

1

**THE DILEMMA OF WOMEN'S SEXUAL AND REPRODUCTIVE  
RIGHTS IN ZAMBIA**

By

**Joyce Shezongo-MacMillan**

*Thesis*  
*LLM*  
*SHE*  
*2508*  
*C.1*

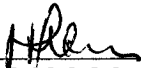
**A Dissertation submitted to the University of Zambia in fulfillment of  
the requirements for the Degree of Master of Laws.**

**THE UNIVERSITY OF ZAMBIA  
LUSAKA**



## CERTIFICATION

This is to certify that I have supervised the dissertation of Joyce Shezongo-Macmillan and I am satisfied that it is ready for submission for examination.



---

Dr. M.M. Munalula



## **DECLARATION**

This Thesis represents the work of the candidate and has not been previously submitted for a degree, diploma or other qualification at this or another University.


**Joyce Shezongo-MacMillan**

**CERTIFICATE OF APPROVAL**

0278793

This dissertation of Joyce Shezongo-MacMillan has been approved as fulfilling the requirements for the award of the Degree of Master of Laws by the University of Zambia.

Signed  \_\_\_\_\_  
Examiner

 \_\_\_\_\_  
Examiner

\_\_\_\_\_  
Examiner

Dated this 7 day of 8 2009

## ABSTRACT

### **The Dilemma of Women's Sexual and Reproductive Rights in Zambia by Joyce Shezongo-Macmillan**

The purpose of the study is to understand the challenges women face in exercising their sexual and reproductive rights in Zambia and to see whether this class of rights can be exercised or enforced fully as individual rights by women. It seeks to answer the broad question, 'Are women's sexual and reproductive rights mere theoretical assertions that cannot be fully enforced or exercised by women in Zambia'? It addresses the following specific questions;

- a) Are women's sexual and reproductive rights a distinct class of rights that can be exercised or enforced as individual rights by women in Zambia?
- b) What challenges, dilemmas or unwanted consequences, if any, do women in Zambia face in exercising or enforcing their sexual and reproductive rights?

The research is qualitative and is both descriptive and analytical. The theoretical and conceptual framework of the study is based on African Feminist thought, Legal Pluralism and Women's Law Approaches.

The study found that women face several challenges in respect of access to the right to sexual and reproductive health care and services. They also face a myriad of social, legal, economic and political factors and suffer unwanted consequences for exercising their right to sexual and reproductive self determination; or for refusing to comply with strictures that violate this right. These factors ensure a sustained ignorance of rights and perceived powerlessness on the part of women.

Women are not only unable to exercise their right to sexual and reproductive self determination in the privacy of their personal lives, but are further unable to contribute to the decision making processes in the public sphere that impact on their lives. Women's lives are thus characterised by a sense of powerlessness in relationships and in public life and different forms of subjugation or multiple manipulations. This milieu sustains an asymmetrical or pyramid model of rights with women's rights at the bottom and men's at the top, which ensures that women's duties and obligations as mothers and wives supersede their individual rights; leading to conflicting interests between women's rights and duties and rights and familial ideologies.

Further, the State's compliance with its responsibilities to human rights under international instruments is also limited. There are thus inadequate health care facilities and services and a lack of appropriate legislative framework and enforcement mechanisms for these rights that constrain women's right to sexual and reproductive health care.

## ACKNOWLEDGEMENTS

I wish to extend my gratitude to all the many women who, in spite of the personal and private nature of the study willingly provided the data in Lusaka, Kabwe, Ndola, Kapiri Mposhi, Monze and Solwezi. I further wish to acknowledge Women and Law in Southern Africa Research and Educational Trust for inspiring me to interrogate this subject and for providing the space for me to collect data and write my dissertation during my work in the respective sites.

I am also grateful to the Management of Hospitals and Clinics in these Districts for granting me access to their clients in the Mother and Child Health (MCH) units and wards for interviews and focus group discussions and access to their libraries and documentation. Indeed I thank the health workers who availed their time to talk to me in spite of their busy schedules and work demands.

I also thank the traditional rulers in the rural sites who granted me leave to talk to their subjects and to the Chieftainesses who agreed to be interviewed, especially Her Royal Highness Chieftainess Lesa and Her Royal Highness Chieftainess Nyakulen'ga. My gratitude also extends to the church leaders who allowed me to interview their flock on a subject that is rarely ever discussed in church. I further thank the Director of Local Courts and the Local Court Justices in the sites who availed their court records and shared information on the subject of the study.

My gratitude also goes to the late Professor Alfred Chanda and Dr. Margret Munalula for giving me the initial push I needed to enroll for the course and in the case of the latter for working with me on the revision of the final draft. I am also grateful to Professor Carlson Anyangwe, who was my supervisor at the start of study, for his guidance, encouragement and unending faith. Finally, I wish to thank Ms. Mekia Mohamed-Redi, a true friend who kept me going when I was discouraged and overwhelmed during the research; and to Nosiku Lishebo who helped with the typesetting and formatting and whose support has been invaluable to me.

## DEDICATION

This work is dedicated to all the women who have sought my help in the legal clinics all over Zambia whose names I cannot remember. Although my role was to provide legal advice and to litigate on their behalf, our interactions went far beyond this. These are the women from whom I have heard the most amazing of life stories and understood the many battles that women fight in their lives. Their unending determination to survive against all odds will forever inspire me.

## TABLE OF CONTENTS

|  |      |
|--|------|
| TITLE PAGE .....   | i    |
| CERTIFICATION.....   | ii   |
| COPYRIGHT PAGE.....  | iii  |
| DECLARATION.....   | iv   |
| CERTIFICATE OF APPROVAL .....                                  | v    |
| ABSTRACT.....  | vi   |
| ACKNOWLEDGEMENTS.....  | vii  |
| DEDICATION.....  | viii |
| <br>   |      |
| CHAPTER ONE.....   | 1    |
| 1. INTRODUCTION.....   | 1    |
| 1.1. Background.....   | 1    |
| 1.2. Definition of Women's Sexual and Reproductive Rights..... | 6    |
| 1.3. Statement of the Problem.....                             | 6    |
| 1.4. Purpose of the Study.....                                 | 7    |
| 1.5. Objectives.....   | 8    |
| 1.6. Significance of the Study.....                            | 8    |
| 1.7. Research Methodology.....                                 | 9    |
| 1.7.1. Sampling.....   | 9    |
| 1.7.2. Sites.....  | 10   |
| 1.7.3. Data Collection Techniques and Instruments.....         | 11   |
| 1.7.4. Data Cleaning, Analysis and Report Writing.....         | 11   |
| <br>   |      |
| CHAPTER TWO .....  | 12   |
| 2. THEORETICAL AND CONCEPTUAL FRAMEWORK.....                   | 12   |
| 2.1. Women's Law and Approach.....                             | 12   |
| 2.2. African Feminism .....                                    | 15   |
| 2.3. Legal Pluralism .....                                     | 22   |

|   |    |
|---|----|
| CHAPTER THREE .....   | 27 |
| 3.LAW AND POLICY REVIEW .....   | 27 |
| 3.1. Soft Norms.....  | 27 |
| 3.2. Hard Norms.....  | 32 |
| 3.3. Domestic Legislation, Policies and Customary Law.....                                | 34 |
| CHAPTER FOUR .....  | 41 |
| 4.CHALLENGES TO WOMEN'S ACCESS TO SEXUAL AND REPTODUCTIVE RIGHTS.....                     | 41 |
| 4.1. The Public Health Delivery System.....   | 42 |
| 4.2. Inadequate Sexual and Reproductive Health Services.....                              | 45 |
| 4.2.1. Limited Contraceptive Methods.....   | 45 |
| 4.2.2. Inadequate Services.....   | 47 |
| 4.2.3. Inadequate Infrastructure and Lack of Supplies.....                                | 49 |
| 4.2.4. Counseling, Infertility Treatment and Cancer Cytological Testing Services.....     | 50 |
| 4.3. Poor Quality and Delivery of Services.....   | 51 |
| 4.4. Inaccessibility Services.....  | 56 |
| CHAPTER FIVE .....  | 58 |
| 5. CHALLENGES TO WOMEN'S ACESS TO SEXUAL AND REPTODUCTIVE SELF DETERMINATION.....         | 58 |
| 5.1. Cultural Prescriptions, Norms, Beliefs and the Social Status of Women in Zambia..... | 59 |
| 5.1.1. Culture and Socialisation.....   | 59 |
| 5.1.2. Violence Against Women.....  | 65 |
| 5.1.3. <i>Lobola</i> .....  | 67 |
| 5.2. The Legal Status of Women.....   | 68 |
| 5.3. Economic and Political Factors.....  | 70 |
| 5.4. Religious Beliefs, Norms and Prescriptions.....                                      | 74 |

|   |     |
|---|-----|
| CHAPTER SIX.....  | 79  |
| 6. UNWANTED CONSEQUENCES AND THE WOMAN'S DILEMMA.....   | 79  |
| 6.1. Unwanted Consequences.....   | 80  |
| 6.1.1. Violence and Related Consequences.....   | 80  |
| 6.1.2. Unsafe illegal abortion.....   | 85  |
| 6.1.3. Criminal Charges.....  | 87  |
| 6.2. The Woman's Dilemma.....   | 88  |
| 6.3. Social Enforcement Mechanisms.....   | 90  |
| <br>CHAPTER SEVEN   |     |
| 7. THE COMPLEXITIES SURROUNDING WOMEN'S SEXUAL AND REPRODUCTIVE RIGHTS AS INDIVIDUAL RIGHT..... | 94  |
| 7.1. Prerequisites to the Exercise of Rights.....   | 94  |
| 7.1.1. Knowledge of rights.....   | 94  |
| 7.1.2. Conflicting Interests.....   | 97  |
| 7.2. State's Obligation to Women's Sexual and Reproductive Rights.....                          | 101 |
| 7.2.1. Provision of Adequate Health Services.....   | 101 |
| 7.2.2. Lack of an Appropriate Legislative Framework.....  | 102 |
| 7.2.3. Lack of Deliberate Strategies for Empowerment.....                                       | 105 |
| 7.2.4. Non-Recognition of the Indivisibility and Interrelatedness of Human Rights.....          | 109 |
| <br>CHAPTER EIGHT .....   | 111 |
| 8. CONCLUSIONS AND RECOMMENDATIONS.....   | 111 |
| 8.1. Conclusions.....   | 111 |
| 8.2. Recommendations.....   | 116 |

|                                |     |
|--------------------------------|-----|
| BIBLIOGRAPHY.....              | 120 |
| LIST OF CASES REFERRED TO..... | 125 |
| LIST OF STATUTES.....          | 125 |
| APPENDIX.....                  | 126 |

# CHAPTER ONE

## 1. INTRODUCTION

### 1.1. Background

This study is in the human rights field and focuses on the subject of women's sexual and reproductive rights. The study is a qualitative one based on women's law methodology i.e. the legal discipline which explores the reality of women's lives and from that perspective interrogates and investigates the law.<sup>1</sup> The study is informed by the theoretical and conceptual approaches of legal pluralism and contemporary African feminist thought. These were seen as the most appropriate framework within which to conduct the study as it is based on the lived realities of women's lives.

The dissertation is divided into eight chapters. Chapters one, two and three set out the background, methodology and theoretical perspectives of the study. The three chapters also define and locate the sources of sexual and reproductive rights. Chapters four and five discuss the structural constraints to women's right to sexual and reproductive health care and the right to sexual and reproductive self determination. Chapter six examines the dilemmas and unwanted consequences that women face in exercising or enforcing these rights, should they choose to do so. Chapter seven then examines and discusses the impact of these challenges on women's sexual and reproductive rights as a class of rights. The final chapter gives the conclusions and recommendations.

### 1.2. Definition of Women's Sexual and Reproductive Rights

Women's sexual and reproductive rights are a class of rights recently recognized in international human rights law. They are a constellation of rights extracted from within existing human rights as contained in the International Covenant on Civil and Political

---

<sup>1</sup> Bentzon, A.W., A. Hellum, J. Stewart, W. Ncube and T. Agersnap, 1998. Pursuing Grounded Theory in Law: South-North Experiences in Developing Women's Law, North-South Legal Perspectives, Series No. 1, 95.

Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Human rights discourse on the right to health and on women's human rights generally, has extracted sexual and reproductive rights from the bulk of human rights.

Sexual and reproductive rights are rights rooted in the fundamental aspects of human sexuality and reproduction. They encompass the right to sexual and reproductive health care and the right to sexual and reproductive self-determination.<sup>2</sup> In the absence of an instrument that expressly defines these rights, definitional questions have arisen. Some authors have argued that reproductive rights are part of the sexual rights package, making sexual rights a much broader concept than reproductive rights.<sup>3</sup> They argue that sexual rights include reproductive rights, women's right to health, women's human rights and the rights of lesbians, gay men and transgender people.<sup>4</sup>

Reproductive rights on the other hand are said to;

Embrace certain human rights that are already recognized in national and international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic right to all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the rights to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.<sup>5</sup>

This variation in terminology and definition raises the question of which of these rights is the genus and which is the specie. It is an unsettled debate but it is clear that these are

---

<sup>2</sup> Obondo, A.E. 2003. Sexual and Reproductive Rights, [www.whrnet.org/doc/issue-sexual rights.html](http://www.whrnet.org/doc/issue-sexual%20rights.html), last viewed October 28, 2004.

<sup>3</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. Sexual Rights: From Concept to Strategy, In K.D. Askin and D.M. Koenig. (eds.), Women and International Human Rights Law, volume 3, 91-121.

<sup>4</sup> Fried and Landsberg-Lewis, 1996. Sexual Rights, 92.

<sup>5</sup> Report of the International Conference on Population and Development Program of Action (ICPD), U.N. Doc.A/CONF.171/13/Rev1. Sales No. 95.XIII. 18, Paragraph 7.3.

actually two separate classes of rights that are closely interactive and interrelated. Sexual rights are those rights relating to sexuality and include rights to sexual expression and pleasure as well as access to health requisites necessary for a healthy sexual life. Reproductive rights relate to reproductive matters such as the right to reproduce and the right to reproductive healthcare.

