2003, Pages 1–11, <https://doi.org/10.1093/bmb/ldg015>

137 Carmen Dolea and Carla AbouZahr, Global burden of obstructed labour in the year 2000, Evidence and Information for Policy (EIP), World Health Organization, Geneva, July 2003.

138 Cron J. Lessons from the developing world: obstructed labor and the vesico-vaginal fistula. Medscape Gen Med. 2016;5(3):14

139 L Lewis Wall, Overcoming phase 1 delays: the critical component of obstetric fistula prevention programs in resource-poor countries, BMC Pregnancy and Childbirth 2012, 12:68, <http://www.biomedcentral.com/1471-2393/12/68>, page 3 of 13.

140 Government of Zimbabwe, Ministry of Health and Child Welfare Harare, (2007), The Zimbabwe National Maternal and Neonatal Health Road Map 2007-2015.

141 Zimbabwe Demographic and Health Survey 2015 page 145, noting that 77% of women give birth with skilled assistance at delivery (up from 66% in 2010/11).

142 Is a national membership-based network of women's rights activists and women's organizations. It is a forum where women meet to engage in collective activism on issues affecting women and girls in Zimbabwe. WCoZ's central role is to provide a focal point for activism on women and girl's rights. We bring women and girls from diverse backgrounds to collectively advocate for the attainment and enjoyment of their rights.

When Zimbabwe's MMR peaked in 2010, delays in seeking and accessing health care accounted for two thirds of maternal deaths.¹⁴³ Medical experts explained to Amnesty International that cases of obstetric fistula would be expected to have occurred during this period.¹⁴⁴ However, subsequent and ongoing challenges within the health system continue to undermine access to quality obstetric care and increase the risk of new cases occurring.

Amnesty International's research suggests that women and girls face significant barriers to accessing timely health care during labour, increasing their risk of experiencing obstetric fistula. The following examples highlight Amnesty's findings related to barriers to emergency obstetric care:

4.2 DELAYS IN DECIDING TO SEEK MEDICAL HELP: PREFERENCE FOR HOME BIRTHS

Barriers to skilled birth assistance and emergency obstetric care are often categorized as delays.¹⁴⁵ The first 'delay' is in deciding to seek appropriate medical help when complications arise.¹⁴⁶ It has been recognised as "the critical component in obstetric fistula prevention."¹⁴⁷

In providing guidance on a human rights based approach to ending maternal mortality and morbidity, the Office of the UN High Commissioner for Human Rights (OHCHR), has emphasized that barriers to adequate sexual and reproductive health services and information that result in "[d]elays in the decision to seek care or opting out of the health system entirely" should not be treated as "idiosyncratic, personal choices or immutable cultural preferences but as human rights failures."¹⁴⁸

In Zimbabwe, "[u]nskilled persons, such as traditional birth attendants, village health workers and relatives/friends, assist in 20 percent [of births], while 3 percent of births receive no assistance".¹⁴⁹ This number is higher among women in rural areas, without a formal education and living in poverty.¹⁵⁰ A significant proportion of women living in poverty (35.3%)¹⁵¹ also continue to give birth without skilled assistance. Giving birth without access to skilled and equipped attendants, increases the risk for women and girls as complications in labour are often not recognised until it is too late.¹⁵²

Amnesty International's interviews, focus group discussions and community dialogues highlighted five key factors that may influence a home birth, without skilled assistance, including: cultural preferences, religious beliefs, economic constraints, lack of decision making power and fears of poor care from the formal health system.

143 United Nations in Zimbabwe Periodic Publication, Issue Paper Series, Paper 1 2013, www.zw.one.un.org/sites/default/files/UN-ZW_IssuePaperSeries-1_MMR_June2013.pdf (hereafter UN Issue Paper Series, Paper 1 2013).

143 Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, (2012) ref: A/HRC/21/22, para. 56.

144 Amnesty International meetings with two Senior Professors of Obstetrics, one in South Africa and one in Zimbabwe, October 2018.

145 Following the theory developed by Thaddeus and Maine, Too far to walk: Maternal mortality in context, Social Science & Medicine Volume 38, Issue 8, April 1994, Pages 1091-1110, see also World Health Organisation Africa, WHO Perspectives on Maternal Mortality in Zimbabwe: A Reflection of the Year 2014, available at: www.afro.who.int/news/who-perspectives-maternal-mortality-zimbabwe-reflection-year-2014

146 Thaddeus and Maine, Too far to walk: Maternal mortality in context, Social Science & Medicine Volume 38, Issue 8, April 1994, Pages 1091-1110 (hereafter Thaddeus and Maine 1994).

147 L Lewis Wall, Overcoming phase 1 delays: the critical component of obstetric fistula prevention programs in resource-poor countries, BMC Pregnancy and Childbirth 2012, 12:68, <http://www.biomedcentral.com/1471-2393/12/68>, page 3 of 13.

148 Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, (2012) ref: A/HRC/21/22, para. 56.

149 Zimbabwe Demographic and Health Survey at page 145 and Table 9.5 Place of delivery on page 154.

150 Zimbabwe Demographic and Health Survey at page 144-145 and Table 9.5 Place of delivery on page 154.

151 Zimbabwe Demographic and Health Survey 2015 found: "Wealth is also correlated with delivery assistance: 62 percent of births to mothers in the lowest wealth quintile were attended by a health professional compared with 96 percent of births to mothers in the highest wealth quintile" at page 146.

152 The UN High Commissioner for Human Rights has stressed that delays are impacted by "a lack of awareness of the emergency signs among family and community members and the lack of empowerment of women to make decisions about their own well-being", Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, (2012) ref: A/HRC/21/22, para 56.

4.2.1 TRADITIONAL CUSTOM OF PATERNITY CHECK

Firstly, interviewees told Amnesty International that home births were important for a traditional custom which dictates that the first child should be delivered at the paternal home, so the mother-in-law can see the baby being born, as a means of verifying paternity.¹⁵³ One interviewee, who experienced obstetric fistula after a traumatic labour at home when she was 15, explained:

“I had a homebirth because by tradition the first child is delivered by your in-laws... my in-laws were adamant to have the first child born in their house. They said that I would only give birth at the hospital beginning with the second child”.¹⁵⁴

Participants of community dialogues appeared to largely recognize and support this practice. It was suggested that giving birth in the home of the “in-laws” may be more important when adolescents become pregnant outside of marriage. As one woman suggested, “if it is an adolescent girl then they will take her to the mother-in-law, and the mother-in-law will want to make sure the child is her son’s, so she won’t want the girl to go to hospital.”¹⁵⁵ In a focus group discussion with 12 Traditional Birth Attendants (TBAs), participants suggested this practice also stemmed from fears the baby would be stolen or swapped at the clinic.¹⁵⁶ An older woman, who had introduced herself as “a grandmother” explained that as the mother-in-law, she “sets the rules of the house” and the children should listen to her if she says they should give birth at home.¹⁵⁷

4.2.2 RELIGIOUS BELIEFS

Secondly, religious beliefs were also presented as a strong factor in home births, especially among members of Apostolic sects that preach against use of formal health services.¹⁵⁸ One woman who had received surgery to repair an obstetric fistula explained that although she followed the Pentecostal faith, her husband’s family are Apostolic, and they had not allowed her to access formal health care during labour as their faith forbade it. Instead, her husband’s grandmother and his relatives oversaw her childbirth.¹⁵⁹ Other women emphasized the influence of religious groups and that “some churches will kick you out if you use health care”,¹⁶⁰ while another older woman explained that “that’s how we grew up, knowing about going to the prophets [to give birth]”.¹⁶¹ Another woman believed traditional birth attendants from the Apostolic faith were well placed to deal with complications in labour “because they have the spirit within them to guide them.”¹⁶²

Nearly a third of Zimbabwe’s population follows the Apostolic faith.¹⁶³ The rise in the Apostolic faith in Zimbabwe has also been found to contribute to home births and delays in seeking skilled medical care.¹⁶⁴ According to government statistics, more than a quarter of births among women in the Apostolic sect take place without any skilled assistance.¹⁶⁵ Studies have highlighted that apostolic leaders often preach that “going to the clinic or hospital shows lack of faith in God”¹⁶⁶ and Apostolic followers usually first seek help from traditional birth attendants and spiritual healers.¹⁶⁷ The religion has been found to promote gender

153 This was described as the belief the mother-in-law will be able to tell if the baby is not her son’s child when she sees it being born, there was strong agreement noted for this reason at the Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018, when it was suggested by a participant nearly all of the other members applauded.

154 Amnesty International Interview with Neria*, 18 July 2018.

155 Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018

156 Amnesty International focus group discussion with Traditional Birth Attendants, Macheke, 25 July 2018.

157 Female participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018

158 At least one third of community dialogue participants self-identified as belonging to an apostolic church (estimated based initial introductions and subsequent comments).

159 Amnesty International interview with Patricia, 19 July 2018

160 Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

161 Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

162 Female participant, community dialogue and drama on Obstetric Fistula, 7 November 2018.

163 UNICEF Zimbabwe (2016), Extended Analysis of Multiple Indicator Cluster Survey (MICS) 2014: Religion, Harare: UNICEF pages 7-8, available: www.zimstat.co.zw/sites/default/files/img/Religion.pdf

164 UNICEF Zimbabwe (2016), Extended Analysis of Multiple Indicator Cluster Survey (MICS) 2014: Religion, Harare: UNICEF page 17, noting “The Apostolic sect had the lowest proportion of women (73%) who had Delivery assisted by any skilled attendant”.

165 UNICEF Zimbabwe (2016), Extended Analysis of Multiple Indicator Cluster Survey (MICS) 2014: Religion, Harare: UNICEF page 17.

166 The last two decades have also seen the rapid rise of apostolic religions in Zimbabwe. Over a third of women currently belong to apostolic faiths, which preach against using formal health services. There is significantly higher risk of maternal mortality among women of apostolic faith, as the religion has been found to promote gender inequality, “high fertility, early marriage, non-use of contraceptives and low or non-use of hospital care.” Munyaradzi et al. (2016) Praying until Death: Apostolicism, Delays and Maternal Mortality in Zimbabwe. PLoS ONE 11(8): e0160170; OPHID Apostolic Birth Attendants 2014.

167 Munyaradzi et al. (2016) Praying until Death: Apostolicism, Delays and Maternal Mortality in Zimbabwe; OPHID Apostolic Birth Attendants 2014.

inequality, “high fertility, early marriage, non-use of contraceptives and low or non-use of hospital care.”¹⁶⁸ There are indications that women of Apostolic faith have significantly higher risk of maternal mortality.¹⁶⁹

Religious beliefs have also been identified as a common reason why patients delay accessing treatment for fistula in hospitals or clinics, which increases the likelihood of complications. A midwife at United Bulawayo Hospitals said that delayed treatment is one of their biggest challenges and that to alleviate this “there must be awareness amongst the Apostolic sects so that their women seek care”¹⁷⁰

4.2.3 FEAR OF THE FORMAL HEALTH SYSTEM

A third factor in the preference for home birth amongst the people Amnesty International interviewed was a fear of poor-quality services in the formal health system. These fears were also expressed among community members. A man said, “kids of today want to go to hospital and instead of the midwife they get cut [C-section], everywhere they give women stitches. Women should give birth at home and their mothers should give them medicine.”¹⁷¹ However, another man suggested “it is women who are the ones who go to the prophets because they hear stories about the clinics and they are afraid of operations, so they rather go to the traditional midwives - it is not always because of husbands.”¹⁷² Community members also raised the fear of being shamed by health professionals and a concern over the lack of privacy and confidentiality among health care workers.¹⁷³ Another woman believed that “the nurses at the hospital don’t take care of women in pregnancy, but can be rough and people stay away”.¹⁷⁴



DANAI'S* EXPERIENCE

A woman with a diagnosed but untreated obstetric fistula recalled her experiences during the labour with her third child in 2013, that led to her condition. Danai had planned to give birth at a health facility as nurses had told her she was expecting twins. Danai explained she went to stay at the clinic’s maternity waiting home in advance of her due date, to overcome any transport challenges as she lives over seven kilometres away from the clinic. However, while at the waiting home, Danai felt frustrated that even though she was in pain, the nurses were not helping her. She explained that the nurses had told her she was not yet in labour and after seven days, she left the clinic’s Waiting Home and returned home. After one night, the pain intensified, and Danai returned to the clinic. A different nurse was on duty and helped Danai to give birth, not to twins but to one large baby who weighed over 4.5 kilograms. Danai felt she had good care during the delivery and returned home with her baby that day. However, Danai started to leak urine. She returned to the clinic two days later to seek help. Danai said the nurses on duty when she returned had treated her poorly and told her she would need to wait for another day and see the nurse who had helped her deliver. Instead, Danai hired a car and went to the closest hospital, where her obstetric fistula was diagnosed.¹⁷⁵ She was unable to afford the cost of obstetric fistula treatment.

168 Munyaradzi et al. (2016) Praying until Death: Apostolicism, Delays and Maternal Mortality in Zimbabwe; OPHID Apostolic Birth Attendants 2014.

169 UNICEF’s representative for Zimbabwe, Reza Hossaini also noting ‘the difficulties of working with the social norms and religious values of the Apostolic faith’, UNFPA <http://zimbabwe.unfpa.org/news/maternal-death-rates-fall-zimbabwe-outside-support#sthash.AkdPvICS.dpuf>. See also Munyaradzi et al. (2016) Praying until Death: Apostolicism, Delays and Maternal Mortality in Zimbabwe; OPHID Apostolic Birth Attendants 2014; OPHID Apostolic Birth Attendants 2014.

¹⁷⁰ Interview with Nurse/Midwife at hospital in Bulawayo, 29 September 2020

¹⁷¹ Male participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

¹⁷² Male participant Community dialogue and drama on Obstetric Fistula with community leaders, Manicaland province, 5 November 2018.

¹⁷³ For example, a woman suggested “men think if a woman goes to hospital and give birth with a male nurse, when that man meets the nurse while they are out drinking, the nurse will taunt him about his wife’s vagina”, Female participant Community dialogue and drama on Obstetric Fistula with community leaders, Manicaland province, Monday 5 November 2018.

¹⁷⁴ Female participant, Community dialogue and drama on Obstetric Fistula with community leaders, Manicaland province, 5 November 2018.

¹⁷⁵ Amnesty International Interview with “Danai”, Bhora 27 July 2018, she explained her medical file is marked with the term “VVF” which demotes a Vesicovaginal fistula, meaning a hole has formed between the bladder and the vagina during child birth.

4.2.4 ECONOMIC CONSTRAINTS

Economic challenges were also found to undermine women's agency to make decisions on where to give birth. Even in cases where women might have wanted to approach the formal health system, they were unable to do so because they were economically dependent on their partners or families who were unwilling to pay for this. For example, two women who were interviewed in Gutu explained the nearest health facility was a Mission Hospital which charged US\$25 to register for maternity care and US\$50 for vaginal delivery. They explained that if a woman needed a caesarean, they had to pay for the drip and the medication in advance, and in emergencies, family members would need to pay the fees up front. The two women alleged that if, after delivery, women are unable to pay the hospital bill, the hospital would keep their IDs and refuse to issue birth certificates.¹⁷⁶ The women were concerned that mothers of girls in their community who are pregnant at 13 or 14 years old, preferred to have them give birth at home, to avoid medical costs. They explained that all young girls are advised they are at higher risk of complications and so they cannot deliver at a clinic but must go to the hospital to give birth, where fees were more expensive.¹⁷⁷

At community level, women explained that they faced challenges reaching clinics and hospitals because they needed to hire private transport to get there. Identifying someone with a car, and raising the money to pay them, could take hours. Community members reported to Amnesty international's researchers that ambulances cost between US\$3-US\$40.¹⁷⁸ These concerns were echoed by medical experts who emphasized the lack of ambulances and long distances to health facilities as contributing to high rates of obstetric fistula in rural areas.¹⁷⁹

The community dialogues in rural areas also highlighted deep gender inequalities in relation to economic power within relationships. There was a pervasive view that women are reliant on men to fund their access to health services.¹⁸⁰ Participants also highlighted the costs of the "preparations"; items for the baby, including nappies, clothing and blankets which pregnant women are required to bring to hospital.¹⁸¹ A woman suggested, "men like to send their wives to TBAs as they cost less and if they go to the clinic then all the money will be finished."¹⁸² One man thought that "Sometimes we [men] are the problem", he explained "sometimes it is a man's fault as he doesn't think his wife needs to go to hospital and because the child will need things to wear [preparations] and he doesn't provide them."¹⁸³ An older woman shared that she gave birth at home, and as soon as she had delivered, her husband told her to go out to the field and plant the crops.¹⁸⁴ Another woman explained, "Men are stingy with resources, they do not think of the future and do not prepare for the pregnancy".¹⁸⁵

Globally, obstetric experts warn "[t]here is a social-economic component related to home deliveries: the poorer a mother is, the higher the chance that the delivery is going to happen at home."¹⁸⁶ Analysis of Zimbabwe's statistical data confirms that 30 percent of women in the poorest two quintiles of the population give birth without skilled birth assistance, compared to five percent of women in the wealthiest quintile, and 20 percent of women overall.¹⁸⁷ Zimbabwe's demographic data suggests the "[l]ack of money to pay for treatment' also explains part of high maternal mortality and morbidity, especially for the vulnerable girls and women in the society."¹⁸⁸

176 Amnesty International interviews with two women affected by childbirth related incontinence, Gutu, 9 November 2018.

177 Amnesty International interviews with two women affected by childbirth related incontinence, Gutu, 9 November 2018.

178 In Mutare, the participants of a focus group discussion emphasised there is only one ambulance linked to the hospital but it is not always available. They estimated to hire a private car to get to hospital in Mutare would cost \$40. In Macheke, the group noted that the clinic does not accept first time mothers for delivery and these cases are referred to the hospital, 32kms away. There is no ambulance and transport was \$3. Although a maternity waiting home has been opened, it was noted it is not liked and under-utilized.

¹⁷⁹Interview with Gynecologist, 29 September, 2020; meeting with Ministry of Health and Child Care Senior official, 2 November 2018.

180 Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

181 Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018. One woman suggested some women are "not organized" and they may have an unplanned pregnancy and not have the preparations.

182 Female participant Community dialogue and drama on Obstetric Fistula with community leaders, Manicaland province, Monday 5 November 2018.

