ENHANCING ACCESS TO DECENTRALISED MATERNAL HEALTH CARE SERVICES IN COUNCIL-RUN CLINICS IN ZIMBABWE: LESSONS FROM KENYA

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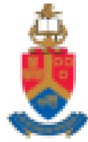

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DEDICATION

This is for my late sister **Vimbai Alice Chikomba**, who always wanted the best for me, and was rooting for me to get into this programme. I love and miss you so much.

ACKNOWLEDGEMENTS

I want to acknowledge the Lord Almighty, the source of my strength and wisdom.

I want to express my gratitude to my supervisors, Dr Michelle Maziwisa and Dr Nkatha Kabira for their tenacity and invaluable contributions in guiding me during the process of writing this dissertation.

My parents, Esther and Waddilove Chikomba, thank you for the prayers, encouragement, and emotional support.

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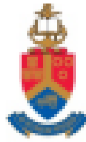
My Kenyan family since day one (Chris and Joshua), thank you so much for everything. To the HRDA Class of 2023, it has been tough, but we pulled through. I am glad to have met and interacted with each one of you.

Above all, I would like to extend my gratitude to the Centre for Human Rights, University of Pretoria for this amazing and life-changing opportunity. I am forever changed.



LIST OF ABBREVIATIONS AND ACRONYMS

AIDS - Acquired Immuno Deficiency Syndrome

CCC - Citizens Coalition for Change

CEDAW- Convention on the Elimination of All forms of Discrimination Against Women

CHW- Community Health Workers

CSOs - Civil Society Organisations

CRC - United Nations Convention on the Rights

DHOs -District Health Offices

ESAP -Economic Structural Adjustment Programme

EU - European Union

FMS - Free Maternal Health Service Policy

GNU - Government of National Unity

GoZ- Government of Zimbabwe

HIV - Human Immunodeficiency Virus

MoHCC - Ministry of Health and Child Care

ICERD - International Convention on the Elimination of all forms of Racial Discrimination

ICESCR - International Covenant on Economic, Social and Cultural Rights

IMF - International Monetary Fund

MDC - Movement for Democratic Change

PPE - Personal Protective Equipment

PHC - Primary Health Care

PMD - Provincial Medical Directorate

PCA – Provincial Councils and Administration Act

RDCs – Rural District Councils Act

SDGs - Sustainable Development Goals

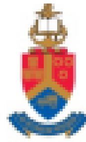
UCs – Urban Councils Act

UNICEF - United Nations International Children's Emergency Fund

UNFPA - United Nations Population Fund

UVP - Urban Voucher Programme

ZANU PF - Zimbabwe African National Union-Patriotic Front



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ABSTRACT

In 2020, during the COVID-19 pandemic, two aggrieved women and the Combined Harare Residents Association took the City of Harare to court for an order compelling the local authority to open its closed clinics. The clinics had been closed due to a lack of funding to acquire personal protective equipment (PPE) and refurbish the dilapidated health infrastructure that could no longer cater for patients needing assistance. This dissertation argues that access to all forms of health services, including sexual reproductive rights encompassing access to maternal healthcare, is essential to any population's survival and continued existence. Health services, including maternal healthcare, must be easily accessible to a country's population up to the lowest local government level. This is achievable through devolution of functions, powers, and authorities to the lowest level of the central government.

This dissertation analyses the causes of pregnant women's failure to access maternal healthcare at council-run clinics in Zimbabwe. It also measures these circumstances against the introduction of devolution in the 2013 Constitution of Zimbabwe, whose objectives include the equitable distribution of resources to all levels of government. Despite the provisions in Chapter 14 of the Constitution, the dissertation concludes that the existing legislative and institutional framework needs to be revised to implement devolution to improve service delivery that benefits local communities, including access to maternal healthcare. There are legislative gaps due to existing Acts of Parliament needing to be updated and requiring alignment with the Constitution, yet there needs to be more political will. Without devolving specific functions to lower tiers of government, they have no fiscal or political autonomy to improve service delivery to their communities independently. It considers Zimbabwe's regional and international obligations on sexual reproductive health rights and observes the dissonance between the current existing legislative framework and practice with regional and international standards. It also draws lessons from Kenya, which has a similar system of devolution and whose Constitution was adopted under a shared-power arrangement, just like Zimbabwe. Finally, the dissertation proffers recommendations, including legislative reforms that introduce institutions to effectively implement devolved functions to improve access to maternal healthcare at the constituency level.

Keywords: maternal healthcare, SRHR, devolution, autonomy, equitable

GLOSSARY OF TERMS

Adequate access - safe, unobstructed access to the location and the specific area(s) in which the services are performed. The adequacy of the access is premised on the availability of healthcare infrastructure.

Adequate healthcare infrastructure - physical facilities that make care accessible; laboratory, training, and other support facilities; reliable supplies of drugs; skilled health workers and professional training systems; and mechanisms to distribute resources and expertise. Access means the services are available, and in adequate supply, and the opportunity to obtain health care exists. Access is established where there are reduced financial, organisational, and social or cultural barriers that limit the utilisation of services. It is measured in terms of affordability, physical accessibility, and acceptability of services and not merely adequacy of supply.

Antenatal care - medical interventions and advice given to women during pregnancy.

Delivery care - the proportion of births attended by skilled health personnel defined as the percentage of live births attended by skilled health personnel (doctor, nurse, midwife).

In-patient care - hospital admission and often handles serious ailments, treatment and monitoring over some time and time for recovery.

Maternal healthcare - health of women during pregnancy, childbirth, and the post-natal period.

Out-patient care – day patient care which in most cases does not require hospitalisation.

Post-natal care - care given to the mother and her newborn baby soon after the birth of the placenta and for the first six weeks of life.

Primary healthcare - a society-based approach that organises and strengthens national health systems to bring services for health and wellbeing closer to communities.

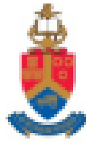
Reproductive healthcare services - maternal and newborn care and access to contraception.

Secondary healthcare - out-patient and in-patient services, including emergency services, usually provided by a district or regional hospital.

Service delivery - the distribution of basic resources citizens depend on, such as municipal health care, and primary education.

Skilled birth attendance - availability of adequately educated and trained health personnel (doctor, nurse, midwife), able to manage pre and postnatal care including complications that may need referrals.

Tertiary healthcare - specialised care in a public hospital such as dialysis.



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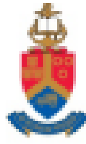

CHAPTER ONE

INTRODUCTION

1.1 Background

Expectant women face challenges in accessing maternal healthcare services in council-run clinics in Zimbabwe. The clinics are oversubscribed and do not have adequate health infrastructure to provide maternal healthcare services.[1] The Coronavirus (COVID-19) pandemic ushered in various challenges including the lack of adequate health facilities and personal protective equipment (PPE).[2] An industrial action by health workers ensued as they could not discharge their duties effectively.[3] Consequently, the public raised concerns as councils could no longer provide services to their communities.[4] Some women were denied proper antenatal care from Rutsanana, Hopley, and Glenview Polyclinics in Harare on the basis that they were oversubscribed.[5]

Some women delivered babies at clinics' entrances, putting their babies' lives in danger, devoid of dignity or respect for their rights to health and life.[6] While exacerbated by COVID-19, challenges in accessing maternal healthcare services date back to the early 2000s, before devolution as envisaged in the 2013 Constitution.[7] The challenges persist to date as health workers demand bribes from expectant mothers seeking assistance, because of paltry remuneration.[8] The author contends that the failure to deliver adequate maternal healthcare services emanates from central government's failure to provide grants to local government, as per the devolution objectives in the Constitution of Zimbabwe, 2013 (the Constitution).[9] Councils' shortcomings in service delivery have been

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[1] N Chingono 'Lives have been lost: Pregnant women in Zimbabwe forced to pay bribes when giving birth' *The Guardian* 3 November 2020 https://www.theguardian.com/global-development/2020/nov/03/lives-have-been-lost-pregnant-women-in-zimbabwe-forced-to-pay-bribes-when-giving-birth (accessed 7 August 2023).

[2] As above.

[3] Chingono (n1).

[4] Low-income area is a neighbourhood, or rural district in which the median income does not exceed 80 percent of the median income for the area in which such census tract or block numbering area is located. Law insider https://www.lawinsider.com/dictionary/low-income-community (accessed 2 July 2023).

[5] F Munyoro and T Rupapa 'Harare sued over clinics' closure, sewer reticulation' *The Herald* 18 September 2020 https://www.herald.co.zw/harare-sued-over-clinics-closure-sewer-reticulation/ (accessed 12 May 2023).

[6] A Chibamu 'HEALTH CRISIS: Women give birth in front of guards at Harare council clinics; major Bulawayo hospital suspends operations due to lack of drugs' *New Zimbabwe* 20 July 2022 https://www.newzimbabwe.com/health-crisis-women-give-birth-in-front-of-guards-at-hre-council-clinics-major-byo-hospital-suspends-operations-due-lack-of-drugs/ (accessed 20 May 2023).

[7] A Meldrum 'Zimbabwe's health care system struggles on' (2008) 371 *The Lancet* 1059.

[8] Chingono (n1).

[9] T Zinyama & DP Chimanikire 'The nuts and bolts of devolution in Zimbabwe Designing the provincial and metropolitan councils' (2019) 11 *African Journal of Public Affairs* 147 at 166.

largely attributed to central government's failure to practically implement devolution of power and finances. The Government of Zimbabwe (GoZ) has over the years failed to set aside a minimum annual health budget allocation of 15 percent in compliance with the Abuja Declaration of 2001.[10] In 2012 and 2015, the budget was as low as seven percent.[11] Consequently, 11 out of 42 council-run clinics were closed in 2020 due to a lack of PPE, adequate infrastructure, and medication, leaving several expectant mothers stranded.[12] Equitable budgetary allocations inform councils' abilities to provide primary healthcare.[13]

1.2 Problem Statement

Although section 264 of the Constitution provides for the devolution of governmental powers and responsibilities to lower tiers of government,[14] local authorities still face limitations in providing essential health services, particularly maternal healthcare services.[15] This lack of autonomy impedes women's access to maternal healthcare services at constituency level.[16] Dilapidated infrastructure, shortages of PPE, the health workers themselves and medication exacerbate the issue.[17] The author argues that the 'devolution' system in Zimbabwe falls short due to excessive interference by central government and budgetary constraints, preventing councils from effectively providing maternal healthcare services. Hence, pregnant women are referred to overwhelmed hospitals outside their localities,[18] contrary to section 76(3) of the Constitution on access to health services.[19] Furthermore, COVID-19 worsened the situation by limiting movement compelling people to rely on local resources.[20] Therefore, this research addresses these

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[10] Office of the United Nations High Commissioner for Human Rights 'Universal Periodic Review of Zimbabwe 40th Session Cycle 3' https://uprdoc.ohchr.org/uprweb/downloadfile.aspx?filename=9599&file=EnglishTranslation (accessed 11 August 2023).

[11] M Mangundu et al 'Accessibility of healthcare in rural Zimbabwe: The perspective of nurses and healthcare users (2020) 12 *African Journal of Primary Health Care and Family Medicine* 1.

[12] Kubatana 'The state of health service delivery in Harare' https://kubatana.net/2020/08/18/the-state-of-health-service-delivery-in-harare/ (accessed 20 July 2023).

[13] Open Council 'Mthuli Threatens Harare's devolution funds over absent billing system' https://opencouncil.co.zw/mthuli-threatens-harares-devolution-funds-over-absent-billing-system/ (accessed 11 August 2023).

[14] Constitution of Zimbabwe, 2013.

[15] S Marumahoko et al 'Governance and urban service delivery in Zimbabwe' (2020) 42 *Strategic Review for Southern Africa* 41.

[16] P Chipunza 'City Council to re-open Edith Opperman' *The Herald* 19 November 2019 https://www.herald.co.zw/city-council-to-re-open-edith-opperman/ (accessed 9 August 2023); A constituency is a district that elects its representative to state or federal government. Oxford Learner's Dictionaries https://www.oxfordlearnersdictionaries.com/definition/american_english/constituency (accessed 20 October 2023).

[17] Marumahoko (n15) 42.

[18] Munyoro (n5).

[19] Meldrum (n7).

[20] Universal Health Coverage Partnership 'Zimbabwe: Data-driven decisions maintain availability and access to essential health services during the COVID-19 response'

challenges by exploring how access to decentralised maternal healthcare services in council-run clinics can be improved, drawing lessons from Kenya. The research demonstrates that the over-interference of the Minister of Local Government, Public Works, and National Housing in the operations of councils contradicts the essence of devolution.[21] By drawing on the experiences of pregnant women in Zimbabwe, this research identifies the reasons behind councils' failure to provide adequate primary healthcare despite the introduction of devolution. It aims to establish GoZ's international, regional and national legal obligations in providing primary healthcare, including maternal healthcare, and to assess the effects of devolution on the provision of maternal healthcare, at constituency level in Zimbabwe. Ultimately, this research intends to draw insights from the Kenyan model, which has similar experiences in devolving healthcare to the constituency level.

1.3 Research Questions

Main question

Why are councils in Zimbabwe failing to provide primary healthcare including maternal healthcare services?

Sub-questions

- What is devolution in the context of Zimbabwe and what implications, if any, does it have on service delivery, specifically access to maternal healthcare, at the constituency level?
- How accessible were maternal health care services pre-2013?
- What are the international, regional and national legal standards that guide the implementation of devolution and the right to healthcare, including maternal healthcare services?
- What are the effects, if any, of devolution on the provision of maternal healthcare?
- What lessons can Zimbabwe adopt from the Kenyan model of devolved healthcare, including maternal healthcare?
- Both central and local government can take what effective steps to ensure access to maternal healthcare at constituency level?

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https://extranet.who.int/uhcpartnership/story/zimbabwe-data-driven-decisions-maintain-availability-and-access-essential-health-services (accessed 10 August 2023).

[21] E Nhancumba 'Government interference frustrating councils' *Newsday* 31 May 2023 https://www.newsday.co.zw/local-news/article/200012286/govt-interference-frustrating-councils (accessed 31 May 2023).

1.4 Literature Review

Various scholars have written on decentralisation and its various forms such as devolution, deconcentration and delegation, and access to maternal healthcare services across the globe. However, there is a gap in the literature on the decentralisation of maternal healthcare services to councils-run clinics, especially in low-income areas in Zimbabwe. This literature review is divided into four parts namely devolution in Zimbabwe, service delivery and access to maternal healthcare, the effects of devolution on service delivery, including maternal healthcare and the Kenyan model on devolution and lessons that may be drawn therefrom. These are discussed as follows:

1.4.1 The concept of devolution in Zimbabwe

Crawford and Hartmann introduce the concept of decentralisation and its various forms including devolution and deconcentration.[22] The authors define decentralisation as the transfer of power, responsibilities and finances from central or national government to subnational levels of government at provincial or local levels.[23] They interrogate the concept's growing popularity in the developing and transitioning countries in sub-Saharan Africa, including Zimbabwe.[24] Nyathi and Ncube define devolution as a tool that enhances efficiency and quality in service provision 'through improved governance and resource allocation.'[25] They refer to the definition in the African Charter on the Values and Principles of Decentralisation, Local Governance and Local Development which defines devolution as a form of decentralisation, which is the 'transfer of power, responsibilities, capacities and resources from national to all sub-national levels of government for purposes of strengthening the ability of the latter to foster people's participation and delivery of quality services.'[26]

Moyo and Ncube outline the essence of decentralisation and its various forms, ranging from delegation to devolution, and are relevant to this study.[27] Ochieng defines delegation as the transfer of aspects of governance such as decision-making and administrative authority and/or responsibility to semi-autonomous lower-level units through legislation or under contract. It falls short of devolution but involves a significant delegation of

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22 G Crawford & C Hartmann 'Introduction: decentralisation as a pathway out of poverty and conflict?' in G Crawford & C Hartmann (eds) *'Decentralisation in Africa: A Pathway out of Poverty and Conflict?'* (2008) at 7.