Human reproduction is by its nature a sexual matter and is often a by-product of the expression of human sexuality. However, the fact that one can express their sexual rights or sexuality without engaging in the act of reproduction separates sexual rights from reproductive rights. This study recognises the indivisibility, interconnectedness and interrelatedness of human rights and treats these rights as two separate but closely related classes of rights.

Some authors have argued that the definition of these rights raise the questions of whether these rights are rights of individuals or couples and therefore whether one can actually speak of women's sexual and reproductive rights as a distinct set of rights.<sup>6</sup> This debate is rooted in the definitions of reproductive rights given in the Teheran and Beijing international Conferences.<sup>7</sup> In 1968, the Teheran Conference recognised that, "parents have a basic right to determine freely and responsibly the number and spacing of their children and a right to adequate education and information to do so".<sup>8</sup> By so defining, the Teheran Conference suggested that these rights are rights of couples. The Beijing Conference on the other hand defined reproductive rights as;

Rights that rest on the recognition of basic rights of all couples and individuals to decide; the right to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in the human rights documents.<sup>9</sup>

---

<sup>6</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. Sexual Rights, 91-121.

<sup>7</sup> United Nations, Doc.E/CONF.76.19, 1984. Report of the International Conference on Population.

<sup>8</sup> Resolution XVIII, United Nations, Doc.A/CONF.32/41, 1968, in United Nations Department of Public Information, The United Nations and the Advancement of Women 1945-1995, 167-169 also United Nations, Doc.DPI.1679, 1995, U.N. Sales No.E.95.1.29.

<sup>9</sup> United Nations Department of Public Information, 1996, New York, Platform for Action and Beijing Declaration, Paragraph 94, 58.

This definition suggests that these are rights of individuals as well as couples. These differences are linked to the debate on women's rights as a distinct set of human rights. It has been asked whether 20<sup>th</sup> Century feminists have been mistaken in trying to identify a set of specific rights that apply only to women.<sup>10</sup> That it may be that a woman is a human being who is being prevented from exercising her rights for some reason directly related to her being a woman. That the very notion of human rights implies universal application and the term women's human rights is a distracting redundancy.<sup>11</sup>

However, it is also argued that sex and gender are important in the observance of human rights and that failure to be aware of this is an important determinant of human rights violations.<sup>12</sup> The argument of women's rights as human rights is more or less a settled matter and justifies the distinction of women's reproductive rights as rights separate from those of men. It is also said that although all persons have reproductive rights, which are founded upon principles of human dignity and equality. However, the fact that women have a unique role to play in human reproduction demands that they have specific rights distinct from those of men.<sup>13</sup>

Berer<sup>14</sup> has made a distinction between the reproductive rights of women and those of men. She argues that the symbiotic relationship of pregnancy is a unique one and puts women on an entirely different plane from men in terms of the extent and nature of their roles in relation to reproduction. Unlike men, women's very bodies and lives are involved in gestation and are perpetually at risk from it. She further argues that even though a man has a right to decide whether he wishes to become a parent and therefore has as much right to practice family planning as a woman does; that this is not the same with a woman's right. Women's rights entitle them to decide whether or not to enter into the

---

<sup>10</sup> Berer, M., 2000. Reproductive Rights: Advocacy and Changing the Law. In Reproductive Health Matters, volume 8 no 16, November 2000, 7.

<sup>11</sup> Berer, M., 2000. Reproductive Rights, 7.

<sup>12</sup> Byrnes, A. "Women, Feminism and International Human Rights Law-Methodological Myopia, Fundamental Flaws or Meaningful Marginalisation? Some Current Issues". 12 Australian Year Book of International Law, 205.

<sup>13</sup> Centre for Reproductive Law and Policy (CRLP), 2000. Reproductive Rights are Human Rights, 3.

<sup>14</sup> Berer, M., 2000. Reproductive Rights, 7.

bodily act of reproducing another human being. She further argues that it is the woman alone who must choose whether to get pregnant and whether to continue or to terminate the pregnancy.<sup>15</sup>

As sexual and reproductive rights are a constellation of existing human rights, there is no human rights instrument that defines them. The only international human rights instrument that, to a certain extent articulates women's sexual and reproductive rights is the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. This is a fairly recent document of the African Union which came into force in 2005 and is discussed in more detail in chapter three. The categorisation of women's sexual and reproductive rights in the Protocol marks a departure from that of Fried and Landsberg Lewis.<sup>16</sup> Fried and Landsberg Lewis suggest that reproductive rights are part of the sexual rights package which includes women's right to health.

The Protocol suggests that reproductive rights are part of the health rights package. The link between women's health rights and sexual rights is of course undeniable. The conceptual foundations of both sexual rights and health rights lie in the development of the concepts and jurisprudence on women's human rights, the work on women's right to health and work in the area of sexual orientation and human rights.<sup>17</sup> Therefore, the apparent variations in definition do not signify or indicate disagreement as to the content and scope of these rights. Rather it signifies a difference in terminological application.

In the midst of this terminological quagmire, women's rights advocates have defined women's sexual and reproductive rights as, "rights of a woman to control her own sexuality and reproductive capacity; making decisions on the number of children she has; their spacing and timing and also whether to have them or not".<sup>18</sup> They relate to an

---

<sup>15</sup> Berer, M., 2000. Reproductive Rights, 7.

<sup>16</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. Sexual Rights: From Concept to Strategy, In K.D. Askin and D.M. Koenig, (eds.), Women and International Human Rights Law, volume 3, 91-121.

<sup>17</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. Sexual Rights: From Concept to Strategy, In K.D. Askin and D.M. Koenig, (eds.), Women and International Human Rights Law, volume 3, 91-121.

<sup>18</sup> Women and Law in Southern Africa Research and Educational Trust, 2002. Lobola: It's Implications for Women's Sexual and Reproductive Rights, 32.

individual woman's ability to control and make decisions about her life which will impact on her reproductive and sexual health.<sup>19</sup>

These rights touch on physical integrity and sexual and reproductive autonomy, the violation of which can lead to an unwanted invasion of women's bodies and violation of the rights to personal liberty, bodily integrity and privacy.<sup>20</sup> This definition suggests that these are rights of individuals and are exclusively female. This study examines the question whether women's sexual and reproductive rights are a distinct class of rights that women can enforce or exercise as individual rights as opposed to rights of couples.

### 1.3. Statement of the Problem

Women's sexual and reproductive rights are recognized human rights under international law. Yet it has been observed that the exercise of these rights by women is still a long way from reality.<sup>21</sup> Women still face problems that can be dealt with or resolved by the exercise or enforcement of sexual and reproductive rights. For example, maternal mortality rates stand at 729 per 100 000 live births in Zambia with the five major causes being haemorrhage (34%), sepsis (12%)<sup>22</sup>, eclampsia (5%)<sup>23</sup>, obstructed labour (8%) and unsafe abortions (4%).<sup>24</sup>

These causes occur as a result of early pregnancy (75% of maternal deaths occur among teenage mothers<sup>25</sup>), short spacing between pregnancies, home deliveries, illegal abortions and long distances to clinics. These are causes that can be avoided by delivering at clinics, by spacing one's pregnancies sufficiently and by delaying early marriage or early pregnancies, i.e. exercising the right to sexual and reproductive healthcare and services.

---

<sup>19</sup> World Health Organisation, 1999. Training Manual: Gender and Rights in Reproductive Health, 151.

<sup>20</sup> Forum for African Women Educationalists in Zambia (FAWEZA), 2004. An Analysis of Traditional and Statutory Laws on Female Reproductive Rights, 11-13 (Unpublished).

<sup>21</sup> <sup>21</sup> Women and Law in Southern Africa Research and Educational Trust, 2002. Lobola.

<sup>22</sup> Infection with harmful bacteria.

<sup>23</sup> Medical condition that precipitates premature birth.

<sup>24</sup> Nsemukila, B., 1998. Situational Analysis of Maternal Mortality in Zambia, Ministry of Health.

<sup>25</sup> Committee on Elimination of Discrimination Against Women 27<sup>th</sup> Session, Government of the Republic of Zambia Country Report, June, 2002.

Secondly, statistical information indicates that:

- a) at least 47% of husbands decide alone on the healthcare of their wives as compared to only 30% of wives deciding alone about their own health;
- b) 50% of husbands decide alone about the timing and number of children as compared to 10% of wives deciding alone;
- c) Even though contraceptive knowledge is almost universal in Zambia with 98% of women and men knowing at least one modern method, only 34% of women report using one such method.<sup>26</sup>

These statistics suggest that there are factors affecting women's health seeking behaviour, so that even where health services and contraceptives are available, women may shun them. These further impinge on women's ability to exercise sexual and reproductive self determination. The comparative effect of these factors is probably higher than those resulting from lack of access to sexual and reproductive health services. The problem is therefore, that while sexual and reproductive rights are recognised human rights, extrapolated from within human rights recognised in the Republican Constitution, women are not asserting these rights.

#### **1.4. Purpose of the Study**

The purpose of the study is therefore to examine and understand the challenges women face in exercising their sexual and reproductive rights in Zambia and to see whether this class of rights can be exercised or enforced fully as individual rights by women. The study is based on the assumption that women do not exercise or enforce their sexual and reproductive rights fully because they face challenges that if removed would enable them to exercise or enforce these rights.

---

<sup>26</sup> Central Statistics Office, Central Board of Health, ORC Macro, 2003. Zambia Demographic and Health Survey, 2001-2002: Lusaka.

## **1.5. Objectives**

The study seeks to answer the broad question, “Are women’s sexual and reproductive rights mere theoretical assertions that cannot be fully enforced or exercised by women in Zambia”? To answer this question the study addresses the following specific questions;

- a) Are women’s sexual and reproductive rights a distinct class of rights that can be exercised or enforced as individual rights by women in Zambia?
- b) What challenges, dilemmas or unwanted consequences, if any, do women in Zambia face in exercising or enforcing their sexual and reproductive rights?

The working hypothesis at the start of the study was that these rights are not mere theoretical assertions as the factors restraining women from asserting them are not so enormous and so beyond women’s control that they cannot be confronted; that given an enabling environment, information and life skills women can exercise and enjoy these rights without facing any unwanted consequences.

## **1.6. Significance of the Study**

Statistics in Zambia indicate high incidence rates in matters associated with sexual and reproductive rights. For example, maternal mortality rate and HIV/AIDS statistics indicate a higher infection rate for women. The incidence of poverty levels is also higher among women than men. Women’s sexual and reproductive rights have to be translated into reality for them to have meaning in women’s lives. It is pointless for international instruments and other documents to recognize these rights if women cannot translate them into their lived realities.

This study is significant because it examines the extent to which theoretical assertions of women’s sexual and reproductive rights have been translated into practice and brings understanding on the challenges women face in this respect. It was designed to draw on the lived experiences of women who have either succeeded or failed at exercising these rights, the challenges they have faced and hence giving others an opportunity to learn

from these experiences. This study will inform various actors, such as women's rights activists, women's lawyers, social workers and health service providers and planners.

## **1.7. Research Methodology**

The various aspects of the research methodology include sampling of the study population; selection of research sites; data collection techniques and research instruments; data cleaning, analysis and report writing. The research is qualitative and is both descriptive and analytical. The theoretical and conceptual framework of the study is dealt with in chapter two.

### **1.7.1. Sampling**

The sample population consisted of women in communities, midwives, maternal health public workers, traditional counsellors and leaders and local court justices. Random sampling was used in the women population. The women population included married and unmarried adolescent mothers; adult married and unmarried women with families of different sizes; post menopausal women some of whom were grandmothers; as well as women from different income brackets. The sample of women was also aimed at randomly capturing women in different circumstances, of different age groups, professional or trade and educational background. Places where women from all walks of life could be found such as clinics, traditional birth attendants associations, home based care groups and churches were used to capture the relevant population.

Women in public life were also interviewed and were randomly picked from a structured list of women in politics, women in leadership in public service, women in leadership in the women's NGO sector and women managers in the private sector in companies randomly picked. Service providers targeted were those working in the area of sexual and reproductive rights and health care. Thus maternal public health workers and local court justices were interviewed in each site. Traditional counsellors and birth attendants were also picked on a random basis often on the recommendations of the local midwives. Traditional leaders were also identified site by site with a minimum of two per site.

### 1.7.2. Sites

The urban sites for the study are Lusaka, Kabwe and Ndola. Lusaka is the capital city of Zambia with a population of over 1 084 703 and located in the centre of the country. Kabwe is formerly a mining city located in the central province and has a population of 176 758. Ndola is a mining city on the Copperbelt province with a population of 374 757. The rural sites selected for the study are Monze, Solwezi and Kapiri Mposhi. Monze is a district in the southern province of the country with a population of 163 578. Solwezi has a population of 203 797 and is a rural district with high urbanisation due to opening of the mining industry. It is located in the north-western province. Kapiri Mposhi is also located in the central province but is less urbanised compared to Kabwe. The selection of these sites was intended to capture the urban and rural divide, ethnic and economic disparities, and centrality or periphery to various services relevant for sexual and reproductive health.

The urban sites have referral hospitals and satellite clinics and administer anti retroviral therapy including administration of prophylaxis for prevention of mother to child transmission of HIV. They are highly urbanised with a variety of economic activities and mark a confluence of ethnicity. The rural sites have rural health centres with basic health services and secondary hospitals that refer patients to referral hospitals. Kapiri Mposhi District Hospital, for example, refers patients to Kabwe General Hospital and Solwezi Hospital refers patients to Ndola Central Hospital in the Copperbelt Province.

Monze, Kapiri Mposhi and Solwezi are rural towns with agriculture and trading being the major economic activities. Additionally, in Solwezi mining activities have recently increased and the town is rapidly urbanising and population is increasing. With regard to ethnicity, Kapiri Mposhi is a confluence of different ethnic groups due to people migrating from all over the country to farming blocks. Monze is strictly a one tribe-dominated area, while Solwezi is a confluence of mostly three ethnic groups.

### **1.7.3. Data Collection Techniques and Instruments**

As this research is qualitative; focus group discussions, in-depth individual interviews with women and key informants (public health workers, traditional counsellors and traditional birth attendants and local court justices) were used to collect data. Perusal of court records as well as authorised health information was also used to collect data. Separate guides were developed for each of the sample population. Ante natal, postnatal and under-five clinics and churches, Traditional Birth Attendants Associations and home based care groups were used to capture the relevant population and as points of entry into communities.