183 Male participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

184 Female participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018

185 Community dialogues, 6 November 2018 and 8 November 2018 Manicaland province.

186 The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, Number 697, April 2017, available: www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Planned-Home-Birth?IsMobileSet=false

187 UNICEF Zimbabwe (2016) Extended Analysis of Multiple Indicator Cluster Survey (MICS) 2014: Religion Harare: UNICEF at page 17 and 28 www.zimstat.co.zw/sites/default/files/img/Religion.pdf

188 Government of Zimbabwe, Ministry of Health and Child Welfare Harare, Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020) at 14, available www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf

4.2.5 LACK OF DECISION-MAKING POWER

Home births may be a personal choice. However, due to the above factors, the women Amnesty International interviewed were not able to make the decision on where to give birth and there is a likelihood that this is the case for other women as well. In order to make an informed choice on where to give birth, pregnant women and girls need access to medical information about the risks of giving birth at home without skilled assistance, and of the importance of having transport ready and available to take them to a health facility in case of a complication or emergency.¹⁸⁹ In cases where there may be additional risks, for example, if the foetus is not in the correct position for birth (a breech position), or if the person is pregnant with multiple foetuses, or if they have had a prior caesarean delivery, medical experts strongly advise against giving birth outside of health facilities.¹⁹⁰ From interviews and community discussions, it was clear that not all women receive the information necessary to make an informed choice on where to give birth.

Gender inequality and discrimination was found to exacerbate women's lack of decision-making agency across all four drivers of home births. Similarly, broader studies relating to obstetric fistula have found the decision on where to give birth and when to seek help, often lies with a husband, mother-in-law, parent, traditional birth attendant or religious leader.¹⁹¹ Injuries from delay in seeking skilled medical care have been found to be more prevalent among women and girls who lack personal autonomy, including related to age of first sex, early/forced marriage, religion, age, and gender-based violence.¹⁹²

TRADITIONAL BIRTH ATTENDANTS

Use of Traditional Birth Attendants (TBAs) is still common among some communities in Zimbabwe, including within the Apostolic Sects, and reflects both the cultural value of TBAs and the inaccessibility of institutional health services,¹⁹³ amid concerns around the poor quality of care at health facilities, especially in rural areas.¹⁹⁴

Zimbabwe's Ministry of Health and Child Care advises pregnant women and girls to give birth in health facilities, with skilled attendants.¹⁹⁵ Rates of institutional deliveries increased from 66% in 2010-11 to 78% in 2014-15.¹⁹⁶ Even before Zimbabwe's 2019 economic and health system crisis, TBAs were recognized as "the lifeline for many women in the country".¹⁹⁷ With doctors and nurses on strike for prolonged periods in 2019, pregnant people's reliance on TBAs was reported to have increased dramatically.¹⁹⁸ In one example, an Apostolic TBA in the Mbare suburb of Harare, was reported to have delivered 100 babies at her home, over an eight day period, prompting a congratulatory visit from First Lady, Auxillia Mnangagwa.¹⁹⁹

The impact of COVID-19 has also increased the reliance on TBAs. An informal survey carried out by The Standard, a local newspaper in Zimbabwe working in collaboration with Information for Development Trust, revealed that rural and urban women in Matabeleland North and other parts of the country, particularly from low-income households, were being forced to deliver at home due to COVID-19 related movement restrictions and limited transport options. The Standard reported that a traditional midwife in Nkayi, had assisted at least eight women to give birth in her village within a month of the imposition of the lockdown and described the number as unusually high in comparison to normal circumstances, where she could go for two months without helping a woman deliver²⁰⁰

189 American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, Committee Opinion Number 697, April 2017, developed in collaboration with committee members Joseph R. Wax, MD, and William H. Barth Jr, MD, available: www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Planned-Home-Birth?IsMobileSet=false

190 American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, Committee Opinion Number 697, April 2017, www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Planned-Home-Birth?IsMobileSet=false

191 L Lewis Wall, Overcoming phase 1 delays: the critical component of obstetric fistula prevention programs in resource-poor countries, BMC Pregnancy and Childbirth 2012, 12:68

192 Maheu-Giroux et al, Risk factors for vaginal fistula symptoms in Sub-Saharan Africa 2016.

193 Naume Zorodzai Choguya, "Traditional Birth Attendants and Policy Ambivalence in Zimbabwe," Journal of Anthropology, vol. 2014, Article ID 750240, 9 pages, 2014. <https://doi.org/10.1155/2014/750240>.

194 Guzha et al. Assessment of quality of obstetric care in Zimbabwe using the standard primipara, BMC Pregnancy and Childbirth volume 18, Article number: 205 (2018) bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1863-5

195 Government of Zimbabwe Ministry of Health and Child Welfare, The Zimbabwe National Maternal and Neonatal Health Road Map 2007-2015, Harare, October 2007, available: www.who.int/pmnch/countries/zimbabwe_roadmap_web.pdf

196 Zimbabwe Demographic and Health Survey 2015 page 145.

197 Naume Zorodzai Choguya, "Traditional Birth Attendants and Policy Ambivalence in Zimbabwe," Journal of Anthropology, vol. 2014, Article ID 750240, 9 pages, 2014. <https://doi.org/10.1155/2014/750240>.

198 Paidamoyo Chipunza, Woman delivers 100 babies in 8 days, The Herald, 15 November 2019, www.herald.co.zw/woman-delivers-100-babies-in-8-days/; Farai Mutsaka, No training, no gloves: Zimbabwe's desperate childbirths, 18 November 2019, <https://apnews.com/c1123a23de3c4b20ac87f595c887671f>

199 Tendai Rupapa, First Lady visits heroic Mbare midwife, The Herald, 16 November 2019, www.herald.co.zw/first-lady-visits-heroic-mbare-midwife/

²⁰⁰ All Africa, Coronavirus -Lockdown Puts Pregnant Women at Risk, 26 April 2020 <https://allafrica.com/stories/202004270656.html>

However, most TBAs lack formal training, sterile equipment and referral access to skilled assistance in cases of complications. Health officials have also highlighted the lack of post-natal follow up from TBAs and the risk of HIV transmission during delivery.²⁰¹

The WHO acknowledges the “important role [TBAs] can play in supporting the health of women and newborns” and recommends using trained TBAs to provide social support to women during pregnancy and to distribute health supplies, such as nutritional supplements.²⁰² In such cases, TBAs have been found to assist in connecting women to health services and increasing the acceptability of institutional maternal services.²⁰³



An untrained midwife who belongs to an Apostolic religious sect where she says she got her midwifery calling, adjusts a pair of surgical gloves as she prepares herself for a long day ahead at her two-room apartment in Mbare high-density suburb in Harare, on November 21, 2019. - Her house has served as a 'maternity ward' since nurses at Harare City Council clinics and maternity homes went on strike. Gwena says in a space of two weeks she has delivered as many as 250 children as a major health delivery crisis in Zimbabwe continues. © JEKESAI NJIKIZANA/AFP via Getty Images

The 12 TBAs who participated in an Amnesty focus group discussion emphasized they were officially no longer providing child-birth services and the group unanimously stressed the importance of pregnant women registering for antenatal care and were consistent in terms of their advice for people to seek formal health services to deliver, especially adolescents. However, some TBAs later clarified that while it was “rare” they helped people to give birth these days, they would help “those who have not yet reached the hospital” and reported they are still acting as TBAs “in emergencies”.²⁰⁴

In discussions with Amnesty International, TBAs described prevalent traditional methods of dealing with labour complications, which may increase risks in cases of an obstructed labour. TBAs gave examples of using elephant or donkey dung to speed up labour. One explained she used a method of taking sand from a mole hill mixed with water to drink, believing “that opens everything up...the baby just slides out.”²⁰⁵ Similar methods of drinking substances, including chicken droppings, emerged from community dialogues and

201 Farai Mutsaka, No training, no gloves: Zimbabwe's desperate childbirths, 18 November 2019, citing Harare's Health director, Dr. Prosper Chonzi, <https://apnews.com/c1123a23de3c4b20ac87f595c887671f>

202 WHO recommendation on partnership with Traditional Birth Attendants (TBAs), 31 May 2015,

<https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-partnership-traditional-birth-attendants-tbas>

203 Miller and Smith BMC Pregnancy and Childbirth (2017) 17:365 Establishing partnership with traditional birth attendants for improved maternal and newborn health: a review of factors influencing implementation, page 7 of 10.

204 Amnesty International focus group discussion with Traditional Birth Attendants, Macheke 25 July 2018, the group gave an example of someone's water breaking or bleeding as an emergency they may help with. After the discussion, one TBA asked for plastic gloves and explained she was currently using “bread plastics” to deliver.

205 Apostolic TBA and Participant of TBA FGD Macheke 25 July 2018.

individual interviews as well.²⁰⁶ Using traditional medicines during labour has been found to be prevalent in Zimbabwe.²⁰⁷ However, such methods may speed up labour and can result in strong contractions and foetal distress,²⁰⁸ and worsen the risk of injuries in cases of obstructed labour.²⁰⁹

Of concern is the varied and limited nature of training TBAs receive, which may leave them ill-equipped to judge when complications arise and [when to] seek necessary emergency obstetric care.²¹⁰ All 12 TBAs reported some level of training, however, while some had received formal first aid training through hospital initiatives, others explained they had learned from shadowing older TBAs or through following the practices of their faith.²¹¹ There appears to be no national comprehensive training program or information dissemination plan in place to target TBAs in Zimbabwe.²¹² The WHO has recommended engaging with TBAs, “women, families, communities and service providers...to define and agree on alternative roles for TBAs, recognizing the important role they can play in supporting the health of women and new-borns.”

Guidance from human rights experts emphasizes the importance of “using appropriate approaches for treatment and counselling and involving communities” in initiatives for ending violence against women and implementing a human rights-based response to maternal mortality and morbidity.²¹³ Experts stress the obligation on States to ensure that effort to increase institutional deliveries “be provided in a way that is both culturally acceptable and responsive to women’s needs”²¹⁴ and that while women need to receive empowerment support to demand their right to give birth with skilled assistance, “[f]amilies and communities need to be able to recognize when complications arise and be able to take action.”²¹⁵ These experts point to examples of positive changes in cultural practices following successful campaigns which “involve and mobilize communities, religious leaders and families using mass media to spread their message as widely as possible.”²¹⁶

4.3 RAISING THE ALARM ON ABUSE OF WOMEN AND GIRLS IN LABOUR DURING HOME BIRTHS: UNTOLD SUFFERING

Amnesty International found that where women lacked equality and the ability to make decisions over where to give birth and when to seek medical help, they risked exposure to dangerous health complications and violence. Women shared traumatic experiences of abusive treatment during their labours at home, which contributed to their maternal injuries.²¹⁷

In 11 cases, women who had been formally diagnosed with an obstetric fistula shared experiences of severe abuse and suffering during labour. In most of these cases, a home birth began in the marital home and under the authority of older women who were untrained to deal with complications, and in some cases, were

206 Community dialogue and drama on Obstetric Fistula, Manicaland province, 5, 6 and 7 November 2018, Participants at shared traditional methods of assisting with labour they had experienced, including being “given something to drink” and one woman who had inserted sticks into her vagina. A number of interviewees and focus group discussion participants referred to retained placenta as a common complication and noted using a wooden spoon forced down a woman’s throat - to spur a gag reflex - could force out the placenta. Another common suggestion was using the Marula tree to tighten the vaginal muscles after giving birth.

207 Panganai T, Shumba P. The African Pitocin - a midwife’s dilemma: the perception of women on the use of herbs in pregnancy and labour in Zimbabwe, Gweru. Pan Afr Med J. 2016;25:9. Published 2016 Sep 19. doi:10.11604/pamj.2016.25.9.7876

208 Panganai T, Shumba P. The African Pitocin - a midwife’s dilemma: the perception of women on the use of herbs in pregnancy and labour in Zimbabwe, Gweru. Pan Afr Med J. 2016;25:9. Published 2016 Sep 19. doi:10.11604/pamj.2016.25.9.7876

209 Advice of medical expert on Maternal Health, meeting with Amnesty International 5 September 2018

210 Amnesty International focus group discussion with Traditional Birth Attendants, Macheke 25 July 2018

211 One Apostolic member of the focus group discussion explained she had a divine calling to become a TBA and received training though following her beliefs that God was guiding her.

212 “No training, no gloves: Zimbabwe’s desperate childbirths”, AP News, 18 November 2019, see: <https://apnews.com/article/c1123a23de3c4b20ac87f595c887671f>

213 OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27, para 15.

214 OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27, para 22.

215 OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27, para 22.

216 OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27, para 36.

217 11 women receiving surgical repair for obstetric fistula at hospital in Chinhoyi identified cases of severe abuse and suffering during labour

reported to have been deliberately violent and abusive. This seems especially so in five cases, where women were married as children.²¹⁸

Shuvai* was one of the women who shared her experience with Amnesty International's researchers. Now aged 29, Shuvai has lived with obstetric fistula for over 11 years. The pain and trauma of her long labour remains seared in her memory.



SHUVAI'S* EXPERIENCE

Shuvai was married and gave birth aged 17. Although she registered for antenatal care, her husband, who was more than a decade older, refused to allow her to give birth at a health facility. He and his family belonged to an Apostolic sect who don't allow medicine and when Shuvai went into labour, her husband's grandmother took charge. Shuvai described the "very rough" treatment she received. Shuvai was made to lie on her back, with her legs in the air and was not allowed to move around. The ordeal lasted four days. On the third day, Shuvai noticed her legs were swollen and liquid was beginning to leak out of her, she was unable to stand. On the fourth day, her baby was pulled out. The baby was dead.

Shuvai's in-laws called her parents to take her to hospital, where she was diagnosed with obstetric fistula and retained placenta. She spent more than six months in hospital recovering from the initial injuries she sustained and needed a wheelchair for 18 months.²¹⁹ Shuvai lived for 11 years with an obstetric fistula, before she was referred to the Ministry of Health and Child Care's Fistula Camps.

Shuvai and Natsai (above) were not the only ones to suffer such abuse. Other women who spoke to Amnesty were also left with severe injuries after abuse while trying to give birth at home and needed to stay in hospital for weeks or months. In another serious case of abuse, Chipo* spent three months in hospital after her pelvic bones were crushed during her long and obstructed labour.²²⁰

Patricia's* experience is also indicative.²²¹ She explained her in-laws "were adamant" to have the first-born child delivered in their house, so that they could confirm the baby had been fathered by their son. Her mother-in-law was a traditional birth attendant who wanted to oversee the labour. But there were complications. Patricia felt her baby died on the first day of contractions. Yet, she was kept at the home for a further three days until her own mother was called and transport found to take her to hospital.²²² At hospital, she was given medication and she was told to "push out the baby". She experienced a still birth. Exhausted, Patricia went to sleep. She described: "when I woke up, the place was just drenched in urine...That's when the problem started". She was 15 years old.²²³

In another case, Chenai* was 16 when she experienced a traumatic labour that resulted in obstetric fistula in 2003. Both of Chenai's parents had died when she was 12 years old and she went to live with her aunt and left school with only primary level education. Chenai became pregnant aged 16, her boyfriend was ten years older and they eloped to live with his parents. She explained they were not formally married as he did not pay lobola.²²⁴ However, Chenai felt her "in-laws" resented her. When she went into labour, Chenai explained her mother-in-law refused to help her with the pains. She described that after two days passed, her mother-in-law realised there was a problem and called the religious preachers to help. They made her push, but realised the baby was dead. Chenai explained that her mother-in-law "took out the baby". Chenai began leaking urine but spent two weeks at home before receiving any medical care. Her female neighbours encouraged her to go to the hospital.

She reflected, "[my] mother-in-law was evil to me".

218 In at least five of the cases documented, women were under 18 at the time of their labour "Chenai" age 16 not formal marriage - boyfriend was 26; "Tendai" age 16 husband 28; "Paida" age 17 husband 28; "Theresa" was age 16, husband was 22; "Patricia" age 15 at time of birth & married.

219 Interview with Patient 1 Shuvai, 19 July 2018 Visit and interviews at hospital in Chinhoyi.

220 Interview with Chipo Chinhoyi, 18 July 2018.

221 Interview with Patricia Chinhoyi, 19 July 2018.

222 Interview with Patricia Chinhoyi, 19 July 2018.

223 Interview with Patricia Chinhoyi, 19 July 2018.

224 A definition of "lobola" describes services or goods given by a groom to his bride's family before a union is socially recognised." See further Chiweshe, Manase, *Wives at the Market Place: Commercialisation of Lobola and Commodification of Women's bodies in Zimbabwe*, *The Oriental Anthropologist*, Vol. 16, No. 2, 2016, Pages 229-243.

A doctor recounted an experience where a pregnant teen said people stepped on her stomach to induce delivery during a home birth. “This is terrible”, he said.²²⁵

Amnesty’s research indicates experiences like Patricia, Shuvai, Chenai and Natsai’s are prevalent. One senior Doctor described a recent maternal death due to horrific obstetric abuse by a TBA,²²⁶ and other medical and health system officials reported similar anecdotal accounts.²²⁷ However, these cases are not formally documented or investigated.

4.4 DELAYS REACHING AND RECEIVING CARE

Additional barriers to skilled birth assistance and emergency obstetric care relate to delays women experience in receiving adequate care once the decision to access care is made.²²⁸ Such delays often indicate a lack of ambulances and transport barriers between health facilities, failures of health care workers to refer complicated cases to the correct level of care,²²⁹ and a shortage of the skills and equipment necessary to provide emergency obstetric care.²³⁰ For example, the delay in referring a pregnant person to an appropriate obstetric facility – one which has the skilled staff and equipment necessary to perform a caesarean section – and delays receiving adequate care when the right health facility is reached.²³¹

Amnesty International’s findings indicate these delays require further monitoring by the government of Zimbabwe, as globally, additional delays in accessing skilled birth assistance relate to health system challenges,²³² and present significant risk factors in cases of obstructed labour that lead to obstetric fistula.²³³

A Doctor in Bulawayo also confirmed these difficulties saying, “patients experience extremely adverse effects due to fistula”, and that, at times, maternal deaths occur twice a month. “Most of these deaths are due to delays in referrals from rural areas and the delays are possibly caused due to patients not accessing care in time.”²³⁴ The Doctor went on to say that nurses at the hospital had enough experience dealing with fistula but that most complications were as a result of patients receiving care too late and this was largely due to lack of access.²³⁵

The WHO has raised “specific concerns in Zimbabwe” related to these delays.²³⁶ As noted above, the current crisis in Zimbabwe’s health system creates dangerous conditions that can increase delays in reaching skilled birth assistance and emergency obstetric care. The increasing fuel costs and shortages exacerbate barriers to transport.²³⁷ In general, challenges “obtaining money to pay for treatment” and “distances to health facilities” were “the most commonly reported problems” in accessing health care for women in 2015.²³⁸

Furthermore, in July 2020, with political tensions rising, authorities used the rise in COVID-19 cases to tighten movement restrictions, impose curfews and deploy the military across the country to enforce lockdown restrictions. The only means allowed to transport people was the government owned Zimbabwe United Passenger Company, but the service was not available in rural areas. Authorisation or exemption letters required for passage through police-staffed roadblocks were affecting pregnant women’s ability to travel. Those whose letters were deemed unsatisfactory were turned back and were unable to reach hospitals. The Standard newspaper reported that the Citizen Health Watch said pregnant women were

²²⁵ Interview with Medical Superintendent, Mashoko Clinic on the 01 October 2020

²²⁶ AI meeting with Senior Gynaecologist, 2 November 2018

²²⁷ AI Meeting with UNFPA officials in 2017 Meetings with medical doctors in 2018.