23 As above.

24 Crawford and Hartmann (n22).

25 M Nyathi & M Ncube 'The myth of devolution in Zimbabwe: The reality post-May 2013' (2017) 24 *University of Botswana Law Journal* 27 at 28.

26 As above.

27 P Moyo & C Ncube 'Devolution of power in Zimbabwe's new constitutional order: Opportunities and potential constraints' (2014) 18 *Law, Democracy and Development* 289 at 290.

authorities and responsibilities.[28] He also defines deconcentration as the distribution of powers and responsibilities in policy, financial and administrative matters among subordinate lower-level units such as regional, district, or local offices of central government without any significant independent local inputs and involves very limited transfer of authority.[29] Mudau acknowledges the lack of implementation of devolution in Zimbabwe and attributes this to the absence of constitutionalism.[30] In De Visser, Steytler and Mangichauta, it is acknowledged that, in law and practice, local authorities remain local agents of central government despite alluding to real devolution.[31]

1.4.2 Service delivery and access to maternal healthcare

This literature outlines the nexus between devolution and access to maternal healthcare. Brosio's acknowledgement of the importance of prioritisation of expenditure on healthcare is relevant as this research focuses on the effect of decentralising maternal healthcare to council-run clinics, yet the process of decentralisation is incomplete without adequate funding being allocated by central government.[32] Similarly, in '*Governance and Urban Service Delivery in Zimbabwe,*' the authors highlight that service delivery effectiveness is a core function of any developing government. They recognise health services as a key component to the well-being of an urban dweller.[33] Murewanhema and others expound on the challenges in accessing maternal healthcare compounded by COVID-19 and also speak to the history of access to maternal healthcare before devolution.[34]

The crux of this research rests on bridging the literature gap in Zimbabwe on the effects of devolution on maternal healthcare as the available literature focuses on service delivery broadly. Chigwata lays a foundation on the political landscape, including the rise of the main opposition (formerly Movement for Democratic Change or MDC) in urban areas.[35] With the opposition in charge of running councils, especially in the urban areas,

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[28] AD Ochieng 'The legal framework for devolution in Kenya' LLB thesis, Moi University, 2014 at 9 https://www.academia.edu/6826288/THE_LEGAL_FRAMEWORK_FOR_DEVOLUTION_IN_KENYA (accessed 25 September 2023).

[29] As above.

[30] FP Mudau 'Decentralisation and constitutionalism in Africa: A comparative analysis of South Africa and Zimbabwe' LLM Thesis, University of Western Cape, 2019 at 9 https://etd.uwc.ac.za/bitstream/handle/11394/7259/mudau_m_law_2020.pdf?sequence=1&isAllowed=y (accessed 20 October 2023).

[31] J de Visser, N Steytler & N Machingauta *Local government reform in Zimbabwe A policy dialogue* (2010) xii.

[32] G Brosio *Decentralization of Africa* (2000) 9.

[33] Marumahoko (n15).

[34] G Murewanhema et al 'Restoring and maintaining robust maternity services in the COVID-19 era: a public health dilemma in Zimbabwe' (2020) 37 *Pan African Medical J*ournal.

[35] TC Chigwata 'Supervision of local government in Zimbabwe: The travails of mayors' (2019) 23 *Law, Democracy and Development* 44 at 45.

the disbursement of funds from central government run by the ruling party (ZANU PF) is likely politically motivated. There may be a delay in the disbursement of funds to councils or the funds may be withheld by the Minister of Finance and Economic Development to sabotage them in discharging their mandates.[36] This has negative implications on service delivery provision including primary healthcare and defeats the essence of devolution.

Finally, Nyikadzino points out that government's failure to timeously amend the Provincial Councils and Administration Act to activate the provincial and metropolitan councils is a stumbling block to the effective devolution of powers by central government.[37] Both articles complement this study as they expound on central government's challenges in implementing devolution, which necessitated this research.

1.4.3 The Kenyan Model of devolution and lessons therefrom

This research seeks to draw lessons from Kenya because it has a devolution system similar to the Zimbabwean one. The Kenyan model is a good example as it has constitutionally entrenched devolved healthcare, clearly separates functions for counties and allows for complementarity with national government. In ascertaining lessons to draw from the Kenyan devolution system, understanding the constitution-making process which gave rise to the concept of devolved healthcare in Kenya, is important[38] The *Report of the Constitution of Kenya Review Commission* outlines the proposed structure of devolution, which was initially a five-tier system, the advantages and disadvantages of the process of devolution and how the process could be refined.[39] This is pertinent in laying the foundation of the Kenyan model of devolution and informs its implementation. Ghai highlights the advantages of devolution in enhancing citizen participation and ensuring the effectiveness of service provision at constituency level, which reduces disgruntlement among the citizens of Kenya and ensures unity.[40] Steytler and Ghai also highlight the devolution implementation strides Kenya took within three years of adopting the 2010 Kenyan Constitution, which this research intends to draw recommendations from.[41]

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36 Open Council (n13).

37 T Nyikadzino & S Vyas-Doorgapersad 'The devolution of governmental powers and responsibilities in post-independent Zimbabwe' (2020) 17 *African Renaissance* 233 at 244.

38 'Report of the Constitution of Kenya Review Commission' 4 Constituency 138: Molo 1 http://kenyalaw.org/kl/fileadmin/CommissionReports/Report-of-the-constitution-of-Kenya-review-commission.pdf (accessed 10 August 2023).

39 'Report of the Constitution of Kenya Review Commission' 1 The main report, 228 https://constitutionnet.org/sites/default/files/KERE-423.pdf (accessed 19 August 2023).

40 Y Ghai 'Devolution: Restructuring the Kenyan State' (2008) *Journal of Eastern African Studies* 211 at 214.

41 N Steytler & YP Ghai 'Devolution: What can Kenya learn from South Africa' in N Steytler & YP Ghai (eds) *Kenyan-South African dialogue on devolution* (2015) 442 at 473.

Kabau's book review of Constitutional law of Kenya on devolution appreciates Kangu's perspective in showcasing the paradigm shift of structures in Kenya as brought about by the 2010 Constitution from a constitutional, legal, and institutional reform and from the top-to-bottom approach where everything was centralised, to a bottom-up approach in decision-making, equitable development and public participation.[42] This ensures that citizens participate in their affairs for the development of their society, including, through access to adequate amenities. Shilimbwa and Kiruthu bring forth the citizenry's dissatisfaction with the implementation of devolution at the county level in Nairobi,[43] which was worsened by disgruntled health personnel who had grievances with counties' failure to adequately remunerate them.[44] Valuable lessons are drawn from this study applicable to the Zimbabwean setting.

This dissertation builds on the literature that has been mentioned herein. The literature lays the foundation for devolution in Zimbabwe and its implications on the social, economic, and political setup in the country. It also provides an extensive background on the Kenyan model of devolution, its implementation and how to refine the existing model.

This research fits in the context of Zimbabwe where access to basic services including maternal healthcare services has become politicised. Since the early 2000s, Zimbabwe's urban centres became MDC strongholds, as the urban dwellers voted them in to be councillors and mayors.[45] In response, the ruling party ZANU PF devised methods to regain control in the urban areas and undermined the powers of councils drastically.[46] McGregor posits that ZANU PF's strategy has been dependent on centralising power onto councils, meanwhile developing a system of patronage through local state institutions and creating 'parallel' party hierarchies to control key urban spaces and access to resources.[47]

The factions in MDC-T (T for Tsvangirai its former President) which then split into MDC Alliance and Citizens Coalition for Change (CCC) (formerly MDC Alliance) were borne of these strategies to undermine the councils. These strategies deteriorated service delivery provision to urban dwellers.[48] While the CCC garnered the most votes in Harare

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[42] T Kabau 'Constitutional law of Kenya on devolution' (A Review) (2016) 2 *Strathmore Law Journal* 213.

[43] BH Shilimbwa & F Kiruthu 'Effects of devolution on maternal health care: The case of level four hospitals in Nairobi City County, Kenya' (2019) 3 2 *International Journal of Current Aspects* 98 at 112.

[44] As above.

[45] J McGregor 'Surveillance and the city: Patronage, power-sharing and the politics of urban control in Zimbabwe' (2013) 39 *Journal of Southern African Studies* 783.

[46] As above.

[47] McGregor (n45)

[48] M Chifamba 'Zimbabwe: Will a divided MDC opposition keep the country safe from a one-party state?' *The Africa Report* 7 January 2021 https://www.theafricareport.com/57513/zimbabwe-will-a-divided-mdc-opposition-keep-the-country-safe-from-a-one-party-state/ (accessed 24 August 2023).

and Chitungwiza for Councillors in the 2018 elections, some of its Councillors, including the mayor were recalled because of the split, leaving lacunas in local government power structures and affecting the implementation of local authority responsibilities.[49] The Ministry of Local Government interferes in council affairs, which impedes adequate service delivery provision due to its imposed policies.[50] Over-interference by central government defeats the essence of bequeathing responsibilities to its lower tiers. These factors have worsened the challenges faced by women in accessing maternal healthcare services as council-run clinics have budgetary constraints and lack the autonomy to determine their affairs. Therefore, this research complements the existing literature on devolution by highlighting the effects of non-implementation of devolution on access to maternal healthcare. It will make recommendations which can be implemented to improve access to maternal healthcare at constituency level.

1.5 Methodology

This is a desktop study, which explores both primary and secondary sources of information. The primary sources include the domestic, regional, and international instruments in both Zimbabwe and Kenya, that have a bearing on the subject matter. Secondary sources such as journal articles, reports, newspaper articles, authoritative texts and other relevant sources will be utilised.

1.6 Structure

This dissertation is broken down into five chapters. Chapter one comprises the background, the problem statement, the literature review and the methodology. Chapter two examines the historical development of access to maternal healthcare in Zimbabwe at constituency level from 1980 to 2013. Chapter three examines the international, and regional standards, and the domestic legislative and institutional framework on devolution and the right to health, specifically women's access to sexual reproductive health and rights (SRHR) services, including maternal healthcare. Chapter four analyses the devolution system in Kenya and draws lessons therefrom. Chapter five comprises the conclusion and recommendations.

1.7 Limitations of the study

This study focuses on Zimbabwe and Kenya. It may be limited by a shortage of reliable resources online that speak directly to the decentralisation of maternal healthcare services to councils in Zimbabwe and the recorded successes or failures, due to a lack of

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[49] J Muonwa 'Breaking: Harare Mayor Jacob Mafume recalled' *New Zimbabwe* 30 March 2022 https://www.newzimbabwe.com/breaking-harare-mayor-jacob-mafume-recalled/ (accessed 31 May 2023).
[50] Nhancumba (n 21).

record keeping and data collection challenges. The inability to conduct empirical research results in lack of information about the actual costs associated with decentralising healthcare services, and makes it difficult to accurately measure the success or failure of such initiatives.

CHAPTER TWO

TRACING THE DEVELOPMENTS IN ACCESS TO MATERNAL HEALTHCARE IN ZIMBABWE (1980-2013)

2.1 Introduction

This chapter traces the historical and legislative development of access to maternal healthcare in Zimbabwe before devolution in three periods as follows: 1980 to 2000 (the period from independence to the early 2000s when the land reform programme occurred), 2000 to 2008 (the period after the rise of the opposition MDC and activism challenging the deteriorating economic situation, the land reform programme and the imposition of sanctions), and 2009 to 2013 (the period from the Government of National Unity (GNU) to the new constitution). The chapter concludes that despite these developments, there is not much improvement from the pre-2013 era due to the lack of implementation of devolution.

2.2 Historical Legal Developments

The domestic legal framework that existed in 1980 included the Lancaster House Constitution, which focused on civil and political rights and did not provide for justiciable socio-economic rights including the right to health.[51] The then Constitution, in section 111A, provided for the promulgation of an Act of Parliament for the appointment of provincial, district or regional governors for the better administration of Zimbabwe.[52] It also provided that an Act of Parliament may be promulgated to provide for the functions and powers of governors.[53] Legislation such as the Provincial Councils and Administration (PCA) Act provided for the establishment of a provincial system of governance superintended by provincial governors and provincial councils and their functions,[54] while the Urban Councils (UCs) Act[55] and Rural District Councils (RDCs) Act[56] catered for the establishment and functions of urban and rural local authorities. The latter Acts also provided for powers of councils in service delivery including healthcare. These Acts are still extant in the post-2013 Constitution regime, albeit, in need of amendments. A comprehensive analysis of the existing legislation and institutions is conducted in Chapter three.

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[51] T Kondo 'Socio-economic rights in Zimbabwe: Trends and emerging jurisprudence' (2017) 17 *African Human Rights Law Journal* 163 at 167.

[52] Veritas 'Constitution of Zimbabwe Amendment No. 19'https://www.veritaszim.net/sites/veritas_d/files/Constitution%20of%20Zimbabwe%20as%20Amended%20by%20Amendment%20(No.%2019)%20Act,%202009_1.doc (accessed 20 August 2923).

[53] As above.

[54] [Chapter 29:11].

[55] [Chapter 29:15].

[56] [Chapter 29:13].

2.3 Institutions

The PCA Act provided for the functions of the governor including promoting the activities of the various Ministries and organs of central government in implementing development plans prepared by the provincial council for each province.[57] Decentralisation was nonexistent, as the provincial governors operated on behalf of central government. The President could establish provincial councils consisting of the provincial governor, mayor, chief, a councillor and three persons appointed by him, whenever he considered it desirable.[58] The provincial councils could possess powers, only vested in them by the Minister.[59] The President could also abolish provincial councils.[60] The UCs Act provided for councillors and mayors whereas the district councils were manned by district administrators who reported under the then Ministry of Local Government, Rural and Urban Development.[61]

Zimbabwe's health system was divided into four (now five) tiers, based on the referral system.[62] The urban and rural councils were tailored to cater for primary healthcare through polyclinics or rural hospitals respectively.[63] The secondary level comprised a network of district hospitals and the tertiary level had a network of provincial hospitals except in Harare and Bulawayo (Metropolitan Provinces).[64] Both offered emergency and in-patient services, save that the latter offered specialist in-patient services. The fourth level offered specialist in-patient services and university teaching facilities.[65] The levels are still extant. The fifth level was recently introduced for purposes of conducting research but will not be discussed herein.[66]

The public healthcare system was, however, centralised, and central government was responsible for policy formulation, regulation, resource mobilisation and

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57 PCA Act, sec 10.
58 PCA Act, sec 11.
59 PCA Act, sec 35
60 PCA Act, sec 36.
61 PlanAfric 'The context for rural planning. Rural district planning in Zimbabwe: A Case Study' (2000) *International Institute for Environment and Development*.
62 Ministry of Health and Child Care 'National Health Strategy 2021-2025' 1 at 15https://www.znfpc.org.zw/wp-content/uploads/2023/01/National-Health-Strategy-for-Zimbabwe2021_2025.pdf (accessed 7 September 2023).
63 As above.
64 USAID 'Zimbabwe Health Assessment 2010' 1 at 11 https://www.hfgproject.org/wp-content/uploads/2015/02/Zimbabwe_Health_System_Assessment20101.pdf (accessed 15 September 2023).
65 As above.
66 Health Strategy 2021-2025 (n62).

disbursements for programme implementation.[67] The provincial level coordinated the planning and overseeing of the implementation of national standards.[68] The district level supervised and coordinated the implementation of primary healthcare in the district.[69] Between 2000 and 2010s, the entire health system shifted to centralisation as the ministry entrenched control over decision-making and partnered with foreign donors including USAID and the European Union (EU) for health programmes.[70] The health officers at provincial and district levels managed the health system, representing the ministry. The Provincial Medical Directorate (PMD) office administered provincial hospitals and all district health offices (DHOs) within its province.[71] The PMD was also responsible for disbursing governmental funds to provincial hospitals and DHOs. DHOs administered rural clinics at the district level.[72] Ultimately, the institutions in place operated on behalf of central government under a centralised system.