### **1.7.4. Data Cleaning, Analysis and Report Writing**

Data cleaning was done at the end of each working day. Emerging issues were clustered into themes for analysis. Analysis was based on both primary and secondary data. The various themes under which the emerging issues were clustered were used as subheadings in relevant chapters during report writing. The study is both descriptive and analytical.

## CHAPTER TWO

### 2. THEORETICAL AND CONCEPTUAL FRAMEWORK

Flowing from the methodological framework discussed in chapter one, this chapter discusses the theoretical and conceptual perspectives and approaches adopted in the study. The study was grounded in the women's law approach to enable the inquiry start with what is problematic for women. Although the women's law approach was the overall underlying perspective for this study, it was used within a combination of contemporary African feminist thought and the analytical framework of legal pluralism. This was appropriate as the women's law approach coincides in many aspects with the arguments of contemporary African thought and legal pluralism.

#### 2.1. Women's Law Approach

As this study is based on the lived realities of women in the country, it draws on the western paradigms of law developed by Scandinavian scholars to 'describe, understand and improve the position of women in law and society'.<sup>27</sup> The women's law approach was inspired by the almost neutral gender laws established by the Scandinavian welfare states. This is a paradigm of women's law, a 'legal discipline which explores the reality of women's lives and from that perspective interrogates and investigates the law'.<sup>28</sup> It seeks and aims at an understanding of the subordination of women, their labour, qualitative characteristics and activities.<sup>29</sup>

The women's law approach puts women and women's experiences at the centre and is defined by Dahl as:

The methodology of women's law is cross disciplinary and pluralistic and calls for a rather free use of the available

---

<sup>27</sup> Dahl, T.S., 1987. Women's Law: An Introduction to Feminist Jurisprudence, Oslo, Norwegian University Press, 47.

<sup>28</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 26.

<sup>29</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 98.

material wherever it can be found. We can nevertheless distinguish three distinct methodological bases as fundamental: the ethical, the empirical and the legal doctrinal. We discuss moral and political questions; we deal with empirical material; and we analyse current law. All this is done from the perspective of one looking upwards from below, which I shall hereinafter call women's perspective. This term implies that we wish to see law, reality and morality from women's point of view.<sup>30</sup>

The women's approach asks the 'woman question', which means 'examining how law fails to take into account the experiences and values that seem more typical to women than men, for whatever reason, or how existing legal standards and concepts might disadvantage women. The question assumes that some features of the law may not only be non-neutral in a general sense but also "male" in a specific sense. The purpose of the woman question is to expose those features and how they operate and to suggest how they might be corrected'.<sup>31</sup> The women's approach therefore challenges the assumption of the gender neutrality of law. It permits the examination of the differences between men and women and thereby exposing how the law discriminates against women. It reveals issues and dynamics that are seldom evident in the male dominated legal culture.<sup>32</sup>

It is used to ascertain the impact of laws on the factual lives of men and women; as a woman centred approach it focuses on the biological, social and cultural differences between men and women with a view of establishing and understanding how law may have different impact or effect on women and men.<sup>33</sup> It is also based on the contention that for the subordination of women to be addressed there is need for a legal and social order that recognises these biological, social and cultural differences, thereby focusing on

---

<sup>30</sup> Dahl, S.T., "Towards an Interpretative Theory of law-The Argument of Women's Law"; In Studies in Women's Law, 27 Institute of Public and International Law Publication, series no 7/1988.

<sup>31</sup> Bartlett, K. in Cook, R. J. "International Protection of Women's Reproductive Rights" in 24 New York University Journal of International Law and Politics, 645.

<sup>32</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 98.

<sup>33</sup> Dengu-Zvogba, K., B.R. Donzwa, E.C.Gwaunza, J.L. Kazembe, W. Ncube, J.E. Stewart, Inheritance in Zimbabwe, 1994, Harare, Women and Law in Southern Africa Research and Educational Trust-Zimbabwe, 22.

the gender aspects of law and legal provisions.<sup>34</sup> It is therefore a useful tool in identifying what is discriminatory against women in the law.

By asking the “woman question” (what about women?),<sup>35</sup> the CEDAW has provisions that attend to the features of international human rights law that do not explicitly discriminate against women but implicitly render women subordinate. It obligates States to pursue by all appropriate means and without delay a policy of eliminating discrimination against women.<sup>36</sup> The idea of starting from the woman’s view point presupposes that women are “knowers” and to a certain extent in a position to define the social relationships in which they find themselves irrespective of what or how society defines them.<sup>37</sup>

This was very important in this study as the focus is the exercise and enforcement or otherwise of rights by women and thereby defining their social relationships. Further, that the question whether women’s sexual and reproductive rights are individual rights as to be enforced and exercised by women solely, requires an answer as to whether women define their rights within their social context or in opposition to its boundaries and if so, how. This supposition of women as ‘knowers’ of course marks a paradigm shift in the exploration of women’s realities, experiences and knowledge, often conducted from a feminist perspective, of their societies.<sup>38</sup>

It follows that in some of its aspects, the women’s law approach coincides with contemporary African feminism and legal pluralism, the other two perspectives used in this study. For example, it does not view women as homogenous and thereby allows the analysis of problems of women with different needs, roles and socio-economic

---

<sup>34</sup> Women and Law in Southern Africa Research and Educational Trust-Swaziland, 1998. Family in Transition: The Experience of Swaziland, Manzini, 12.

<sup>35</sup> Bartlett, K.,

<sup>36</sup> CEDAW, Article 2.

<sup>37</sup> Women and Law in Southern Africa Research and Educational Trust-Swaziland, 1998. Family in Transition, 12.

<sup>38</sup> Stewart, J., (ed.), 1997. Paving a Way: A Review and Research Primer of WLSA Research Methodologies, Harare, 23.

backgrounds.<sup>39</sup> In this aspect it coincides with African contemporary thought which recognises the non-homogeneity of African women. In its view of the gender aspects of the law and the need for a legal and social order that recognises and deals with the differences between men and women, it marks common ground with both African feminism and legal pluralism.

This approach grounds the research agenda in the identification of specific problems women experience by exploring the actual experiences of women with the problem or event; and by considering viable solutions when problems were experienced.<sup>40</sup> It was therefore an important underlying perspective in this study. The researcher was however mindful of the criticism of this perspective, that as it focuses on women it has a risk of assuming that the experiences of women are not replicated in men's lives<sup>41</sup>. Further, that to get a deeper understanding of the problem, one needs to include men's perceptions and experiences.<sup>42</sup>

The study attempts to answer the question whether women's sexual and reproductive rights are individual rights. It recognises that some of the women's experiences may be similar to those of men, especially since literature suggests that sexual and reproductive rights are also rights of couples. However, as the study focus is women's sexual and reproductive rights specifically and not sexual and reproductive rights generally, men's views or experiences were not part of the data collected unless these men were key informants.

## 2.2. African Feminism

The feminist theory was chosen because it is about power and inequality.<sup>43</sup> It confronts the reality of women's lives by examining their experiences. It underscores issues of discrimination and subordination that need to be discussed to understand the status of

---

<sup>39</sup> White S.V., D. Kaunda-Kamanga, T. Kachika, A.L. Chiweza, F. Gomile-Chidyaonga, 2002.

*Dispossessing the Widow: Gender Based Violence in Malawi*, Blantyre, 12.

<sup>40</sup> Stewart, J., (ed.), 1997. *Paving a Way*, 23.

<sup>41</sup> White, S. V. D. Kaunda-Kamanga, T. Kachika, A.L. Chiweza, F. Gomile-Chidyaonga, 2002.

*Dispossessing the Widow: Gender Based Violence in Malawi*, Blantyre, 12.

<sup>42</sup> Bentzon, A.W., 1998. *Pursuing Grounded Theory in Law*, 101.

<sup>43</sup> McKinnon, C., 1982. *"Feminism, Marxism,*

women. Feminist legal thought also places sexuality and inequality within the framework of the status of women in society.

The problems that women face in respect of sexual and reproductive rights are linked to power relations between men and women and the inequalities in society caused primarily by patriarchy. Whereas sexuality is a fundamental issue in women's enjoyment of their rights, patriarchy has reduced it to a bargaining tool for women to access certain rights and resources. Sexuality is controlled directly by men as individuals or indirectly through natal and marital family structures. According to feminist thought, the deprivation of one's sexuality "defines each one's conception of one's lack of power per se".<sup>44</sup>

Weber<sup>45</sup> defines power as the ability to influence a person's behaviour and the capability of an actor to overcome resistance in achieving a desired goal. She claims that power does not have to be exercised in order to be presented as it also refers to the ability to induce acceptance of orders whether through coercion or manipulation. She identifies five classifications of power, namely, reward, coercive, referent, expert and legitimate power (or authority). These types of power reduce, negate and deprive women of the autonomy to make choices.

It is contended that different opinions between liberal, Marxist and radical western feminists about what is unequal, unjust or oppressive exist. However, all schools of feminism share the same ideals of justice, equality and freedom.<sup>46</sup> The problem for feminists is therefore one, i.e. women's subordination by men within the patriarchal system. Therefore, arguments by feminists such as Simone de Beauvoir, whose school of thought exalts all women as possessing the capacity to realise their innate power to overcome obstacles in spite of inequality, would have been worth employing in this analysis. Simone de Beauvoir believed that one of the keys to a woman's liberation is economic.<sup>47</sup>

---

<sup>44</sup> McKinnon, C., 1982. "Feminism, Marxism."

<sup>45</sup> Weber, M., 1919. Authority and Autonomy in Marriage. In M. Weber, Frauenfrage und Frauengedanke. Tubingen, Ger.: J.C.B. Mohr: 67-79.

<sup>46</sup> Dahl, S.T., 1997. Women's Law: An Introduction to Feminist Jurisprudence, 19.

<sup>47</sup> Tong, 1989. Feminist Thought: A Comprehensive Introduction, 211.

As the economic status of women is a variable in women's exercise of their rights, this would have been a useful framework within which to conduct the analysis.

However, a tension has been noted between African and western feminists arising from the critique of western feminism by contemporary feminists on the continent. African feminism criticises and departs from western feminism by rejecting western feminisms sexual hegemony and the manner in which it globalises women's problems. Therefore, as this study is located on the African continent; contemporary African feminist thought was preferred and found more appropriate for the study. It was however, noted from the beginning of the study that there is no homogeneity in African feminism as a result of the diverse social realities on the continent<sup>48</sup> and so a common denominator was constantly sought in the analysis.

African feminist thought is rooted in black feminism which is identified by its opposition to racism and sexism encountered by black women. Black feminists seek not only to dismantle the assumptions of dominant cultures and to recover and reclaim the lives of black women, but also to develop methods of analysis for interpreting the ways in which race and gender are inscribed.<sup>49</sup> While western feminism concerns itself primarily with sex and power, African feminists argue that feminism should grapple with more than the issues of sex and power and take into account the interconnectedness of race, sex, class and other forms of subjugation or multiple manipulations.<sup>50</sup>

African feminist thought recognises that men are not the only oppressors and so to remove them will not solve the problem.<sup>51</sup> This is important to this study because while sexual and reproductive rights are personal they are also social and oppressors may

---

<sup>48</sup> Msimang, S., 2002. African Feminism II: Reflections on Politics made Personal in: Agenda on African Feminisms 2, number 54.

<sup>49</sup> Smith V., 1990. West African Review 2003, [www.westafricanreview.com](http://www.westafricanreview.com), last visited November 2004, 271.

<sup>50</sup> McFadden, P., 2000. Issues of Gender and Development from an African Feminist Perspective, [www.world.org/programs/regions/Africa/patricia\\_mcfadden4\\_p.htm](http://www.world.org/programs/regions/Africa/patricia_mcfadden4_p.htm)

<sup>51</sup> West African Review 2003. [www.westafricanreview.com](http://www.westafricanreview.com), last visited November, 2004.

include the natal and marital families and society in general. McFadden<sup>52</sup> says that women's sexual subordination and exploitation are part of a broader system of economic political and social domination. It is argued that by taking this broad view, African feminism fully articulates the concerns of African women.<sup>53</sup>

One of the "multiple" forms of subjugation recognised by African feminism is colonialism, which is said to have led to the historical conditions of imperial expansion and racist fascination.<sup>54</sup> That the interaction with colonialism led to changes in the dominant meanings of sex and other matters among the indigenous people.<sup>55</sup> Pereira<sup>56</sup> for example, asks whether the element of sex as a 'dirty' or 'filthy' thing was an indigenous conceptualisation or whether it was introduced by Victorian interpretations of Christianity. It is also evident that the formative period of State customary law, to give another example, was contemporaneous with the imposition of the colonial State and its legal system.<sup>57</sup> In this process customary law as applied by the customary law courts was altered so that State customary law is not necessarily the customary law applicable in peoples' daily lives.

Further, customs and traditions also became a means by which the local rulers and family heads bargained with the colonial State for purposes of retaining part of their political power in their community and families,<sup>58</sup> thereby impacting the relationships in the communities and families. Rwezaura states that the relationship between the coloniser and the colonised was one of masculinisation of the coloniser and feminisation of the colonised people, was then reflected in male-female relationships. Individuals especially

<sup>52</sup> McFadden, P., 2001. Political Power: The Challenges of Sexuality, Patriarchy and Globalisation in Africa, African Women's Voices- Women's World, [www.wworld.org/programs/regions/Africa/patricia\\_mcfadden2\\_p.htm](http://www.wworld.org/programs/regions/Africa/patricia_mcfadden2_p.htm)

<sup>53</sup> McFadden, P., 2000. Issues of Gender and Development.

<sup>54</sup> Mama, A., 1996. "Women's Studies and Studies of Women in Africa during the 1990s", CODESRIA Working Paper, Series 5/96.

<sup>55</sup> Runganga A. and P. Aggleton., 1998. "Migration, the Family and the Transformation of Sexual Culture". Sexualities, 1, 63-68.