²²⁸ Thaddeus and Maine, Too far to walk: Maternal mortality in context, Social Science & Medicine Volume 38, Issue 8, April 1994, Pages 1091-1110.

²²⁹ Geleto et al. Barriers to access and utilization of emergency obstetric care at health facilities in sub-Saharan Africa: a systematic review of literature, Systematic Reviews December 2018, 7:183; Mocumbi S. et al, Obstetric fistulae in southern Mozambique:

²³⁰ Thaddeus and Maine Too far to walk: Maternal mortality in context, Social Science & Medicine Volume 38, Issue 8, April 1994, Pages 1091-1110 .

²³¹ Thaddeus and Maine, 1994

²³² Thaddeus and Maine 1994.

²³³ Wall L, Overcoming phase 1 delays: the critical component of obstetric fistula prevention programs in resource-poor countries, Pregnancy and Childbirth 2012, 12:68, www.biomedcentral.com/1471-2393/12/68

²³⁴ Interview with Doctor, 29 September 2021, Hospital in Bulawayo

²³⁵ Note above

²³⁶ WHO Africa, WHO Perspectives on Maternal Mortality in Zimbabwe: A Reflection of the Year 2014 available: www.afro.who.int/news/who-perspectives-maternal-mortality-zimbabwe-reflection-year-2014


²³⁷ Aljazeera, Zimbabwe increases fuel prices as economic crisis deepens, 22 May, 2019

<https://www.aljazeera.com/economy/2019/5/22/zimbabwe-increases-fuel-prices-as-economic-crisis-deepens>

²³⁸ Zimbabwe Demographic and Health Survey 2015 page 148, noting “The most commonly reported problems [for women accessing health care] are obtaining money to pay for treatment (43 percent) and distance to the health facility (33 percent).

failing to access prenatal care services, due to the public transport ban.²³⁹ Bernard Madzima, the former Director of the Department of Family Health in the Ministry of Health and Child Care told the Standard Newspaper that it was possible that expecting mothers were failing to access hospitals because the authorities had not put in place adequate measures to assist them. He said, "Definitely there will be issues of complications in terms of unavailability of transportation during the lockdown period and it will need community efforts to ensure that a pregnant woman who needs to get to a health facility manages to do so".²⁴⁰



 ↑ A stranded mother carries her child by a road with little traffic as she awaits transport to get into the central business district of Harare on June 2, 2020. - Zimbabwean security forces on June 2, 2020, cleared Harare's city centre and turned back thousands of commuters and motorists as authorities reinforced restrictions to combat the spread of the COVID-19 coronavirus following a spike in new cases © JEKESAI NJIKIZANA/AFP via Getty Images

In October 2020, the Senior Doctor at Mashoko Clinic confirmed this challenge when he stated that although the clinic does not charge for maternal services, lack of transport often results in patients delaying getting treatment.²⁴¹ Similarly, a Matron at a hospital in Chinhoi identified lack of transport as a risk factor in fistula

²³⁹ Zimbabwe Standard: Coronavirus - Lockdown Puts Pregnant Zim Women At Risk, 26 April, 2020 <https://www.thestandard.co.zw/2020/04/26/coronavirus-lockdown-puts-pregnant-zim-women-risk/>

²⁴⁰ Zimbabwe Standard: Coronavirus - Lockdown Puts Pregnant Zim Women At Risk, 26 April, 2020 <https://www.thestandard.co.zw/2020/04/26/coronavirus-lockdown-puts-pregnant-zim-women-risk/>

²⁴¹ Interview with Doctor, Mashoko Clinic on the 01 October 2020

cases saying “Lack of transport is a problem, for example, someone may be in obstructed labour but they live far away in marginalized areas. The delay increases risk of fistula”.²⁴²

A lack of ambulances between health facilities also creates dangerous delays. ‘Evah*’ described the barriers she faced in 2012, when it took her over 12 hours to reach a health facility that could provide emergency obstetric care. She was pregnant with her fourth child and went into labour at 6am. Her parents had to find US\$50 to pay for a private car to take her to the clinic. But she was then referred to Harare, approximately 35 kilometres away, only arriving at 7 pm. By the time she had a caesarean section around 21h00 the baby had already died. Evah suffered an obstetric fistula.²⁴³

In 2018, participants in community discussions told Amnesty International’s researchers that ambulances were few and far between. As one woman explained, “It is not easy to see an ambulance [in the community] as there is only one, so if it goes somewhere else...either you wait, or you hire a car.”²⁴⁴ The participants of another focus group discussion in a rural area approximately 90 kilometres from Mutare, Zimbabwe’s fourth largest city, emphasized there is only one ambulance linked to the Mutare Provincial Hospital in Mutare, but it is seldom available.²⁴⁵ They estimated the cost to hire a private car to get to Mutare hospital from their community would be US\$40. In Macheke, a small town just over 100 kilometres from Harare, the group noted that the clinic does not accept first time mothers for delivery and these cases are referred to the hospital, 32kms away. There is no ambulance and transport costs US\$3. Although a maternity waiting home has been opened, community members explained it is under-utilized and was not liked.²⁴⁶

WHO warns that globally, “[m]any women and their babies die as a result of poor care, even after reaching a health facility.”²⁴⁷ Several people Amnesty International interviewed also raised concerns regarding the availability and quality of emergency obstetric care at public health facilities. More specifically, Amnesty International found three historical and recent examples where women reported they had faced delays in referral to a provincial hospital for a caesarean-section and the failed referral pathways between health facilities had contributed to women’s suffering with obstructed labour. In a case from 1995, a woman was referred from a clinic to a district hospital for emergency assistance when the baby’s hand came out through her rectum during labour. By the time the ambulance arrived, however, she had delivered the baby, experiencing a large tear between her vagina and rectum. She was referred to a hospital for treatment, and then again to a larger hospital, but there was no room to accommodate her. She was sent back to the lower level health facility – where the tear was sewn by a student nurse. She has been unable to access any subsequent treatment and can no longer control her bowel movements, she feels “they botched it up.”²⁴⁸

In at least two other cases,²⁴⁹ women faced agonizing delays of over eight hours, because emergency obstetric care was unavailable at the provincial hospital and they were referred, again, to the central hospital in Harare, over 260kms away.²⁵⁰ While these are a small number of cases, the challenges women recounted fit within a broader pattern of barriers to maternal health services that are documented in Zimbabwe.²⁵¹ Over recent years, civil society groups and the Auditor General have highlighted multiple cases of maternal deaths where women have been left unattended despite reaching health facilities.²⁵²

²⁴² Interview with Matron in Chinhoyi on 5 October 2020

²⁴³ Interview with Evah in Chinhoyi, 19 July 2018

²⁴⁴ Participant of a focus group discussion outside Mutare with women of reproductive age, 20 July 2018.

²⁴⁵ Participant of a focus group discussion outside Mutare with women of reproductive age, 20 July 2018.

²⁴⁶ “Maternity waiting homes (MWHs) are accommodations located near a health facility where women can stay towards the end of pregnancy and/or after birth to enable timely access to essential childbirth care or care for complications.” A systematic review of studies relating to Maternity Waiting Homes found: “Poor utilization was due to lack of knowledge and acceptance of the MWH among women and communities, long distances to reach the MWH, and culturally inappropriate care. Poor MWH structures were identified by almost all studies as a major barrier, and included poor toilets and kitchens, and a lack of space for family and companions.” See further, Penn-Kekana et al. Understanding the implementation of maternity waiting homes in low- and middle-income countries: a qualitative thematic synthesis, *BMC Pregnancy Childbirth*. 2017 Aug 31;17(1):269,

²⁴⁷ Quality, equity, dignity: the network to improve quality of care for maternal, newborn and child health – strategic objectives. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO <https://apps.who.int/iris/bitstream/handle/10665/272612/9789241513951-eng.pdf?ua=1>

²⁴⁸ Interview with Agnes* Masvingo, 21 July 2018.

²⁴⁹ Interview with Evah and Theresa, Chinhoyi, 19 July 2018 and Interview with Agnes, Masvingo 21 July 2018. In A2’s case (1995) she was referred to a district hospital and then to larger hospital but there was no space for her, so returned to the district hospital.

²⁵⁰ Meeting with a senior Gynaecologist at hospital in Harare in April 2017, who highlighted an awareness of skill failings among some doctors at provincial hospitals and a lack of confidence in performing C-Sections. A mentoring program had been piloted by Liverpool University but the implemented was reported to have fallen away once funding ended.

²⁵¹ See concerns raised by the CRC Committee, Concluding Observations Zimbabwe 2016, paras 58 and 59; CEDAW Committee Concluding observations Zimbabwe 2012 (ref CEDAW/C/ZWE/CO/2-5).

²⁵² White Ribbon Alliance Zimbabwe; CHW. See also AG report 2017; Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page 280, noting cases of negligence and non-attendance during visits to health facilities, including “two cases of non-attendance to patients by doctors and nurses which led to death of a pregnant woman at hospital in Chiredzi; CWGH, Heads should roll at Parirenyatwa, www.cwgh.co.zw/heads-should-roll-at-parirenyatwa/

Such delays in accessing emergency obstetric care indicate pervasive health system challenges.²⁵³ Zimbabwe has an obligation to use the “maximum available resources” for the progressive realization of economic, social and cultural rights.²⁵⁴ As described above, efforts to improve maternal health outcomes remain drastically hampered by a failure of the government to allocate sufficient funding for the public health system.

4.5 EARLY AND UNINTENDED PREGNANCIES

According to the WHO, efforts to prevent obstetric fistula should also focus on reducing the number of early and unplanned pregnancies and ending harmful practices, such as “child marriage”.²⁵⁵ Globally, adolescent girls and women who are impoverished, less educated and who have the least control over their sexual and reproductive health - especially those married as children - are most at risk.²⁵⁶ Many obstetric fistula patients are “as young as 13 or 14 years”.²⁵⁷

Zimbabwe’s demographic health data highlights multiple social and economic disadvantages which are associated with these root causes. A key challenge is the high rates of adolescent pregnancy and child marriage, which increase the risk of maternal death and injuries. According to demographic health data, nearly one third (32%) of Zimbabwean girls are married by the age of 18,²⁵⁸ with higher rates of early marriage among girls with less education and in rural areas.²⁵⁹ The country also has high adolescent birth rates and while, nationally, 22 percent of girls aged 15-19 have begun childbearing, adolescent pregnancy rates are more than five times higher among girls in poverty (than in wealthiest quintile) and twice as high among those with only primary education.²⁶⁰ One fifth of maternal deaths in Zimbabwe occur among girls aged 15-19.²⁶¹ “One of the biggest risk factors for fistula in Zimbabwe is age, their bodies [adolescent girls] are not ready for a baby”, a doctor at Mashoko Clinic said²⁶²

Amnesty International has previously reported on barriers to sexual and reproductive health services and information for adolescent girls in Zimbabwe.²⁶³ The organisation’s 2018 report, “Lost without Knowledge”, found many girls risk being forced into marriages by families hoping to avoid the stigma associated with pre-marital sex, or the cost of raising a child.²⁶⁴ The report also highlighted how user fees for maternal health care and transport costs continue to be reported as barriers to seeking maternal and new-born care for women in Zimbabwe.²⁶⁵

253 Thaddeus and Maine, Too far to walk: Maternal mortality in context, Social Science & Medicine Volume 38, Issue 8, April 1994, Pages 1091-1110.

254 Art 2(1) UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993,, available at: <https://www.refworld.org/docid/3ae6b36c0.html>

255 World Health Organization, 10 facts on obstetric fistula, available at www.who.int/features/factfiles/obstetric_fistula/en/ accessed 19 September 2019.

256 Maheu-Giroux M, Filippi V, Maulet N, et al. Risk factors for vaginal fistula symptoms in Sub-Saharan Africa: a pooled analysis of national household survey data. BMC Pregnancy and Childbirth. 2016;16:82. doi:10.1186/s12884-016-0871-6, the authors reviewed demographic data from 19 sub-Saharan countries, and found rates of vesico-vaginal fistula were 41% higher among “those that had sexual intercourse before the age of 14 [compared to] those that had a sexual debut at an older age. (page)

257 OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27, para 11.

258 Zimbabwe Demographic and Health Survey 2015, page 69, Table 4.3 Age at first marriage.

259 Zimbabwe Demographic and Health Survey 2015, page 63.

260 Zimbabwe Demographic and Health Survey 2015 page 80, Table 5.11 and Key Indicators, page 10.

261 OHCHR Report of the Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights, 2011, A/HRC/18/27, para 10.

²⁶²Interview with Medical Superintendent, Mashoko Clinic on the 01 October 2020

263 “Lost without Knowledge”: Barriers to sexual and reproductive health information in Zimbabwe, Amnesty International, Index: AFR 46/7700/2018

264 Amnesty International, Lost Without Knowledge: Barriers to sexual and reproductive health information in Zimbabwe, 2018, Index: AFR 46/7700/2018.

265 Amnesty International, Lost Without Knowledge: Barriers to sexual and reproductive health information in Zimbabwe, 2018, Index: AFR 46/7700/2018.

5. BARRIERS TO TREATMENT

“[I] just stayed at home and accepted my predicament... I never thought I could get healed from this, I thought I would have to live like this for the rest of my life”.

Woman with obstetric fistula.²⁶⁶

The trauma of experiencing obstetric fistula is exacerbated by a lack of information about the causes and treatment of the condition and on-going difficulties accessing necessary health services and treatment.

5.1 STRUGGLE FOR INFORMATION

One of the key barriers to treatment is the lack of information about obstetric fistula and potential treatment. All the women who spoke to Amnesty researchers and had received surgical treatment for obstetric fistula, recounted how they had struggled to find information about the causes and treatment of their condition. One of the women, Trinity*, recalled how she realised she had become incontinent while she was recovering in hospital from a long labour. She remembers the nurses told her she had “a lifelong condition and would never stop dripping urine”.²⁶⁷ On hearing this, Trinity explained, “[I] just stayed at home and accepted my predicament... I never thought I could get healed from this, I thought I would have to live like this for the rest of my life”.²⁶⁸ It is a further indication of the barriers to information that most of the women who spoke to Amnesty’s researchers also had believed they were the only person with the condition. As Trinity regretted, “It was only when I came [to the government’s obstetric fistula programme at Chinhoyi hospital] that I realised I wasn’t the only one. All along I thought I was the only one”.²⁶⁹ Similarly, Nelly*, a woman who had lived with obstetric fistula for 44 years and was waiting to receive further surgery under the government’s Fistula Treatment Camps, explained: “in my life until now I’ve never met anyone else with fistula”.²⁷⁰

The challenges around accessing accurate health information about obstetric fistula were also evident at community level. All the women and girls Amnesty International spoke with, who self-reported incontinence related to childbirth injuries but had not been formally diagnosed with obstetric fistula, had no information about the government’s obstetric fistula treatment program and most also lacked information about obstetric fistula in general. These findings in Zimbabwe are consistent with the broader literature.²⁷¹ Global studies

²⁶⁶ Interview with Trinity, Chinhoyi, 19 July 2018.

²⁶⁷ Interview with Trinity, Chinhoyi, 19 July 2018.

²⁶⁸ Interview with Trinity, Chinhoyi, 19 July 2018.

²⁶⁹ Interview with Trinity, Chinhoyi, 19 July 2018.

²⁷⁰ Interview with Nelly, Chinhoyi, 18 July 2018.

²⁷¹ Maheu-Giroux et al. Prevalence of symptoms of vaginal fistula in 19 sub-Saharan Africa countries: a meta-analysis of national household survey data, *Lancet Glob Health* 2015;3: e271–78 at page e275.

indicate that most women who experience an obstetric fistula face an enormous struggle to access corrective surgery.²⁷² Those few who do, often wait years before receiving treatment.

The Ministry of Health and Child Care has made some significant progress to build on. In 2017, they activated a toll-free phone number and circulated a WhatsApp message to encourage referral of women “unable to control her urine or faeces” to the program.²⁷³ However, the Ministry reported they have experienced challenges reaching impoverished, rural women and girls who are less likely to have access to a mobile phone, with information about the condition.²⁷⁴

Chenai was one of the women who benefitted from the WhatsApp information, when her aunt who is based in Harare sent her the toll-free number to register for treatment. Chenai was waiting to receive additional surgery for her obstetric fistula as part of the Ministry of Health and Child Care programme. She told Amnesty International researchers she was feeling optimistic but explained that she had lived without hope for nearly 10 years, because she could not afford even basic health services.



CHENAI'S* EXPERIENCE

Chenai suffered a traumatic home birth,²⁷⁵ and spent six months in hospital as a result of her injuries, which included an obstetric fistula. She remembers that when she left hospital, she was told she had “a puncture in her bladder” and would need to see a specialist to repair the hole.²⁷⁶ She sought help from doctors at Mutare Hospital, who told her she needed to see a specialist. She felt she could not even ask how much the treatment would cost, she had no money or income and her parents had already passed away. “I knew she could never afford it.”²⁷⁷

Chenai moved to Harare to live with her aunt and for over 10 years, she thought she was the only person with the condition and tried to keep it hidden.

It was only in 2018 when her aunt saw the WhatsApp message about the Ministry of Health and Child Care Fistula Program, that Chenai tried again to access treatment. She explained that when she met other women with obstetric fistulas, she was comforted and “felt happy and free.” But she speculated that many other women had the problem of obstetric fistula and were “living in fear of the condition, thinking there is no solution”. She wanted to be “an ambassador” to urge other women to come forward for treatment. Chenai was now looking forward to her future and was hopeful to be able to work and to have a baby.²⁷⁸

Primary health care facilities are often the main source of health information, especially in rural communities. Senior doctors and officials in the Ministry of Health and Child Care who spoke with our researchers indicated that many health care workers may lack the necessary information about obstetric fistula to correctly diagnose the condition or advise women on treatment. A doctor involved in the Ministry's obstetric fistula program also suggested “health professionals don't really know about obstetric fistula”, noting “many nurses don't know the condition exists.”²⁷⁹ A senior nurse at a rural clinic explained that she did not know about the government's obstetric fistula program. When she was shown the WhatsApp message, she clarified that she would not refer eligible patients to the toll-free number without official instruction to do so directly from the Ministry of Health and Child Care.²⁸⁰ She explained such updates of health policies and programs are regularly sent from the Ministry of Health and Child Care via directives or through internal Memos. The Ministry of Health and Child Care were unable to confirm why, as of December 2019, they have not informed all public health facilities and staff of the Obstetric Fistula Camps.