2.4 Implementation

2.4.1 The period from independence to the early 2000s (1980-2000)

The government pioneered several initiatives to provide healthcare services across Zimbabwe such as the Primary Health Care (PHC) approach which was adopted in 1980.[73] This period was characterised by low death rates and quick responses to outbreaks. The PHC scheme encompassed delivery platforms including primary, secondary, tertiary and quaternary facilities.[74] Most of these facilities provided primary healthcare services, which referred complicated cases to the next levels of healthcare services such as central hospitals.[75]

Mission hospitals and private sector facilities were responsible for the provision of services in rural and urban areas, respectively.[76] Primary healthcare centres were and continue to be places of first instance for expectant mothers before referral to any major health institutions.[77] An initiative by the MOHCC and United Nations International Children's

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67 Health Strategy 2021-2025 (n62).

68 Ministry of Health and Child Welfare 'National tuberculosis control programme five-year strategic plan 2009 – 2013' https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/zimbabwe/zimbabwe_national_tb_strategic_plan_2009-2013_1.pdf(accessed 12 September 2023).

69 As above.

70 Health Assessment (n64).

71 As above.

72 Health Assessment (n64)

73 Mupwanyiwa A et al 'Exploring factors that influence the uptake of maternal health care services by women in Zimbabwe' (2020) 8 10 *Open Journal of Social Science.*

74 As above.

75 Health Strategy 2021-2025 (n62).

76 S Chirongoma 'Church related hospitals and health care provision in Zimbabwe' in E Chitando (eds) *The Zimbabwe Council of Churches and Development in Zimbabwe* (Palgrave MacMillan 2020).

77 Health Assessment (n64).

Emergency Fund (UNICEF) introduced community health workers (CHWs) in Matabeleland South.[78] UNICEF notes that CHWs became the key link between the community and the formal health system, especially in hard-to-reach areas, a crucial benefit for pregnant women.[79] The CHWs also encouraged their communities to seek health services, including maternal, neonatal and child health services at clinics.[80]

However, central government's recorded successes in the health sector were short-lived. Central government's introduction of the International Monetary Fund (IMF)-led Economic Structural Adjustment Programme (ESAP) in the 1990s caused an expenditure decline on health from 6.2 percent in 1990 to 4.2 percent in 1996.[81] Factors such as financial austerity, and inflation contributed significantly to the deteriorating health delivery system, including access to maternal healthcare.[82]

2.4.2 The early 2000s up to the political and economic crisis in Zimbabwe (2000-2008)

During this period, the Movement for Democratic Change, an opposition political party gained traction and took over urban councils as councillors and mayors.[83] Central government was displeased and in 2005, introduced Operation Murambatsvina to get rid of illegal structures in urban areas, leaving thousands of people homeless. This was also to punish the urban electorate.[84] An economic crisis ensued as a repercussion of the economic sanctions imposed following the land reform programme. This led to the exodus of health personnel and the deterioration of the health infrastructure in many parts of Zimbabwe.[85] This limited access to maternal healthcare services by expectant mothers, and degenerated the quality of health facilities in remote parts of Zimbabwe.[86] After the imposition of sanctions by the United States of America and United Kingdom and the deteriorating economic situation, the sector also faced severe declines in donor health funding.[87] The lack of donor funding from the IMF, and the EU among others saw the

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78 Ministry of Health and Child Care 'CHWs, traditional leaders foster community participation in health' http://www.mohcc.gov.zw/index.php?option=com_content&view=article&id=163:chws-traditional-leaders-foster-community-participation-in-health&catid=84:frontpage&Itemid=435&highlight=WyJtYXRlcm5hbCJd (accessed 20 August 2023).
79 As above.
80 (n78).
81 Mupwanyiwa (n73).
82 As above.
83 McGregor (n45).
84 Chirongoma (n76).
85 Ministry of Health and Child Care 'Launch of UK programme to support a resilient health System in Zimbabwe'http://www.mohcc.gov.zw/index.php?option=com_content&view=article&id=200:launch-of-uk-programme-to-support-a-resilient-health-system-in zimbabwe&catid=84:frontpage&Itemid=435&highlight=WyJtYXRlcm5hbCJd(accessed 17 August 2023).
86 As above.
87 (n85).

closure of several public health centres. Mission hospitals and private facilities remained operational, but the mission hospitals could not shoulder the entire health system. Pregnant women in urban areas were compelled to approach private health facilities, which became more expensive due to increased demand.[88]

2.4.3 The period between 2009-2013

After the contested 2008 elections, ZANU PF and MDC formed a GNU between 2009 and 2013.[89] The political arrangement pleased donors, restored stability and improved the economic situation. Since 2009, the GNU received support from development partners to rebuild the crumbling healthcare system to increase maternal and child health interventions.[90] In 2011, the GoZ introduced the urban voucher system, an initiative sponsored by the World Bank which implemented a results-based programme in eighteen rural districts. The programme intended to improve the coverage and quality of healthcare services for mothers and children. The same initiative surfaced again in 2014.[91]

Funding towards the health sector improved, from US$167 million in 2009 to US$428 million in 2012, due to the interventions of the GNU.[92] There was an allocation of eight percent of the total expenditure to health in partial compliance with the Abuja Declaration which requires governments to allocate 15 percent of the budget to health.[93] This increased maternal healthcare uptake by women at health institutions. However, towards the end of the GNU, the situation regressed.

In 2013, the new Constitution introduced devolution. In law, fiscal and political autonomy were expected to improve access to services but the situation persisted. A detailed discussion on this is found in Chapter 3. In 2020, COVID-19 led to the suspension of services which affected access to maternal healthcare in low-income communities. However, studies show that women from wealthy backgrounds do not encounter similar

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88 (n85).

89 O Dodo et al 'Four years into Zimbabwe's Government of National Unity: Assessing the challenges and successes from the civil society's perspective' (2012) *9 A Journal of Contemporary Research* 202 at 204.

90 W Ha et al 'Is religion the forgotten variable in maternal and child health? Evidence from Zimbabwe' (2014) 118 *Social Science and Medicine* 80.

91 Cordaid 'Video: Increasing access to maternal health services in urban Zimbabwe'https://www.cordaid.org/en/news/video-increasing-access-to-maternal-health-services-in-urban-zimbabwe/(accessed 22 August 2023).

92 Mupwanyiwa (n73).

93 Mupwanyiwa (n73).

challenges as women from low-income communities as they can afford to access maternal healthcare services in private facilities. [94]

2.5 Conclusion

While strides were made in accessing maternal healthcare, complaints by members of the public failing to access basic maternal healthcare services in Zimbabwe's low-income areas have not ceased. Women from wealthy backgrounds have better access to maternal healthcare as they can afford services at private facilities. The challenges faced pre-2013 are still being faced post-devolution. While access to maternal healthcare improved during the 2009 to 2013 period as opposed to the late 1990s to early 2000s, this was short-lived. Primary healthcare was and still is centralised in central government which, due to its position, may not be better suited to address issues at constituency level, despite possessing the financial muscle to do so.

[94] Mupwanyiwa (n73).

CHAPTER THREE

DOMESTIC, REGIONAL, AND INTERNATIONAL FRAMEWORKS

3.1 Introduction

This chapter examines regional and international legal and policy frameworks that Zimbabwe, as a state party, is obligated to meet. It examines the legislative, policy and institutional framework on devolution and the right to health in Zimbabwe, with a specific focus on women's access to SRHR services. This includes maternal healthcare services and how they align with regional and international human rights standards. The chapter examines GoZ's implementation efforts in line with the existing legislative and policy framework and analyses the successes and failures thereof.

Zimbabwe's healthcare services are provided by public and private facilities, church organisations and for-profit clinics.[95] The healthcare system is overseen by the Ministry of Health and Child Care (MoHCC) (formerly the Ministry of Health and Child Welfare) since 1980.[96] The ministry is responsible for several outcomes related to priority health interventions in the areas of reproductive, maternal, newborn, child health and the delivery of quality services through appropriate policy and regulatory frameworks, among other things.[97] Lately, the Zimbabwean healthcare system relies on donor funding from the IMF and the EU for sustenance.[98] This has been critical, especially in the rural areas where there is a shortage of well-resourced clinics and hospitals with running water, electricity, skilled attendants, and drugs.

Below is a discussion of the international, regional and domestic framework.

3.2 International legal framework

Zimbabwe is a state party to various international and regional human rights instruments that protect the right to health, including SRHR. Section 46(1)(c) of the Constitution stipulates that the Constitution and domestic law shall be interpreted in line with regional and international standards.[99] Zimbabwe is a dualist state and treaties are binding after acceptance by Parliament and incorporation into national legislation.[100]

95 USAID 'Zimbabwe Health Assessment 2010' 11https://www.hfgproject.org/wp-content/uploads/2015/02/Zimbabwe_Health_System_Assessment20101.pdf (accessed 15 September 2023).
96 The National Health Strategy of Zimbabwe 2016-2020https://faolex.fao.org/docs/pdf/zim204475.pdf (accessed 25 August 2023).
97 As above.
98 (n85).
99 Constitution, sec 46.
100 Constitution, sec 327(2).

Article 5(e)(iv of the International Convention on the Elimination of All forms of Racial Discrimination guarantees the right to health without any distinction as to race, colour, national or ethnic origin.[101] Articles 11(1)(f) of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) stipulates the right to protection of health. [102] The International Covenant on Economic, Social and Cultural Rights (ICESCR) protects the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[103] States are mandated to take the necessary steps to achieve reductions in the infant mortality rate and for the healthy development of the child through legislative or administrative means.[104] Article 24 of the United Nations Convention on the Rights of the Child (CRC) mirrors Article 12 of the ICESCR.[105] Zimbabwe ratified these treaties on 13 May 1991, save for the CRC which was ratified on 11 September 1990.[106] The Universal Declaration of Human Rights serves as customary international law and covers a wide range of rights including medical care. [107]

The right to health is interrelated with rights to human dignity, life, non-discrimination, equality, and access to information.[108] These address integral components of the right to health.[109] Access to health can be impacted if the health personnel are not professional. An individual's dignity may be impacted if they are insulted and embarrassed in front of others in public. Lack of access to information on SRHR including family planning impedes women's health rights in issues of child spacing which may lead to complications and maternal mortality. The GoZ acknowledges that the causes of child mortality and maternal deaths include lack of basic medical support, depleted infrastructure, and a lack of a motivated workforce.[110]

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101 International Convention on the Elimination of All Forms of Racial Discrimination, 1965.
102 Convention on the Elimination of all forms of Discrimination Against Women, 1979.
103 International Covenant on Economic, Social and Cultural Rights, 1966 art 12(1).
104 As above.
105 Convention on the Rights of the Child, 1990.
106 United Nations Treaty Bodies 'Ratification status for Zimbabwe' https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=195&Lang=EN (accessed 20 October 2023).
107 Universal Declaration of Human Rights, art 25.
108 Office of the High Commissioner for Human Rights 'Committee on Economic, Social and Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)' (2000) https://www.refworld.org/pdfid/4538838d0.pdf (accessed 14 September 2023).
109 As above.
110 Parliament of Zimbabwe National Assembly 5 April 2022 Hansard Vol 48https://parlzim.gov.zw/national-assembly-hansards/?skw=maternal&orderby=date&order=desc (accessed 20 September 2023).

The right to health imposes obligations to respect, protect, and fulfil.[111] The obligation to fulfil requires facilitation, provision, and promotion.[112] It also requires states to adopt appropriate legislative, administrative, budgetary, judicial and other measures towards the full realisation of the right to health.[113] The obligation to respect mandates states to refrain from directly or indirectly interfering with the enjoyment of the right to health.[114] The obligation to protect requires states to employ measures that deter third parties from interfering with Article 12.[115]

Article 12 mandates the accessibility of health facilities in sufficient quantities in all areas to allow for access to health facilities expeditiously.[116] An expectant mother must easily access emergency services like ambulances without any impediments. This requires infrastructure development, including roads, and health facilities themselves, which should be adequately equipped with machinery, medication, and other relevant health equipment.[117] Staff must be properly trained and capacitated to provide quality care.[118] If powers and resources are devolved to the constituency level then the lower tiers will have autonomy to introduce policies and improve access to maternal healthcare. They may improve the road and transportation barriers and introduce ambulances to ferry expectant mothers to health facilities.

The ICESCR's General Comment 14 imposes obligations on states that must be realised immediately.[119] The immediate obligations include guaranteeing that the right will be exercised without discrimination of any kind (Article 2(2)) and taking steps toward the full realisation of Article 12 (article 2(1)).[120] Such steps must be deliberate, concrete, and targeted toward the full realisation of the right to health. It also articulates the essential elements of realising the right to health: availability, accessibility, acceptability, and quality.[121]

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[111] L Sithole 'Women's right to access family planning and maternal health care services in Hwange rural district, Zimbabwe: challenges and opportunities' PhD thesis University of Cape Town, 2021 at 54 https://open.uct.ac.za/handle/11427/34007 (accessed 3 September 2023).
[112] General Comment 14 para 33.
[113] As above.
[114] General Comment 14 para 33.
[115] As above.
[116] General Comment 14 para 12(a).
[117] Sithole (n111) 160.
[118] As above.
[119] n108, para 30.
[120] As above.
[121] General Comment 14 para 14.

Functioning public healthcare facilities, goods, and services, as well as programmes, must be available in sufficient quantity within the state party, based on its developmental level.[122] These include adequate hospitals, clinics, and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs. The services must be within safe physical reach for all, especially vulnerable and marginalised groups, such as ethnic minorities and indigenous populations, women, children, older persons, persons with disabilities, and persons with HIV/AIDS.[123] Payment for privately and publicly provided healthcare services must be based on equity and affordable for all, including socially disadvantaged groups, and not disadvantage the poor.[124]

General Comment 22 on Sexual Reproductive Health Rights also provides that states must adopt appropriate legislative, administrative, budgetary, judicial and other measures to ensure the full realisation of the right to sexual and reproductive health.[125] CEDAW's General Recommendation 24 encourages states to report on measures that state parties have taken to ensure women receive appropriate services in connection with pregnancy, delivery, and the postnatal period.[126] States are required to report on the rates at which these measures have reduced maternal mortality and morbidity in their countries.[127] State parties should also supply free services where necessary to ensure safe pregnancies, childbirth, and post-partum periods for women.[128]

The CEDAW Committee notes that any woman can be at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity, and post-natal services.[129] The CEDAW Committee mandates state parties to ensure women's rights to safe motherhood and emergency obstetric services and to allocate the maximum extent of available resources.[130] In *Alyne da Silva Pimentel v Brazil,* a Brazilian woman of African descent died

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[122] General Comment 14 para 14
[123] As above
[124] General Comment 14 para 12.
[125] General Comment 22 (2016) on the right to sexual and reproductive health (article 12 of the ICSECR) Para 22http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD/pyfcp3Ylzg(accessed 12 September 2023).
[126] CEDAW General Recommendation 24: Article 12 of the Convention (Women and Health)https://www.refworld.org/docid/453882a73.html(accessed 13 September 2023).
[127] As above.
[128] General Recommendation 24 para 26-27.
[129] As above.
[130] As above.

after emergency surgery was delayed for over 14 hours after suffering pregnancy-related complications. She was not transferred to a better-equipped hospital as there was no ambulance to ferry her.[131] Here, the CEDAW Committee reinforced that the failure of a state to provide emergency obstetrics care for a pregnant woman amounts to violations of the rights to life, non-discrimination and health guaranteed under CEDAW. This case shows that the maternal mortality crisis is linked to the deep inequalities faced by women in realising their right to health. It exposes the barriers in transportation and competent facilities encountered by women in accessing maternal healthcare predicated on one's social status. The requirements of availability, accessibility, affordability, and quality mandated by General Comment 14 are difficult to achieve. In Zimbabwe ambulance shortages compound delays that women and girls experience reaching and receiving care at health facilities.[132] This violates the rights to health and SRHR.[133] Zimbabwe is enjoined to fulfil its obligations, in keeping with the CEDAW Committee's jurisprudence on advancing pregnant women's rights to maternal healthcare.