<sup>56</sup> Pereira, C., "Where Angels Fear to Tread?", Feminist Africa Issue 2, 2003; [www.feministafrica.org/fa%202/02-2003/sp-charmaine.html](http://www.feministafrica.org/fa%202/02-2003/sp-charmaine.html)

<sup>57</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 101.

<sup>58</sup> Rwezaura B., 1990. "Researching on the Law of the Family in Tanzania: Some Reflections on Method, Theory and the Limits of Law as a Tool for Social Change". Armstrong, A., (ed.) Perspectives on Research Methodology, WLSA Working Paper no. 2, 13.

women and young people appealed to the colonial State to lighten some of their burdens under tradition through the deployment of liberal values such as natural justice and equity.<sup>59</sup> Therefore, there was significant interference into existing social systems and social fields. This interference had a resultant impact on the lives of women and on power relations between men and women.

African feminism also recognises the global oppression that women face. Colonialism led to an externally enforced and regulated integration of Africa into the world capitalist economy and global village. Rwezaura further argues that the ushering in of Africa into the global world caused the transformation of Africa. That African political, economic and social systems were affected by the interaction of indigenous concepts, colonial administration, religion and globalisation. Thus, African lives are impacted upon by global issues and trends. New meanings are assimilated into existing systems and thereby profoundly changing certain elements of more traditional culture.

This view is useful in this study because the law review indicates that sexual and reproductive rights are recognised at both international and domestic levels and that international law has an impact on domestic law and practice. There have been marked developments in international law at the global level. Zambia as a party to various international human rights instruments has obligations imposed at international level that are supposed to have effect at national level.

Further, contemporary African feminist thought recognises that there are complexities and contradictions in African women's realities. It argues that African women are not homogeneous and therefore different women are oppressed differently. It questions whether African women have always been sexually repressed and whether this repression cuts across all categories of women.<sup>60</sup> This aspect was useful for this study because literature indicates certain differences between women in rural and urban settings,

---

<sup>59</sup> Rwezaura B., 1990. "Researching on the Law of the Family in Tanzania: Some Reflections on Method, Theory and the Limits of Law as a Tool for Social Change". Armstrong, A., (ed.) Perspectives on Research Methodology, WLSA Working Paper no. 2, 13.

<sup>60</sup> Bentzon, A., 1998. Pursuing Grounded Theory in Law, 101.

educated women and uneducated women as well as women with independent sources of income and women without independent sources of income.

Contemporary African feminist thought raises questions about African women's personhood and integrity.<sup>61</sup> African female sexuality includes pleasure, choice, elements of desire, intimacy and reciprocity between sexual partners. McFadden<sup>62</sup> examines issues such as the relationship between sexual pleasure and power; the critical need to distinguish sexuality from reproduction; the reassertion of feminist agency as the starting point for confronting sexual violations; and the necessity of sexual choice for women. These are all intellectual and political issues that not only challenge masculinist structures, subjectivities and practices but also raise challenges for feminist intellectual and political practice.<sup>63</sup>

Issues distinguishing sexuality from reproduction are important. African feminism claims that there are 'silences' in the debate about African women's sexuality that need to be understood as they have many sources that need to be explored; that these also need to be transformed into appropriate responses.<sup>64</sup> These rights also raise issues of reciprocity and the complexity of being both rights of individuals and couples. These views are useful in this study because sexual and reproductive rights are not merely about procreation but also about sexuality, power, self-determination and bodily integrity.

Further, unlike western feminism, to which sexual orientation is a major concern, African feminist theory places emphasis on heterosexual concerns, looking at male and female sexuality in heterosexual relationships. It is argued that it is not hetero-normative

---

<sup>61</sup> McFadden, P., "The Challenges of Sexuality", *African Women's Voices-Women's World*, [www.wworld.org](http://www.wworld.org), last visited November, 2004.

<sup>62</sup> McFadden, P., *The Challenges of Sexuality*, 2004.

<sup>63</sup> Oguno, L., 2001. "Moving the Mountains, Making the Links, in: Bhavnani, "Womanism: The Dynamics of Contemporary Black Female Novels in English". *Signs: Journal of Women in Culture and Society*, 11-22.

<sup>64</sup> Bennet, J., Presentation at Curriculum Advisory Group of the Feminist Studies Network Workshop on Identity, Sex, Gender and Culture. Institute of African Studies Chalets, University of Ghana, Legon, Accra, 26-30 May 2003.

masculinity that prioritises male sexual choice and sexual pleasure in sexual relations.<sup>65</sup> There are other facets of an individual and interpersonal nature, such as intimate violence that do so to the exclusion of all other facets of individual and interpersonal well being. African feminism examines all these facets making the analysis broad and pertinent to the sexual and reproductive concerns of women on the continent.

These arguments are relevant for this study because of two reasons. First, it is a study based in a jurisdiction that outlaws homosexuality and where there are no artificial insemination facilities, so that power issues surrounding sexuality and reproduction only arise in or because of heterosexual relationships. Secondly, the question of whose sexual choice and pleasure is prioritised in heterosexual relations and the incidences of intimate violence are important variables in this study.

Arguments by contemporary African feminists<sup>66</sup> that challenge the status quo and describe the constraints of contemporary patriarchy in Africa are also relevant to this study. Contemporary African thought postulates that the lack of serious recognition and reward to women for their reproductive roles creates continued dependency on patriarchy and patriarchal structures. To this end, the issues of African women transcend 'bread, butter and power' issues and extend to personal aspirations, thwarted by poverty, disease and contemporary African patriarchy.<sup>67</sup>

Lack of individual agency on the part of African women is a complex matter impacted by social, political, economic, religious and cultural factors that manifest in women's everyday lives. Central to African feminism therefore, is the valuing of the everyday experiences of black women.<sup>68</sup> The recognition of the need to use these experiences to redefine, re-discover or recreate African women is thus important. This is central to this

---

<sup>65</sup> Pereira C. 2003, "Where Angels Fear to Tread?", *Feminist Africa: Issue 2 of 2003*. [www.feministafrica.org/fa%202/02-2003/sp-charmaine.html](http://www.feministafrica.org/fa%202/02-2003/sp-charmaine.html) last visited November, 2004.

<sup>66</sup> Women's World, "Talking about Feminism in Africa with Amina Mama", [www.wworld.org/progs/regions/africa/amina\\_mama.htm](http://www.wworld.org/progs/regions/africa/amina_mama.htm) last visited December, 2004.

<sup>67</sup> McFadden, P. 2003. "Sexual Pleasure as Feminist Choice", *Feminist Africa*, [www.wworld.org](http://www.wworld.org), last visited November 2004.

<sup>68</sup> Ogunjipe, L., 2001. 139 "Moving the Mountains, 11-22.

dissertation as it seeks to identify the experiences of African women and how these can be used to upset the status quo.

As a result of these perspectives and views on the interactions of individuals and on the political, economic and social realities of African women, African feminists have sought a broad understanding of women's problems. African feminism thus addresses the nuances of contradictions, complexities and interrelationships in the realities of women's lives especially in relation to sexual and reproductive rights.

### **2.3. Legal Pluralism**

Although legal centralism appears to be popular with legal researchers, it was not deemed an appropriate approach for this study. Legal centralism posits that State law or State recognised law and enforced law is the most important normative order and all other norms are either illegal, insignificant or irrelevant. That law is and should be the law of the State, uniform for all persons, exclusive of all other law and administered by a single set of institutions.<sup>69</sup> It conceives of legal pluralism as a situation where the official legal system recognises more than one system of law.<sup>70</sup>

The legal pluralist approach departs from this centralist view and was picked for this study for two reasons. First, the subject under study spans international and national laws and how these are applied in the Zambian jurisdiction. The State as a signatory to international human rights instruments has obligations there under with a set up of international tribunals, courts or treaty monitoring bodies to report and answer to. Further, at national level there exists a plural system of laws composed of imported British substantive and procedural laws, indigenous statutes and a multiplicity of customary laws.

---

<sup>69</sup> Griffiths, J., 1986. "What is Legal Pluralism?". *Journal of Legal Pluralism*, 24, 1-55.

<sup>70</sup> Bentzon, A.W., 1998. *Pursuing Grounded Theory in Law*, 30.

There is established at national level a system of courts-the Local Court which administers customary law, the Subordinate Court which applies statutory law and is an appellate court to the local court; the High Court and Supreme Court which apply statutory law and also have appellate jurisdiction; and the traditional courts presided over by traditional rulers whose jurisdiction is not recognised in the written law.<sup>71</sup> The written law controls the application of customary laws by the courts.<sup>72</sup>

The legal administration system consists of one formal legal system designed to apply this multiplicity of laws. There are therefore several sources of laws in operation at any one time, a plurality of normative orders affecting women's lives, the choices and decisions they make as well as a plethora of arenas where these are made.<sup>73</sup> These arenas are semi autonomous social fields that have a rule upholding and rule generating capacity.<sup>74</sup> Among these are the family, church and traditional rulers' courts which make their determinations based on a variety of considerations, among them practical considerations, common sense and knowledge of the law however skewed or religious norms.<sup>75</sup>

This study deals partly with the enforcement of rights and therefore understanding which normative order women choose to enforce their rights and why is important. This approach will help in understanding why women settle for 'less' when the written law often confers 'more'. The study also deals with the exercise of rights and this view will help understand why women will not exercise their rights in particular circumstances or which rights they choose to exercise and why. There is need for an exploration of women's experiences in this intersection within this pluralist setting. The legal pluralism approach is an appropriate tool to use in understanding this intersection and making this exploration.

---

<sup>71</sup> Bbuku-Chuulu, M., P.M. Chileshe, H. Ntalasha, A. W. Chanda, 1999. Justice in Zambia: Myth or Reality. Women and Law in Southern Africa Research and Educational Trust-Zambia. 30.

<sup>72</sup> Subordinate Courts Act; to the extent that is not inconsistent with written law and not contrary to good conscious and natural justice.

<sup>73</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 40.

<sup>74</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 40.

<sup>75</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 40.

Research has shown that complex and situation sensitive determinations which affect women can and do emanate from institutions other than the State courts, such as the family and the church.<sup>76</sup> Women choose to use these particular institutions to make these determinations irrespective of what their rights are in the statute. They may also prefer to settle for determinations made by these institutions that fall far below the rights the statute may confer on them, because of their personal priorities of what is more important.<sup>77</sup>

This study deals with the enforcement and the exercise of rights. It is therefore important to understand why women will not exercise or enforce their rights in particular circumstances or which rights they choose to enforce or exercise. Understanding which normative order women choose to do this is equally important. Legal pluralism recognises the presence of situations that are ‘characterised by the presence in one social field of more than one legal order’.<sup>78</sup> Legal pluralism takes cognisance of the concept of semi autonomous social fields.

It is thus a tool that assists in describing and analysing the rule generating and rule upholding processes which affect the position of women and gender relations in a situation where plurality of normative structures inform human relations.<sup>79</sup> This perspective is important because it allows the examination of these social fields where these decisions are made. These social fields need to be examined because the study is also done within the African feminist view that women’s oppression comes from a multiplicity of sources, and these arenas may well be one such source.

The legal pluralist approach explores the existing legal diversity and its usefulness or appropriateness to the lives of women. The application of a multiplicity of laws in one formal legal system leads to an interplay between these laws, creating an intersection. It is said that most women in the African context are in legal disputes within the family

---

<sup>76</sup>Bbuku-Chuulu, M., E. Muyovwe, E. Mbozi, P.M. Musanya, W. Mwenda, S. Kasonde-Ngandu, 1997. *Inheritance in Zambia*, 48.

<sup>77</sup>Griffiths, J. 1986. “What is Legal Pluralism?”, *Journal of Legal Pluralism*, 24, 1-55.

<sup>78</sup>Bentzon, A.W., 1998. *Pursuing Grounded Theory in Law*, 41.

<sup>79</sup>Bentzon, A.W., 1998. *Pursuing Grounded Theory in Law*, 41.

which are likely to be situated in this intersection between the different systems of laws.<sup>80</sup> There is need for an exploration of women's experiences in this intersection within this pluralist setting. The legal pluralism approach is an appropriate tool to use in understanding this intersection and making this exploration.

The anthropological conceptualisation of legal pluralism is especially important in this study because it is a framework that enables the researcher to describe the way in which the position of women is constituted through the normative interplay that is inherent in human interactions in different social fields.<sup>81</sup> The legal pluralist approach recognises that the State does not have a monopoly over law and regulations and law is merely one of the key factors in regulating people's behaviour. It is not at the centre of peoples' lives and other sources of regulation exist which members of society recognise as binding. This approach is therefore helpful in examining any other key factors regulating women's behaviour especially in the area of sexual and reproductive rights.

Further these social fields are not independent but are interactive. That these interactions are influenced by knowledge of a wide variety of norms ranging from legislated to religious norms.<sup>82</sup> This approach permits the analysis of women's knowledge of their sexual and reproductive rights whether as conferred by international law, domestic law or customary law. This approach also permits the analysis of the way in which the position of women is defined and gender boundaries are drawn through this interaction<sup>83</sup>, and limited or expanded through this knowledge. This view also creates an analytical framework through which to examine the interaction between statutory provisions and court determinations as well as normative structures of law.<sup>84</sup>

Given that the study is located in a place where both customary law and statutes are in operation and constant interaction; this is a useful perspective to employ. The conceptual framework of legal pluralism transcends legal centralism's dichotomous perception of

---

<sup>80</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 41.

<sup>81</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 41.

<sup>82</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 41.

<sup>83</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 41.

<sup>84</sup> Moore, S.F. 1978. Law as Process, 56.

general law and customary laws as separate and distinct systems of law.<sup>85</sup> It is noted that in its application of law the Zambian High Court has taken cognizance of customary law and occasionally employed it contemporaneously with statutory law.<sup>86</sup> It opens up new and crucial ways within which the interaction of law and life can be explored thereby making it possible to obtain a more holistic picture of the factors that affect women's lived realities.

---

<sup>85</sup> Bentzon, A.W., 1998. Pursuing Grounded Theory in Law, 42.