272 Maheu-Giroux et al. Prevalence of symptoms of vaginal fistula in 19 sub-Saharan Africa countries: a meta-analysis of national household survey data, *Lancet Glob Health* 2015;3: e271–78 at page e275.

273 The Ministry of Health and Child Care's WhatsApp message, as of 15 April 2018, reads: “Obstetric fistula (OF) is a devastating childbirth injury that leaves women incontinent of either urine or faeces or both. The Ministry of Health and Child Care in collaboration with United Populations Fund (UNFPA) and Women and Health Alliance International (WAHA) is providing free surgery for women with OF at hospital in Chinhoyi. If you know any woman who is unable to control her urine or faeces may you please contact Sandra on toll free line 08080231 for booking. Please forward to all social groups Thank you”

274 Amnesty International meeting with Senior Health officials in the Ministry of Health and Child Care, 2 November 2018.

275 Interview with Amnesty International, 18 July 2018

276 Amnesty International interview with “Chenai” Chinhoyi 19 July 2018

277 Interview with Amnesty International, 18 July 2018.

278 Interview with Chenai, 19 July 2018 visit and interviews at hospital in Chinhoyi

279 Amnesty International Interview with Senior Obstetrician, 18 July 2018.

280 Visit to a rural clinic in Manicaland, July 2018

Daisy's* case is indicative of challenges some women with obstetric fistula face accessing treatment. When Amnesty International researchers met Daisy in 2018, she had been unable to access health information and treatment for obstetric fistula since her diagnosis with the condition in 2013.



DAISY'S* EXPERIENCE

Daisy experienced an obstetric fistula after giving birth to her third child in 2013.²⁸¹ Although Daisy spent three weeks in hospital after the birth and was formally diagnosed with vesicovaginal fistula (VVF) on her medical records,²⁸² she was not told what the treatment for an obstetric fistula could be.

Daisy explained that she was sent home from the hospital with a catheter bag, but after a few weeks she removed it, as it leaked, and the wound was infected. When she returned to the hospital, another catheter tube was inserted, but this one had no bag to collect the urine which freely flowed out of the tube. Daisy felt there was no point in keeping the catheter if urine was flowing and especially as it was painful. Daisy made several visits to her local clinic and a mobile clinic for help but did not receive any information on treatment options for obstetric fistula. She was given pills that she thinks were for iron, and contraceptives but feels, "what they thought it was and what I feel it is are two different things".

In 2017, Daisy had another infection and was given antibiotics at the clinic. She thinks this medicine interacted with her contraceptives as she became pregnant. Daisy was told she would have to give birth at the hospital as her medical file indicated she had an obstetric fistula.²⁸³ She had a difficult pregnancy and a near miscarriage but gave birth in the hospital. After the birth, the doctor advised her they could not help with her fistula and she would need to see a specialist in Harare, that would cost US\$150. Daisy explained she and her husband had already spent all their savings, more than US\$200, on her medical fees seeking help for her incontinence and during pregnancy. They could not afford this amount. Before her injury, Daisy had worked selling fruits and vegetables, but she is no longer able to work.

Despite regular and recent interactions with the health system between 2013 and 2018, Daisy had not received any information about the Ministry of Health and Child Care fistula treatment program.²⁸⁴

Amnesty International found that a lack of information about obstetric fistula may be prevalent among community health care workers as well.²⁸⁵ In 2017, UNFPA and the Ministry of Health and Child Care piloted a successful community referral program, by training community health workers on the symptoms of obstetric fistula. Community and village health care workers have formed an important part of Zimbabwe's primary health care system since the 1980's.²⁸⁶ In Zimbabwe, Village Health Workers undertake health promotion services within communities, providing information about disease prevention and referrals to the formal health system.²⁸⁷ Village Health Workers are therefore well placed to help identify women in their communities who have experienced symptoms of obstetric fistula and refer them to the Ministry of Health and Child Care treatment programme.

Although Village Health Workers are not medically trained, they do receive a short course of formal training from the Ministry of Health and/or NGOs and receive a small stipend for their work.²⁸⁸ However, none of the five Village Health Workers or the village health promotor who attended the community drama and dialogue

281 Amnesty International interview, Bhora, 27 July 2018.

282 A vesicovaginal fistula is a hole "between the bladder and the vagina that allows the continuous involuntary discharge of urine", Reichert M, Schwandner T, Hecker A, et al. Surgical Approach for Repair of Rectovaginal Fistula by Modified Martius Flap. *Geburtshilfe Frauenheilkd.* 2014;74(10):923-927. doi:10.1055/s-0034-1383149 www.ncbi.nlm.nih.gov/pmc/articles/PMC4210382/

283 Daisy explained she still has these records and the words "VVF" are written on the file that she was given after her third delivery.

284 Amnesty International researchers provided Daisy with the number for the Ministry of Health and Child Care program and she was placed on the waiting list.

285 Village Health Worker, community dialogue and drama, Manicaland province, Monday 5 November 2018, she explained she knew someone with the condition who went to a doctor, but no help was given.

286 Rukundo et al. Health systems strengthening in rural Zimbabwe: Identifying strategies to improve Community Health Worker performance, Conference Paper 142nd APHA Annual Meeting and Exposition 2014; MSF, Zimbabwe: Village health workers turning the tide on HIV- one long bike ride at a time, 16 April 2019 www.msf.org.za/stories-news/news-our-projects/zimbabwe-village-health-workers-turning-tide-hiv-one-long-bike-ride

287 Ibid.

288 Ibid.

on 5 November 2018 had heard of obstetric fistula.²⁸⁹ Of the six village health workers who attended a similar drama performance and dialogue outside of Mutare the following day, only three had previously heard of obstetric fistula, one from training in the 1990's, one from a training in 2018, and the third because she had met someone with the condition.²⁹⁰ Amnesty also met with Village Health Workers in Bhora, 100 kilometres outside of Harare, who had heard about obstetric fistula through a 2017 research project that had been carried out in the community, but they did not know that treatment was possible and did not have information about the Ministry of Health and Child Care treatment programme.²⁹¹ Village Health Workers who participated in interviews and discussions for this report indicated that information on obstetric fistula has not yet been systematically shared with them.

Without access to information, many women have faced challenges even getting a diagnosis. All the 15 women with undiagnosed childbirth related incontinence who spoke to Amnesty International researchers indicated that they had struggled to get information about the cause and treatment options for their condition. For example, Hazel* explained she has lost count of the number of times she has tried to get help from the health system. She has experienced faecal incontinence since she gave birth to her first child in 2001. Hazel explained she immediately asked for help at the clinic but was told to sit in a salt bath. When her symptoms persisted, she returned a week later, but her concerns were dismissed. Eighteen years later, Hazel was still without a diagnosis for her condition. She explained that in 2009, she was referred to Harare hospital and admitted for tests – but the tests were too expensive for her to complete. When Hazel has returned to the clinic for help, she has been told repeatedly to go to the hospital in Harare or use private health care. However, a private doctor charges US\$7 for a consultation and it is also too costly for her to get there.²⁹² Hazel has since had three more children, and each time she has visited the clinic for maternal health services, and she has asked for help for her incontinence.²⁹³

Without access to information about their health status, several women noted they had turned to spiritual or traditional healers for help. For example, one woman - whose sisters thought she was bewitched because of her injuries following childbirth - sought help from Apostolic church prophets and was given things to bathe in. However, she noted "those are just false prophets who will tell you what you want to hear...it hurt me, you go to every high and low place to find a solution."²⁹⁴ Another woman, Patricia, who thought her condition was "chronic and incurable" had similarly tried to seek help from traditional healers, she explained, "We did it all, we went to witchdoctors, prophets, spiritualists but it didn't help... In fact, it worsened the situation."²⁹⁵ When she was informed about the Ministry of Health and Child Care surgery program which provides free treatment for obstetric fistula, her husband gave her permission to go-ahead. But after she booked for the surgery, he began to worry, she explained, "people in the community started feeding him false ideas and he told me not to go".²⁹⁶ Patricia knows of four women with the same condition in her community who are afraid to register for surgery, "they are afraid they will die on the operating table", they are waiting to see if she gets healed.²⁹⁷

The provision of education and access to information about health problems in the community is a core obligation under the right to health.²⁹⁸ However, according to the Ministry of Finance's data, allocations to the Ministry of Health and Child Care for "Education Materials, Supplies and Services" of ZWL\$40,000 (US\$2,515.72) was not released in 2019.²⁹⁹ Furthermore, allocations for "Communication information supplies and services" were not fully released, with nearly ZWL\$1.8 million (US\$113,208) spent compared to the budget allocation of ZWL\$4.2 billion (US\$264 million).³⁰⁰

Amnesty International's findings indicate a widespread failure to ensure that information about the causes and treatment for obstetric fistula is adequately disseminated and that all sections of the population can access it.

289 One of the Village Health Workers who attended the meeting, explained she had been motivated to come because she wanted to "find out about fistula and how it happens" Community dialogue and drama on Obstetric Fistula, Manicaland province, 5 November 2018.

290 Community dialogue and drama on Obstetric Fistula, Manicaland province 6 November 2018

291 Amnesty International interview with VHWs, Bhora, 27 July 2018

292 Interview with Hazel, Hopley, 16 July 2018.

293 Interview with Hazel, Hopley, 16 July 2018.

294 Interview with Amanda Masvingo, 23 July 2018

295 Amnesty International interview with "Patricia" 19 July 2019

296 Interview with Patricia, 19 July 2018.

297 Interview with Patricia, 19 July 2018.

298 CESCR General Comment 14, para 43.

299 Ministry of Finance and Economic Development, 2020 Proposed Estimates of Expenditure, 14 November 2019 at page 216, available: www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&id=54&Itemid=787

300 Ibid.

5.2 COSTS OF POSTNATAL CARE

As a serious maternal morbidity, obstetric fistula should be diagnosed within postnatal care.³⁰¹ However, a third of women in Zimbabwe experience barriers to postnatal care, according to the latest demographic health information.³⁰² A maternal health specialist advised Amnesty International researchers, that one major barrier was the cost, as the government's "free maternal health policy" relates only to giving birth and fails to cover any hospital treatment for maternal morbidities.³⁰³ Therefore, women in Zimbabwe who experience injuries in childbirth, like obstetric fistula, need to pay for postnatal and on-going health services. Women reported to have been quoted between US\$150-US\$4000 for the costs of obstetric fistula surgery. In addition, women who shared their experiences with Amnesty International, reported leaving hospital after giving birth with astronomical bills of hundreds of dollars which did not cover the costs of treatment for obstetric fistula. Such debts increase household poverty and further prevent women's access to treatment for their injuries. One woman, Patricia, had undiagnosed incontinence since she gave birth to her sixth child in 2008. She explained that she knew there would be fees involved if she needed surgery as she had paid US\$25 to repair a tear following the birth of her third child in 1998, "I knew I would have to pay again and I could not get the money, so I did not go back".³⁰⁴

It was community health workers who linked Patricia to the Ministry of Health and Child Care Program and gave her the toll-free number. Patricia lived in a rural community near Chipinge in Manicaland province. Although she had been diagnosed with an obstetric fistula, she was unable to afford the costs of transport to health facilities or the hundreds of dollars in medical fees for treatment. Patricia described her long struggle for answers about her condition, she explained:

"[A]fter I gave birth I became depressed and didn't even have hope to carry on... I thought the condition was chronic and incurable"³⁰⁵

Patricia stayed in hospital for over a month after her childbirth injury and was left with a bill of US\$1400, but this amount related only to her hospital stay and did not cover treatment for her obstetric fistula. She explained that a week after giving birth, she saw a doctor for the first time and was diagnosed with an obstetric fistula. After a month, she was transferred to Mutare Provincial Hospital for fistula surgery in December 2010. However, she recalled, "when I arrived at Mutare, they told me it was the holiday season and I would have to come back in March [2011]". When Patricia returned to the hospital in the new year, she was asked for referral documentation from Chipinge hospital and forced to make several journeys between the two health centres to try and retrieve her records. She ran out of money to afford the bus fare to return to Mutare hospital and could not afford the US\$400 for the surgery. At home, Patricia worried "in her heart" that she had been bewitched by her mother-in-law.³⁰⁶



CHANTEL'S* EXPERIENCE

Chantel gave birth at hospital after a long labour that resulted in a still birth and left her with an obstetric fistula. She explained that her parents collected her from the hospital the day she gave birth and took her home where they buried the child. But the next day she realised there was a "burst of water". Chantel returned to the hospital, where she was told there had been a mistake with her delivery and she had "burst her bladder". Chantel explained she then went to a provincial hospital and was told she has "a small hole" and needed to go to Parirenyatwa Hospital in Harare. Unable to afford the costs of transport or hospital fees, she told her mother she was no longer treatable. Instead, they tried going to prophets and she was given herbs and medicine, but it didn't work. Chantel felt there was "no relief coming from anywhere". She lived with her condition for more than ten years. When she spoke to Amnesty International researchers, Chantel had received treatment under the Ministry of Health and Child Care program and was spreading the news about fistula surgery in her community.³⁰⁷

301 World Health Organisation, Postnatal Care Guidelines, Highlights from the World Health Organization 2013 Guidelines, April 2015, available www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf

302 Zimbabwe Demographic and Health Survey 2015 page 146, noting "[o]ne in three mothers (32 percent) did not have any postnatal health check". <https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/ZDHS%20Preliminary%20Results.pdf>

303 Amnesty International meeting with maternal health expert gynaecologist, Harare, November 2018.

304 Amnesty International interview with Patricia

305 Interview with Patricia Chinhoyi, 19 July 2018

306 Interview with Patricia Chinhoyi, 19 July 2018

307 Amnesty International Interview with Chantel 18 July 2018

Without access to information about their health conditions and inaccessible treatment, women also faced discrimination and isolation. Amnesty International found that the lack of information about obstetric fistula and the barriers to treatment among women with the condition, directly exacerbated their sense of isolation and risk of stigma.

6. DISCRIMINATION AND OTHER ABUSES EXPERIENCED BY WOMEN WITH OBSTETRIC FISTULA

There is stigma associated with incontinence, which often compounds the isolation of women who have suffered an obstetric fistula.³⁰⁸ One review from Zimbabwe found the psychological impact of obstetric fistula on women included feelings of “helplessness, sadness, suicidal thoughts, stigma and blame, feelings of worthlessness, fear, shame and social withdrawal”.³⁰⁹

When Amnesty International researchers visited remote and rural communities and met with women who had experienced childbirth related incontinence, nearly all of them explained that they tried hard to keep their condition a secret. Women who had received treatment for obstetric fistula also shared their experiences of hiding their condition. Women described fearing superstition, humiliation, or violence from other community members if their injuries became known.

6.1 FEAR, ISOLATION AND DISCRIMINATION

Amanda* was in her fifties and lived in a rural area outside of Jerera, Zaka in Masvingo Province. She had lived with childbirth related incontinence for over 20 years and had not told anyone about her condition as she was afraid she “could be killed if people found out”. Amanda told us “you have to be clever” about keeping it secret.³¹⁰ Another woman told Amnesty International researchers she feared for her life if her condition became known within her community.³¹¹ Another elderly woman in Masvingo, Catherine*,

308 Maheu-Giroux et al. Prevalence of symptoms of vaginal fistula in 19 sub-Saharan Africa countries: a meta-analysis of national household survey data, *Lancet Glob Health* 2015;3: e271–78 at page e275; UNFPA 2007 www.unfpa.org/sites/default/files/resource-pdf/living_fistula_eng_0.pdf page 13; Changole et al. “I am a person but I am not a person”: experiences of women living with obstetric fistula in the central region of Malawi *BMC Pregnancy and Childbirth* (2017) 17:433 DOI 10.1186/s12884-017-1604-1.

309 Mutambara Maunganidze and Muchichwa, Towards Promotion of Maternal Health: The Psychological impact of Obstetric Fistula on Women in Zimbabwe, *International Journal of Asian Social Science*, 2013, 3(1):229-239 : <https://ideas.repec.org/a/asi/ijoass/2013p229-239.html>

310 Interview with Amanda, Jerere, 23 July 2018.

311 Interview with Nelly, Chinhoyi, 18 July 2018.

elaborated, “when you are handicapped you find solutions for people not to find out”.³¹² She had lived with childbirth related incontinence since 1974.



SISTERS SEPARATED BY A SECRET

Two women came forward to discuss their experience of childbirth related incontinence with Amnesty researchers. It was only at the meeting that the sisters realised they each had similar health challenges, yet they had both kept silent about their suffering for decades. They lamented having to keep their conditions secret, and not knowing and being able to care and support each other.

Amnesty found that women’s fears of stigma are well-founded. Women reported experiencing cruel and discriminatory treatment from husbands, relatives, neighbours and community members. Patricia described the rough treatment she received from her husband’s family after she developed obstetric fistula during her first pregnancy, when she was aged 15.³¹³ Although her husband initially accepted her condition and they had another baby, Patricia felt “he is disgusted by me”. She described their relationship as “contentious” and she has experienced domestic violence.³¹⁴ In part, Patricia blames her husband’s parents for causing “a lot of strife in our house”. She explained how her parents in law belittle her because of the smell of her incontinence. Patricia felt they resented that her health condition, made it difficult for her to help with physically demanding work around the home. She said,

**“[I]t bothered [my husband] when his parents came to tell him he should get rid of me because of the condition...and to look for someone else who was ‘normal’...Our happy moments were short lived
³¹⁵...They would say things like...I was impossible to love, because of the stench of urine...At my mother-in-law's house I could not spend the night because of the unkind words.”³¹⁶**

Patricia told Amnesty researchers she felt tormented and her mother-in-law would “accuse me of being lazy and unproductive” and resented her inability to work.³¹⁷ Patricia was especially hurt when her mother-in-law would not allow her to cook or prepare food. Patricia explained she was forced to isolate herself because of the hurtful way her husband’s family and neighbours treated her;³¹⁸

“It affected my friendships and relations with family, I couldn’t go to church or travel... at church gatherings they would talk about me, [that] I stank of urine, and if I tried to help with things like cooking, they would say I was ruining their food. If I went to bath, they would accuse me of being lazy. It hurt me so much...I was forced to isolate myself.”³¹⁹

In contrast, Patricia’s mother has been a constant support, “I could visit them without any problem and she would sit with me and even eat the food I prepared”.³²⁰ Patricia had received surgery for her obstetric fistula and was hopeful for her future.