Zimbabwe already provides free maternal services in its public hospitals true to General Comments 14 and 22. However, reducing maternal mortality requires equipping primary health facilities at constituency level with proper amenities to identify emergencies expeditiously, together with ambulances and medicines. This is achievable if devolution is implemented effectively. General Recommendation 24 notes that the treatment of women in a clinical context informs their access to healthcare.[134] The service must be acceptable and respectful to their dignities and sensitive to their needs.[135] Oftentimes, women in rural areas in Zimbabwe opt for home deliveries due to ill-treatment (rude comments) by health personnel.[136]

The Human Rights Committee in General Comment 6 states that the right to life should not be construed narrowly but that it intersects with rights such as healthcare. This is in harmony with General Comment 3 on the right to life in the African Charter on Human and Peoples' Rights, 1981 (African Charter).[137] The Human Rights Committee has noted in

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131 CEDAW Committee 10 August 2011 UN Doc CEDAW/C/49/D/17/2008.
132 Amnesty International Zimbabwe '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' https://www.amnesty.org/en/documents/afr46/4112/2021/en/(accessed 20 September 2023).
133 As above.
134 General Recommendation 24 para 14.
135 *Z v Poland* Application No. 46132/08.
136 MK Dodzo & M Mhloyi 'Home is best: Why women in rural Zimbabwe deliver in the community' https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181771(accessed 28 September 2023).
137 O Afulukwe-Eruchalu & E Durojaye 'Developing norms and standards on maternal mortality in Africa: lessons from UN human rights bodies' (2017) African Human Rights Yearbook 82 at 89.

its Concluding Observations that lack of access to reproductive healthcare services, including emergency obstetric care and contraception for women, is a violation of their right to life and expressed concern over high rates of maternal mortality.[138] This escalates the high numbers of global maternal mortality despite efforts to reduce it significantly. Regional and international standards complement each other in a joint effort to reduce maternal mortality through set standards necessitated by states like Zimbabwe reneging from their obligations in protecting, respecting, and fulfilling women's health rights.

Where the international framework fails to cater for the lived realities of African women, the regional framework sufficiently bridges the gap as evidenced in the following section.

3.3 Regional legal and policy framework

The African Charter on the Values and Principles of Decentralisation, Local Governance and Local Development was adopted in 2014 and entered into force in 2019. However, Zimbabwe is yet to ratify this treaty. The treaty signifies a commitment by African states to decentralise functions and equitable sharing of resources to ensure citizen participation and development at the local level.[139] Ratifying this treaty would increase the threshold of obligations on Zimbabwe. The treaty encourages states to ensure that both local and central governments are bound by laws enforcing cooperation and complementarity of both organs and views local governments as the key cornerstones of any democratic system.[140] The Constitution leaves room for discretion when it comes to the implementation of devolution. Hence, the GoZ has no incentive to implement it effectively and expeditiously. If bound on a regional scale, the government will have to adhere to its obligations to avoid being admonished by fellow states. If the government ratifies the treaty, it allows citizens or organisations to approach regional mechanisms such as the African Commission on Human and Peoples' Rights (African Commission) for recommendations on implementation. This would be an ideal treaty to ratify, as it would bind Zimbabwe to its obligations and ensure its commitment to its citizens in implementing devolution.

The African Charter provides for the right to enjoy the best attainable state of physical and mental health.[141] States are mandated to take necessary measures to protect

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138 As above.
139 African Charter on the Values and Principles of Decentralisation, Local Governance and Local Development.
140 As above art 11.
141 African Charter art 16.

the health of their people and ensure they receive medical attention when they are sick.[142] However, Article 16 missed an opportunity to provide for maternal health obligations.[143] The African Commission has acknowledged that most African countries may lack resources to implement the right to health to the required standard but encourages states to utilise every available resource to enforce the right to health including maternal healthcare.[144] This prevents arguments of limited resources usually advanced by states for failure to adequately provide socio-economic rights.[145]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) has made significant strides in catering for the lived realities of African women, a step further from the CEDAW.[146] It mandates state parties to ensure that women's health rights, including SRHR, are respected and promoted.[147] Article 14 (2)(b) mandates state parties to establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding.[148]

The Maputo Protocol's two General Comments serve as guiding principles in interpreting and clarifying obligations arising from it.[149] General Comment 1 emphasises the need to provide enabling environments for accessing SRHR services.[150] General Comment 2 on Article 14 (1)(a), (b), (c) and (f) and Article 14 (2)(a) and (c) lays down states' obligations on women's reproductive health, particularly on the right to have access to abortion services.[151] It reiterates General Comment 14 on the right to health, specifically the rights to fertility control, contraception, family planning education, and abortion that are guaranteed to women in the African context.[152] General Comment 2 complements Article 14(2) by highlighting the necessity of the availability, financial and geographical accessibility as well as the quality of women's sexual and reproductive healthcare services, without any discrimination relating to age, health condition, disability, marital

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142 African Charter art 16(2).
143 Sithole (n111).
144 E Durojaye 'Article 14: Health and Reproductive Rights' in F Viljoen et al (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women: A Commentary* (2023) 308 at 318.
145 Constitution, sec 76(4).
146 As above.
147 Protocol to the African Charter on Human and Peoples' Rights on the rights of women in Africa, 1995.
148 As above.
149 Durojaye (n144) 319.
150 As above.
151 Centre for Human Rights 'A guide to the General Comments on Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the rights of women in Africa' 1 at 3https://www.chr.up.ac.za/images/publications/centrepublications/documents/final_guide_to_the_general_comments_2015.pdf(accessed 14 September 2023).
152 Sithole (n111) 84.

status, or place of residence.[153] Article 14 directs states to establish and strengthen healthcare services in pre-natal, delivery and post-natal services.[154] Anything less is a violation of Article 14(2) of the treaty. Zimbabwe must create an environment that allows women to exercise their reproductive health services. However, the challenges discussed under the international legal framework apply here. Women's rights are violated due to the inaccessibility of health infrastructure to ensure the realisation of SRHR.

The Maputo Protocol is the first human rights treaty to allow abortion in cases of sexual assault, and incest among others.[155] The Protocol also takes cognisance of the impact of HIV/AIDS in accessing SRHR in the African context.[156] Additionally, Zimbabwe committed through the Abuja Declaration to take all necessary measures to avail the needed resources for health services delivery from all sources and that they are efficiently and effectively utilised.[157] Countries pledged to allocate at least 15 percent of states' annual budget to improve the health sector.[158]

The African Commission Resolution on Maternal Mortality**,** 2008 called upon African governments to address the issue of maternal mortality individually and collectively and Zimbabwe is mandated to comply with the same.[159] The Guidelines on Combating Sexual Violence and its Consequences in Africa articulate states' obligations to realise women's rights to sexual and reproductive health in Article 14 as they encourage the adoption of laws that prevent violence against women, which has adverse effects on their health rights.[160] Reporting Guidelines for States regarding obligations under the Maputo Protocol apprise states of reporting legislative efforts in advancing SRHR guaranteed in Article 14.[161] General Comment 3 on the right to life complements Article 14 as the African Commission notes that states have a responsibility to address threats to life such as preventable maternal deaths by establishing functioning health systems and eliminating discriminatory laws and practices that restrict access to healthcare services.[162]

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153 As above.
154 Durojaye (n144) 319.
155 Durojaye (n144) 310.
156 As above.
157 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, 2001 https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf(accessed 12 September 2023).
158 As above.
159 Resolution on Maternal Mortality in Africa, ACHPR/Res.135(XXXXIV)08. https://achpr.au.int/index.php/en/adopted-resolutions/135-resolution-maternal-mortality-africa-achprres135xxxxiv08(accessed 10 October 2023).
160 Durojaye (n144) 324.
161 Durojaye (n144) 323.
162 As above.

The African Court on Human and Peoples' Rights and the African Commission are yet to decide on cases relating to access to maternal healthcare.[163] However, the right to maternal healthcare has been interpreted progressively in comparative jurisdictions across the continent. These have persuasive value in the Zimbabwean courts and serve as guiding principles for judges to adopt. The Constitutional Court of Uganda found a violation of the rights to health, life, gender equality and freedom from inhuman and degrading treatment, for preventable deaths in childbirth, where two women died in hospital due to unavailability of basic maternal commodities.[164] The court pronounced that the Government of Uganda's omission to adequately provide basic maternal healthcare services and emergency obstetric care in public health facilities violated the rights to health and life, and the rights of women guaranteed under Uganda's Constitution.[165] The Government of Uganda was ordered to prioritise and provide sufficient funds in the national budget for maternal healthcare.[166] The Court also ordered that all healthcare workers who provide maternal healthcare services in Uganda be fully trained, and for the government of Uganda to properly equip all health centres.[167]

This judgment is in line with the Maputo Protocol on treating women with dignity. Progressive courts should adopt best practices from other jurisdictions in enforcing human rights and be guided by regional and international standards. Zimbabwean courts should produce binding jurisprudence to complement existing laws that will ensure compliance with regional and international obligations arising on accessing maternal healthcare.

3.4 Devolution in Zimbabwe and maternal health

The Constitution provides for three tiers of government, namely national, provincial, and local governments.[168] The institutional framework for devolution involves central government, the provincial and metropolitan Councils and the local authorities.[169] The Constitution provides for traditional leaders but these are not direct beneficiaries of devolution.[170] The Constitution is silent on whether any tier will supervise or monitor

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[163] Durojaye (n144) 323.
[164] *The Center for Health Human Rights and Development (CEHURD) and 3 Others v Attorney General* Constitutional Petition No. 16 of 2011).
[165] M Mulumba "Ugandan Court decision enshrines access to basic maternal health care as a Right"https://blog.petrieflom.law.harvard.edu/2020/08/26/uganda-maternal-health-care-right/ (accessed on 7 December 2022)
[166] As above.
[167] Mulumba (n165).
[168] Constitution, sec 5.
[169] As above.
[170] Constitution, sec 282.

another, and neither is there a dispute resolution mechanism.[171] It is also silent on resource allocation decisions including varying budgets.[172] The UCs Act provides for local authority revenue collection through income-generating projects, subject to the Minister's approval.[173] However, the Constitution provides for equitable sharing of resources from national government to provincial and metropolitan councils and local authorities. It also mandates the enactment of legislation to provide for conditional and unconditional grants to the two lower tiers.[174]

Devolution is provided for in section 264(1) of the Constitution.[175] Devolution is defined as a system of government where powers and functions of a state are transferred to lower levels formally recognised by the Constitution.[176] It organises governance and manages state power both vertically and horizontally.[177] It combines self-governance at the local level and shared governance at the national level.[178] The Zimbabwean system resembles devolution but falls short as the lower levels have been reduced to implementers of central government programmes. The author contends that Zimbabwe practises delegation as opposed to devolution, hence, the dissertation title refers to decentralisation as opposed to devolution.

The Constitution does not define what devolution is, leaving it subject to interpretation.[179] The type of devolution to be implemented is unclear, although it seems more economic than political.[180] Devolution seeks to devolve governmental powers, responsibilities and finances to provincial and metropolitan councils and local authorities.[181] The Constitution stipulates that the councils must be competent to carry out functions effectively and efficiently.[182] Devolution of governmental powers and responsibilities seeks to enhance citizens' participation in making decisions affecting

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[171] TC Chigwata 'Emerging debates and prospects for devolution in Zimbabwe' (2019) 1https://www.researchgate.net/publication/332971143_Emerging_debates_about_and_prospects_for_devolution_in_Zimbabwe (accessed 5 September 2023).
[172] As above.
[173] UCs Act, sec 221(1).
[174] Constitution, sec 301.
[175] Constitution, secs 264-279.
[176] CW Wahome 'Impact of devolved health on maternal healthcare in Kenya: The case of Nyandarua County' MA thesis, University of Nairobi, 2019 at 8 http://erepository.uonbi.ac.ke/bitstream/handle/11295/109212/KATE%20WAHOME%20WANJIRU...Final.pdf?sequence=1 (accessed 21 September 2023).
[177] Ochieng (n28).
[178] As above.
[179] Chigwata (n171) 11.
[180] As above.
[181] Constitution, sec 264(1).
[182] As above.

them.[183] Devolution seeks to 'promote democratic, effective, transparent and accountable government in Zimbabwe as a whole.'[184]

The foundation of devolution laid out in the Constitution is not strong. Section 264(1) provides that devolution of functions may be done 'whenever appropriate,' while the Chapter 14 preamble refers to 'wherever desirable.'[185] The provisions are vague, with no clarity on how the appropriateness may be determined. The word 'must' in section 264(1) indicates that this is a peremptory provision yet the 'wherever appropriate' aspect alludes to a discretion to be exercised by central government.

The composition of the provincial councils which includes Members of Parliament (MPs) and Senators poses challenges.[186] Because Ministers of State for Provincial and Devolution of Affairs (formerly known as provincial governors) are appointed by the President, the likelihood of impartiality is limited.[187] They report to the President and decisions made at the provincial level may be motivated by their loyalties to the appointing authority.[188] There is also a proliferation of roles for MPs and Senators who already have their responsibilities in Parliament. Chigwata argues that this double representation may inhibit checks and balances among the different tiers.[189]

There is no distinction between provincial ministers and chairpersons of provincial and metropolitan councils and there are no defined roles for the provincial ministers in the Constitution.[190] The place of provincial and metropolitan councils is still unclear as the Constitution does not provide taxation, legislative and executive powers to them, to be regarded as a government that can manage its affairs.[191]

Zimbabwe has ten provinces (8 provincial councils and 2 metropolitan councils).[192] Their functions comprise undertaking social economic development in their provinces, including planning and implementing social and economic development activities such

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183 A Nhamo 'Devolution in Zimbabwe' (2022) 1 at 3https://sdgs.un.org/sites/default/files/2022-04/11.%20Alpha.Nhamo_Ministry%20of%20Local%20Government%20and%20Public%20Works_DEVOLUTION%20IN%20ZIMBABWE.pdf(accessed 27 August 2023).
184 As above.
185 Constitution, sec 264(1).
186 Constitution, sec 268.
187 '5 new provincial Ministers appointed' *The Herald* 12 September 2023https://www.herald.co.zw/5-new-provincial-affairs-ministers-appointed/(accessed 13 September 2023).
188 Moyo (n 30) 300.
189 Chigwata (n171) 10.
190 Chigwata (n171) 18.
191 Chigwata (n171) 17.
192 Constitution, sec 267(1).

as the provision of healthcare.[193] Hence, there is need for councils to take charge of development programmes at the local level.

The Constitution lacks clarity on what devolution to local authorities entails. It provides for the general functions of local authorities which include managing the affairs of citizens both in urban and rural areas across Zimbabwe and are managed by councils composed of councillors.[194] Local authorities have the power to govern the local affairs within their areas through the UCs Act of 1995 but have no legislative powers.[195] Therefore, there is no clarity between the functions of provincial and metropolitan councils and local authorities. It is not clear if devolution to local authorities is of resources and/or discretionary powers. Ultimately, the Constitution focuses on devolution to provincial and metropolitan councils to the exclusion of local authorities and without specificity, the scope of functions of the lower tiers is not easily determinable.