<sup>86</sup> *Chibwe v. Chibwe, S.C.Z. Appeal No. 38 of 2000.*

## **CHAPTER THREE**

### **3. LAW AND POLICY REVIEW**

In examining the definition of women's sexual and reproductive rights in chapter one, it was pointed out that there is no specific defining instrument for these rights in the fashion of international covenants or conventions. The absence of a defining instrument marked the genesis of a new analytical jurisprudence among scholars and proponents of human rights, which has succeeded in widening the scope of existing human rights to include sexual and reproductive rights. Women's sexual and reproductive rights are recognised human rights, located in and extracted from the soft and hard norms of international human rights law. Rooted in both soft and hard norms, they are composite rights. In this chapter, we locate the sources of this class of rights.

#### **3.1. Soft Norms**

The discourse on women's rights during and following the United Nations decade for women led to the extraction of women's human rights from the existing rights in international human rights instruments. This extraction led to a critical awareness of the absence of an express provision on women's sexual and reproductive rights. This in turn led to the growth of a jurisprudence of extrapolating these rights from existing human rights.

Some authors on human rights subjects argue that it is possible to articulate sexual and reproductive rights within the scope of existing rights.<sup>87</sup> An example of marital rape as a violation that can be enforced under the existing right to freedom from torture is given. Similarly, Cook<sup>88</sup> talks about sexual non-discrimination rights as relative rights whose application can ensure women's reproductive rights. This discourse also found expression in consensus documents of international conferences.

---

<sup>87</sup> Cook, R. J., and M. F. Fathalla, 1996. Advancing Reproductive Rights Beyond Cairo and Beijing. In Askin and Koenig, (eds.), Women and International Human Rights Law, volume 3, 73.

<sup>88</sup> Cook, R., 2003. "International Protection of Women's Reproductive Rights", 24 New York Journal of International Law and Politics, 645.

The series of conferences that led to key consensus documents in this area can be traced from the World Conference on Human Rights held in Teheran in 1968.<sup>89</sup> After that, sexual and reproductive rights gained more attention and became more focused during successive women's conferences, among them; the 1984 International Conference on Population; the Vienna World Conference on Human Rights of 1993; the International Conference on Population and Development (ICPD) held in 1994 in Cairo; and the Beijing World Conference for Women of 1995. These conferences reaffirmed these rights

The 1968 Teheran Conference definition was reformulated at the 1984 Mexico City International Conference on Population as,

All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information education and means to do so...<sup>90</sup>

The Beijing Conference on the other hand defined reproductive rights as,

Rights that rest on the recognition of basic rights of all couples and individuals to decide; the right to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in the human rights documents.<sup>91</sup>

The Beijing Declaration and Platform for Action (BPFA) further expanded the definition of women's human rights to include;

... rights to have control over and decide freely and responsibly on matters of their sexuality including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction including full respect for the integrity of the person require mutual

<sup>89</sup> Resolution XVIII, U.N. Doc.A/CONF.32/41 (1968) in United Nations Department of Public Information, The United Nations and the Advancement of Women 1945-1995, 167-169 U.N.Doc.DPI.1679, U.N. Sales No.E.95.1.29 (1995).

<sup>90</sup> Report of the International Conference on Population Mexico City, 6-14 August 1984, Recommendation 30, U.N. E./CONF.76/19 (1984).

<sup>91</sup> United Nations Department of Public Information, 1996, New York, Platform for Action and Beijing Declaration, Paragraph 94, 58.

respect, consent and shared responsibility for sexual behaviour and its consequences.<sup>92</sup>

The BPFA includes sexual rights by recognising women's need to control their sexuality. This expansion further led to the inclusion of sexual and reproductive rights in the scope of women's rights. Sexual and reproductive rights have in recent discourse, been defined as the rights of a woman to control her own sexuality and reproductive capacity<sup>93</sup> and matters related hereto.

On the premise of extracting women's sexual and reproductive rights from existing human rights, the International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights recognises women's right to life as including several elements. It includes the right of a woman not to have her life put at risk or endangered by reason of pregnancy. It further includes the right to reduced risk factors for high risk pregnancies which are too early, too close, too late, or too many due to lack of access to or knowledge of contraception or due to forced and early marriage. Also included in the IPPF Charter definition of women's right to life, is the right to access health care services or information, counselling or services related to sexual and reproductive health.<sup>94</sup>

Similarly, the right to bodily integrity and security of the person is traditionally understood to relate to actions concerning individuals in the custody of the State. The IPPF Charter has however interpreted this right as including several elements. Among these is the security from sexual violence and assault by one's intimate partner or other person. It also includes the right to be free from medical interventions related to one's sexual and reproductive health without their full, free and informed consent.

The IPPF Charter also interprets the right to be free from externally imposed fear, shame, guilt, beliefs based on myths and other psychological factors inhibiting one's sexual responses or impairing their sexual relationships, as part of the right to bodily integrity

---

<sup>92</sup> Beijing Declaration and Platform for Action, Paragraph 96, UN Docs A/CONF.177/20 Add 1.

<sup>93</sup> Women and Law in Southern Africa Research and Educational Trust, 2002, *Lobola*, 32.

<sup>94</sup> International Planned Parenthood Federation (IPPF), 1996. *Charter on Sexual and Reproductive Rights*.

and security of the person. The right to be free from forced pregnancy, sterilisation and abortion is also understood to be part of the meaning of the right to bodily integrity and security of the person.<sup>95</sup>

Other soft norms that extrapolate sexual and reproductive rights from the substantive human rights are interpretations and recommendations of human rights Treaty Monitoring Committees (TMC). These committees monitor state party compliance with each of the six major United Nations human rights treaties. The TMCs make general comments or recommendations that provide a working interpretation of the rights or the scope of rights in the treaty that they monitor. For example, commenting on Article 12 of the CEDAW<sup>96</sup>, the CEDAW TMC made a general recommendation to the effect that,

State Parties should prioritise the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended to remove punitive provisions imposed on women who undergo abortion.<sup>97</sup>

The TMC was in essence saying that the scope and meaning of Article 12 includes prioritising prevention of unwanted pregnancy and legalising abortion although the article does not make direct or specific reference to this.

Some TMCs, such as the Human Rights Committee, (HRC) are also mandated to examine individual complaints where the state party recognises the TMC's authority to hear such complaints. By so doing, they interpret the scope of human rights provisions in the context of the facts presented. An example of such an interpretation of the scope of a

---

<sup>95</sup> International Planned Parenthood Federation (IPPF), 1996. Charter on Sexual and Reproductive Rights

<sup>96</sup> Which reads in part "State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning"?

<sup>97</sup> Convention for the Elimination of all forms of Discrimination Against Women, Committee General Recommendation 24, paragraph 31 (c).

human rights provision made by a TMC on the basis of a complaint by an individual is the one made by the United Nations Human Rights Committee in *KL v. Peru*.<sup>98</sup>

In this 2001 case, a 17-year-old Peruvian woman was fourteen weeks pregnant when doctors at a public hospital in Lima diagnosed the foetus with *anencephaly*, a fatal anomaly in which the foetus lacks most or all of a forebrain. The young woman decided to have an abortion. Abortion is legal in Peru for therapeutic reasons, however, because Peru failed to adopt clear regulations, this woman whose health was endangered by such pregnancy was left at the mercy of public officials.

The petitioner in the case was denied access to the procedure by the hospital's director, and was compelled to carry the foetus to term. She was forced to breast-feed for the four days the infant survived. The Committee indicated that the refusal of the State to provide a therapeutic abortion had in actual effect endangered KL's life thereby posing a threat to her right to life. The Committee held that the kind of treatment received by KL at the hands of the public health officers also amounted to an abrogation of the right to be free from cruel, degrading or inhuman treatment.

The ruling specifically establishes these facts as amounting to a threat to the complainant's right to life; an abrogation of the complainant's right to be free from cruel, inhumane, and degrading treatment; violation of her rights to privacy and special protection of the rights of a minor. Traditionally, the extent of the right to be free from cruel, degrading or inhuman treatment is understood in the civil and political context of corporal punishment and torture by the state or its agents. This decision thus presents a non-traditional interpretation of the meaning and extent of this right.

Although the Cairo and Beijing Declarations and Programs for Action and the IPPF Charter have defined reproductive and sexual rights, they are not binding international

---

<sup>98</sup> Conventions on Civil and Political Rights, CPR/C/85/D/1153/2003, see also <http://www.reproductiverights.org>, last viewed November 2005.

instruments.<sup>99</sup> Their normative status is that of texts of consensus documents agreed upon by the participating international community and have no force of law. These documents are therefore soft norms. As soft norms, these documents are merely ethical frameworks for State Parties' moral obligation to comply. Similarly, rulings of TMCs may not have force of law under domestic legal frameworks. Therefore, the rulings of TMCs cannot be enforced and depend on the State Party's willingness to comply. What this body of soft norms does is to give a non-traditional interpretation of the basic human rights contained in the international human rights instruments, thereby extrapolating women's sexual and reproductive rights.<sup>100</sup>

### 3.2. Hard Norms

The international instruments, from which women's sexual and reproductive rights are extrapolated, are hard norms, which are legal standards to which nearly every world government has legally bound itself. They are the principal sources of human rights and provide the foundation for women's sexual and reproductive rights. These are primarily the ICCPR and ICESCR and the CEDAW as well as the African regional human rights instruments, the most significant of which, on this subject, is the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa discussed above.

The CEDAW is a primary modern human rights instrument in respect of women's sexual and reproductive rights and has several relevant provisions. For example, in article 5 (b), the CEDAW talks about family education and its inclusion of a proper understanding of maternity. Article 11 dwells on the improving of various employment and labour

---

<sup>99</sup> Choike, P., [Sexual and Reproductive Rights in the Political Arena](http://www.choike.org/nuevo_eng/informes/1393.html), [www.choike.org/nuevo\\_eng/informes/1393.html](http://www.choike.org/nuevo_eng/informes/1393.html), last viewed April, 2005.

<sup>100</sup> Traditional interpretation being the understanding of the scope of any given human right contained in the Universal Declaration of Human Rights (UDHR); International Convention on the Elimination of all forms of Racial Discrimination (ICERD); The International Covenant on Civil and Political Rights of the United Nations (ICCPR); The International Covenant on Economic, Social and Cultural Rights of the United Nations (ICESCR); The Convention on Elimination of All forms of Discrimination Against Women of the United Nations (CEDAW); The Convention on the rights of Children of the United Nations (CRC); The Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment without reading sexual and reproductive rights into them.

conditions relevant for women's enjoyment of the right to found a family. Article 12 deals with measures appropriate to women's access to health care during pregnancy, confinement and post natal period, including family planning. Article 16 (e) expressly refers to women's equal right to decide freely and responsibly on the number and spacing of children and the access to information, education and means to exercise these rights.

In the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, some of these rights find expression under the heading of 'health and reproductive rights'. These are<sup>101</sup>:

1. The right to control fertility
2. The right to decide whether to have children, the number of children and the spacing of children
3. The right to choose any method of contraception
4. The right to self protection and to be protected against sexually transmitted diseases including HIV/AIDS
5. The right to be informed on one's health status and on that of one's partner particularly if affected with sexually transmitted infections including HIV/AIDS in accordance with international recognised standards and best practices
6. The right to have family planning education

Although the Protocol does not use the term sexual rights and makes no mention of the rights of homosexuals and transgender persons, it articulates the health and reproductive rights of women in Africa.<sup>102</sup> In doing so, it implicitly recognizes women's sexual rights to choose a sexual or marriage partner, freedom from sexual assaults, unwanted sexual advances or coercive sex, protection from harmful sexual practices and the freedom to develop one's personality independently.

The Protocol further requires State Parties to protect 'women's reproductive rights' by authorising medical abortion in cases of sexual assaults and where continued pregnancy

---

<sup>101</sup> Article 14 (1) (a) (b) (c) (d) (e) (f) (g).

<sup>102</sup> Article 14.

will endanger the mental and physical health of the mother or unborn child.<sup>103</sup> In the Protocol, reproductive rights are part of the health rights package. It should also be noted that the six rights enumerated in the Protocol are the same rights recognised in the Beijing Platform for Action and the IPPF Charter as comprising reproductive rights.<sup>104</sup> The six rights of the Protocol can be said to be either subsumed in the rights listed in these consensus documents or actually identical.

### **3.3. Domestic Legislation, Policies and Customary Law**

Human rights cannot be enjoyed in abstract. There has to be a framework within which they are to be enjoyed at national level. In Zambia, international instruments are not self effecting at national level following ratification. The State has to enact legislation to domesticate the provisions of the international instruments for implementation and realisation. Although there is no statute or Act of the legislature that defines women's sexual and reproductive rights in the country, there are several pieces of legislation that have the effect of providing for and to a limited extent, securing an environment for the protection or enforcement of women's sexual and reproductive rights. These are the Republican Constitution, the Marriage Act, the Termination of Pregnancy Act, the Public Health Act, the Penal Code and the Midwifery and Nurses Act.

The Republican Constitution in the Bill of Rights lists fundamental freedoms or human rights, with a provision for interpretation, protection and enforcement by courts.<sup>105</sup> Notably, all the human rights protected by the Constitution are civil and political rights. Economic, social and cultural rights recognised in the ICESCR are not included in the Zambian Bill of Rights. They are treated as principles to be considered in the development of State policy.<sup>106</sup>

---

<sup>103</sup> Article 14 (2).

<sup>104</sup> United Nations Department of Public Information, 1996, New York, Platform for Action and Beijing Declaration, Paragraph 95, 58-59.

<sup>105</sup> The Constitution of Zambia, Chapter 1 of the Laws, part 3.

<sup>106</sup> The Constitution of Zambia, Chapter 1 of the Laws, part 9.

The Constitution is important to sexual and reproductive rights because it carries the non-discrimination clause in Article 23, which prohibits discrimination. Unfortunately, the clause has exceptions relating to the practice of customary law and personal law. The effect of this is that the areas of marriage, divorce and maintenance where the issues of women's sexual and reproductive rights mostly fall are regulated by rather discriminatory customary laws and practices.