Several women also explained that as a daughter-in-law, they were expected to do many of the menial jobs, like fetching water and firewood, but that carrying heavy loads made the incontinence worse. As one woman described, when lifting, water [urine] would “whoosh out”.³²¹ Like Patricia, women also spoke of their distress that friends and neighbours would not eat the food they prepared; they say, “leave it,” said Theresa*³²² They were saddened by their isolation from family and community functions and from Church. Another woman

312 Interview with Catherine, Masvingo, 22 July 2018.

313 Interview with Patricia, Chinhoyi 19 July 2018

314 One issue of tension was medical advice from Drs after her surgery to abstain from sexual intercourse for three months to allow the wound to heal. Patricia describes her husband “accused me of colluding with the nurses at the clinic” to avoid sex. Chinhoyi 19 July 2018

315 Interview with Patricia, Chinhoyi 19 July 2018

316 Interview with Patricia, Chinhoyi, 19 July 2018.

317 Interview with Patricia, Chinhoyi, 19 July 2018.

318 Interview with Patricia, Chinhoyi, 19 July 2018.

319 Interview with Patricia, Chinhoyi, 19 July 2018.

320 Interview with Patricia, Chinhoyi, 19 July 2018.

321 Interview with Chipo, Chinhoyi, 18 July 2018.

322 Interview with Theresa, Chinhoyi, 19 July 2018, see also Interview with Patricia, Chinhoyi, 19 July 2018., who explained, “if I tried to help with things like cooking, they would say I was ruining their food”.

receiving fistula treatment at Chinhoyi hospital lamented; "even going to a funeral is impossible because of this condition"³²³

Amnesty International found that other women with obstetric fistula and childbirth related incontinence had similar experiences. Natsai explained that her husband's family treated her badly and she can no longer live with them. However, she felt fortunate to have the support of her parents and husband.



CHENAI'S CASE

Chenai had similar experiences of abandonment and discrimination because of her obstetric fistula. In 2003, Chenai experienced a fistula when she was 16 years old, after she gave birth in the home of her boyfriend's family, under the supervision of his mother and religious preachers. Chenai's labour lasted five days, she suffered a still birth and started to leak urine. With encouragement from female neighbours, Chenai went to the hospital for help two weeks later but explained she did not receive treatment or clear information about obstetric fistula. Chenai stayed two more months living with her boyfriend's family, before she returned to live with her aunt who had raised her. When her aunt could not accept her condition, Chenai's sister took her in and has supported her ever since. Over the next 14 years, Chenai struggled with the health consequences of her injury. Unable to afford sanitary pads or creams, she has suffered from painful skin sores and blisters. She had never met anyone else with fistula. Chenai explained she was worried that "many women have problems [of obstetric fistula] for a long time and think there is no solution".

The general lack of information about the causes and treatment of obstetric fistula was found to increase women's risk of discrimination and abuse within their families and communities. As one woman explained, she was afraid to tell anyone about her fistula injury, for fear of suspicion, but her fear and secrecy around the condition made her feel more alone.³²⁴

When Amnesty International researchers visited communities, they found very little information was available about obstetric fistula. Participants in community dialogues in rural areas outside of Mutare, emphasized that there is no Shona word for obstetric fistula.³²⁵ On hearing the word "fistula" a traditional midwife at a focus group discussion in Macheke asked: "Do we even know these English things?"³²⁶ However, whenever the causes and symptoms of obstetric fistula were explained, many community members expressed some recognition.³²⁷

Participants in community dialogues and dramas reflected on people they knew within the community who may have the condition and who had been treated poorly, in part, because of a lack of understanding. One man contemplated that a woman he knew may have this injury. He explained that "people just said the woman was bewitched and that was finished as far we were concerned."³²⁸ Another participant noted that she knew a woman who smells of urine, and explained that she had previously assumed she was "too lazy to go to the toilet" and "that she had been holding her urine too long and had burnt a hole".³²⁹ A woman mentioned a woman in her community who is referred to as "Zambia" because she always wears a chitenge³³⁰ cloth wrapped around her. She suggested it showed that there were women with the condition in the community.³³¹

The responses of participants at community dialogues and dramas also highlighted how the lack of information about obstetric fistula exacerbates gender inequalities and stereotypes and increases the risk of stigma and abuse for women with the condition. A Village Headman's concerns illustrated some of the challenge's women face. He suggested that with obstetric fistula "a wife can't perform her roles and when

323 Interview with Trinity, Chinhoyi, 19 July 2018.

324 Interview with Patricia, Bhora, 27 July 2018.

325 Amnesty International Community dialogue and drama on Obstetric Fistula, held in rural communities outside of Mutare 5-7 November 2018.

326 Focus Group Discussion with Traditional Midwives in Macheke, 2018. Among the eight participants of the FGD in Mutare, only one person had heard about OF.

327 At least seven participants at the Community dialogue and drama on Obstetric Fistula, Manicaland province, 5, 6 and 7 November 2018.

328 Male participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

329 Female participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018

330 Chitenges are pieces of printed material with many uses, they are commonly worn by women in southern, east and west Africa, around the waist, or used as headscarves or to carry babies.

331 Female participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018

the roles are gone, so what am I going to stay with her for? ...that's why a man should have two wives, so he has a spare".³³² Another man explained, "sometimes people don't understand and think the woman [with obstetric fistula] is bewitched and that is why they may beat the wife."³³³ Another man considered that "[obstetric fistula] brings a lot of shame when the wife is with such a condition...so [I] would end up staying with the wife because would feel sorry for them, but would tell them, [I] can't be in love if there is no intimacy."³³⁴ Another man explained he knew a woman with the condition and her husband wanted to leave her.³³⁵

Across all the community meetings, women highlighted how, in general, they were expected to tend to husbands who are unwell, yet raised their scepticism that men would support them if they fell sick.³³⁶ One woman noted that "men promise 'in sickness and in health' but that is not what they do."³³⁷ A woman explained that when a person she knew developed the condition, "The husband's relatives told him the marriage is over and he should find someone else."³³⁸ However, several men emphasized that women also contributed to negative gender stereotypes. As one man explained, "if I have a wife like this, it will be women, my mother, telling me I must leave that woman."³³⁹

6.2 CHALLENGES OF SELF-CARE

"The challenge is that fistula patients need a lot of resources for hygiene management such as pads or cotton wool. This can be a challenge to get so a patient may fail to seek care because she cannot be on public transport without proper hygiene resources like pads" – Senior Nurse at United Bulawayo Hospitals"³⁴⁰

Amnesty found that women with obstetric fistula and childbirth related incontinence took great care to conceal their condition and to maintain their cleanliness as best they could. However, they faced enormous challenges in accessing the hygiene products they need to maintain their health and dignity. Women's poverty - often exacerbated by their inability to continue working with their health condition and their economic reliance on husbands [or relatives?] - made it impossible for most to afford the soap, laundry detergent, sanitary pads, cotton wool, Vaseline and creams they need to bath, wash clothes and prevent blisters and sores.

332 Village Headman, Community dialogue and drama on Obstetric Fistula with community leaders, Manicaland province, Monday 5 November 2018. It was also noted in the discussion that women may be divorced if sexual intimacy deteriorates, for example "that some men may divorce if their wives' vaginas became too wet."

333 Male participant (under 30 years) Community dialogue and drama on Obstetric Fistula, Manicaland province, 5, 6 and 7 November 2018.

334 Male participant Community dialogue and drama on Obstetric Fistula with community leaders, Manicaland province Monday 5 November 2018.

335 Male participant (under 30 years) Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

336 Such sentiments were raised by women across all three community dialogues. See for example, one female participant who asked the meeting, "I'll be nursing a husband if he had prostate cancer, so why can't the man stay? At which, the other women in the audience clapped loudly in support of this comment, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

337 Female participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

338 Female participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018, she explained her friend has four children and when she was pregnant with the second child she could not go to hospital and went to TBA, they tried to deliver until it [bladder] broke and then she went to hospital.

339 Male participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

³⁴⁰ Interview with Senior Nurse at hospital in Bulawayo, 29 September 2020



This is one of the old shirts that a woman with obstetric fistula used as an alternative to hygiene products. She demonstrated how she would fold the shirt and place it inside a plastic bag to act like a sanitary pad, that she then tied around her waist, under her clothing. © Amnesty International 2018.

Women described how they wanted access to sanitary or diaper pads to absorb the flow of urine, especially if they needed to travel.³⁴¹ However, the costs were prohibitive. Ten adult diapers cost US\$11.78 in Zimbabwe in March 2021.³⁴² Instead, all the women Amnesty spoke to relied on making their own pads, mostly by cutting up old clothes and using plastic bags. One woman explained that she would try and use old t-shirts as it is a softer material.³⁴³ Many women, like the 30-year-old mother of four we interviewed, had to make-do with using her own old clothing.³⁴⁴ Despite their innovation, nearly all women Amnesty International interviewed emphasized the discomfort, as the roughness of the cloth materials they used would lead to blisters and sores. As one woman from Hopley described, "my skin would peel off".³⁴⁵

The burden of keeping clean added hours to women's daily labour. Women described bathing as many as five times a day,³⁴⁶ and spending time constantly washing their clothes and home-made cloth pads. An elderly woman, who had lived with her condition for decades, described the humiliation of washing her own towel diapers along with her grandchildren's. Again, poverty added to their burden, and women highlighted that bars of laundry soap are cheaper than laundry powder, but are ineffective in removing urine odour, and the powerful detergents are prohibitively expensive. As of April 2021, the cost of 1KG of laundry detergent was US\$2.99.³⁴⁷ At the time of the interviews, nearly all women with obstetric fistula and childbirth related incontinence were financially dependent on family members. The increasing cost of living in Zimbabwe, due to the economic crisis in 2018-2019 has placed even more people under the food poverty line.³⁴⁸ In April 2021, a single person's estimated monthly costs in Zimbabwe were US\$627.33, excluding rent, and the estimated monthly costs for a family of four were US\$2,216.11, also without rent.³⁴⁹ Women interviewed by Amnesty International for this report all struggled to access even US\$1 for their health needs.

Amnesty International researchers found a prevalent view within the community that women with obstetric fistula would be distinctive by their odour. Women who were affected by obstetric fistula and childbirth related incontinence explained their own concerns and fears. Women described feeling "stressed" in situations when their daily reality exposed them to having to change pads outside their homes. One woman who lived near Mutare who had an obstetric fistula for 16 years, explained that she changed her cloth pads regularly, but would often need to then carry around the wet clothing with her, so she could wash it at home.³⁵⁰

Several other women described a similar approach. One woman painted a lonely picture of how when she went to work on the land, she would take a bag of cloths with her and would position herself in a remote corner, far away from other people. She explained she would change her cloth pads in the corner and then

³⁴¹ Many women also travelled with a blanket wrapped around them as another layer of protection.

³⁴² Price obtained by Amnesty Researcher on SPAR website <https://www.spar.co.zw/products/122050/active-adult-diapers-xlarge-10s>

³⁴³ Prices reported by interviewees in June 2018. Amnesty researchers verified prices at community stores and a larger supermarket franchise store in Mutare.

³⁴⁴ Interview with Chipso, Chinhoyi, 18 July 2018.

³⁴⁵ Interview with Hazel, Hopley, 16 July 2018.

³⁴⁶ One elderly grandmother with undiagnosed childbirth related incontinence, explained she was so conditioned to waking early to bath before others that even in her seventies, she still wakes to bath in the cold river by 6:30am each day, Interview with Catherine, Masvingo, 22 July 2018.

³⁴⁷ OK Zimbabwe Limited see: https://www.okonline.co.zw/?product_cat=laundry

³⁴⁸ World Food Program Zimbabwe in the grip of hunger, World Food Program, 30 December 2019: <https://www.wfp.org/stories/zimbabwe-grip-hunger>

³⁴⁹ Cost of Living in Zimbabwe, NUMBEO: https://www.numbeo.com/cost-of-living/country_result.jsp?country=Zimbabwe

³⁵⁰ Interview with Chipso, Mutare, 20 July 2018,

carry the wet items home [at the end of the day].³⁵¹ Similarly, another woman noted she would also try and work in the fields, but that the work would aggravate skin sores from the pads, and that she feared "If I spend the whole day in the field and I delay changing my undergarments then people around could pick it [the smell] up."³⁵² Women explained that the "stress" of worrying constantly about keeping clean took an enormous toll on their wellbeing.

Community meetings confirmed that "women carrying bags of sodden cloths could lead to rumours in the community."³⁵³ After a community discussion in Macheke, participants speculated whether a number of women in their community may have experienced obstetric fistula because of their usual carrying of bags of smelly cloths. Similarly, one woman we interviewed near Mutare had been identified in her community as someone who may have a fistula injury as she was locally known as the "lady who walks with a bag".

6.3 DIFFICULTIES UNDERTAKING PAID AND UNPAID WORK WITH OBSTETRIC FISTULA

Women told Amnesty International how obstetric fistula injuries seriously limited their economic independence and ability to work. The women told Amnesty researchers that, firstly, it was very difficult to undertake physical labour, as the exertion could be painful and would increase the flow of urine. Women described challenges lifting and carrying heavy items and working in the fields. As noted above, this was often reported to cause resentment with family members. For example, Chipso explained that her mother-in-law would be angry, accusing her of being lazy, and say "I don't want to do work for her while she is sitting". She would often tell her son: "I don't want this daughter-in-law" and ask him: "why are you staying with her in this condition".³⁵⁴

Amnesty International researchers met Hazel inside her mudbrick shack in the settlement of Hopley, just 14 kilometres from Harare. Hazel has suffered from urine and faecal incontinence since she gave birth to her first child in 2001. As noted above, despite many visits to clinics and hospitals, including during subsequent pregnancies, Hazel has been unable to get a diagnosis or answers about her condition. She feels low and helpless and lamented, "life is passing me by".³⁵⁵ One of Hazel's major worries is her inability to work. Before her childbirth related injury, Hazel earned US\$12 a day braiding hair and took pride in being an entrepreneur. She was the main provider for her four children. Now, unable to stand for long periods, she relies on her husband to support them. The family survives on US\$150/month and her two elder children have had to move schools, because of debts amounting to US\$500 in school fees. Hazel described her relationship with her husband as strained; she knows he is unfaithful, but he has warned her not to "meddle in his affairs" if she wants to continue living with him.³⁵⁶

Secondly, some women reported losing jobs because of stigma related to their incontinence. Patricia had been earning US\$250 a month as a maid but lost her job when her employers became aware of her incontinence, she explained, "they felt I was messing up the home" and they would not let her cook any meals for the children. Now Patricia feels "unable even to sell at the market." Her husband abandoned her, and she was forced to live with an aunt.³⁵⁷

Thirdly, women's poverty often increased after experiencing obstetric fistula because of their reliance on husbands and family members, leaving them financially vulnerable. Before suffering an obstetric fistula, Nelly farmed vegetables and sold them at the market. When she suffered an obstetric fistula during childbirth, her husband divorced her and, unable to work, she was pushed further into poverty.³⁵⁸

Women's lack of economic independence because of their maternal injuries created enormous hardship and challenges accessing the hygiene products they needed for selfcare. It also increased the risk of domestic violence, including economic abandonment.

The stigma and isolation women experienced because of their health condition also made it harder for women to access support, if it was to become available. For example, following community meetings, local

351 Interview with Chantel, Chinhoyi, 18 July 2018.

352 Interview with Trinity, Chinhoyi, 19 July 2018.

353 Participant of FGD in Mutare, 20 July 2018, one participant noted: "most of the time people won't have pads or cotton so [they] use cloth and [we] see them washing the cloths - and if someone is mouthing [about] you it becomes a problem."

354 Interview with Chipso, Chinhoyi 18 July 2018

355 Interview with Hazel, Hopley 16 July 2018.

356 Interview with Hazel, Hopley 16 July 2018.

357 Interview with Patricia, Chinhoyi 19 July 2018.

358 Interview with Nelly, Chinhoyi 18 July 2018

leaders suggested that women with obstetric fistula should be included on their lists of vulnerable groups in the community who are entitled to receive maize contributions, yet highlighted this would be impossible as women were keeping their condition hidden.

7. VOICES OF HOPE

“Hearing the other stories makes me not think too much, I have hope...this is something than can be healed.”³⁵⁹

Despite the suffering that women with obstetric fistula and childbirth related incontinence have endured, many expressed their hope to help prevent new cases and to support other women with the condition to seek treatment. During the research, Amnesty International also heard from doctors, community health workers, family members and friends of women with obstetric fistula who were committed to playing their part in spreading information and understanding about the condition.