The PCA Act provides for the establishment of a provincial system of governance managed by provincial governors and provincial councils.[196] It provides for the functions of the provincial governor, including promoting the activities of the various Ministries and organs of central government in implementing development plans prepared by the provincial council for each province.[197] Thus, provincial governors were operating on behalf of central government, an indication that there was no decentralisation. The Act gives the President powers to establish provincial councils consisting of the provincial governor, mayor, chief, a councillor and three persons appointed by the President, whenever he 'considers it desirable.'[198] The provincial councils possess powers, only vested in them by the Minister.[199] The President can also abolish provincial councils.[200] This Act is outdated and its alignment to the Constitution is underway.

The Provincial Councils and Administration Bill H.B5 of 2021 was gazetted on 31 March 2021.[201] There is a lack of political will in central government to prioritise the Bill

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193 Constitution, sec 270.
194 Constitution, sec 274(1).
195 Constitution, sec 276.
196 [Chapter 29:11].
197 PCA Act, sec 10.
198 PCA Act, sec 11.
199 PCA Act, sec 35.
200 PCA Act, sec 36.
201 Kubatana 'Legal analysis of the Provincial Councils Administration Amendment Bill' https://kubatana.net/2021/05/06/legal-analysis-of-the-provincial-councils-administration-amendment-bill/ (accessed 4 September 2023).

despite its first reading to the National Assembly in 2021.[202] The Bill was expected to stipulate the roles and responsibilities of the three tiers of government to avoid duplication of functions.[203] There is no clarity on how central government officials in devolved areas will interface with lower tiers of government.[204] The Bill was drafted in a muddled manner as some clauses specifically amend the provisions of the Act while most of the clauses seem intended to form a new Act of Parliament.[205]

Local government is split into two, urban councils established under the UCs Act and rural areas established under the RDC Act.[206] The former provides for the establishment of municipalities and towns and their administration by local boards, municipal and town councils.[207] The Act also serves to confer functions, powers, and duties upon municipal and town councils together with local boards.[208] Section 198 provides for the powers of local authorities.[209] It states that a council shall have the power to undertake and carry out any or all the functions stipulated in the Second Schedule of that Act.[210]

The RDCs Act provides for the declaration of districts and the establishment of rural district councils, confers and imposes functions upon RDCs and provides for the administration of these areas.[211] Both Acts are complemented by the Regional Town and Country Planning Act, 1976 which provides for the delineation of boundaries across the country.[212] Both urban and rural councils have the power to operate hospitals, clinics, and dispensaries and to take any measures which they consider necessary for the maintenance of health.[213] They also have powers to provide, operate or carry on services

202 Veritas 'BILL WATCH 28/2021 - The Provincial Councils and Administration Amendment Bill' https://www.veritaszim.net/node/4954 (accessed 2 September 2023).

203 ZEPARI 'Policy Brief towards successful implementation of devolution in Zimbabwe' 13 February 2020 1https://zepari.co.zw/sites/default/files/2020-04/Towards%20Successful%20Implementation%20of%20Devolution%20in%20Zimbabwe%20-%20WEB.pdf(accessed 29 August 2023).

204 As above.

205 Veritas Bill Watch (n202).

206 D Mandiyanike 'Capacity building in a hostile environment: The case of Zimbabwe's Rural District Councils' (2013) 13/14 *Commonwealth Journal of Local Governance* at 109 at 115.

207 Veritas 'Urban Councils Act [Chapter 29:15]'https://www.veritaszim.net/node/186(accessed 3 September 2023).

208 As above.

209 UCs Act, sec 198(1).

210 As above.

211 [Chapter 29:13].

212 Chapter 29:12].

213 UCs Act, sec 25 Second Schedule; RDCs Act, sec 34.

for the care and welfare of newly born infants and for giving advice, guidance and instructions to expectant mothers and mothers of newly born infants.[214]

Regrettably, both entities are dependent on the Minister's authorisation to carry out some of their responsibilities.[215] While both Acts acknowledge the role of councils in carrying out their affairs for the benefit of their communities, the influence of central government is still extant.[216] Despite the introduction of metropolitan councils in the Constitution, there is no clearly defined power-sharing structure in the legislative framework. Both the UCs and RDC Acts are yet to be tabled before Cabinet and approved for amendments, to align with the 2013 Constitution. As a result, there is a gap in the legislative framework required for the implementation of devolution.

The Devolution and Decentralisation Policy was introduced in 2020 to cure lacunas in the current legal framework.[217] The GoZ introduced this policy as a sign of commitment to implement devolution.[218] The policy seeks to create the necessary conditions and institutional capacities of provincial and metropolitan councils and local authorities to assimilate and exercise devolved powers.[219] However, the policy does not stipulate the actual decentralisation and separation of powers among the different tiers of government. The Office of the President and Cabinet still play an oversight role in the affairs of the lower tiers.[220] Ultimately, what remains are vague provisions of the Constitution, legislation requiring amendments and a policy that brings in more gaps than clarity.

3.5 Challenges

3.5.1 Lack of clarity on competencies in legislation

The lack of clarity in legislation poses challenges. Without specific provisions on mandates of the three tiers, national government has no incentive or political will to effectively devolve functions to lower tiers. The PCA Bill does not clarify how devolved functions will be carried out by local authorities. There is no laid-out procedure on how responsibilities and finances will be channelled to the lower tiers. None of the laws

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[214] UCs Act, sec 28 Second Schedule; RDCs Act, sec 38.

[215] UCs Act, sec 198(2); T Nyikadzino & S Vyas-Doorgapersad 'Zimbabwe's transition to a devolved system of government: Critical factors for success' (2022) 10(1) *Africa's Public Service Delivery and Performance Review* 604.

[216] Constitution, sec 2.

[217] 'Devolution and decentralisation policy'(2020) 1 https://ucaz.org.zw/wp-content/uploads/2019/08/DEVOLUTION-AND-DECENTRALISATION-POLICY-pdf-min.pdf(accessed 30 August 2023).

[218] As above.

[219] Devolution and decentralisation policy (n217).

[220] Kubatana 'Is there any political will on the Implementation of Devolution in Zimbabwe' https://kubatana.net/2021/07/21/is-there-any-political-will-on-the-implementation-of-devolution-in-zimbabwe/ (accessed 4 September 2023).

specifically confer functions to the lower tiers and how they will harmonise their functions without duplication. The devolved economic development programmes cannot succeed without a clear devolved political governance framework.[221] Ultimately, central government is inconsistent even in the disbursement of funds that contribute to service delivery.

This affects communities' ability to carry out social development programmes including provision of maternal healthcare. Outdated legislation gives powers to the Minister of Local Government who overrides local government decisions and sometimes commits councils to contracts beyond their financial capability for the Minister's gain, which impacts other services such as healthcare.[222] The failure to stipulate local authorities' functions in the Constitution leads to overinterference as the Minister can interfere and even amend the provisions of the UCs and RDCs Acts. Nevertheless, if devolved healthcare is constitutionalised, it will be challenging to interfere or strip local authorities of their autonomy. Central government needs to relinquish control to local authorities and not 'micromanage' every aspect of service delivery. However, central government cannot risk exposure to its corrupt benefits from dubious contracts.[223]

3.5.2 Financial arrangements

Devolution mandates the equitable sharing of resources and the transfer of responsibilities and resources from central government to establish a sound financial base for each provincial and metropolitan council and local authority.[224] This is done through the annual national budget by the Minister of Finance and Economic Development.[225]

The Constitution provides for the financing of the devolution agenda, through the intergovernmental fiscal transfer target of at least five percent of national revenue in any financial year as stipulated in section 301(3).[226] The allocation to provincial councils and local authorities considers the population, physical infrastructure and poverty

221 Zinyama (n9) 147.
222 Kubatana 'Pomona waste management deal' https://kubatana.net/2022/05/24/pomona-waste-management-deal/ (accessed 20 October 2023).
223 FS Matiashe 'Zimbabwe : Battle for control of Harare City Council rages on' *The African Report* 27 May 2022 https://www.theafricareport.com/206754/zimbabwe-battle-for-control-of-harare-city-council-rages-on/ (accessed 30 September 2023).
224 Nhamo (n183) 4.
225 Veritas 'The 2022 Citizens' Budget' https://www.veritaszim.net/sites/veritas_d/files/2022_Citizens_Budget.pdf (accessed 20 october 2023).
226 ZEPARI Policy brief (n203).

prevalence.[227] These funds ought to assist the two lower tiers in discharging their functions for the benefit of their communities.

While commendable, the five percent that is set aside to develop local infrastructure is insufficient to cater for all the provinces for adequate service delivery including maternal healthcare. Moreover, some regions have long been marginalised and require more funding allocation to successfully manage the lack of health amenities across Zimbabwe. While councils can fundraise for themselves, they still largely rely on central government for grants. The annual equitable allocation is pegged in the local currency which is devalued by inflation. The allocation is also inconsistent. In 2022, it was 4.3 percent.[228] The limited funds affect the availability of adequate health infrastructure, including medicines and PPE which impacts on accessibility of maternal healthcare.

Additionally, local government is responsible for hiring and dismissing its health workers.[229] Health professionals at council-run clinics are remunerated through salary grants received from central government.[230] However, the disbursement of grants is inconsistent, which results in nonpayment of salaries and disgruntled employees. Furthermore, there is no equitable distribution and decentralisation of resources from central government as mandated by the objectives of devolution. Devolution encourages transparency and good governance, and the failure to implement it results in corruption. As the lower tiers continue to rely on central government for funding, they cannot effectively manage key services such as healthcare, without financial reserves of their own.[231]

3.6 Domestic legal framework on the right to health

Socioeconomic rights impose a positive obligation which demands a redistribution of resources.[232] The Constitution of Zimbabwe guarantees that every citizen and permanent resident of Zimbabwe has the right to access basic healthcare services, including reproductive healthcare services.[233] The Constitution has no right to access maternal healthcare but the right is implied from the definition of reproductive healthcare services. The Constitution also mandates the state to take reasonable legislative and

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227 As above.
228 Citizens' budget (n225).
229 S Nyoka 'Zimbabwe clinics struggle for nurses after exodus to the UK' *BBC News* 9 March 2022 https://www.bbc.com/news/world-africa-60524576 (accessed 20 October 2023).
230 As above.
231 J Mukoyi 'Chapter 14 of the Constitution and Implementation of Devolution in Zimbabwe' (2020) 10 *International Journal Scientific and Research Publications* 999 at 1003.
232 Kondo (n51).
233 Constitution, sec 76(1).

other measures, 'within the limits of the resources available to it,' to achieve the progressive realisation of the right to health.[234]

Progressive realisation recognises that socioeconomic rights are achievable over time. This takes into cognisance states' developmental status. However, states are also mandated to devote maximum available resources, local and international, to achieve this by prioritising socioeconomic rights in resource allocation.[235] The phrase 'within the limits of the resources available to it' in section 76(4) makes it difficult to ascertain the threshold of the limits and is often taken advantage of by GoZ to offer substandard basic services to its citizens.

In addition, the right to health is not absolute and is subject to the limitation clause (section 86(2)). Section 86(2) provides that the right can only be limited by a law of general application and to the extent that such limitation is 'fair, reasonable, necessary and justifiable in a democratic society based on openness, justice, human dignity, equality and freedom.'

The Constitution also provides that the state must take all practical measures to ensure the provision of basic, accessible, and adequate health services throughout Zimbabwe.[236] It also enjoins the state to take appropriate and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution.[237] This means expectant mothers should not be denied access to maternal healthcare services at any institution in Zimbabwe. However, this has not been the case as outlined in this chapter.[238]

Section 118 of the Public Health Act provides that central government may aid under-resourced local authorities that lack infrastructure.[239] The MoHCC may, subject to conditions they may fix, use resources from the Public Health Funds to contribute towards any costs incurred by any local authority in connection with maternal or child health issues.[240] Section 118(1)(c) supports the concept of devolution, requiring the allocation of grants from central government to be administered by local authorities in promoting health rights. However, it perpetuates the reliance of local government on central

234 Constitution, sec 76(4).
235 General Comment 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) Para 13 https://www.refworld.org/pdfid/4538838e10.pdf (accessed 20 October 2023).
236 Constitution, sec 29(1).
237 Constitution, sec 29(2).
238 Page 38.
239 [Chapter 15:17].
240 As above.

government, as the Constitution does not provide for local authorities' revenue-raising powers. The revenue-raising powers provided by the UCs Act are subject to the Minister's approval which interferes with the autonomy of the local authorities in implementing their development programmes.

The Zimbabwe National Family Planning Council Act provides for the structure, functions, and powers to provide for child spacing and fertility services in Zimbabwe.[241] It stipulates promotion and implementation of primary healthcare and other community-based development programmes relating to family health.[242] The Act also provides for functions of a council which include participating actively with other organisations or institutions in the formulation and implementation of primary healthcare programmes and other community development activities related to family health.[243] This encourages the devolution of both resources and powers so that councils can contribute significantly to programmes that benefit their communities, including maternal healthcare services.

The National Health Strategy 2021-2025 documents strides taken by the MoHCC in reducing maternal mortality and provision of maternal healthcare across Zimbabwe in line with Sustainable Development Goals (SDGs) and Vision 2030.[244] It proffers strategies to adopt to improve access to maternal healthcare such as increasing health personnel, continuing free maternal services at public hospitals and improving health infrastructure.[245] While this strategy complements existing legislation and works as a commitment by the government to the people, it focuses on the right to health overall. There is no stand-alone policy specifically for maternal healthcare, yet it is an integral aspect of health requiring prioritisation as it has a bearing on the right to life of mothers and babies and contributes to the general welfare of society.[246] It also gives authority to the ministry to establish health posts at the community level, instead of local authorities, disregarding the tenets of devolution.[247]

241 [Chapter 15:11].
242 As above.
243 Zimbabwe National Family Planning Council Act, sec 22(1)(c).
244 Health Strategy 2021-2025 (n62).
245 As above.
246 The importance of maternal health carehttps://online.regiscollege.edu/blog/maternal-health-care/#:~:text=Maternal%20health%20care%20is%20essential,care%20and%20leading%20healthier%20lives. (accessed 20 October 2023).
247 Health Strategy 2021-2025 (n62) 67.

3.7 Implementation post-2013 Constitution

3.7.1 Jurisprudence

Zimbabwean courts have not adjudicated many cases enforcing the right to health including access to maternal healthcare services since before the 2013 Constitution. However, the Supreme Court of Zimbabwe, in 2014, acknowledged the importance of SRHR.[248] Mildred was raped and failed to get abortion services timeously due to bureaucratic red-tape at clinics and police stations in Zimbabwe, until the timeframe allowed by the Termination of Pregnancy Act [Chapter 15:10] for one to have an abortion lapsed.[249] Here, the court encouraged the use of regional and international standards in judicial processes, regardless of their incorporation into domestic law. This is a good defence against the dualist and sovereignty arguments usually advanced by states to renege from their obligations. The court acknowledged that Article 16(1) of CEDAW allows women to decide on child spacing and to freely access SRHR information, enabling them to exercise these rights.[250] The court noted that Article 14(1) encourages states to respect and promote women's rights in the authorisation of medical abortions under specified circumstances.[251] This is a welcome development in the Zimbabwean courts in the 'new' constitutional order. However, Zimbabwe will benefit from more jurisprudence enforcing the right to health and women's access to maternal healthcare. CSOs must intervene and assist women in this regard.