The Termination of Pregnancy Act<sup>107</sup> in Zambia provides for legal and medical abortion in the following circumstances:

- if the continuance of the pregnancy would involve-
  - (i) Risk to the life of the pregnant woman; or
  - (ii) Risk of injury to the physical or mental health of the pregnant woman; or
  - (iii) Risk of injury to the physical or mental health of any existing children of the pregnant woman; greater than if the pregnancy were terminated;
- Or if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Termination may also be procured under section 152 (2) of the Penal Code which provides that where a female child is raped or defiled and becomes pregnant the pregnancy may be terminated in accordance with the Termination of Pregnancy Act.

The scope of the Termination of Pregnancy Act is limited by the fact that abortion is criminalised by the Penal Code.<sup>108</sup> Section 151 of the Penal Code provides that any person who with intent to procure the miscarriage of a woman or female child whether she is or is not with child unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind or uses any other means whatsoever, commits a felony and is liable upon conviction to imprisonment for a term not exceeding seven years.

---

<sup>107</sup> Chapter 304 of the Laws.

<sup>108</sup> Section 151.

Connected to the Termination of Pregnancy Act is the Nurses and Midwives Act of 2000.<sup>109</sup> This act allows nurses and midwives to provide therapeutic, palliative and rehabilitative care and treatment of illnesses normally carried out in nursing and midwifery practice. The nurses and midwives can now assess, diagnose and provide relevant therapeutic interventions; carry out physical examinations; insert Intra-Uterine Devices; conduct resuscitation and incubation; conduct vacuum extraction to post abortion patients; prescribe drugs; provide counselling and information, care and procedures relevant to nursing and midwifery. This Act is important to women's sexual and reproductive rights because it expands the category of public health service providers who can provide post abortion care and other service relevant to women's sexual and reproductive health. This is especially important in an under resourced country like Zambia as it allows more women located in areas where only nurses and midwives are present, to access services.

Solemnisation of marriage is provided for under The Marriage Act.<sup>110</sup> This Act is relevant to the subject of sexual and reproductive rights for two reasons. It sets out the minimum marriage age of 21 years for statutory marriages thereby protecting girls and young women from early marriage. It also has the effect of securing the right to marry for persons below the age of 21 years by obtaining consent from parents or guardians or the High Court. Unfortunately, this provision extends only to persons wishing to marry under the statute. There is therefore no provision dealing with forced and early marriages under customary law.

The Public Health Act<sup>111</sup>, provides for the prevention and suppression of diseases and generally regulates all matters connected with public health in Zambia. It has provisions relevant to the control of venereal diseases and makes wilful or culpable negligent infection of any other person with venereal disease a criminal offence. This Act also provides for privacy and confidentiality in health care services.

---

<sup>109</sup> Chapter 300 of the Laws.

<sup>110</sup> Chapter 50 of the Laws.

<sup>111</sup> Chapter 295 of the Laws.

Finally, the Penal Code has provisions relevant to women's sexual and reproductive rights as defines criminal acts. The Penal Code has provisions covering a wide array of sexual offences mostly directed at women such as abduction, rape, incest, insulting a female person. These offences give rise to criminal charges and penalties. The effect of these provisions is to punish the trespass of the rights of women to life, security of the person, freedom from torture and inhuman treatment. This is probably Zambia's most implemented piece of legislation.

It was stated earlier that although not given the force of law, economic, social and cultural rights are treated as principles to be considered in the development of State policy.<sup>112</sup> There are thus several policies relevant to this subject. These policies provide the plan and strategies government intends to use to implement law and national programs and to achieve national goals and visions. These national laws and policies are important because they create the framework within which the State affects the behaviour of people and the environment in which people can exercise or enforce their human rights. They are also an indicator of government's commitment to promoting human rights. They determine the distribution of key services and dictate the cost of such services. The economic, social and cultural rights that are excluded from the Bill of Rights therefore find some form of expression in the various national policies.

Two of the key policy documents in respect of sexual and reproductive rights are the National Health Policy and the Reproductive Health Policy. The National Health Policy outlines the infrastructure of the public health system, coverage of health services and regulates public health services providers. The essential health package according to this policy addresses six major thrusts for health services: maternal and child health, malaria, family planning, HIV/AIDS/STDs, tuberculosis, and water and sanitation<sup>113</sup>. Implemented through the National Health Strategic Plan, the objective of the reproductive health section of the Policy is to improve maternal health and prevent

---

<sup>112</sup> The Constitution of Zambia. Part 9.

<sup>113</sup> Government of the Republic of Zambia-Ministry of Health, 1997. Reproductive Health Policy, Strategies, and Guidelines.

maternal and neonatal deaths.<sup>114</sup> None of the strategies in this document relate to women's access to safe abortion.

The National Reproductive Health Policy is a more focused policy that intends to address a number of areas in reproductive health.<sup>115</sup> These include, safe motherhood, family planning, maternal nutrition, adolescent health and development, sexually transmitted diseases including HIV/AIDS, abortion, infertility, and reproductive health service provision and crosscutting reproductive health issues such as prevention and management of violence against women. The goal of the Policy is;

to achieve the highest possible [sic] of reproductive health for all Zambians through the implementation of a multi-sectoral approach, which aims at addressing the reproductive health needs of individuals and families and supporting their physical, mental, emotional and social development through the life cycle.<sup>116</sup>

The Policy is directed by ten guiding principles one of which is on commitment to the concept of reproductive health, which encompasses;

- safe motherhood, including post abortion care;
- Family Planning,
- Adolescent Health, STD/HIV/AIDS, and;
- Gender issues throughout the life of individuals, within the context of population and sustainable development and reduction of poverty.

Women's access to safe abortion is therefore not one of the things encompassed by the term reproductive health in this principle.

The other key component of the policy is the 'Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines'. This is the Ministry of Health document that provides for the delivery of family planning services in the country. It also addresses

---

<sup>114</sup> Government of the Republic of Zambia-Ministry of Health, 1991. National Health Policies and Strategies: Health Reforms.

<sup>115</sup> Government of the Republic of Zambia-Ministry of Health, 1997. Reproductive Health Policy, Strategies, and Guidelines.

<sup>116</sup> Reproductive Health Policy, Strategies, and Guidelines.

the issue of prevention and management of abortion. It stipulates that all health workers will address the problem of contraceptive failure or induced abortion in a sensitive and humane manner and will counsel women and inform them about the possibilities of legal abortion and the requirements according to the Termination of Pregnancy Act.

Literature suggests that the scope of these rights might be different under indigenous concepts. A study by Women and Law in Southern Africa Research and Educational Trust-Zambia found an indigenous concept of human rights<sup>117</sup>, which was not exactly the same as the common law or international law concept. Some literature has identified women's sexual and reproductive rights as understood by customary law<sup>118</sup>, to include the right to found a family, conjugal rights of sex and consortium for married persons and compensation for breach of promise to marry. The analysis by Forum for African Women Educationalists in Zambia (FAWEZA) further argues that the right to choose one's partner does not exist as a right under customary law. Clearly the human rights value system is different under customary law.

It is also under customary law that *lobola* is paid with some serious implications on women's reproductive rights, including the deprivation of women's right to reproductive self determination.<sup>119</sup> *Lobola* as practiced among the patrilineal ethnic groups, denotes the purchase by the husband and his kin of the bride's reproductive capacity including ultimate control over her children. In matrilineal systems research has suggested that a woman's fertility is vested with her matrikin and that such women are worse off as they fall under "two Lords"- husband and father.<sup>120</sup>

Under customary law when a man pays *lobola* the children born to his wife during the marriage are his children and he is in turn entitled to a portion of the *lobola* paid when

---

<sup>117</sup> Chuulu, M.B., P.M. Chileshe, E. Mbozi, M. Munalula, W.S. Mwenda, S.K. Ngandu, 1997. The Changing Family in Zambia, Lusaka: Women and Law in Southern Africa Research and Educational Trust-Zambia, 13.

<sup>118</sup> Forum for African Women Educationalists in Zambia, 2004. An Analysis of Traditional and Statutory Laws on Female Reproductive Rights, 11-13.

<sup>119</sup> Women and Law in Southern Africa Research and Educational Trust, 2002. Lobola, 32-41.

<sup>120</sup> Assessment of the Need for Contraceptive Introduction in Zambia I, <http://www.who.int/reproductive-health/publications>, viewed September 14, 2005

those children marry. Literature<sup>121</sup> also suggests that under customary law the responsibility for preventing pregnancy, spacing children and ensuring that the wife survives pregnancy and childbirth is a joint one held by husband and wife. Expectant mothers were sent away to their parents until the child could walk to avoid another pregnancy while the child was too small. Breastfeeding mothers were required to abstain from sex under the belief that the occurrence of another pregnancy would spoil the breast milk<sup>122</sup>. Extra marital relations were seen as detrimental to pregnancy or to the child and therefore deemed a civil trespass.

---

<sup>121</sup> Munachonga, M. L., "Socio-Economic and Cultural Determinants of Fertility in Zambia". Report of the National Commission for Development Planning, 1989.

<sup>122</sup> Assessment of the Need for Contraceptive Introduction in Zambia I, <http://www.who.int/reproductive-health/publications>, viewed September 14, 2005

## CHAPTER FOUR

### 4. CHALLENGES TO WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE AND SERVICES

In the previous chapters we established that even though there is no authoritative definition of sexual and reproductive rights emanating from an international human rights instrument, sexual and reproductive rights are recognised as human rights. We said earlier that women's sexual and reproductive rights have been defined as "rights of a woman to control her own sexuality and reproductive capacity; making decisions on the number of children she has; their spacing and timing and also whether to have them or not".<sup>123</sup> Therefore, women's sexual and reproductive rights are those human rights that entitle a woman to determine, express and enjoy her personhood free of coercion, discrimination and violence by having control over her body, sexuality and reproductive capacity and being able to access services and information peculiar and pertinent to this determination, expression, enjoyment or control.

This assertion suggests that these rights can be clustered in two, that is, rights relating to reproductive health care and services and rights relating to reproductive self determination.<sup>124</sup> The former extends to the rights to benefits of scientific progress including health care and technology related to abortion, infertility and contraception as well as information on the effects of use of this technology; health care and health protection; freedom from torture and inhuman treatment including freedom from non-consensual medical trials and degrading treatment; information and education; privacy; life, liberty and security of the person. These rights are based on the recognition of the fundamental nature of women's well-being and the right to health care and health protection. International human rights law obligates the State Party to human rights treaties not only to refrain from violating human rights but to commit funds to improve

---

<sup>123</sup> Women and Law in Southern Africa Research and Educational Trust, 2002, *Lobola*, 32.

<sup>124</sup> Centre for Reproductive Law and Policy, 2002. Promoting Reproductive Rights: A Legal Human Rights Perspective, New York.

services so that human rights can be enjoyed. This chapter seeks to examine the challenges faced by Zambian women in accessing sexual and reproductive health care and services.

#### **4.1. The Public Health Delivery System in Zambia**

As mentioned in chapter three, the right to the highest attainable health is not a right in the Republican Constitution's Bill of Rights. It is merely a matter to be considered in the development of State Policy.<sup>125</sup> Nonetheless, the Zambian government has taken some steps to increase the possibility for citizens to enjoy the right to health. In 1992 government made some elaborate health reforms through the National Health Policies, Strategies and Guidelines with the aim of improving delivery of public health services. The country introduced four levels of health units namely, community health posts, rural and urban health centres or clinics; district hospitals; general or provincial hospitals; and tertiary or specialist hospitals.<sup>126</sup>

There are 206 urban centres serving a catchment population of 30 000-50 000 in a radius of 30 kilo meters and 880 rural centres with a catchment population of 10 000 within a 30 kilo meter radius in the whole country. District Hospitals, which are also first level referral institutions, are found in most, but not all, of the 72 districts. They are intended to serve a population of 80,000 – 200,000 and provide medical, surgical, obstetric and diagnostic services and with all clinical services to support health centre (and health post) referrals.<sup>127</sup>

The General Hospitals which are 2nd level institutions are at provincial level and are intended to cater for a catchment area of between 200,000 –800,000 people, with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental, psychiatry and intensive care services. These hospitals are also intended to act as a referral for the first level institutions. Finally, at the apex are the central and specialist

---

<sup>125</sup> The Constitution of Zambia. Part 9.

<sup>126</sup> Ministry of Health, 1991. National Health Policies and Strategies: Health Reforms.

<sup>127</sup> Ministry of Health, 1991. National Health Policies and Strategies: Health Reforms.

hospitals (University Teaching Hospital, Ndola Central Hospital and Kitwe Central Hospital) with a catchment population of 800,000 and above, with specializations in internal medicine, surgery, paediatrics, obstetrics, gynaecology, intensive care, psychiatry, training and research.<sup>128</sup> Other health services are provided by the Zambia Flying Doctor Service; the members of the Churches Medical Association of Zambia and private clinics and hospitals.

Currently, registration figures of qualified medical staff indicate that there are 7051 enrolled nurses, 2,901 registered nurses, approximately 3,500 nurse-midwives, 531 physicians and 12,093 clinical officers but it is not clear how many are in practice or where they practice. The reforms also set up an elaborate management structure consisting of District Health Boards (DHB) and District Health Management Teams (DHMT) and Provincial Boards. At the top of this structure was the Central Board of Health which was subsequently dissolved. The various classes of medical staff were employees of these boards and have now been transferred to the Ministry of Health.<sup>129</sup>

The Ministry of Health has a budget and approved budget estimates for integrated reproductive health for 2005 were ZMK1 074 225 446 and ZMK5 010 645 388 for 2006.<sup>130</sup> The budget for integrated reproductive health ranked fifth on the budget for programs in the national health budget, after management control and prevention of HIV/AIDS/STIs; control and treatment of leprosy; environmental health and health promotion in that order.<sup>131</sup> To date the health sector constitutes less than 15 percent of the national budget.<sup>132</sup>

In respect of women's sexual and reproductive health services, these health reforms provided for extensive maternal and child health clinics (MCH) which provide the

---

<sup>128</sup> GRZ, Ministry of Health, National Health Strategic Plan, 2001-2005, 13.

<sup>129</sup> National Health Policies and Strategies: Health Reforms, 1991.

<sup>130</sup> Non-Governmental Coordinating Council (NGOCC), 2007. Gender Analysis of the 2006 National Budget. Lusaka.