At community dialogues, some participants who had experienced the reality of how obstetric fistula impacted women within their families, shared powerful testimonies of support. One man told a community meeting that “I’ve accepted it and seen it,” explaining his aunt had been raped aged 14 and had a child, but straight after giving birth “she had this problem”. He recalled that his aunt “was then given to an old man to live with, it wasn’t a good life, when the man died, she was still young, she could not sit anywhere without cloths.”³⁶⁰

Amnesty International also heard from an Apostolic Prophet, William, who explained the hardship his family experienced when his sister developed an obstetric fistula, following her first pregnancy, aged 19. Prophet William explained that although his sister went to hospital in the early stages of her labour, it was three days before she gave birth. The baby was born alive, but his sister noticed, “urine was flowing down all the time”. She arrived crying at his home and explained that her husband had sent her away after his family had consulted a prophet in their community, who advised them her condition was the result of a curse William had placed on her. William and his wife were supportive and welcomed his sister. They paid for his sister to see a medical doctor, who explained the injury was an accident following childbirth and - to William’s relief - was not a curse. William paid over US\$850 for his sister to have three surgeries at Mutare hospital over the course of a year. She was healed. However, William had to sell his tobacco crop and three of his cattle to cover the costs of the surgery. After she recovered, his sister returned to her husband and has since had another child, this one delivered by caesarean section.³⁶¹

At the community meetings, Amnesty International researchers observed that after the performance of the drama by Eastern Arts Ensemble, and with information about the how obstetric fistula occurs, many more men expressed that they may be prepared to support their wives if they should develop the condition during childbirth – one older man explained “now we know it is curable, I could stay.”³⁶² Another said that “if you understand why the injury happened and the reason, then you can’t leave”.³⁶³ Another man reflected, “men are hard to women, they need to understand the source of the problem or [they] won’t stay as [they] will blame the wrong thing, now they understand they are part of the problem, men can stay.”³⁶⁴ Women also expressed that they could share a household with a woman with obstetric fistula. While an elderly man implored “the person you marry, you love her and stay with her and she is your wife forever.”³⁶⁵ Several

359 Interview with Chipso, Chinhoyi, 18 July 2018

360 Male participant Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

361 Interview with Prophet William Manicaland province, 6 November 2018

362 Older male participant (under 30 years) Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

363 Male participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018

364 Male participant (under 30 years) Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018.

365 Older male participant (under 30 years) Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018

younger men also said they would stay and support a wife who developed obstetric fistula. One suggested he would find the budget to help his wife with hygiene products, another that “he could stay with his wife, because she became sick while they were together and [it was] better to stay.”³⁶⁶

In closing one of the community meetings, a Chief added that he was happy to have information about obstetric fistula.³⁶⁷ He urged the community:

“There is no witchcraft here...let’s spread the good news, that women are not witched but they can be cured.”³⁶⁸

Indications from Amnesty’s community dialogues and drama performances are that change in the underlying factors that promote home birth is also possible. One elderly man explained his apostolic church used to believe in Traditional Birth Attendants “but we stopped it as a church, now we see our role is to take care [only] of the spiritual needs.”³⁶⁹ A grandmother who had been adamant it was her role to determine where women in her household gave birth, ended a community discussion by reflecting, “I don’t want to go back to the way things were before so [women] should give birth in hospital.”³⁷⁰ One Senior Doctor, described a recent maternal death due to horrific obstetric abuse by a Traditional Birth Attendant, but warned the problem is not individual Traditional Birth Attendants, but the need to change the mindset around home birth and health seeking.³⁷¹

Change was also evident within some Apostolic sects. Prophet William now encourages women to give birth in health facilities. He explained that as a Prophet he has the powers to cure headaches and health conditions, but that he prays and then sends people to the hospital.³⁷² He preaches that Traditional Birth Attendants are not trained, and warns, “they don’t know medicine and they have only soap and herbs and don’t give good care.”³⁷³

Women who had developed obstetric fistula while giving birth at home also wanted to advise women to give birth in health facilities and expressed willingness to support educational campaigns at community level. As one woman who had received treatment for her obstetric fistula, Trinity, explained, “I would want to advise pregnant women to go to the hospital in good time. Because the [traditional] midwives who do home deliveries don’t always do a good job...so go to the hospital and have a safe delivery and come back in one piece.”³⁷⁴

Women who had received surgery for fistula expressed a desire to challenge the lack of information about the condition. Many volunteered to help promote awareness of the Ministry of Health and Child Care’s surgical program in their communities and among women at risk. Chenai suggested she “liked to be an ambassador” and work with older women in the community to change their attitudes about home births.³⁷⁵

Participants at community drama and dialogues stressed that “we must teach each other that it [obstetric fistula] is curable”.³⁷⁶

7.1 HUMAN RIGHTS CHAMPIONS

In nearly all cases, an obstetric fistula can only be treated through surgery.³⁷⁷ Success rates with expert care are high (+/- 90%).³⁷⁸ However, the medical literature emphasises the importance of highly skilled surgery, with the first attempt to repair a fistula being the most likely to succeed.³⁷⁹ Globally, there is a shortage of

366 Male participant (under 30 years) Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018; at least eight participants at Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018

367 Village Chief, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

368 Village Chief, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

369 Male participant, community dialogue and drama with community leaders, Manicaland province, 5 November 2018.

370 Female participant (GOGO JIVE) Community dialogue and drama on Obstetric Fistula, Manicaland province, 7 November 2018

371 Amnesty International meeting with Senior Gynaecologist, 2 November 2018

372 Interview with Male Prophet in the Zion Apostolic Church, Manicaland province, 6 November 2018.

373 Interview with Male Prophet in the Zion Apostolic Church, Manicaland province, 6 November 2018. William has three children of his own, aged between 18 and 6 and his wife gave birth to all three in hospital.

374 Interview with Trinity Chinhoyi, 19 July 2018.

375 Interview with Chenai, 18 July 2018.

376 Female participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

377 Worldwide Fistula Fund <https://worldwidefistulafund.org/what-is-fistula.aspx>

378 Bengtson et al. Identifying Patients with Vesicovaginal Fistula at High Risk of Urinary Incontinence After Surgery, *Obstetrics & Gynaecology*: November 2016 - Volume 128 - Issue 5 - p 945-953 doi: 10.1097/AOG.0000000000001687: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5079772/>

379 Wall LL et al. A Code of Ethics for the fistula surgeon, *International Journal of Gynaecology and Obstetrics* (2008) 101, 84–87 at page 86. <https://files.givewell.org/files/DWDA%202009/WFF/Wall%202008-A%20code%20of%20ethics%20for%20the%20fistula%20surgeon.pdf>

health care professionals with the necessary specialist skills.³⁸⁰ Amnesty International was advised by a Professor of Obstetrics, that Zimbabwe has similar challenges, especially as the surgical training is not provided in medical school.³⁸¹ Doctors highlighted that as obstetric fistula mainly affects women in poverty, there is little incentive to learn the surgical skills because they are unlikely to be utilised in private practice.³⁸² Most doctors in Zimbabwe work at least part time in private practice to supplement the low incomes from the public sector. A doctor explained he can charge US\$1,000 for a C-Section in a private hospital and the operation takes 30 minutes. In contrast, a fistula surgery may take 4-6 hours.³⁸³ “The repairs are difficult; the challenges are that it [doing a repair] requires a lot of time.”³⁸⁴

Nevertheless, [by 2019] 12 doctors had volunteered to support the Ministry of Health and Child Care fistula repair program and had received surgical mentorship from international fistula experts.³⁸⁵ One of the doctors involved described his vocation as “to restore dignity to women who have lost so much.”³⁸⁶

Nurses in the public health sector have also supported the program. The nurses take on a significant number of additional duties during the government’s Fistula Repair Camps, without any additional remuneration. Regrettably, the performance of the camps has been greatly reduced because of COVID-19. A study published in April 2021 by Chimamise *et al.* noted that due to restrictions imposed by the pandemic, only 25 women were repaired in 2020 compared to 313 in 2019.³⁸⁷

380 UN Report of the Secretary-General, Intensifying efforts to end obstetric fistula, 2016 ref: A/71/306 para 8.

381 Amnesty International Interview with Senior Obstetrician, July 2018; Amnesty International Interview with Senior Official in Ministry of Health and Child Care, 2 November 2018.

382 Amnesty International Interview with Senior Obstetrician, July 2018.

383 An obstetrician explained a Surgeon would charge about \$3000 in private practice for equivalent time of a fistula surgery. They may charge 1000 US dollars for a C-Section in a private hospital, the operation takes 30 minutes and in contrast, a fistula surgery may take 4-6 hours, Amnesty International Interview with Senior Obstetrician, 18 July 2018.

³⁸⁴Interview with Doctor at hospital in Chinhoyi , 5 October 2020

385 WAHA covers the costs of surgical experts from DRC and Ethiopia to travel to Zimbabwe as part of the obstetric fistula program.

386 Amnesty International Interview with Senior Obstetrician, 18 July 2018.

³⁸⁷Chimamise C, Munjanja SP, Machinga M, Shiripinda I (2021) Impact of Covid-19 pandemic on obstetric fistula repair program in Zimbabwe. PLoS ONE 16(4): e0249398. <https://doi.org/10.1371/journal.pone.0249398>

8. HUMAN RIGHTS VIOLATIONS

“Maternal mortality and morbidity are a product of discrimination against women, and denial of their human rights, including sexual and reproductive health rights.”³⁸⁸

Obstetric fistula is a devastating maternal morbidity that is preventable and, in most cases, treatable. Amnesty International has found that pregnant women and girls in Zimbabwe remain at unacceptable risk of obstetric fistula and that people who experience this life changing injury face enormous barriers to health information and treatment.

The findings in this report indicate patterns of human rights failures by the government of Zimbabwe to uphold sexual and reproductive health rights and the rights to equality and privacy and to be free from torture and other ill-treatment.

8.1 ZIMBABWE’S HUMAN RIGHTS OBLIGATIONS

The government of Zimbabwe is bound by its commitments under international and regional human rights law and the National Constitution, to ensure women and girls survive pregnancy and childbirth and can live “a life in dignity.”³⁸⁹ Zimbabwe has ratified or acceded to several international and regional human rights treaties which protect the right to sexual and reproductive health and related rights, including the rights to equality, privacy and to be free from torture and other ill-treatment.³⁹⁰ Zimbabwe’s national Constitution also includes a Declaration of Rights, which enshrines a number of fundamental human rights and freedoms.³⁹¹ Section 76 of the Constitution provides the right to access health services and specifically includes reproductive healthcare services.³⁹² The Constitution also protects the right to equality³⁹³ and privacy³⁹⁴

388 Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality,(2012) ref: A/HRC/21/22, para 14.

389 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) para 1; Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality,(2012) ref: A/HRC/21/22, para 8

390 These include the Convention on the Rights of the Child (CRC), International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of Persons with Disabilities and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol) and African Charter on the Rights and Welfare of the Child (ACRWC).

391 Constitution of Zimbabwe Chapter 4.

392 Constitution of Zimbabwe Section 76.

393 Constitution of Zimbabwe Section 56.

394 Constitution of Zimbabwe Section 57, the Right to Privacy, includes at S57 (e) the right not to have their health condition disclosed.

which are necessary to support the full realization of sexual and reproductive health and rights.³⁹⁵ The Constitution recognizes the right to dignity³⁹⁶ and gender equality as a guiding value³⁹⁷ and prohibits discrimination on grounds including an individual's sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock.³⁹⁸ The Constitution obligates the State, as well as every institution and agency of the government at every level, to respect, protect, promote and fulfil these rights and freedoms.³⁹⁹

Zimbabwe's Constitution further provides that interpretation of the Declaration of Rights "must take into account international law and all treaties and conventions to which Zimbabwe is a party."⁴⁰⁰ This clause has been interpreted by Zimbabwe's Constitutional Court to support a purposive interpretation of Zimbabwe's Constitution and legislation to ensure alignment with the country's commitments under international human rights law.⁴⁰¹

8.1.1 OBLIGATION TO PREVENT OBSTETRIC FISTULA

The Committee on Economic, Social and Cultural Rights (ESCR Committee) has emphasised that ensuring access to reproductive, maternal and child health care is a core obligation under the right to health; meaning it is immediate, non-derogable and that a State cannot "under any circumstances whatsoever, justify its non-compliance".⁴⁰² The Committee have also clarified other core obligations that are relevant to the right to sexual and reproductive health,⁴⁰³ and which are discussed below in relation to the obligation on Zimbabwe to prevent and ensure treatment of obstetric fistula.

In guidance on the steps to be taken by States Parties to realise the right to health, the ESCR Committee has elaborated that provisions under the International Covenant on Economic, Social and Cultural Rights (ICESCR) aimed at the "reduction of the stillbirth rate and of infant mortality and for the healthy development of the child"⁴⁰⁴ (Article 12.2 (a)), are related to "the right to maternal, child and reproductive health".⁴⁰⁵ As such, States Parties are required to implement measures "including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."⁴⁰⁶ Also of relevance, the Committee has stressed that the ICESCR requires that States take steps towards the "creation of conditions which would assure to all medical service and medical attention in the event of sickness",⁴⁰⁷ and that States are obligated to ensure the "provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education".⁴⁰⁸

The right to health is also protected under the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW),⁴⁰⁹ which requires States to ensure "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".⁴¹⁰ The CEDAW Committee has previously raised concerns on Zimbabwe's high maternal mortality rate, and "women's limited access to quality reproductive

395 The ESCR Committee has confirmed that "the right to sexual and reproductive health is...indivisible from and interdependent with other human rights." Noting in particular, "civil and political rights underpinning the physical and mental integrity of individuals and their autonomy, such as the right to life; liberty and security of person; freedom from torture and other cruel, inhuman or degrading treatment; privacy and respect for family life; and non-discrimination and equality." CESCR Committee General Comment 22 at para. 10.

396 The right to dignity is expressly protected in the Constitution (S51)396 and cannot be limited by any law, (S86 (3) (b)).

397 Constitution of Zimbabwe Section 3 (g) and see also Section 56 (2) 'Women and men have the right to equal treatment including to the right to equal opportunities in political, economic, cultural and social spheres.'

398 Constitution of Zimbabwe Section 56 (3) states that "Every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their nationality, race, colour, tribe, place of birth, ethnic or social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock."

399 Constitution of Zimbabwe Section 44.

400 Constitution of Zimbabwe Section 46 1 (c), which provides: "When interpreting this Chapter, a court, tribunal, forum or body must take into account international law and all treaties and conventions to which Zimbabwe is a party."

401 Judgment No. CCZ 12/2015 Const. Application No. 79/14 *Loveness Mudzuru and Another v Minister of Justice, Legal & Parliamentary Affairs and Others*, where the Court relied on Zimbabwe's obligations under both the CRC and the African Charter on the Rights and Welfare of the Child (ACRWC) when finding that child marriage violated the Constitution, noting, for example, "The meaning of s 78(1) of the Constitution is not ascertainable without regard being had to the context of the obligations undertaken by Zimbabwe under the international treaties and conventions on matters of marriage and family relations at the time it was enacted on 22 May 2013."

402 CESCR, General Comment 14, para 47.

403 CESCR, General Comment 22, para 49

404 ICESCR article 12.2 (a)): "The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;"

405 CESCR, General Comment 14, para 14.

406 CESCR, General Comment 14, para 14.

407 ICESCR article 12.2 (d)).

408 CESCR General Comment 14, para 12, elaborating on Article 12.2 (d): The right to health facilities, goods and services.

409 Convention on the Elimination of all Forms of Discrimination Against Women, Article 12.

410 Convention on the Elimination of all Forms of Discrimination Against Women, Article 12 (2).

and sexual health services, especially in rural and remote areas.”⁴¹¹ Similarly, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol), requires States to “ensure that the right to health of women, including sexual and reproductive health is respected and promoted.”⁴¹² The Protocol specifically imposes the obligation on States Parties to “provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas”⁴¹³ and to “establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding”.⁴¹⁴

The right to health of girls is also protected by the Convention on the Rights of the Child (CRC). Article 24(2) (d) obliges States “To ensure appropriate pre-natal and post-natal health care for mothers”⁴¹⁵ and in CRC General Comment 15 the CRC Committee noted that “preventable maternal mortality and morbidity constitute grave violations of the human rights of women and girls and pose serious threats to their own and their children’s right to health”⁴¹⁶.

The cases highlighted in this report are indicative of Zimbabwe’s continued failures to meet these necessary human rights standards.

8.1.2 BARRIERS TO EMERGENCY OBSTETRIC CARE AND SKILLED BIRTH ATTENDANCE

Under the right to health, States are required to ensure that health services, goods, facilities and programs are available, accessible, acceptable and of quality.⁴¹⁷ The ESCR Committee has elaborated that in relation to sexual and reproductive health, this requirement includes providing a sufficient number of “trained medical and professional personnel and skilled providers” and emergency medicines and that the “fullest possible range of sexual and reproductive health care” is provided to the population.⁴¹⁸ The African Commission on Human and People’s Rights (the African Commission) has stressed the obligation on States Parties “to provide [sexual and reproductive health-care] services that are comprehensive, integrated and rights-based”.⁴¹⁹ The CEDAW Committee has previously called on the government of Zimbabwe “to raise awareness of, and increase, women’s access to health care facilities and medical assistance by trained personnel, especially in rural and remote areas.”⁴²⁰ Under these international human rights standards, barriers faced by women and girls include any requirements or conditions that disadvantage their access, such as unaffordable fees, distance from health facilities and the absence of convenient and affordable public transport.⁴²¹

This report has raised urgent concerns regarding the failure of the government of Zimbabwe to meet these obligations. A key barrier to emergency obstetric care is the prevalence of home births without skilled assistance, identified in this report for reasons of cultural preferences, religious beliefs, economic constraints, lack of decision-making power and fears of poor care from the formal health system. Additionally, in relation to the accessibility of care, this report has raised urgent concerns that the on-going crisis in the health system in Zimbabwe, the impact of COVID-19 and the related political and economic instability in the country, have significantly undermined pregnant people’s access to affordable and quality maternal health services.

COST BARRIERS

Affordability is a key aspect of accessibility, and the ESCR Committee have repeated their emphasis that States must “ensure that individuals and families are not disproportionately burdened with health

411 CEDAW Committee Concluding Observations 2012, para 33, ref: CEDAW/C/ZWE/CO/2-5

412 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, Article 14.

413 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, Article 14 (2)(a)

414 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, Article 14.2 (b).

415 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>

416 UN Committee on the Rights of the Child (CRC), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15, available at: <https://www.refworld.org/docid/51ef9e134.html>

417 CESCR General Comment 14, para 12

418 CESCR, General Comment 22, para 12.

419 African Commission, 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 29.

420 CEDAW Committee Concluding Observations 2012, para 34 (b), ref: CEDAW/C/ZWE/CO/2-5; Maputo Protocol Article 14 (2).

421 CEDAW Committee, General Recommendation 24, para 21; Maputo Protocol 14 (2) (a) and (b) and see further the African Commission General Comment No. 2 on article 14(1)(a), (b), (c) and (f) and article 14(2)(a) and (c).

expenses”.⁴²² The ESCR Committee has advised that essential goods and services should be provided without costs where possible,⁴²³ and has elaborated that States must “guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups.”⁴²⁴ Similarly, the OHCHR has warned that out-of-pocket costs cannot impede accessibility of care, irrespective of whether services are provided by public or private facilities.⁴²⁵

Hyper-inflation in Zimbabwe in 2019 significantly increased the costs of health goods and services, while devaluing the wages for health care personnel. However, the government’s failure to allocate sufficient budgetary funding to the health system and to adequately resource its own commitment to remove fees for maternal health services, is a key factor in the cost barriers. Local authority clinics continue to charge fees for antenatal care and delivery, while hospitals that are providing free services have become severely overcrowded. Zimbabwe has an obligation to allocate the maximum available resources towards realizing the right to health.⁴²⁶ To this end, the OHCHR has clarified the need for States to “adopt a human rights-based approach to identifying budgetary needs and allocations.”⁴²⁷ The ESCR Committee has also emphasised that the requirement on States Parties to develop, implement and allocate adequate budget allocation to national action plans on sexual and reproductive health is another core obligation under the right to health.⁴²⁸ However, Ministry of Finance data indicates significant shortfalls in the Ministry of Health and Child Care’s expenditure, against approved allocations.⁴²⁹ The Special Rapporteur on violence against women, has advised that “[t]he failure of States to dedicate adequate resources to women’s specific health needs is a violation of women’s right to be free from discrimination.”⁴³⁰ Human rights treaty bodies have called for States to take positive measures to create an enabling environment that improves the social conditions, such as poverty and unemployment, which impact women’s right to equality in health care.⁴³¹

The Special Rapporteur on violence against women has also stressed that “[i]n the context of reproductive care and childbirth, health systems must have the necessary budgetary resources needed to provide quality, accessible reproductive and maternal healthcare thus ensuring that women’s reproductive health needs and interests are met during childbirth... and in other sexual and reproductive health contexts.”⁴³² Emphasizing the obligation on States to “devote the maximum available resources to sexual and reproductive health, including maternal health and childbirth programmes” the Special Rapporteur has called for them to “allocate adequate funding, staffing and equipment for maternity care wards and facilities, in line with international human rights law.”⁴³³

TRANSPORT BARRIERS

This report has documented historical and recent cases which are indicative of some of the challenges pregnant people face when they are unable to access transport in medical emergencies. The lack of available emergency medical transport and the high costs of private transport to health facilities increase delays to skilled maternal care and emergency health services, especially for women and girls in remote and

422 CESCR, General Comment 22, para 17 and citing Committee on Economic, Social and Cultural Rights general comment No. 14, para. 19.