In 2020 during the COVID-19 pandemic, the GoZ closed nonemergency units and reassigned the limited health force to address the potential influx of COVID-19 patients. This led to the cancellation of antenatal, childbirth and post-partum care for pregnant women and girls.[252] Consequently, Aurage Katume and Melody Mapani, together with the Combined Harare Residents Association, filed an application at the High Court in Harare challenging the closure of 42 council-run clinics.[253] The closure was due to lack of COVID-19-related resources including PPE, resulting in challenges for expectant women in accessing maternal healthcare. These two women were ill-treated by health personnel and could not access adequate medical attention at local clinics. Aurage Katume was

[248] *Mildred Mapingure v Minister of Home Affairs and Others* Supreme Court 22/2014.
[249] As above.
[250] *Mapingure* 2014 (n248).
[251] *Mapingure* 2014 (n248).
[252] Amnesty International 'The devastating effects of COVID-19 on maternal health in Zimbabwe'https://www.amnesty.org/en/latest/campaigns/2020/04/the-devastating-effects-of-covid19-on-maternal-health-in-zimbabwe/(accessed 10 August 2023).
[253] *Combined Harare Residents Association and 2 Others v City of Harare and 3 Others* Harare High Court, 5165/2020.

turned away at the clinic where she was registered to give birth. She hired a taxi to another clinic and gave birth after 'she was extorted by midwives to get service' and Melody Mapani lost her baby after being sent from one clinic to another in July 2020.

The applicants sought an order to compel the City of Harare to reopen all its 42 council-run clinics so that expectant mothers would access maternal healthcare services without any impediments.[254] They also sought an order compelling the Minister of Finance and Development to release funds to facilitate the purchasing of health infrastructure to allow for the clinics to open. Ultimately, they alleged a violation of section 76 of the Constitution on the right to have access to basic healthcare services. The court granted the order compelling the City of Harare to ensure that all pregnant women receive emergency medical service and that all council-run clinics be opened and operational by 14 October 2020.[255] Since then, the City of Harare started opening its clinics and improved health service delivery to the expectant women in the affected areas. This case highlighted the challenges faced by local authorities in catering for their communities in providing maternal healthcare. It also showed the financial and access barriers faced by women in low-income communities where there is insufficient health infrastructure and citizens rely on public health facilities.

One would expect such challenges to be diminishing, post-devolution due to councils having the resources to finance their projects and provide services such as healthcare with ease. Chigwata posits that with devolution comes fiscal autonomy, to raise and spend revenue.[256] However, this is not so as devolution is yet to be implemented and functions devolved to the lower tiers. There is a lack of political will to prioritise the implementation of devolution, yet it seeks to improve the lives of all citizens. Adequate resources ensure adequate health infrastructure including PPE and properly equipped facilities to cater for expectant mothers. Notwithstanding that an *ex tempore* judgment was given in this case, it paves the way for further public interest litigation in advancing access to maternal healthcare in Zimbabwe as the attitude of the courts in this matter is quite encouraging.

254 N Ndoro 'High Court orders City of Harare to open all clinics, attend to pregnant mothers' *Nehanda Radio* 8 October 2020https://nehandaradio.com/2020/10/08/high-court-orders-city-of-harare-to-open-all-clinics-attend-to-pregnant-mothers/(accessed 12 September 2023).
255 Chingono (n1).
256 (n171).

3.7.2 Initiatives

Progress has been made by the GoZ because, before the 2013 Constitution, there was no provision for the right to health in both the Constitution and the Public Health Act. The CEDAW Committee made recommendations to Zimbabwe for the right to be incorporated in the country's legislation. The current existing legislative framework was in response to these recommendations.[257] GoZ should also remove restrictive abortion laws and women's limited access to quality reproductive and sexual health services, especially in rural and remote areas.[258]

In 2014, the Urban Voucher Programme (UVP) was reintroduced for women who could not afford maternal healthcare to do so freely at selected health institutions through the Results Based Financing facility.[259] One completes a questionnaire at their local clinic to determine their eligibility for the programme. If they qualify, they are referred to any of the health facilities that offer the programme. The project was rolled out in 11 health centres, five in Harare and six in Bulawayo, as well as in two central hospitals, one in each city. The initiative aims to improve access, and healthcare outcomes through the provision of vouchers for antenatal, delivery, and post-natal services.[260] Expectant mothers in low-income households are targeted by this programme to increase their access to health services and assisted births.[261] The programme has made significant strides, for example, 3,500 women in Bulawayo local clinics such as Magwegwe and Pelandaba benefited significantly from it between January and March 2023.[262] Whenever necessary, the referred clients are transported from primary health centres to central hospitals by ambulances for free. Before this initiative, most expectant mothers could not visit health clinics regularly because they could not afford the US$25 registration fee. In 2017, the UVP assisted more than 2,600 women at a clinic in Hopley, Harare.[263]

257 Cedaw Committee 'Concluding observations of the Committee on the Elimination of Discrimination against Women /C/ZWE/CO/2-5 https://icj2.wpenginepowered.com/wp-content/uploads/2012/03/Concluding-Observations-CEDAW-Zimbabwe-2012-eng.pdf(accessed 20 October 2023).

258 As above.

259 The World Bank 'Improving access to maternal health for Zimbabwe's expectant mothers'https://www.worldbank.org/en/news/feature/2019/01/10/improving-access-to-maternal-health-for-zimbabwes-expectant-mothers(accessed 25 August 2023).

260 Cordaid (n91).

261 Amnesty International (n252).

262 N Tshili 'Government voucher system benefits 3 500 pregnant women' *The Chronicle* 8 May 2023https://www.chronicle.co.zw/govt-voucher-system-benefits-3-500-pregnant-mothers/(accessed 20 August 2023).

263 World Bank (n259).

The Rural Based Treasury Initiative in rural areas subsidised healthcare services to provide a package of free healthcare for pregnant women and children under five.[264] The GoZ also constructed and refurbished maternity waiting homes to provide close observation to expectant mothers to reduce maternal mortality in compliance with the obligations to protect, respect and fulfil the right to health.[265] However, none of these programmes can be attributed to devolution, more so, because efforts to implement devolution began during the tenure of the Mnangagwa administration.

As there are no defined roles for the three tiers of government, there is continued involvement of central government in all initiatives relating to health, up to the constituency level. Despite this initiative being after the 2013 Constitution, provincial and metropolitan councils and local authorities have been reduced to implementers. Central government is divorced from the needs of the communities as its initiatives tend to favour hospitals under its purview. For instance, in one of the programmes, reproductive health equipment was procured for five central hospitals and 'selected' polyclinics in the two major cities, Harare and Bulawayo.[266]

In 2016, GoZ introduced the National Health Strategy (2016 to 2020) seeking to harmonise local government health services with those of the MoHCC, citing that local government is incapable of providing adequate healthcare services due to dilapidated infrastructure.[267] Despite the introduction of devolution, central government continues spearheading initiatives on access to maternal healthcare.

In 2018, GoZ removed maternal user fees for pregnant women, in keeping with the requirements in General Comment 14 on the right to health.[268] The GoZ also reported that maternal mortality rates reduced from 960 per 100 000 live births in 2010 to 462 in 2019. This is in line with achieving SDG 3 on 'Equity and Quality in Health: Leaving no one behind' through the 2016-2020 National Health Strategy, which seeks to ensure healthy lives and promote well-being for all at all ages.[269] The Zimbabwe maternal mortality rate is currently

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264 Hansard(n110).

265 As above.

266 UNFPA 'Zimbabwe Annual Report 2022' https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/unfpa_zimbabwe_2022_annual_report_final_print.pdf (accessed 14 September 2023).

267 Health Strategy 2016-2020 (n96).

268 Zimbabwe's Second Voluntary National Review 2021https://hlpf.un.org/sites/default/files/vnrs/2021/279562021_VNR_Report_Zimbabwe.pdf(accessed 12 September 2023).

269 UNICEF 'Zimbabwe Annual Report 2021'https://www.unicef.org/zimbabwe/media/5591/file/Zimbabwe%20Annual%20Report%202021.pdf(accessed 15 September 2023).

at 363 per 100 000 live births while the global rate is 223 per 100 000.[270] Central government has partly attributed this to the UVP.[271] States including Zimbabwe strive to achieve these milestones to maintain good standing in the global community.

In 2019, the country experienced demonstrations from health personnel working in public health facilities due to lack of proper remuneration and PPE.[272] Health professionals at government hospitals and council-run clinics in Harare declared incapacitation.[273] As expectant mothers experienced challenges in accessing maternal healthcare services, they resorted to home deliveries. In Mbare, a low-income suburb in Harare, a midwife assisted pregnant women who had been turned away from health facilities due to the industrial action, to deliver their babies in her home.[274] She delivered about 100 babies in 8 days.[275]

In 2020, the world was affected by COVID-19. Zimbabwe introduced lockdowns through the Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) Order, 2020,[276] to minimise the spread of the virus. A disruption of critical health services including access to maternal healthcare services ensued as a result.[277] Access to SRHR information and services was restricted, leaving expectant mothers at risk.[278] Because of the lockdown, a lot of services, including transportation services were suspended or reduced. During this period, many pregnant women and girls were unable to afford transportation costs, causing a reduction in the number of women who went to health facilities.[279] Many of those who attended were unable to get any service as their local clinic was either closed or did not have adequate health infrastructure for providing maternal healthcare services.[280] Where the health facilities were operational, the health personnel demanded bribes from patients to get admitted for delivery.[281] There were reports of babies being born in queues outside maternity clinics.[282] Some women resorted

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[270] UNFPA 'Sexual and Reproductive Health'https://zimbabwe.unfpa.org/en/topics/sexual-reproductive-health-5#:~:text=UNFPA%20provides%20technical%20and%20financial,2022%20Housing%20and%20Population%20Census.(accessed 12 September 2023).
[271] Tshili (n262).
[272] P Chipunza 'Harare municipal nurses down tools' *The Herald* 4 November 2019https://www.herald.co.zw/breaking-harare-municipal-nurses-down-tools/(accessed 8 August 2023).
[273] As above.
[274] Chingono (n1).
[275] As above.
[276] Statutory Instrument 83 of 2020.
[277] Amnesty International (n252).
[278] Amnesty International (n252).
[279] Amnesty International (n252).
[280] Kubatana (n12).
[281] Chingono (n1).
[282] As above.

to home deliveries without skilled attendants and potentially delivered in unhygienic conditions without necessary amenities such as water and gloves.[283] Regrettably, this issue persists post-COVID-19 as civil society organisations (CSOs) in Zimbabwe are still recording cases of women experiencing challenges in accessing maternal healthcare.[284] Pregnant women are still being treated harshly by health workers.[285] There is a lack of adequate health infrastructure such as water and PPE.[286] Zimbabwe still fails to meet the 15 percent Abuja Declaration threshold. This renders the status of health facilities at both central and local government levels undesirable as it is characterised by major access inequalities.[287] The latest budget allocation on health is 12.7 percent (ZW$117 billion).[288] While this is commendable, the rate of inflation erodes the local currency, rendering it insufficient to cover the health needs of all Zimbabweans.

Ultimately, central government continues to flagrantly disregard the Constitution. Local government still plays a secondary role to central government. Central government continues to oversee most initiatives in healthcare and is carrying out roles that ideally should be carried out by local government in terms of the devolution objectives, including the UVP and the Rural Based Treasury Initiative.

Notwithstanding, the free maternal services, many council-run clinics continue to charge fees due to funding deficits from central government.[289] Women and young girls who were unable to pay the clinic fees resorted to public hospitals under the administration of the central government where fees were waived, which however led to overcrowding of the maternity units.[290] The role of politics and how it disadvantages citizens is very apparent here. The opposition CCC has a stronghold in the urban councils, especially in Harare and Bulawayo. Central government which controls the resources and manages the national budget is run by ZANU PF. Therefore, central government is bound to introduce initiatives for its political mileage such as free maternity services, hence the

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283 Amnesty International (n252).
284 Kubatana 'Highfields Women Petition Parliament over Maternal Health Services' https://kubatana.net/2022/01/26/highfields-women-petition-parliament-over-maternal-health-services/ (accessed 20 September 2023).
285 ZLHR 'ZLHR, CHRA Intervenes on ill-treatment of pregnant women' https://www.zlhr.org.zw/?p=3131 (accessed 20 October 2023).
286 Zimbabwe's health system is in intensive care: How it got there' *The Conversation* 2 September 2022 https://theconversation.com/zimbabwe-health-system-is-in-intensive-care-how-it-got-there-189670 (accessed 20 October 2023).
287 Hansard (n110).
288 ZIMCODD '2022 National Budget Analysis' https://zimcodd.org/wp-content/uploads/2021/12/2022-National-Budget-Analysis-1-DECEMBER-2022.pdf (accessed 27 September 2023).
289 Amnesty International Zimbabwe (n132).
290 As above.

lack of political will to implement devolution. If devolution is implemented, councils run by the opposition will flourish, ensuring their continued tenure in office as citizens will continue to vote for them. If, however, councils cannot consistently access the conditional grants and the five percent equitable allocation to implement programmes that improve service delivery, central government would have succeeded in sabotaging them.

3.8 Conclusion

This chapter analysed the international, regional and domestic framework on devolution and the right to health including access to maternal healthcare. While the 2013 Constitution made positive strides in providing for devolution, the provisions do not set out the specific functions of the two lower tiers of government. There is no political will to implement the devolution provisions effectively. Zimbabwe is a signatory to regional and international instruments that guarantee the right to health including SRHR, encompassing access to maternal healthcare. However, the existing domestic legislative framework and implementation efforts fall short. Unlike the regional and international instruments, there is no specific domestic legislation on SRHR including access to maternal healthcare. While the Termination of Pregnancy Act provides for the same conditions for having an abortion as the Maputo Protocol, in practice, some factors impede the successful realisation of these rights.[291] The Zimbabwean society is conservative and shuns some of the benefits that accrue from the exercise of SRHR especially for women in rural areas. The domestic legislative framework is in dissonance with regional and international legal standards. Ultimately, reliance is placed on policies which are difficult to enforce. On the other hand, regional and international standards are complementary as they reiterate the need for access to health services and information to inform the full enjoyment of SRHR. As a dualist state, Zimbabwe must endeavour to domesticate, regional and international standards so that it is not only accountable to other states but to its citizens through domestic enforcement mechanisms, including the courts.

[291] *Mapingure* 2014 (248).

CHAPTER FOUR

LESSONS FROM KENYA

4.1 introduction

This chapter provides for the policy, institutional and legislative frameworks of devolution and access to maternal healthcare in Kenya. This chapter aims to draw lessons from the Kenyan experience in accessing maternal healthcare services at the county level. The author chose Kenya for drawing lessons because both countries have similar models of devolution as they maintain their unitary aspect while devolving certain aspects of governance to its lower levels. It is in this 2010 Constitution that the country introduced devolved healthcare. Finally, it examines both successes and challenges in devolving healthcare, specifically maternal healthcare, from the Kenyan perspective.

4.2 Devolution in Kenya and maternal health

The Constitution of Kenya introduced a devolved system of government, adopted from the Bomas draft.[292] It devolved functions including health to the 47 counties.[293] The Constitution highlights that counties are enjoined on these responsibilities for social and economic development in their respective areas.[294] This system establishes counties with a mandate to administer laws, amass revenue and manage certain resources in their territories.[295]

The system is two-tier, with national and county governments.[296] The Kenyan Constitution also provides that the national and county governments are interdependent and shall conduct their mutual relations based on consultation and cooperation.[297] In addition, there is need for cooperation between national and county governments. Either governmental level is enjoined to perform its functions and exercise its powers in a manner that respects the functional and institutional integrity of the other government.[298] Importantly, it must respect the constitutional status and institutions of government at the other level.[299]

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[292] Constitution of Kenya 2010, Chapter 11.

[293] United Nations Kenya 'Katiba at 10: a landmark Constitution and a blueprint for deepening democracy'https://kenya.un.org/en/127032-katiba-10-landmark-constitution-and-blueprint-deepening-democracy#_ftn1(accessed 18 September 2023).

[294] As above.

[295] YP Ghai 'History, objectives and transition' in C Bosire, YP Ghai & JC Ghai (eds) *Understanding devolution* (2015) at 12.

[296] Constitution of Kenya, art 4.