<sup>131</sup> Non-Governmental Coordinating Council (NGOCC), 2007. Gender Analysis of the 2007 National Budget. Lusaka.

<sup>132</sup> Non-Governmental Coordinating Council (NGOCC), 2008. Gender Analysis of 2008 National Budget. Lusaka.

integrated services. The services are integrated to provide for a one stop shopping approach that includes;<sup>133</sup>

- a) family planning and contraceptive services;
- b) antenatal, post-natal and under five care including preventive STD/HIV services;
- c) cervical cancer screening and abortion services including legal, surgical and medically managed abortion;
- d) post abortion care (PAC) comprising of emergency care (treatment of bleeding and infection if present and the removal of retained products of conception);
- e) provision of counselling and family planning services on discharge of the patient and linkage to other reproductive health services.

Adolescent reproductive health corners or youth friendly reproductive health desks are also a feature of the district health structure.

This study identified several key services necessary for a healthy sexual and reproductive life for women in the health care delivery system including:

- a) a wide array of contraceptive methods including emergency post coital contraception,
- b) abortion, post abortion and menstrual regulation services;
- c) antenatal, perinatal and postnatal care and services;
- d) prophylaxis for HIV/AIDS transmission in pregnant women and infants and emergency prophylaxis for victims of sexual assault;
- e) gynaecology and obstetrics specialist care, counselling and information;
- f) paediatric care,
- g) internal medicine, surgery, intensive and psychiatric care

However, despite the setting up of an elaborate public health structure and other ambitious health reforms undertaken by the State, women still face many challenges in accessing sexual and reproductive health care and services.<sup>134</sup> The findings show that women's access to these services is limited by inadequate services at institutions caused

<sup>133</sup> Ministry of Health, Integrated Reproductive Health: Plan of Action 2000-2002, 10.

<sup>134</sup> Ministry of Health, 1992, The National Health Policies and Strategies.

by insufficient health units and understaffing, unacceptability of services and limited access to existing health units due to long distances. The efficient delivery of family planning services is still hindered by low prestige of family planning relative to other maternal and child health activities and lack of adequate management support among the different levels of the health care system.<sup>135</sup>

## 4.2. Inadequate Sexual and Reproductive Health Services

Several health facilities of different classes were found in the sites, namely, District Hospitals in Kapiri Mposhi and Monze; General Hospitals in Sowlezi and Kabwe and Specialist Hospitals in Ndola (Ndola Central Hospital) and Lusaka (University Teaching Hospital).<sup>136</sup> All sites had rural and urban health centres or clinics. There were also big church ran hospitals in Kapiri Mposhi (Mpunde Mission Hospital) and Monze (Chikuni Mission Hospital) districts. There were also private clinics in all sites and private hospitals in Lusaka. However, data shows that not only are the health units inadequate but the nature of services offered thereat is also inadequate for a variety of reasons. Further, the health units are inaccessible in some areas and there are severe limitations in the availability of staff to deliver these services.

### 4.2.1. Limited Contraceptive Methods

There is a limit in the choice of contraceptive methods available in the public health clinics. It was said that the public health sector does not stock the wide array of contraceptives available on the market. Even though more than eight oral contraceptives were said to be available in the country for example, most rural and urban centres or clinics visited in the sites only had one oral contraceptive method in stock.<sup>137</sup> Other methods were viewed with scepticism by staff. Senior midwives indicated for example, that after Depo-Provera<sup>138</sup> was withdrawn by the Ministry of Health in the 1980s, there

<sup>135</sup> Assessment of the Need for Contraceptive Introduction in Zambia, <http://www.who.int/reproductive-health/publications>, viewed September 14, 2005

<sup>136</sup> Ministry of Health, 1992. The National Health Policies and Strategies.

<sup>137</sup> *Microgynon*, an oral contraceptive popularly referred to as the pill.

<sup>138</sup> A long term contraceptive implant withdrawn by the Ministry of Health in the 1980's due to alleged negative side effects.

has been scepticism on the part of service providers towards long term implant contraceptives.

So, although Depo-Provera has been reinstated on the contraception distribution list of the Ministry of Health, the only long term acting contraceptive widely available is Norplant found only at urban health clinics, district, general and specialist hospitals. The contraceptive requirements of a clinic are indicated by the responsible personnel and the type ordered is influenced by the preferences and scepticism of such staff. The church ran hospitals do not, for religious reasons, offer contraceptives or only offer contraceptives to married women.

Some methods were restricted to certain levels of the health system. The Intra-Uterine Device (IUD) and Norplant for example were only administered in 'equipped health centres' where there was capacity for monitoring clients.<sup>139</sup> Therefore, methods such as the IUD, long term injectable contraceptives, implants, female condoms, diaphragms and caps, foams and jellies were not available at the poorly equipped rural health centres and only few urban clinics and district, general and specialist hospitals had these in stock. *Spermicides*<sup>140</sup> were altogether not available in both rural and urban public clinics and hospitals as they were said not to form part of the Ministry of Health contraceptive distribution program.

Thus, women had a limited number of contraceptive methods to choose from. Michelo,<sup>141</sup> interviewed at the Monze District Hospital indicated that she had been referred from a rural health centre to access Intra-Uterine Device (IUD) because her blood pressure levels could not tolerate the oral or injectable contraceptives which were the only available methods at her rural health centre.

Other contraceptive related services such as post coital or emergency contraception for sexual assault victims were only found available at the University Teaching Hospital and

---

<sup>139</sup> A metal object inserted in the uterus to prevent conception.

<sup>140</sup> A type of contraceptive inserted in the vaginal canal.

<sup>141</sup> Not her real name. Individual interview, Monze, 15.11. 2006.

the Ndola Central Hospital. Dorcus<sup>142</sup> a rape victim, interviewed in Solwezi, said that she had gone to the General Hospital for this service immediately following the assault and was told that no emergency contraception was available. Similarly, post exposure prophylaxis (PEP) for HIV was only found at UTH paediatrics' unit where a pilot project was being conducted and was only being availed to children and not adults. Thus, women victims of sexual assault cannot access these important and life saving sexual and reproductive health services.

#### 4.2.2. Inadequate Services

Terminations of pregnancy services are also inadequate in that women cannot always access the preferred modern methods for termination of pregnancy. While Doctors in specialist hospitals use manual vacuum aspiration, which is a preferred method worldwide, those in district hospitals use dilation and sharp curettage (D&C) under general anaesthesia. Use of *Mifepristol* and *Misoprostol*<sup>143</sup> for termination of pregnancy was only found at the University Teaching Hospital. The two drugs were reportedly not on the list of estimated drug needs on the integrated reproductive health drug lists. Thus abortion services are inadequate. Recently, post abortion care was added to the integrated reproductive health services in public clinics, but even this service is currently only available at district, general and specialist hospitals where some members of staff have received orientation and training.

Most of the services are inadequate due to lack of adequate human resource and specialists in the hospitals and clinics and this shortage has serious implications for the adequate delivery of services. Most rural health centres had one midwife and two or three nurses, a clinician and no doctors. At Saint Dorothy Clinic in Solwezi, there were only three nurses stationed there and as there is no laboratory assistant, they have to run the HIV tests themselves for the prevention of mother to child transmission program. Consequently, the time allocated for the maternal and child health clinic is reduced to create time for the nurses to run the tests.

---

<sup>142</sup> Individual Interview, Solwezi, November, 2006.

<sup>143</sup> Drugs used in termination of pregnancy or for menstrual regulation.

Even the University Teaching Hospital, which is a specialist hospital in Lusaka, was said to be facing a critical shortage of midwives. The specialist services of a gynaecologist or obstetrician were not available in Kapiri Mposhi and women have to travel long distances to consult one or wait for the visiting specialist who frequented the hospital at regular intervals or were referred to other hospitals.

Chimuka<sup>144</sup> a respondent interviewed in Kapiri Mposhi narrated her ordeal in this respect;

I was referred to Kapiri District Hospital from Nkole Rural Health Centre. At Kapiri they said there was no specialist and referred me to Kabwe General Hospital; my husband and I only had enough money to get back to Nkole. So my husband went back to get maize to sell so we could travel to Kabwe. It was a few days before he came back and by the time I got to Kabwe General I was so bad that the doctor had to do a complete hysterectomy.

Similarly, counselling services are inadequate due to lack of staff to provide the service. Women suffering from post partum depression or victims of sexual assaults receive no counselling as there are limited counselling services in clinics. Most of these counselling services focus on HIV pre and post testing and the counsellors are mostly volunteers working on a part time basis. The number of clients needing counselling is so overwhelming for the volunteer staff that they cannot give each client as much time as is needed. Other counselling services found were for ante natal, perinatal and postnatal clients; termination of pregnancy clients and post abortion patients.

An interview with the post abortion unit at the University Teaching Hospital indicated that more than 5000 women have been admitted to hospitals for post induced abortion care, suggesting that few women access safe abortion services. The Termination Of Pregnancy Act requires that the termination must be approved by three medical practitioners one of whom is a specialist in the ground upon which it is sought. There are few medical practitioners in the countryside and this means that women in rural areas

---

<sup>144</sup> Not her real name. Individual interview, Kapiri Mposhi, 17.3.2006.

may not be able to find the three signatories. At Nkole Rural Health centre, in the Kapiri Mposhi site for example, the clinic is headed by a clinician, assisted by a midwife/public health nurse and one male nurse. A woman seeking a termination would therefore have to be referred to Kapiri District Hospital or Kabwe General Hospital to be able to access three medical practitioners. A similar situation was found in Mwembeshi where women are referred to Kabwe General Hospital.

This problem is not peculiar to rural areas. The rape victim, Dorcas<sup>145</sup>, who could not access post coital emergency contraception, at her General hospital, explained how she failed to get an abortion at the University Teaching Hospital because she couldn't get the three signatures required. As she was fast approaching her 20th week of pregnancy she could not wait to complete the lengthy process required of her and had to have the procedure done in Harare.

The Act not only requires the signatures of three medical practitioners but also permits refusal to perform termination of pregnancy by medical practitioners on grounds of conscientious objection. Therefore, a woman has to find three practitioners who. Although Nurses and midwives can provide post abortion care they are not authorised to perform manual vacuum aspiration on legal or medically procured abortion. This restricts the cadre of workers able to provide the service.

#### **4.2.3. Inadequate Infrastructure and Lack of Supplies**

Not only are the clinics understaffed and lacking in specialist services, but they are also under supplied with requisites and do not always have the relevant infrastructure. When both Luanshimba and Nkole Rural Health Centres were visited in Kapiri Mposhi, there were no chemicals or reagents to use for the RPR<sup>146</sup> tests on pregnant women. Some of the pregnant women interviewed were as far gone as the seventh month and had not yet had this test. This means that venereal disease would remain undetected till after birth.

<sup>145</sup> Not her real name. Individual interview, Lusaka, 22.3.2006.

<sup>146</sup> A test to establish the presence of venereal disease. Untreated venereal disease may be fatal to the foetus.

Other requisites such as gloves and other needs of traditional birth attendants were also not available forcing some of these attendants to use plastic paper bags as gloves.

Data also shows that there is inadequate infrastructure in clinics and hospitals. Some rural clinics did not have laboratories or operating theatres. In Solwezi and Monze for example, women needing the fistula surgical procedure could only have it done when a visiting specialist came to the hospitals. Women are given an appointment and sent back home till the appointment date when the visiting specialist performs the procedure.

The specialist in an interview indicated that it was a specialised procedure and needed great expertise to be done in the “inadequate surgical facilities of rural, general or district hospitals”.<sup>147</sup> The problem of fistulae was found to be particularly common in Monze and Solwezi sites where early childbirth is prevalent. Scanning and ultra sound services were also not readily available, and altogether absent in rural health centres. At Ndola Central Hospital scanning room for example, patients included women who had travelled from Luanshya, Mpongwe, Masaiti and Lufwanyama districts.

The problem of infrastructure was not restricted to rural sites but also manifested in the urban areas. At the University Teaching Hospital there is inadequate space in the maternity wing recovery wards and two women were sharing a bed each or a mattress on the floor. A recovery room designed for eight people had a total of 24 patients. At Chawama Clinic in Lusaka women were discharged early to create space for others in the recovery room. Women who had delivered by 0700 hours were discharged by 1000 hours of the same morning.

#### **4.2.4. Counselling, Infertility Treatment and Cancer Cytological Testing Services**

Preventive and appropriate treatment for infertility was available only where there were specialist medical practitioners. Apart from the UTH, Ndola Central, Kabwe General and Kapiri Mposhi District Hospitals, the availability of this service in particular was not well known by staff and communities. Routine tests that are important to women’s sexual and

---

<sup>147</sup> Dr. Sikazwe, Solwezi General Hospital, 19.11.2006.

reproductive health were only available at general hospitals and usually only on the recommendation of a specialist. There are inadequate facilities for periodic cytological screening for the early detection of pre-invasive cervical cancer, yet it is the most common cancer among women and one of the major causes of mortality<sup>148</sup>. In rural health centres the service does not exist and so far only the general hospitals, UTH, Ndola Central and two urban clinics in Lusaka are able to provide cervical cancer screening. Mammogram was reportedly available at the University Teaching Hospital only.

### 4.3. Poor Quality and Delivery of Services

The second challenge found in respect of women's access to sexual and reproductive health services relates to the poor quality, delivery and unacceptability of services provided. The presence of male personnel in laboratories and scanning rooms was a matter of concern for women. Women in urban areas who underwent an examination called HSG<sup>149</sup> especially complained that a male laboratory technician assisted the gynaecologist during this examination. Women interviewed felt that such an invasive examination should only be performed by female technicians.<sup>150</sup> Hospital staff indicated that women shunned this examination as a result.<sup>151</sup> Male nurses were also found in charge of some adolescent health corners. Female youth interviewed indicated that they were uncomfortable with male nurses at the youth reproductive health corner. They therefore shunned this facility.<sup>152</sup>

The presence of male staff was not the only problem relating to the unacceptability of services. The location of the youth reproductive health corner and youth friendly desk was also a cause of concern among female youth interviewed. In one clinic the corner

---

<sup>148</sup> Ministry of Health, 2000. The Reproductive Health Policy, 19.