423 CESCR, General Comment 22, para 17 and citing Committee on Economic, Social and Cultural Rights general comment No. 14, para. 19.

424 CESCR, General Comment 22, para 49 (c).

425 Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, (2012) ref: A/HRC/21/22, para. 46.

426 OHCHR, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, U.N. Doc. A/HRC/21/22 (2012), para. 45. U.N. Committee on Economic, Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, para. 33.

427 OHCHR, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, U.N. Doc. A/HRC/21/22 (2012), pgs. 4-8.

428 Committee on Economic, Social and Cultural Rights, 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), para 49 (b).

429 Ministry of Finance and Economic Development data indicated the 2019 National Budget allocation to Health was proposed at ZWL\$6.5 billion, by September 2019, only ZWL702 million had been spent, www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&id=54&Itemid=787

430 Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, UN ref: A/74/137, para 39.

431 Human Rights Committee, Concluding Observations: Kyrgyzstan, para. 401, U.N. Doc. A/55/40 (2000); CEDAW Committee, General Recommendation 25 (2004) on temporary special measures (Article 4), para. 81; CRC General Comment 15 (, para. 10.

432 Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, UN ref: A/74/137, para 76

433 Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, UN ref: A/74/137, para 80.

rural areas and/or who are living in poverty.⁴³⁴ The ESCR Committee has emphasized that States must take “positive measures” to ensure that health services and information are accessible, especially for marginalized people, including “persons living in rural and remote areas”.⁴³⁵ Likewise, the Maputo Protocol specifically requires States Parties to make health services accessible and recognizes the barriers to health services faced by rural women.⁴³⁶

DECISION MAKING ON ACCESS TO SKILLED BIRTH ASSISTANCE

Amnesty International found that in many cases, women and girls were denied the opportunity to make informed decisions on where to give birth and whether to access skilled medical assistance. In this report, cultural and religious preferences for home births were found to be linked to pervasive gender inequalities and stereotypes related to women and girls’ sexuality and their perceived role as mothers.

The principle of accessibility of the right to health, includes the right to seek, receive and impart information and ideas concerning health issues.⁴³⁷ The ESCR Committee has recognised that pervasive inequalities and unequal power distribution often “limits the choices that individuals can exercise with respect to their sexual and reproductive health”.⁴³⁸ The ESCR Committee has emphasised that the obligation on States to fulfil the right to health includes the duty to tackle “[s]ocial misconceptions, prejudices and taboos about... pregnancy, delivery” to ensure they do not “obstruct an individual’s enjoyment of the right to sexual and reproductive health.”⁴³⁹

The African Commission has also stressed that “[t]he right to dignity enshrines the freedom to make personal decisions without interference from the State or non-state actors” and have recognised that women’s “right to make personal decisions involves taking into account or not the beliefs, traditions, values and cultural or religious practices, and the right to question or to ignore them.”⁴⁴⁰

The CRC Committee, CEDAW Committee, ESCR Committee and the Human Rights Committee have urged States to adopt measures to eliminate gender stereotypes about women in family and society, and address discrimination and practices that disproportionately impact women.⁴⁴¹ The ESCR Committee has recognised that “Gender-based stereotypes, assumptions and expectations of women as men’s subordinates and of women’s role as only caregivers and mothers in particular, are obstacles to substantive gender equality including the equal right to sexual and reproductive health and need to be modified or eliminated, as does men’s role only as heads of the household and breadwinners.”⁴⁴²

The ESCR Committee has stressed the obligation on States to “take affirmative measures to eradicate social barriers in terms of norms or beliefs that inhibit individuals...from autonomously exercising their right to sexual and reproductive health.”⁴⁴³ Examples of affirmative measures include the “crucial role of education and awareness-raising”,⁴⁴⁴ which is required as part of the obligation to eliminate stereotypes under the Maputo Protocol.⁴⁴⁵ The CRC and CEDAW Committees have similarly emphasized the importance of

434 Such challenges are well-recognised as a barrier to skilled birth assistance and emergency obstetric care, see for example, Geleto et al. Barriers to access and utilization of emergency obstetric care at health facilities in sub-Saharan Africa: a systematic review of literature, *Systematic Reviews* December 2018, 7:183; Mocumbi S. et al, *Obstetric fistulae in southern Mozambique*: 434 Thaddeus and Maine 1994.

435 Committee on Economic, Social and Cultural Rights, 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), para 12.

436 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, Article 14 (2) (a)

437 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 12.

438 Committee on Economic, Social and Cultural Rights, 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), para 8.

439 Committee on Economic, Social and Cultural Rights, 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), para 48

440 African Commission, 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 24

441 Human Rights Committee, Concluding Observations: Cape Verde, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012); Jordan, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010); Canada, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999); CEDAW Committee, General Recommendation 25 (2004) on temporary special measures (Article 4), para. 10; CRC General Comment 15 para. 10.

442 Committee on Economic, Social and Cultural Rights, 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), para 27, referring to CEDAW, Art. 5.

443 Committee on Economic, Social and Cultural Rights, 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), para 48, and see also at para 35: “The Committee has confirmed States must “take measures to rectify, entrenched social norms and power structures that impair the equal exercise of that right, such as gender roles, which have an impact on the social determinants of health. Such measures must address and eliminate discriminatory stereotypes, assumptions and norms concerning sexuality and reproduction that underlie restrictive laws and undermine the realization of sexual and reproductive health”.

444 Frans Viljoen, *An Introduction to the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa*, 16 Wash. & Lee J. Civil Rts. & Soc. Just. 11 (2009) at page 31.

445 Frans Viljoen, *An Introduction to the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa*, 16 Wash. & Lee J. Civil Rts. & Soc. Just. 11 (2009) at page 31.

comprehensive and holistic “public information and awareness-raising campaigns”⁴⁴⁶ as “part of long-term strategies to eliminate harmful practices.”⁴⁴⁷ The Special Rapporteur on violence against women has warned that such “harmful stereotypes are often justified by the belief that childbirth is an event that requires suffering” and that women’s “own physical and emotional health is not valued”.⁴⁴⁸

Challenging the gender discrimination at the root cause of obstetric fistula requires sustained effort and political will. However, despite the urgency of Zimbabwe’s obligations, the government has consistently failed to act. In 2012, the CEDAW Committee expressed “serious concern” at “the persistence of harmful norms, practices and traditions, patriarchal attitudes and deep-rooted [gender] stereotypes...in all spheres of life,”⁴⁴⁹ in Zimbabwe and the State’s “limited efforts to address such discriminatory practices” and the failure to take “sustained measures to modify or eliminate stereotypes and harmful practices.”⁴⁵⁰ Similarly, in 2016, the CRC Committee emphasized its serious concern “in particular [for] adolescent girls, who suffer marginalization and gender stereotyping”⁴⁵¹ and that “the State party has not taken sustained measures to modify or eliminate stereotypes and harmful practices”.⁴⁵²

The ESCR Committee has warned that States’ failure to “take affirmative measures to eradicate...practical and social barriers to the enjoyment of the right to sexual and reproductive health” amount to violations of the obligation to fulfil the right to sexual and reproductive health.⁴⁵³

8.1.3 OBLIGATION TO PROTECT PREGNANT PEOPLE FROM GENDER-BASED VIOLENCE AND MISTREATMENT DURING HOME BIRTHS

Several serious cases are documented in this report relating to abuse of women and girls during labour perpetrated outside of health facilities and by private individuals, often family members. Women reported suffering from verbal and physical abuse, including being made to stay in uncomfortable and painful birthing positions for long periods of time. Such abusive treatment is an example of discrimination against women and girls that may amount to torture or other ill-treatment.⁴⁵⁴ The prevalence of cases of abuse within a small study sample size, such as for this report, indicates that many other women and girls in Zimbabwe may have experienced similar treatment. Yet, such cases are rarely documented or framed as human rights violations.⁴⁵⁵ This report has raised alarm that such cases may be more prevalent in contexts of early, child and forced marriage.

The right to health contains core freedoms which “include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference...”⁴⁵⁶ Amnesty International found that where women lacked equality and the ability to make decisions over where to give birth and when to seek medical help, they were at risk of mistreatment and abuse, in addition to being exposed to maternal injuries, such as obstetric fistula. The Special Rapporteur on violence against women has clarified that mistreatment and violence against women during pregnancy and childbirth, “not only violates the rights of women to live a life free from violence but can also threaten their rights to life, health, bodily integrity, privacy, autonomy and freedom from discrimination”.⁴⁵⁷

A State can be responsible for violations of rights by third parties and private actors if it failed to act with due diligence to prevent these violations, protect people from abuse or investigate and punish those

446 CRC Committee Concluding Observations to Zimbabwe 2016. Para 27, ref: CRC/C/ZWE/CO/2

447 Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, para 74, ref: CEDAW/C/GC/31-CRC/C/GC/18

448 Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, UN ref: A/74/137, para 46.

449 CEDAW Committee Concluding Observations to Zimbabwe 2012 para 21, ref: CEDAW/C/ZWE/CO/2-5

450 CEDAW Committee Concluding Observations to Zimbabwe 2012 para 21, ref: CEDAW/C/ZWE/CO/2-5

451 CRC Committee Concluding Observations to Zimbabwe 2016. Para 26, ref: CRC/C/ZWE/CO/2

452 CRC Committee Concluding Observations to Zimbabwe 2016. Para 46, ref: CRC/C/ZWE/CO/2

453 Committee on Economic, Social and Cultural Rights, 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), para 63.

454 The Special Rapporteur on Torture notes “Gender-based discrimination includes violence directed against or disproportionately affecting women (A/47/38), para 9; The CEDAW Committee has similarly found that gender-based violence is a form of gender-based discrimination, CEDAW Committee, General Recommendation 19.

455 Alisha Bjerregaard and Christina Zampas, UN Rapporteur denounces abuses against women during childbirth, November 1, 2019 *ReproHealthLaw* Blog: <https://ilg2.org/2019/11/01/un-rapporteur-denounces-abuses-against-women-during-childbirth/>

456 Committee on Economic, Social and Cultural Rights, 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), para 8.

457 Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, UN ref: A/74/137, para 8.

responsible.⁴⁵⁸ The CRC and CEDAW Committees have emphasised the importance of due diligence obligations under the respective Conventions, which require States to “prevent violence or violations of human rights, protect victims and witnesses from violations, investigate and punish those responsible, including private actors, and provide access to redress for human rights violations”⁴⁵⁹ and to “ensure that private actors do not engage in discrimination against women and girls, including gender-based violence.”⁴⁶⁰ Furthermore, this obligation is immediate and is not subject to available resources.⁴⁶¹

The ESCR Committee has also emphasized that the obligation on States to protect the right to sexual and reproductive health requires them “to take measures to prevent third parties from directly or indirectly interfering with the enjoyment of the right”.⁴⁶² In guidance on the substance of the right to the highest attainable standard of sexual and reproductive health, the ESCR Committee have emphasised that it is a core obligation that States “enact and enforce the legal prohibition of harmful practices and gender-based violence”,⁴⁶³ “including domestic violence... harmful practices...[and] child and forced marriages...”⁴⁶⁴ Furthermore, States must ensure “effective protection from all forms of violence, torture and discrimination and other human rights violations that negatively impact on the right to sexual and reproductive health.”⁴⁶⁵ The Special Rapporteur on the right to health has stressed that States must “ensure that neither third parties nor harmful social or traditional practices interfere with access to prenatal and post-natal care and family-planning or curtail access to some or all contraceptive methods”.⁴⁶⁶

The ESCR Committee has called on States to take “preventive, promotional and remedial action to shield all individuals from the harmful practices and norms and gender-based violence that deny them their full sexual and reproductive health”,⁴⁶⁷ including by using laws and policies to prohibit “conducts by third-parties that cause harm to physical and mental integrity or undermine the full enjoyment of the right to sexual and reproductive health”.⁴⁶⁸

HARMFUL PRACTICES

This report has highlighted the underlying gender discrimination and stereotypes that perpetuate cultural and religious preferences for home births. Amnesty International has raised alarm that some of the cases of abuse that women have described in these contexts amount to gender-based violence and may amount to torture or other ill-treatment. The abuse also meets the criteria of a ‘harmful’ practice, as set out by the CRC and CEDAW Committees,⁴⁶⁹ in so far as:

- The abuse during labour has resulted in a denial of the dignity and integrity of the pregnant person and violated their human rights;

458 CEDAW Committee, General Recommendation No. 19 (11th session, 1992) on Violence against Women, para 9; Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, (2012) ref: A/HRC/21/22, para 22, citing “Committee on the Elimination of Discrimination against Women, general recommendation No. 28, para. 13. See also Committee on the Elimination of Discrimination against Women, general recommendation No. 19, para. 9, and CEDAW/C/49/D/17/2008, paras 7.5 and 8.”

459 Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, para 11 citing the Committee on the Elimination of Discrimination against Women general recommendations Nos. 19, para. 9; 28, para. 13; 30, para. 15; the views and decisions of the Committee on individual communications and inquiries; and Committee on the Rights of the Child general comment No. 13, para. 5.

460 Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, para 11; CEDAW General Recommendation 19, para 24.

461 E/CN.4/2000/4, para 43 and 44; CEDAW/C/49/D/17/2008, para. 7.6; and Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, para 31, ref: CEDAW/C/GC/31-CRC/C/GC/18

462 Committee on Economic, Social and Cultural Rights, 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), para 42

463 Committee on Economic, Social and Cultural Rights, 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), para 49 (d).

464 Committee on Economic, Social and Cultural Rights, 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), para 59.

465 Committee on Economic, Social and Cultural Rights, 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), para 7, referencing ESCR Committee’s General Comment No. 14.

466 Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/66/254, 3 August 2011, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement>, at para 55.

467 Committee on Economic, Social and Cultural Rights, 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), para 29

468 Committee on Economic, Social and Cultural Rights, 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), para 42.

469 The joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, ref: CEDAW/C/GC/31-CRC/C/GC/18, sets out the criteria of a ‘harmful’ practice, at para 16.

- The gender-based violence is an example of discrimination, which has resulted in serious negative consequences, including “physical, psychological, economic and social harm”;
- The treatment is rooted in “traditional, re-emerging or emerging practices that are prescribed and/or kept in place by social norms that perpetuate male dominance and inequality of women and children, on the basis of sex, gender, age and other intersecting factors”; and
- “They are imposed on women and children by family members, community members or society at large, regardless of whether the victim provides, or is able to provide, full, free and informed consent.”⁴⁷⁰

It is a core obligation, under the right to health, that Zimbabwe must immediately “enact and enforce the legal prohibition of harmful practices and gender-based violence, including female genital mutilation, child and forced marriages and domestic and sexual violence including marital rape, while ensuring privacy, confidentiality and free, informed and responsible decision-making, without coercion, discrimination or fear of violence, on individual’s sexual and reproductive needs and behaviours”.⁴⁷¹ The Maputo Protocol also requires States to enact and enforce laws to prohibit all forms of violence against women, take measures to prevent violence, punish the perpetrators of violence against women and implement programmes for the rehabilitation and reparation for women victims.⁴⁷² This obligation extends to discrimination based on harmful practices endangering the health and well-being of women.⁴⁷³

In the context of addressing harmful practices, the CRC and CEDAW Committees have emphasized that “girls need to be equipped with the skills and competencies necessary to assert their rights, including to make autonomous and informed decisions and choices about their own lives.”⁴⁷⁴

CHILD MARRIAGE

Child marriage is recognised as a harmful practice and a human rights violation.⁴⁷⁵ As this report documents, the continued practice of child marriage puts girls’ health and futures at risk. Zimbabwe has an obligation to enforce the prohibition of marriage between any person under the age of 18, as set out in the National Constitution and under commitments made in the Maputo Protocol (article 6) and the African Children’s Charter (article 21).⁴⁷⁶ The ESCR Committee has also emphasized that it is a core obligation under the right to health that the State “must immediately “enact and enforce the legal prohibition of harmful practices” including child marriage.”⁴⁷⁷

In 2016, the Constitutional Court of Zimbabwe ruled that marriages below the age of 18 were unconstitutional.⁴⁷⁸ However, the government has been slow to act.⁴⁷⁹ Three years after the judgment, the government is yet to outlaw child marriages, which continue to manifest as a violation of the obligation to protect the rights of women and girls. In 2018, the African Commission and the African Committee of Experts on the Rights and Welfare of the Child, released a joint general comment, on Ending Child Marriage, which warns of the increased risk of domestic violence and social isolation associated with child marriage and recognizes that such risks can also underpin the barriers to maternal health services which contribute to avoidable maternal morbidity and mortality.⁴⁸⁰ The Special Rapporteur on torture and other cruel, inhuman

470 The joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, ref: CEDAW/C/GC/31-CRC/C/GC/18, sets out the criteria of a ‘harmful’ practice, at para 16.

471 Committee on Economic, Social and Cultural Rights, 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), para 49 (d).

472 Article 4 (2), Maputo Protocol.

473 Christine Ocran, Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 15 *Afr. J. Int’l & Comp. L.* 147 (2007), page 148.

474 Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices 2014, para 61.

475 Article 21(2) of the African Children’s Charter prohibits the betrothal and marriage of all children before the age of 18.

476 Article 21(2) of the African Children’s Charter prohibits the betrothal and marriage of all children before the age of 18.

477 Committee on Economic, Social and Cultural Rights, 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), para 49 (d).