[297] Constitution of Kenya, art 6.

[298] Constitution of Kenya, art 189.

[299] As above.

The Kenyan Constitution also stipulates that the relationship between national and county governments must be consultative and cooperative as none is superior to the other. Both levels have the power to secure resources.[300] Counties possess the power to control their budgets and have the constitutional mandate to make and enforce laws.[301] Counties are divided into four levels namely rural counties, counties with both rural and urban characters and urban and city counties, although there is room for a fifth level through county legislation.[302] When a dispute arises, the governments are mandated to make an effort to settle the dispute, including the use of procedures such as negotiation, mediation and arbitration in national legislation. Additional legislation may be promulgated for this reason.[303]

Devolution in Kenya is premised on the country's national values and principles of government which include 'patriotism, national unity, sharing and devolution of power, democracy and participation of the people.[304] Hence, devolution is integral to Kenya and its people. A correlating aspect is on inclusiveness, equality non-discrimination and protection of the marginalised, which are major tenets of devolution.[305]

The Kenyan Constitution provides for the objects of devolution, including fostering national unity and promoting equitable sharing of resources and self-governance to enhance citizen participation.[306] The crux of devolution is to ensure citizen participation and inclusivity to foster accountability, national unity and to promote self-governance to the lowest level in Kenyan communities.[307] Devolution to counties emphasises the concept of separation of powers and the need to have reliable sources of revenue to enable them to govern and deliver services effectively.[308]

Counties are mandated to assist, support, and consult in the implementation of legislation and to liaise with national government for purposes of exchanging information, coordinating policies and administration.[309] The functions and powers of national and county governments may differ but are complementary.[310] Where a function is conferred

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300 Friedrich Ebert Stiftung 'Devolution made simple' https://library.fes.de/pdf-files/bueros/kenia/09856.pdf(accessed 20 September 2023).
301 Constitution of Kenya, art 185.
302 Ghai (n295) 6.
303 Constitution of Kenya, art 189(3)&(4).
304 Constitution of Kenya, art 10(2).
305 As above.
306 Constitution of Kenya, art 174(1).
307 Constitution of Kenya, art 10(2).
308 Constitution of Kenya, art 175.
309 Constitution of Kenya, art 6.
310 Constitution of Kenya, art 186(1).

on both levels of government, it becomes a purview of both and where it is not assigned, it becomes the mandate of national government.[311] Where clarity is required, the Parliament of Kenya will promulgate legislation to that effect.[312] The Senate is responsible for representing the counties and protecting their interests, especially in determining the allocation of national revenue among them.[313]

In addition to the Constitution of Kenya, there are other Acts of Parliament that are critical in the implementation of devolution.

The Intergovernmental Relations Act provides for structures to facilitate the objects of devolution as provided for in the Constitution.[314] It facilitates the working relationship between national and county governments and among counties themselves.[315] The Act provides for structures concerned with mechanisms of transferring powers, functions, and competencies between the two tiers of government and ultimately promotes accountability between them and among the county governments.[316] This Act sets out the framework to assist in the implementation of devolution and sets out responsibilities for either level of government. When there are stipulated functions, implementation is made easier.

The County Governments Act provides for Kenya's levels of devolution namely the county level, sub-county level, the ward level, and the village level. The Governor heads the County level, the Sub-County Administrator appointed by the Governor and approved by the County Assembly oversees the Sub-County level, (same level as the electoral constituency for MPs).[317] The Ward Administrator heads the Ward level, which is represented by an elected County Assembly Member. The Village level is supervised by a Village Administrator appointed by the Governor and approved by the County Assembly.[318] The Governor also appoints the Village Council through the Village Administrator and approved by the County Assembly. This Act also allows the County to further decentralise its functions and services below the village with the approval of the

311 Constitution of Kenya, art 186(2).
312 Constitution of Kenya, art 186(4).
313 Ghai (n295) 39.
314 2 of 2012, sec 5.
315 As above.
316 (n314).
317 17 of 2012.
318 As above.

County Assembly.[319] It gives effect to Chapter 11 of the Constitution and the counties' powers and responsibilities in service delivery.[320]

The National Government Coordination Act establishes an administrative and institutional framework for the coordination of national government functions at the national and county levels of governance.[321] It also lays down the framework for respecting the counties' decentralised units when national government is establishing its service delivery coordination units.[322]

The Urban Areas and Cities Act establishes a legislative framework for the classification, governance and management of urban areas and cities.[323] It also provides for the participation of the residents in the governance of urban areas and cities.[324] The governance of urban areas and cities is premised on the following principles: recognition and respect for the constitutional status of counties; the carrying out by a board of such functions as may be delegated by the county government and financial accountability to the county.[325] The Act also abolished cities, municipalities, councillors, county, or town council clerks.[326]

The Public Finance Management Act promotes good financial management at the national and county government levels to facilitate the expenditure of resources. It is applied to both levels of government.[327] It provides for the financing of both tiers of government and the distribution of devolution funds. The Act ensures that counties have autonomy in the preparation and approval of their healthcare strategies and budget estimates for healthcare services.[328] It provides for instances where national government may provide incentives to counties to prioritise certain health programmes through conditional grants.[329] Financial deficits are some of the challenges faced when

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319 (n317).

320 P Wanyande 'The implementation of Kenya's system of devolved government' in N Steytler & YP Ghai (eds) *Kenyan-South African dialogue on devolution* (2015) at 430.

321 1 of 2013.

322 As above.

323 13 of 2011.

324 As above.

325 (n323).

326 Friedrich Ebert Stiftung (n300) 12.

327 Act 18 of 2012.

328 A Mwenda 'Highlights of the Public Finance Act, 2012https://www.healthpolicyproject.com/ns/docs/Kenya_PFMAct_Summary.pdf(accessed 20 September 2023).

329 As above.

implementing devolution. Laying out a comprehensive legal framework for the distribution of resources informs the implementation of projects by counties.

The Transition to Devolved Government Act is possibly the most important Act introduced for implementing devolution. This Act was promulgated to facilitate the transition from a centralised to a decentralised Kenya. It provides for a transitional body responsible for the analysis and the phased transfer of the functions of the national and county governments.[330] The body would determine the needed resources for each function and develop a framework for the effective and comprehensive transfer of functions.[331] This Act ensured a smooth transition to a devolved system. Without it, worse challenges would have been faced in carrying out functions without the requisite institutions in place.

The Division of Revenue and the County Allocation of Revenue Acts of 2013 provide for the equitable division of revenue raised between national and county governments in the 2013-2014 financial year.[332] The latter provides for the division among counties of conditional allocations and an equitable share of revenue allocated to the county level and for the responsibilities of the national and county governments. [333]The County Governments Public Finance Management Transition Act, 2013 provides a framework for the establishment and functions of transition county treasuries, transitional county budget process and expenditures for counties.[334] These Acts facilitated the transition from a centralised to a decentralised system of government in Kenya, provided for the establishment of the relevant institutions and financed the devolution projects.

4.3 Domestic legal framework on the right to health

The following Acts and policies lay out the framework for accessing healthcare in Kenya.

The Kenya Constitution provides that every person has the right to the highest standard of health, which includes the right to healthcare services, including reproductive health care.[335] The Kenyan Constitution provides for three issues that potentially improve the progress towards improving access to maternal healthcare including devolution, the

330 1 of 2012.
331 As above.
332 Wanyande (n320) 431.
333 As above.
334 Wanyande (n320).
335 Constitution of Kenya, art 43(1)(a).

right to life, and the right to healthcare. [336] It provides for the functions of counties and one of them is County health services which includes the provision of primary healthcare.[337]

The Health Act, 21 of 2017 establishes a unified health system, to coordinate the relationship between national and county governments' health systems.[338] It provides for the regulation of healthcare services and providers and establishes the various administrative structures and their respective functions at both the National and County levels.[339]

The Kenya Health Sector Referral Implementation Guidelines of 2014 provide for the six levels of the referral systems in Kenya. These are: Level 1 is community health service comprising community-based health activities under the Comprehensive Community Strategy, Levels 2 and 3 are primary healthcare services which comprise dispensaries, clinics, health centres, and maternity homes, Levels 4 and 5 are the county referral health facilities comprising of all facilities operating in and managed by the county.[340] The county referral systems receive referrals from primary care facilities in its area of responsibility, from other county facilities in the county, and facilities outside the county (horizontal referral) and community units.[341] The National Referral Health Facilities (Level 6) include the facilities that provide specialised healthcare services, such as hospitals, laboratories, blood banks, and research institutions. These facilities operate with a defined level of autonomy.[342]

The Kenya Health Policy 2012-2030 provides for an institutional framework that specifies the institutional and management frameworks required under the devolved system. The policy ensures operational autonomy and delivery of efficient and cost-effective healthcare services while implementing devolution of administration and management of healthcare service delivery to the community level.[343] While the guiding principle of this

336 J Kagia 'Improving maternal health in Kenya: Challenges and strategies for low resource nations' (2013) 80 *Linacre Q* 161.

337 Constitution of Kenya, Fourth Schedule Part 2 2(c).

338 N Gichuki 'Challenges of devolved health care in Kenya: an analysis of the policy and legislative framework' (2020) 7 *KAS African Law Study Library* 501 at 510.

339 As above.

340 Ministry of Health 'Kenya Health Sector Referral Implementation Guidelines' 2014 15https://publications.universalhealth2030.org/uploads/ministry-of-health-referral-guidelines.pdf(accessed 21 September 2023).

341 As above.

342 Gichuki (n338).

343 J Bigambo & K Keya 'Devolution at 10 in Kenya: An analysis of trends and dynamics in implementation' 1 at 11https://www.kas.de/documents/286528/0/Devolution+at+10+in+Kenya+an+Analysis+of+Trends+and+Dynamics+in+Implementation.pdf/a5c7f110-f2a9-32f9-8784-ea9d94bc4f24?t=1651824111693(accessed 24 September 2023).

policy is equity in the distribution of health services, the noticeable trend is that women from lower socio-economic status still face challenges in accessing quality maternal healthcare.[344]

Section 15 of the Primary Health Care Act stipulates that counties are responsible for mobilising and allocating adequate resources necessary for the provision of primary healthcare, among other responsibilities. The Facilities Improvement Financing Act and the Digital Health Act, of 2023 have provisions to achieve universal access to affordable healthcare across Kenya and revenue use to the counties to mitigate loss.[345] There is a semblance of micromanagement of the counties' role by national government as the Facilities Improvement Financing Act gives it control to manage finances collected by counties. This may be in response to the complaints by health professionals who criticised devolution as will be discussed further in this chapter.

Specifically on maternal healthcare, the 47 counties have made significant strides.[346] Counties preside over devolved functions such as the provision of healthcare which were previously the responsibility of the national government.[347] Devolved healthcare was introduced to ensure the provision of easily accessible services across the country and to improve local uptake of the service by citizens.[348] This was intended to benefit marginalised communities by increasing the accessibility of healthcare at the local level.[349] Devolved healthcare was designed such that each county would have a county referral hospital, formerly a provincial hospital.[350] District hospitals were also upgraded to sub-county hospitals to act as referral units within the sub-counties.[351] The devolved healthcare responsibilities include community health, primary healthcare and county referral services. The national government retained the responsibility of national referral services.[352]

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344 As above.

345 K Opalo 'President must do more to sell healthcare plan' The Sunday Standard 21 October 2023 https://www.standardmedia.co.ke/opinion/article/2001483812/president-must-do-more-to-sell-healthcare-plan (accessed 22 October 2023).

346 Constitution of Kenya, Fourth Schedule.

347 Gichuki (n338) 2.

348 V Nyasarora 'Devolution of health services in Kenya: What you need to know of devolved healthcare'https://kenyayote.com/devolution-health-services-kenya-need-know-devolved-healthcare/(accessed 19 September 2023).

349 As above.

350 Constitution of Kenya, Fourth Schedule.

351 As above.

352 S Kilonzo, E Kamaara & K Magak 'Improving access to maternal healthcare through devolution in Western Kenya' in K Mohmand & M Loureiro (eds) *Interrogating decentralisation in Africa* (2017) at 92.

Devolution allows counties to be responsible for key management functions such as planning, budgeting and financial management, human resources and the provision of emergency medicines and medical supplies.[353] Healthcare is an exclusive function of counties. County healthcare services also include the control of pharmacies, ambulance services, cemeteries among other functions.[354] This allows them to determine their health system and their communities' priorities and allows for quick and autonomous decisions on resource mobilisation and allocation.[355] However, devolving the health function brought about institutional and resource utilisation challenges which needed handling to ensure effective and sustainable healthcare provision at the county level.[356] Therefore, counties have a mammoth task of ensuring that local communities have access to quality healthcare and access to SRHR, including awareness raising on family planning and the incorporation of reproductive health into national strategies and programmes.[357]

4.4 Implementation post-2010 Constitution

Kenya's focus on maternal healthcare services began as part of the Maternal Child Health programme in 1972. Only in 1987 was the Safe Motherhood Initiative in Nairobi introduced, which came with specific programmes to reduce maternal mortality and improve maternal health.[358] Previously, efforts focused on training traditional birth attendants to screen high-risk pregnancies for complications; now they are directed towards providing women with access to skilled care during pregnancy and delivery.[359] While efforts to reduce maternal mortality to 170 per 100 000 live births by the year 2010 and to increase the number of health professionals were envisioned in the National Reproductive Health Strategy for 1997, these efforts were only realised after the devolution of healthcare functions.[360] A study conducted in 2019 indicated that devolution eliminated unnecessary bureaucracies that impeded access to maternal healthcare. The devolved health system poses fewer barriers compared to the old centralised system.[361]

353 London School of Hygiene and Tropical Medicine 'Health sector devolution: Why it matters' https://resyst.lshtm.ac.uk/health-sector-devolution(accessed 23 September 2023).
354 Development Initiatives 'Impact of devolution on health service delivery in Kenya: County roundtable forums'https://devinit.org/what-we-do/events/impact-of-devolution-on-health-service-delivery-in-kenya-county-roundtable-forums/#:~:text=Devolution%20in%20Kenya,function%20of%20the%20county%20governments(accessed 18 September 2023).
355 As above.
356 Kilonzo (n352).
357 Kilonzo (n352).
358 P Godia et al 'Maternal Health Services' 111https://dhsprogram.com/pubs/pdf/SPA8/06Chapter6.pdf(accessed 21 September 2023).
359 As above.
360 Godia et al (n358) 112.
361 Wahome (n176) 17.