478 *Loveness Mudzuru and Another v Minister of Justice and Others* 2016, ruled that Section 22(1) of the Marriage Act and The Customary Marriages Act [Chapter 5:07] The Court confirmed the legal age for marriage as 18 for both girls and boys from the date of the judgment

479 The Marriages Bill was published in July 2019, which aims to consolidate the law relating to customary and civil marriages within a single Act of Parliament and includes provision to prohibit marriages involving children. However, the Bill is contentious, and Zimbabwe remains uncompliant with the court’s judgment to prevent or prosecute subsequent cases of child marriage, www.veritaszim.net/node/3606

480 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, on Ending Child Marriage, 2017, at page 8.

or degrading treatment or punishment has highlighted that “child and forced marriage...are acknowledged as forms of gender-based violence that constitute ill-treatment and torture.”⁴⁸¹

8.1.4 THE PROHIBITION OF TORTURE AND OTHER CRUEL, INHUMAN AND DEGRADING TREATMENT

The government of Zimbabwe has an obligation to protect women and girls from torture and other cruel, inhuman or degrading treatment or punishment, which are all absolutely prohibited under international law.⁴⁸² The failure of States to protect sexual and reproductive rights has been found to violate the absolute prohibition of torture and other cruel, inhuman or degrading treatment in several cases.⁴⁸³ International and regional human rights bodies have recognized that States have a duty to protect persons not only from acts by state officials but also those committed by “non-state actors”, including private individuals.⁴⁸⁴ States must take reasonable steps to avoid a risk of torture and other ill-treatment of which the authorities know or should know. The Committee on Torture has applied this principle to States parties’ failure to prevent and protect victims from gender-based violence.⁴⁸⁵ For example, if a State does not exercise due diligence and equal protection in preventing and punishing domestic violence, then it bears responsibility for the abuses.⁴⁸⁶ Torture is defined in Article 1(1) of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and requires an act meet the following four requirements:

- (1) It must be intentional;
- (2) It must cause severe pain or suffering, whether physical or mental;
- (3) It must be carried out for a specific purpose - including for a reason based on discrimination; and
- (4) It must be carried by an official or at least with a degree of official involvement or acquiescence.

As noted above, the cases in this report are examples of gender-based discrimination. The suffering inflicted was intentional and has resulted in severe pain and suffering. The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has clarified that “[t]he purpose and intent elements of the definition of torture are always fulfilled if an act is gender-specific or perpetrated against persons on the basis of their sex.”⁴⁸⁷ The Special Rapporteur has further highlighted that discrimination and ill-treatment “is often accepted by communities due to entrenched discriminatory perceptions”.⁴⁸⁸ Discrimination against certain groups is recognised to increase their risk of torture or other ill-treatment and violence in the community and family.⁴⁸⁹

Following the recommendations of the Special Rapporteur, the government of Zimbabwe, in accordance with its obligations under international human rights law, “must exercise due diligence to prohibit, prevent and redress torture and ill-treatment whenever there are reasonable grounds to believe that such acts are being committed by private actors. This includes an obligation to prevent, investigate and punish acts of violence against women”.⁴⁹⁰

481 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2016, ref: A/HRC/31/57, para 58

482 The prohibition of torture and other ill-treatment has been included in many international and regional human rights treaties, with the primary one being the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, but also Article 5 of the Universal Declaration, Article 7 of the ICCPR and Article 5 of the African Charter on Human and People's Rights. While Zimbabwe has ratified these treaties, it is important to note that the prohibition of torture is a rule of customary international law, meaning it is binding on all States even if they are not party to treaties containing the provision, see Amnesty International, *Combating Torture and other Ill-Treatment*, 2016, Index: POL 30/4036/2016, page 55.

483 Gender perspectives on Torture: Law and Practice, Center for Human Rights & Humanitarian Law American University Washington College of Law, page 276.

484 Amnesty International, *Combating Torture and other Ill-Treatment*, 2016, Index: POL 30/4036/2016.

485 CAT Committee, General Comment 2, para 18. See also Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/31/57 (2016) paras 10-11.

486 Amnesty International, *Combating Torture and other Ill-Treatment*, 2016, Index: POL 30/4036/2016, at page 117.

487 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2016 ref A/HRC/31/57, para 8.

488 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2016 ref A/HRC/31/57, Para 9.

489 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2016 ref A/HRC/31/57, Para 9.

490 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2016 ref A/HRC/31/57 para 10, citing the Committee on the Elimination of Discrimination against Women, general comment No. 28 (2010) on the core obligations of States parties under article 2 of the Convention.

Amnesty International has raised concerns that cases of abuse of women while in labour may be pervasive and known to the government of Zimbabwe. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has clarified that in “cases where States are or ought to be aware of patterns of continuous and serious abuse in a particular region or community, due diligence obligations require taking reasonable measures to alter outcomes and mitigate harms, ranging from the strengthening of domestic laws and their implementation to effective criminal proceedings and other protective and deterrent measures in individual cases.”⁴⁹¹

The Zimbabwean authorities have an obligation to take all appropriate measures to address negative gender stereotypes, inequalities and related social or cultural norms concerning sexuality and reproduction, which lead to gender and other forms of discrimination and may amount to torture or other ill-treatment.⁴⁹²

8.1.5 OBLIGATION TO ENSURE ACCESS TO JUSTICE, INFORMATION AND TREATMENT FOR OBSTETRIC FISTULA

Zimbabwe’s Ministry of Health and Child Care has made progress in increasing access to treatment for obstetric fistula, through the development of surgical Camps at Chinhoyi Provincial Hospital since 2015. However, one major shortfall of the program is the limited circulation of information about the Obstetric Fistula Camps. Amnesty International found the government has failed to provide information about the obstetric fistula repair program to all health facilities, throughout the country, and there is limited information at community level about the causes and treatment for obstetric fistula. Referral rates to the Ministry of Health and Child Care fistula program remain low.⁴⁹³ Amnesty International found that most media promotion of the government’s fistula program has centred on Harare. There is concern that the budget allocated to the Ministry of Health and Child Care for communication and education was underspent as of September 2019.⁴⁹⁴ Such limitations perpetuate the challenges to identify the scale of the problem of obstetric fistula and the government of Zimbabwe is yet to undertake research into the demographic root factors which drive obstetric fistula in the country.

ACCESS TO INFORMATION

The UN High Commissioner for Human Rights has stressed that “[i]n a human rights framework, women are active agents who are entitled to participate in decisions that affect their sexual and reproductive health.”⁴⁹⁵ In order to claim their rights, women and girls, families and communities need access to information. The provision of education and access to information about the main health problems in the community is a core obligation under the right to health.⁴⁹⁶ Where States “fail to take measures to ensure that up-to-date, accurate information on sexual and reproductive health is publicly available and accessible to all individuals”, they are in violation of the obligation to fulfil the right to health.⁴⁹⁷

The Maputo Protocol specifically imposes the obligation on State Parties to “provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas”.⁴⁹⁸ The Special Rapporteur on the right to health has said: “Health information needs to be of the highest quality, freely available on a non-discriminatory basis, accessible to the individual’s particular communication needs (including special physical or cultural circumstances), and presented in a manner culturally and otherwise acceptable to the person”.⁴⁹⁹

In an effort to promote, protect and fulfil the right to information the government of Zimbabwe is encouraged to increase platforms which they can disseminate information on obstetric fistula. Community radio stations

491 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2016, ref: A/HRC/31/57, para 56, citing Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices (2014).

492 CEDAW and CRC Committees joint General Comment No. 31 and No. 18 paras 6 and 31 and citing CEDAW articles 4 (1) 14; art. 5 (a); and art. 16 (2); see also CESCR Committee General Comment 22 para 35.

493 www.unicef.org/zimbabwe/media/1031/file/Health%20Development%20Fund.pdf page 33

494 Ministry of Finance and Economic Development, 2020 Proposed Estimates of Expenditure, 14 November 2019, page 217, available: www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&id=54&Itemid=787

495 Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality,(2012) ref: A/HRC/21/22, para 17.

496 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 43.

497 Committee on Economic, Social and Cultural Rights, 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), para 63.

498 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, Article 14 (2) (a).

499 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, ref:A/64/272, (2009) para 23.

can collaborate with various government departments and organisations to produce content that is critical for community empowerment. They can cover issues ranging from health to gender relations and target isolated and marginalised community members who currently have limited access to information⁵⁰⁰.

ACCESS TO CARE AND TREATMENT

The ESCR Committee has stated that the right to health imposes certain obligations, known as core obligations, which are immediate, non-derogable and with which a State cannot “under any circumstances whatsoever, justify its non-compliance”.⁵⁰¹ These include the obligation of States to ensure the right of access to health facilities, goods and services on a non-discriminatory basis and to ensure reproductive, maternal and child health care.⁵⁰²

Despite the positive examples of care and support some women received, Amnesty found that many women who had visited government health facilities for assistance with the conditions of incontinence related to childbirth injuries, had been given misinformation about their diagnosis and/or potential treatment. This is concerning as one of the core obligations of the right to health is promotion of “appropriate training for health personnel, including education on health and human rights”.⁵⁰³ States must also ensure that health workers meet appropriate standards of education, skill and ethical codes of conduct and that they are trained to recognize and respond to the specific needs of vulnerable or marginalized groups”.⁵⁰⁴

Women also reported that health fees related to injuries during childbirth were prohibitively expensive. Expenses included astronomical hospital bills for post-natal care, in addition to quotes for obstetric fistula surgery as high as between US\$150 to US\$450, which was an insurmountable barrier for nearly all women. Furthermore, women and girls with childbirth related incontinence, including obstetric fistula, need access to health goods including barrier creams, antibiotics and pain medication and sanitary products that are essential for their health and wellbeing, yet few could afford these vital commodities. Women in poverty are likely to be disproportionately impacted by the costs of health seeking because of obstetric fistula.⁵⁰⁵ The government of Zimbabwe is also failing to uphold the core obligation, under the right to sexual and reproductive health, to “guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups”.⁵⁰⁶

It is commendable that the Ministry of Health and Child Care have worked with partners to provide access to obstetric fistula surgery for over 300 women in 2019, free of charge⁵⁰⁷. However, more women and girls need to be connected to this programme and health care information, goods and services, should be made available for everyone who is placed on the waiting lists.

The right to dignity is interconnected with the right to equality, non-discrimination and privacy and is a key aspect of the acceptability of maternal and reproductive health services under the right to health.⁵⁰⁸ Article 3 of the Maputo Protocol protects the right to dignity and expressly prohibits any degradation,⁵⁰⁹ while also placing an obligation on States Parties to take measures to protect women “from all forms of violence”.⁵¹⁰

ACCESS TO JUSTICE

Anyone whose right to health has been violated must have access to effective judicial or non-judicial remedies at national and international levels. Victims must also be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.⁵¹¹

500 BEYOND TOKENISM: The Need to License Community Radio Stations In Zimbabwe, AFR 46/1613/2015, Amnesty International, 2015

501 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 47.

502 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), paras 43 and 44.

503 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 44 (e).

504 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 35.

505 Committee on Economic, Social and Cultural Rights, 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), para 17 and citing Committee on Economic, Social and Cultural Rights general comment No. 14, para. 19, noting that States “must “ensure that individuals and families are not disproportionately burdened with health expenses”.

506 Committee on Economic, Social and Cultural Rights, 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), para 49 (c).

507 Chimamisse C, Munjanja SP, Machinga M, Shiripinda I (2021) Impact of Covid-19 pandemic on obstetric fistula repair program in Zimbabwe. PLoS ONE 16(4): e0249398. <https://doi.org/10.1371/journal.pone.0249398>

508 CEDAW Committee, Gen. Recommendation No. 24, supra note 10, para. 22.

509 Maputo Protocol Article 3(3) “States Parties shall adopt and implement appropriate measures to prohibit any exploitation or degradation of women.”

510 Maputo protocol Article 3 (4) “States Parties shall adopt and implement appropriate measures to ensure the protection of every woman’s right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence.

511 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 59.

It is a core obligation on States, under the right to health, to “ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health.”⁵¹²

The ESCR Committee has advised that “[w]here third parties contravene the right to sexual and reproductive health, States must ensure that such violations are investigated and prosecuted, and that the perpetrators are held accountable, while the victims of such violations are provided with remedies.”⁵¹³

512 Committee on Economic, Social and Cultural Rights, 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), para 49(h)

513 Committee on Economic, Social and Cultural Rights, 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), para 64.

9. CONCLUSIONS AND RECOMMENDATIONS

Obstetric fistula is a devastating maternal morbidity that is preventable and curable. As this report has documented, women and girls who are pregnant in Zimbabwe remain at unacceptable risk of this life changing injury. Those who have experienced obstetric fistula, face further human rights abuses because of the enormous barriers to accessing information and treatment.

The findings of this report indicate failures by the government of Zimbabwe to uphold women and girls' sexual and reproductive health rights and protect them from abuses of their right to be free from discrimination, violence and torture and other ill-treatment.

Amnesty International found that the government has not allocated sufficient resources to the health sector and despite declaring a policy of free maternal services, has failed to fund or operationalize the initiative. A lack of ambulances and high fuel prices, compound delays reaching and receiving care at health facilities. The situation is urgent as the country weathers the impact of the COVID-19 crisis and barriers to maternal health services are increasing.

Amnesty International further found that economic and cultural challenges undermined women's agency to make decisions on where to give birth. A preference for home births was influenced by traditional practices and the costs associated with giving birth in health facilities. However, in some cases, home births were found to expose pregnant people to dangerous health complications and violence. In some cases, this report has documented serious abuse that may amount to torture and ill-treatment of women and girls committed by private individuals, during labour at home. Women and girls were left with life changing injuries and often hospitalized for weeks or months and faced astronomical bills as a result. The government of Zimbabwe has an urgent obligation to investigate these cases.

The lack of information about the causes and treatment of obstetric fistula was found to increase women's risk of discrimination and abuse within their families and communities. Most women had lived for years with obstetric fistula, or undiagnosed conditions of incontinence related to childbirth, with many thinking they were the only person with the condition. The fear of stigma and discrimination because of their health status led most women to try and keep their incontinence hidden and they all faced isolation and enormous barriers to health information and treatment for obstetric fistula.

In most cases, women were unable to work, and were pushed further into poverty as a result of their maternal injuries. Their health status also increased the risk of domestic violence, including economic abandonment. Without financial assistance and support, it is impossible for most women to afford the essential health commodities needed to bath, wash clothes and prevent blisters and sores.

Despite the success of the Ministry of Health and Child Care fistula programme to provide surgical repair for obstetric fistula, promotion of the program has yet to reach all health facilities, throughout the country. Raising awareness of the causes and treatment of obstetric fistula will help dispel myths and superstition that women with obstetric fistula have been bewitched.

The Ministry of Health and Child Care fistula program provides a positive start for a national information campaign. Women who have received surgery for fistula expressed a desire to be "ambassadors" and work with community members to provide information and help change attitudes. As participants at Amnesty

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Amnesty International

International's community drama and dialogues stressed; "we must teach each other that it [obstetric fistula] is curable"⁵¹⁴

RECOMMENDATIONS

THE GOVERNMENT OF ZIMBABWE SHOULD:

Increase efforts to prevent obstetric fistula by:

- Fully funding and operationalizing the free maternal health care policy, and include post-natal care, including health services related to maternal morbidities, within this policy;
- Ensuring skilled obstetric care is available at all District and Provincial hospitals and that surgical theatres at each of those facilities are operational, staffed and stocked with the equipment and medicines necessary for performing caesarean sections;
- Taking immediate action to prevent, investigate and punish acts of violence and ill-treatment against women during childbirth and ensure that neither third parties nor harmful social or traditional practices interfere with access to prenatal and post-natal care;
- Raising awareness and ensuring the availability of information in communities and families, specifically for husbands, older women and traditional birth assistants, on the causes of obstetric fistula and the importance of giving birth with skilled medical care;
- Undertaking public information and education campaigns, including within media, communities and in schools to transform cultural views, taboos and harmful gender stereotypes, and promote gender equality and information on the right to sexual and reproductive health;
- Increase platforms for disseminating information to the entire society in Zimbabwe on what obstetric fistula is, how to prevent and cure it. The government is encouraged to partners with civil society organisations and media groups to achieve this much needed objective;
- Beginning to include maternal morbidity within health system data and undertaking measures to collate accurate prevalence and incidence data to determine the scale of obstetric fistula in Zimbabwe;
- Developing a national obstetric fistula strategy, which addresses prevention, treatment and rehabilitation of obstetric fistula and ensures the participation of women affected by obstetric fistula in its development;
- Ensuring efficient referrals between health facilities – including by providing and operationalizing inter-facility ambulances – so that women who experience complications during labour can access skilled obstetric care;
- Improving access to sexual and reproductive health information and services, including contraception, and maternal health including pre- and post-natal services, by removing user fees and age-related barriers for adolescents and by amending the Termination of Pregnancy Act (1977) and the Criminal Law Act (2007), to decriminalize abortion in all circumstances as recommended by the African Commission on Human and People's Rights and UN treaty bodies.⁵¹⁵
- Enacting legislation to prohibit child marriage;
- Developing youth-friendly services available at primary health care level, targeting areas where there are particularly high rates of early, child and forced marriage.

Increase efforts to identify and treat women with maternal morbidities, including obstetric fistula, by:

- Developing and urgently disseminating clear guidance for health care providers, including Village Health Workers, and providing training where necessary, on identifying symptoms of obstetric fistula and other maternal morbidities and the treatment options, along with official instructions to

514 Female participant, Community dialogue and drama on Obstetric Fistula, Manicaland province, 6 November 2018.

515 African Commission on Human and People's Rights 18 January 2016, Press Release: Launch Of The Campaign For The Decriminalization Of Abortion In Africa: Women And Girls In Africa Are Counting On Us To Save Their Lives! www.achpr.org/press/2016/01/d287/

ensure all cases are referred to the Ministry of Health and Child Care's waiting list for the Obstetric Fistula Camps for treatment;

- Ensuring that all women who have experienced obstetric fistula are identified and that their health needs are supported for the duration of the waiting period for treatment, through the provision of hygiene and medical products, including creams, pain and infection medications and sanitary/incontinence pads, to ensure women and girls who are affected by child birth related incontinence can continue with education and employment, in particular women in rural and remote areas;
- Improving the coverage and quality of post-partum care and ensuring all such services are provided without fees under the government's free maternal health care policy;

TO THE INTERNATIONAL COMMUNITY:

Provide technical and financial support, including prioritizing access to hygiene and sanitation products for women who are waiting to receive surgery as well as training programmes for doctors providing treatment for women with obstetric fistula.

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“I NEVER THOUGHT I COULD GET HEALED FROM THIS”

BARRIERS TO TREATMENT AND HUMAN RIGHTS ABUSES AGAINST WOMEN AND GIRLS WITH OBSTETRIC FISTULA IN ZIMBABWE

Although repair of obstetric fistula was established as a public health intervention in 2015 in Zimbabwe, research has shown that access to maternal healthcare which could prevent obstetric fistula as well as treatment for obstetric fistula has remained limited for many women and girls in Zimbabwe.

While various social, economic and cultural factors have been found to impact access to quality healthcare which may prevent and repair obstetric fistula, access has been primarily impeded because the government of Zimbabwe, despite declaring a policy of free maternal services, has not adequately funded or operationalised relevant initiatives. The situation has been compounded by COVID-19 as inappropriate state responses have reversed the gains made in previous years.

This report analyses the barriers to access that women in Zimbabwe face in relation to obstetric fistula prevention and treatment and concludes that the government of Zimbabwe has failed to uphold sexual and reproductive health rights and the rights to equality and privacy and to be free from torture and other ill-treatment of women and girls in the country, in direct violation of various commitments it has under international and regional law as well as its own Constitution.