A United Nations report indicates that counties in Kenya spent 41 percent of their resources on social services in the first five years (2013-2018) and this improved access to maternal healthcare.[362] The percentage of births attended by skilled health personnel increased from 62 percent to 70 percent.[363]

Devolved healthcare in Kenya has brought significant improvement in semi-urban areas like Narok County.[364] Since devolution, the county has increased healthcare facilities and the number of healthcare professionals.[365] Hence, there is a direct correlation between the availability of more health facilities and healthcare professionals to access maternal healthcare.[366] In Nyandarua County, declining maternal mortality rates were recorded as opposed to the period before devolved healthcare initiatives were implemented.[367]

In a study conducted in western Kenya, health users indicated that health services, including referral maternal healthcare, are now closer to the citizens.[368] The services are available, accessible, affordable and acceptable, resulting in an influx of patients accessing maternal healthcare services.[369] In Uasin Gishu County ambulances were procured for both county and sub-county health facilities due to the availability of devolution funds.[370] While patients had positive things to say about devolution, healthcare workers had a different view.[371] Initiatives such as the Free Maternal Services (FMS) Policy have led to an influx of patients, yet the existing facilities have not been improved to cater for this.[372]

Between 2014 and 2022, Kenya's under-five mortality rate reduced from 52 deaths per 1 000 to 41 deaths per 1 000, and the infant mortality rate from 39 to 32 deaths per 1 000.[373] Counties hired over 36 000 health workers causing the total health workforce to increase significantly compared to pre-devolution numbers.[374] Between 2016 and 2021,

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362 United Nations Kenya (n293).
363 As above.
364 Bigambo and Keya (n343) 12.
365 Bigambo and Keya (n343).
366 As above.
367 Wahome (n176).
368 Kilonzo (n352) 96.
369 As above.
370 Kilonzo (n352) 98.
371 As above.
372 Bigambo and Keya (n343).
373 M Njuki 'Devolution of health docket has borne fruit despite obstacles' *The Standard*https://www.standardmedia.co.ke/opinion/article/2001473998/devolution-of-health-docket-has-borne-fruit-despite-obstacles(accessed 25 September 2023).
374 As above.

the total number of health workers in counties improved from 59 726 to 96 453.[375] Post-devolution, counties in hard-to-reach areas have significantly more health workers compared to the pre-devolution period. Turkana had less than 10 medical officers before devolution, a number that has increased sixfold to 61 doctors in 2023.[376] Counties can now provide a wide range of specialised health services even in areas where these services were not available before devolution.[377]

Devolved healthcare was complemented by central government's efforts through the introduction of the Policy FMS also known as Linda Mama.[378] Statistics from the Ministry of Health of Kenya indicate that the initiative increased the utilisation of maternal healthcare services from 44 percent in 2012-2013 to 62 percent in 2016.[379] Tama et al state that after the implementation of the FMS, deliveries increased by 96 percent, 83 percent, and 74 percent in Kilifi, Kajiado, and Vihiga counties respectively.[380] This was attributed to women who could not, beforehand, afford the cost of maternal healthcare services before this policy.[381]

While the policies behind some of these factors originated from central government (the FMS programme), the implementation happened because of the complementary relationship between counties and national government. County-level decisions had a significant role to play in the perceived positive effects of devolution as regards access to referral maternal healthcare.[382] While in some counties devolved healthcare was a resounding success; this was not the case everywhere. In Nairobi County, there were misgivings about devolved healthcare, specifically from health personnel. After devolution, there was a delay in the disbursement of funds, causing a shortage of medication and disgruntled health personnel due to counties' failure to remunerate them adequately and expeditiously.[383]

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375 Kilonzo (n352) 98.
376 As above.
377 M Njuki 'Time to safeguard devolution gains in health sector' *People Daily* 31 May 2023https://www.pd.co.ke/features/opinion/time-to-safeguard-devolution-gains-in-health-sector-2-182766/ (accessed 23 September 2023).
378 BB Masaba & RM Mmusi-Phetoe 'Free maternal health care policy in Kenya; Level of utilization and barriers' (2020) 13 *International Journal of Africa Nursing Sciences*.
379 As above.
380 Masaba and Mmusi-Phetoe (n378) 12.
381 As above.
382 Kilonzo (n352) 97.
383 As above.

4.5 Lessons from Kenya

4.5.1 Clarity on local competencies in legislation

The Kenyan Constitution fundamentally changes the relationship between government and citizens. The Constitution reiterates strengthening public participation and governance as core elements of Kenya's strategy to accelerate growth and address deep-seated inequalities in economic opportunities and service delivery in different parts of Kenya.[384] While significant strides have been made, challenges have also been experienced. The new administration under President Ruto has attempted to frustrate the governors and the current system of devolution through over-interference.[385]

Devolution in Kenya initially caused serious disruption to public health services. Primary health facilities lost essential sources of revenue. There were delays in paying health personnel salaries.[386] An industrial action ensued, with health workers clamouring for health services to be centralised because the counties had not fully established structures to effectively operate including County Treasuries and Assemblies, nor had they employed staff to manage them.[387] The roles and responsibilities of the different key personnel in the health sector between county and national government and within counties were unspecified.[388]

There was no clarity on responsibilities over the critical management of responsibilities including inter-county transfers, in-service training and health worker promotions between the County Department of Health as the County Public Services Boards and the National Ministry of Health.[389] There was no agreed-upon organisational structure, and there were significant delays in the appointment of senior County Health Sector top managers, who were relevant in the implementation of healthcare.[390] However, when these issues were addressed, the situation improved. The establishment of the Commission of Revenue Allocation, the County Public Service Board for human resources,

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384 S Ngigi 'Devolution in Kenya: The good, the bad and the ugly' (2019) 9 *Public Policy and Administration Research* 9 at 11.

385 J Mbaka 'Scorecard: Raila accuses Ruto of clinging to devolved functions' *The Star* 16 September 2023https://www.the-star.co.ke/news/realtime/2023-09-16-scorecard-raila-accuses-ruto-of-clinging-to-devolved-functions/(accessed 24 September 2023).

386 L Kimathi 'Challenges of the devolved health sector in Kenya' (2017) 42 *African Development* 55 at 65.

387 As above.

388 London School of Hygiene and Tropical Science 'Disruption, disillusion and contestations: the effects of rapid implementation of devolution on the health sector in Kenya' (2018)https://resyst.lshtm.ac.uk/resources/disruption-disillusion-and-contestations-the-effects-of-rapid-implementation-of-devolution(accessed 22 September 2023)

389 As above.

390 R Yussuf Buro, A Yitambe & K Rucha 'Implementation of devolution of the healthcare system: A quality perspective in selected public hospitals in Garissa County, Kenya' (2021) 2 *International Academic Journal of Health, Medicine and Nursing* 142 at 154.

the County Assembly Service Board for salaries disbursements and a transition authority assisted in curbing some of the implementation challenges Kenya was facing.[391] While this might be costly, it proves to be beneficial in the long term.

One of Kenya's major victories in its devolution system is the existence of clear and specific legislation which outlines the administrative and institutional framework that coordinates the functions and working relationship of the two tiers of government. It also stipulates the need to respect the counties' decentralised units and distribution of resources. As discussed earlier, various Acts were promulgated for the facilitation of devolution. A critical piece of legislation is the Transition to Devolved Government Act which provides for a transitional authority. The other Acts provide for offices and structures at county level for receiving the devolved functions and actioning them. In addition, devolved healthcare and other county functions are specifically provided for in the Constitution, which protects them from any interference or denial of their autonomy. There is no room for lack of implementation as citizens can enforce the provisions of the Constitution through the courts.

One identified gap is the division between national and county functions on policy-making versus implementation, which is disorganised.[392] In the health sector, the exclusive national government functions are policy-making and national health facilities, while county exclusive powers are 'county health services.'[393] National government also has powers over national referral health facilities. However, some functions such as health are in the purview of both governments.[394] Concurrent powers imply that both levels of government possess equal powers over concurrent matters, a situation which further negates clarity in the division of power.[395] The Constitution of Kenya is contradictory because while advocating for local self-governance in one breath, in another, it indicates that counties must be dependent on the national headquarters of their parties for directions, which undermines the autonomy of the counties.[396]

4.5.2 Financial arrangements

Within the first five years of devolution, counties invested in upgrading dilapidated health infrastructure. In addition, devolution attracted capital and skills to the constituency

391 Wanyande (n320) 424.
392 Bigambo and Keya (n343) 22.
393 Bigambo and Keya (n343) 23.
394 As above.
395 Bigambo and Keya (n343) 22.
396 As above.

level.[397] There is evidence of improved access to maternal healthcare services due to devolution. There is increased access to maternal healthcare for expectant mothers and a rapid reduction in morbidity and mortality for both the mother and baby.[398] 89 percent of mothers now deliver under skilled care as compared to 66 percent before devolution.[399]

The Kenyan Constitution provides that every financial year national government must allocate not less than 15 percent of all revenue collected to counties, leaving it with 85 percent.[400] This is the first source of revenue for counties.[401] Reports indicate that counties rely extensively on financial transfers from central government to finance their budgets.[402]

Contrary to the five percent allocated by the Zimbabwean Constitution, the Kenyan Constitution provides for the allocation of not less than fifteen percent of all revenue.[403] The African Commission has, in the past, expressed concerns regarding inadequate budgetary allocation to the health sector, which inhibits universal access to healthcare services for women and girls.[404] Similarly, the issue of resource allocations is a hindrance not only in the Kenyan system but in the Zimbabwean setup as well. As a result, counties have occasionally requested for the health function to revert to national government.

Notably, devolution in Kenya was brought about to manage the ethnic divide fuelled by their 40 ethnic groups.[405] Some groups were excluded from development and leadership roles. Some areas were already well-developed and functioning better than others.[406] Devolution, while seeking to bridge that divide, also contributes to the fragmentation of the pooling function, creating further barriers to the equitable distribution of resources across counties.[407] To mitigate this, the Kenyan government introduced the Equalisation Fund to cater for long marginalised communities.[408] The Equalisation Fund is critical in the Zimbabwean setup. Matabeleland, Midlands, Masvingo and Mashonaland West Provinces have always been marginalised in terms of accessing the country's

397 Njuki (n373).
398 As above.
399 Njuki (n373).
400 Constitution of Kenya, art 203(2).
401 Friedrich Ebert Stiftung (n300) 17.
402 As above.
403 Constitution of Kenya, art 203(2).
404 Durojaye (n144) 322.
405 Constitution of Kenya, Article 203(2).
406 Z Nyambura 'Kenya: Politics split on ethnic divide' *DW* 26 October 2017 https://www.dw.com/en/in-kenya-politics-split-on-ethnic-divide/a-37442394 (accessed 20 October 2023).
407 Friedrich Ebert Stiftung (n300).
408 As above.

resources.[409] Zimbabwe may benefit from introducing a similar initiative to mitigate the differences in development that may be occasioned by an equitable distribution of the five percent equitable allocation of capital grants. Priority must be given to the already marginalised areas.

While a lot of work still needs to be done, Zimbabwe may draw lessons herein. If fiscal autonomy is guaranteed in the Constitution, communities will fundraise effectively and manage their service delivery development programmes. In addition, increasing the threshold from five to fifteen percent may allow for the equitable allocation to cater for a wider range of services including maternal healthcare. This may effectively attract skills to the constituency level. When this happens, access to maternal healthcare is guaranteed because health infrastructure will be improved and skilled health professionals will be able to attend to expectant mothers anytime, if adequately remunerated. Ultimately, to ensure access to maternal healthcare, organisational structures must be in place and operational. Resources must be available for health infrastructure and for remunerating health professionals adequately, so that they are motivated to do their work.

4.6 Conclusion

This chapter sought to draw lessons from the Kenyan experience in devolved healthcare, including access to maternal healthcare. It also examined the legislative and policy framework of devolution that was established to ensure the effective implementation of devolution. The chapter gave examples from surveys conducted in Narok, Nyarandua and Nairobi counties to ascertain the populace's experiences post-devolution. The majority of the recipients of the services spoke positively about devolution while the health professionals hoped for the health function to be reverted to national government due to remuneration issues. Finally, the chapter provided lessons that can be adopted by Zimbabwe including promulgating transitional legislation that stipulates the decentralisation of functions and resources and establishing institutions specific to the implementation of devolution.

[409] N Mtombeni & VM Matiza 'Migration dynamics and the devolution agenda in Matabeleland South Province of Zimbabwe' (2022) 5(2) *Southern Africa Journal of Education, Science and Technology* 64.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This research interrogated the challenges faced by women in accessing maternal healthcare in council-run clinics due to a lack of health personnel and funding, which is exacerbated by the relationship between the tiers of government. The Constitution of Zimbabwe introduced the concept of devolution whose objectives include decentralising powers, functions, and resources to the lower levels of government to ensure citizen participation at the constituency level among others. Before 2013, while local authorities were granted certain powers by the UCs Act and the RDCs Act to provide services such as healthcare, devolution sought to bequeath more powers, responsibilities, and autonomy coupled with financial freedom. However, ten years later, there is a gap in the legislative and institutional framework for implementing devolution. There is no specificity on how functions and resources will be distributed among the tiers of government, which in turn affects the provision of services such as healthcare. This is because of a lack of political will.

Devolution encourages effective service delivery including healthcare to the constituency level. Healthcare provision requires adequate budgetary allocations to remunerate health professionals and have a functioning, easily accessible, and affordable quality health infrastructure including medicines.

The regional and international standards provide a comprehensive foundation that state parties are obliged to adhere to, both on devolution and the right to health including SRHR. However, states due to sovereignty tend to be lackadaisical in adhering to their obligations. Zimbabwe is a dualist state and without domesticating these regional and international standards, it is not bound. Besides the Constitution, there is no tangible legislative framework that entrenches devolution as most applicable laws are yet to be aligned with the Constitution. There are no laws that effectively entrench women's SRHR, specifically maternal healthcare.

Furthermore, this research considered the experiences of Kenya, which has a similar model of devolution. Kenya's 2010 Constitution introduced devolution, and devolved healthcare to its 47 counties. The lessons drawn from the Kenyan experience include the promulgation of legislation that caters to the transition from a centralised to a decentralised system of government. The legislation also caters to new institutions and offices to implement the objectives of devolution. Counties were granted powers to make

their policies and implement them. Counties have the power to employ and remunerate health personnel and improve the health infrastructure. While it is conceded that this has not been without any challenges as the health personnel have advocated for healthcare to be reverted to central government due to remuneration challenges, significant progress has been achieved under the Kenyan system.

5.2 Recommendations

Pursuant to the analysis of the Zimbabwean experience and the lessons drawn from Kenya, this research proffers recommendations to Parliament, judges, CSOs, and other actors in Zimbabwe as follows:

Short-term recommendations

Parliament must

- Fast-track legislative and policy reforms including the PCA Bill to facilitate the implementation of devolution.

CSOs must

- Litigate more to enforce the SRHR of women, including access to maternal healthcare.
- Facilitate awareness-raising campaigns on access to SRHR at constituency level.
- Offer free legal advice and services to citizens intending to litigate on implementing devolution.

Medium-term recommendations

Parliament must

- Amend the UCs and RDCs Acts and other related legislation to specify the responsibilities of all three tiers of government in implementing devolution.

Ministers and the Cabinet must

- Increase expenditure for well-planned health infrastructural improvement to ensure improvement of operations in health facilities.
- Ensure the financial independence of local government by enhancing revenue collection and improving budgetary allocations for effective service delivery, including maternal healthcare services.
- Increase the equitable allocation from five to fifteen percent.

- Introduce an Equalisation Fund to cater for the needs of long-marginalised areas in Zimbabwe.
- Ensure all tiers of government are properly equipped for the implementation of devolution.
- Incentivise health work by issuing proper housing and security to workers, especially in rural areas for health workers, encouraging the newcomers to settle in any area within the constituency thus improving the quality of health services.
- Ensure compliance with the Abuja Declaration's fifteen percent budget allocation on healthcare.
- Ensure that appropriate structures are already in place at the constituency level to undertake decentralised functions, including healthcare.
- Roll out capacity-building programmes for administrative staff to enable them to perform the devolved functions in the same manner used when the functions were still under the authority of central government.

Long-term recommendations

Lawmakers must

- Promulgate domestic legislation specific to the protection and prioritisation of women's health rights including SRHR encompassing maternal healthcare.
- Enact legislation that grants lower levels of government legislative powers to promulgate policies for effective implementation of development programmes.
- Ensure ratification of the African Charter on the Values and Principles of Decentralisation, Local Governance and Local Development, 2014**.**

Judges must

- Interpret the Constitution in a teleological manner to compel central government to adhere to its regional and international obligations on devolution and SRHR including access to maternal healthcare.
- Develop Zimbabwe's jurisprudence on devolution and access to SRHR, and desist from dismissing cases on technicalities to promote socioeconomic rights, including maternal healthcare.

Local authorities must

- Enhance fundraising efforts with the available resources instead of relying on central government for funding.
- Ensure that both central and local governments work together to effectively realise access to maternal healthcare.
- Improve SRHR accessibility, especially in remote areas.

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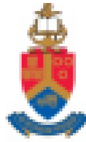

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