<sup>149</sup> An internal examination of the reproductive tract similar to an x-ray.

<sup>150</sup> Focus group discussion, Lusaka Civic Center Clinic, 22.3.2006.

<sup>151</sup> Key informant interviews, Lusaka, 22.3.2006.

<sup>152</sup> Focus group discussions in Mwembeshi, Nkole and Luanshimba (in Kapiri Mposhi), 17.3.2006 to 19.3.2006.

was facing the front or main entrance to the clinic grounds. Anybody entering the corner would be in full view to the public present at the clinic. One respondent stated:

Everybody can see you enter there and the community believes that girls who go to the youth friendly corner are sexually active and probably suffering from a sexually transmitted disease. The whole community will start talking about how you were seen at the clinic till your mother hears of it.<sup>153</sup>

Further, the lack of privacy and confidentiality in the delivery of sexual and reproductive health services also contributes to the poor quality and delivery of services. In the maternal health wing privacy is only available in the palpating room where women are physically examined. In some clinics there is no palpating room and the main room where everything is done is divided by curtains. The medical history is given in full view and within the hearing of other clients present.

During an observation of the antenatal clinic at Solwezi Central Clinic, clients were seen laughing at the medical history of a woman who indicated eleven live births. The same situation prevailed in the out patients wing and is discouraging for clients to honestly reveal their complaints. In a General Hospital ward, records of patients who had undergone fistulae surgical procedures were placed in a manner where any visitor could read them. With inadequate curtaining to demarcate the ward there was little or no privacy for the patients.

The quality and nature of delivery of services is also compromised by the lack of information to the client. It was said that public health staff do not give clients adequate information on their health status. Delia<sup>154</sup> narrated how her husband threw her out of the matrimonial home because she had Pelvic Inflammatory Disease (PID) an infection of the reproductive tract and pelvis. The clinician did not explain to Delia what this illness was and merely prescribed a drug called *Doxycycline* for her;

---

<sup>153</sup> Focus group discussion, Mwembeshii (Kapiri Mposhi), 17.3.2006.

<sup>154</sup> Not her real name. Individual interview, Lusaka, 23.3.2006.

When I got home I showed my husband the prescription so that he could give me money to buy the drug and he went into a rage saying that I had a venereal disease because this drug was the one given to my brother in law when he had syphilis. My husband threw me out of the matrimonial home. A few days later I asked my sister in law about this disease and she explained to me that PID was not a venereal disease but a condition common to women. A family council had to be convened where a community health nurse explained what PID was to my husband and his relatives before he could let me go back to the matrimonial home.<sup>155</sup>

In another case, Malcolm Watson Hospital was sued for negligence by Mrs Bwalya after she fell pregnant following a *bilateral tubal ligation* (BTL).<sup>156</sup> Although the Supreme Court found that she did not prove her case of negligence on a balance of probabilities,<sup>157</sup> the evidence before the court shows that the gynaecologist did not explain to Mrs Bwalya the possibilities of failure of the procedure. The gynaecologist said in evidence that when a patient comes back with a pregnancy after a BTL they explain that this is “not unusual” and recommend a termination of pregnancy, yet one of the requirements of the procedure is that the failure rate of the procedure must be explained to the patient who should be clear that the operation is not 100% guaranteed.<sup>158</sup> The gynaecologist was in actual effect admitting that she would only have told the patient about the failure rate after the fact. As a result of the lack of this information, Mrs Bwalya. did not take precautions or use contraceptives and fell pregnant.

Similarly, Angela<sup>159</sup> was diagnosed with RVVF (recto-visico vaginal fistula)<sup>160</sup> during the postnatal clinic and referred to the Solwezi General Hospital for a surgical procedure.

<sup>155</sup> Individual interview, Lusaka, 23.3.2006.

<sup>156</sup> A surgical procedure where the fallopian tubes are tied or cut in order to prevent pregnancy and is also referred to as a laparotomy or laparoscopy.

<sup>157</sup> *Rosemary Bwalya v. ZCCM and two others, SCZ, Appeal 164/03.*

<sup>158</sup> Filshie, G.M., 1999. *Sterilisation: Risk Management*. The Obstetrician and Gynaecologist, vol. 1, 26-31.

<sup>159</sup> Not her real name. Individual interview, Lusaka, 24.3.2006.

<sup>160</sup> A medical condition where a fistula or tearing occurs in the wall of the vagina or/and the rectum often occurring in young mothers due to early childbirth and prolonged labour.



The staff at the clinic had not explained what RVVF was to Angela, her husband or her mother who had actually accompanied her to the postnatal clinic. Her husband and even her family believed that this was a venereal disease as she was leaking urine and faeces and had an offensive odour. She was forced to leave the matrimonial home until the matter was resolved by a meeting in a legal aid clinic where she sought maintenance for her child from her spouse. Angela's mother and her relatives in a focus group discussion expressed dissatisfaction with services rendered to young mothers by the maternal and child health unit and that the whole episode could have been avoided if the doctor had explained this illness.<sup>161</sup>

Staff attitude was another issue raised by respondents as regards quality and service delivery. Interviews with patients at the post abortion care unit indicated that members of staff exhibit an attitude of suspicion or disbelief towards their clients. Miriam<sup>162</sup> bitterly narrated her experience with staff at the post abortion care unit at UTH;

I was not yet aware that I was pregnant and took a pain killer called *Dextrogesic* for my migraine. I later began to bleed and had severe abdominal cramps. I went to the local clinic where the nurse said I had had an abortion and referred me to UTH. I explained what happened to the nurse but she wrote 'self induced abortion' on my card. My husband and his family were furious and accused me of procuring an abortion due to infidelity.<sup>163</sup>

Another woman interviewed at UTH recovery room had this to say;

I took an HIV test to get on the prevention of mother to child transmission but when my time came to deliver I was referred to UTH as a high risk pregnancy. I think my status was indicated on the card because the midwife was very rough with me. At one point she actually said to me "...after all you know what you have".<sup>164</sup>

---

<sup>161</sup> Individual interview, Solwezi, 19.11.2006.

<sup>162</sup> Not her real name.

<sup>163</sup> Individual interview, Lusaka, 24.3.2006.

<sup>164</sup> Individual interview, Lusaka, 24.3.2006.

A focus group discussion of female youths indicated that nurses conducting counselling for clients seeking services for termination of pregnancy often discouraged them from undergoing the procedure and “preached” to them instead of helping them make an informed decision. The youths said that the pre abortion counsellors also had a judgemental attitude, looking and talking to them as though they were negligent and now have to do this ‘terrible thing’. It was said that nurses had serious reservations to the service of termination of pregnancy and deliberately discouraged it by displaying a negative attitude towards the procedure.<sup>165</sup>

The delivery of services is also hampered by lack of information, education and communication (IEC) materials on the services available as well as on general reproductive health matters. Data shows that in the urban sites women have learnt a lot from a television program called ‘Your Health Matters’ run by the Ministry of Health five days a week. Rural communities that do not have television have not benefited from this program. There were IEC materials found in the clinics and at the Health Board offices visited in the sites, and these were mostly about Tuberculosis, HIV/AIDS, Anti Retroviral Treatment and ante natal facilities.

Women therefore have no information on services contained in the integrated reproductive health system as delivered by the Ministry of Health. Women expressed ignorance of availability of services for termination of pregnancy, infertility treatment, free contraception, female condoms and other contraceptive options other than the pill. Some women also expressed ignorance at the fact that they were entitled to contraceptives and even *tubal ligation* without a husband’s consent.<sup>166</sup>

This lack of information, education and communication was not limited to the communities but extends to health staff. Some of the nurses and midwives were not sure whether the Termination of Pregnancy Act actually allows legal termination or not.<sup>167</sup>

---

<sup>165</sup> Focus group discussion, Evelyn Hone College, Lusaka, 28.3.2006.

<sup>166</sup> Focus group discussions, Lusaka, 22<sup>nd</sup> - 28<sup>th</sup> 3. 2006; Kabwe, 6<sup>th</sup> -7<sup>th</sup> .3.2006 ; Ndola, 10-12.4. 2006 and Kapiri Mposhi, 17-19.3, 2006.

<sup>167</sup> Key informant interviews, Kapiri Mposhi, 17-19.3, 2006; Solwezi, 19.11.2006 and Monze, 15.11. 2006.

Apart from a few nurses interviewed in urban sites and medical doctors most nurses and midwives were not aware that the Ministry of Health guidelines allowed women to undergo *tubal ligation* without the husband or partner's consent and were still subjecting women to partner consent requirements.

Most nurses and midwives had never seen a copy of the 'Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines'. This is the policy document of the Ministry of Health that provides for the delivery of family planning services in the country. It also addresses the issue of prevention and management of abortion. It stipulates that all health workers will address the problem of contraceptive failure or induced abortion in a sensitive and humane manner and will counsel women and inform them about the possibilities of legal abortion and the requirements according to the Termination of Pregnancy Act.<sup>168</sup>

#### **4.4. Inaccessibility of Services**

Finally, the fact that there are inadequate health units with wide catchment radius means services are in some parts of the country almost inaccessible. The findings show that whereas women in urban sites can easily access sexual and reproductive health services at peri-urban and urban clinics, this is not so for women in rural areas. Distance from the clinic was a serious factor in accessing these services. Respondents spoken to in rural communities even where there are big mission hospitals complained that they have to travel long distances to get to the government clinics that provide family planning services. In Kapiri Mposhi rural, women travel up to 30 kilometres to get to such clinics. This costs women money in fares of up to K25 000 (about US\$ 5) per return trip.

Chimuka's situation prior to her being referred to the general hospital illustrates the problems around accessibility:

---

<sup>168</sup> Ministry of Health, 2004. Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines.

After the traditional medicine failed to work, my husband took me to Nkole rural health centre by bicycle. I was referred to Kapiri District Hospital, which is about 30 kilometres from home. That day we went back home and my husband only took me to Kapiri hospital two days later.<sup>169</sup>

Chimuka had to travel 6 kilometres to Nkole Rural Health Centre from her home; then almost 30 kilometres to the district hospital; and finally 68 kilometres to the general hospital in Kabwe.

In Kapiri the distances are so appalling that one clinic has erected a mother's shelter. Women can lodge at the shelter in their eighth month of pregnancy so that they are at the clinic when labour begins. Ambulance services were only found at district hospitals and the vehicles were said to be in bad shape by hospital personnel.<sup>170</sup> The ambulances are also used as general-purpose transport for purchase of supplies and even ferrying the local chiefs to and from town.<sup>171</sup> During data collection in Solwezi a very sick woman could not be moved to the district hospital because the ambulance was in the workshop.

The situation is worse for adolescents who need parental consent to travel these long distances. Focus group discussions with adolescent mothers at the clinics in rural sites indicated that they had never made use of the reproductive health corners even though some of them had heard that contraceptives were available free of charge. The major complaint was lack of resources to access these facilities as one needed transportation to the clinic. Data therefore suggests that there are serious limitations in the delivery of sexual and reproductive health services. Government statistics indicate that over 53% of Zambian women still deliver at home because of limited access to health care facilities,<sup>172</sup> and the maternal mortality rates remain high in the country.<sup>173</sup>

---

<sup>169</sup> Individual interview, Kabwe, 6.4.2006.

<sup>170</sup> Key informant interview, Solwezi, 19.11.2006, Kabwe, 7.4.2006, Kapiri Mposhi 19.3.2006 and Ndola, 10.4. 2006.

<sup>171</sup> Key informant interview, Solwezi District Hospital, 20.11. 2006.

<sup>172</sup> Dr Christine Kaseba, 'Zambia's Maternal Mortality Rate High', <http://www.zamnet.zm/news.viewnews.cgi?category=3&id=112668462> viewed September 16, 2005.

<sup>173</sup> Central Statistics Office, Ministry of Health/MACRO, Zambia Demographic and Health Surveys, 2001-2002.

## CHAPTER FIVE

### 5. CHALLENGES TO WOMEN'S SEXUAL AND REPRODUCTIVE SELF DETERMINATION

The challenges to women's access to sexual and reproductive health care, services and protection are linked to other factors that act as a restraint on women's ability to exercise self determination in respect of sexual and reproductive matters. In the previous chapter women's sexual and reproductive rights were clustered in two- rights relating to reproductive health care and services and rights relating to reproductive self determination.<sup>174</sup> The challenges relating to the former were dealt with in chapter four. The latter, dealt with hereunder, consist of those rights that protect women from unwanted invasion or intrusion of their bodies and other non-consensual acts and restrictions on women's physical autonomy and are based on women's rights to non-discrimination, physical integrity and autonomy.

Women's sexual and reproductive self determination denotes that a woman should be able to make sexual and reproductive decisions autonomously and must not be coerced into any such decisions. It thus denotes freedom from sexual harassment, externally imposed fear, shame, guilt or beliefs based on myths and other psychological factors inhibiting one's sexual responses or impairing their sexual relationships; the right to freedom from forced pregnancy, sterilization and abortion; and to protection from restrictions on grounds of thought, conscience and religion such as restrictive interpretation of religious texts, beliefs, philosophies and customs that curtail freedom of thought on sexual and reproductive issues. For example, women have a right to decide whether or not to marry and if so to marry a person of their choice; and a right to decide whether and when to have children and if so how many.

---

<sup>174</sup>Centre for Reproductive Law and Policy, 2002. Reproductive Rights: 2000 Moving Forward. 8-10.

Women are however restrained in making decisions relating to these matters autonomously by issues rooted in the economic, social, cultural, political, legal and religious features of the country. These restraining factors constitute the challenge to women's sexual and reproductive self determination and this chapter looks at these challenges and how they impinge on women's ability to make autonomous sexual and reproductive decisions and choices.

### **5.1. Cultural Prescriptions, Norms, Beliefs and the Social Status of Women in Zambia**

The factors that impinge on women's ability to make autonomous sexual and reproductive decisions and choices are inextricably and deeply rooted. They are informed by a people's beliefs, values, myths and practices and have an impact on how people treat themselves and others. This intricate web of values, beliefs, myths and practices by which people live their lives constitutes their culture. Literature indicates that within traditional society, responsibilities for preventing pregnancy, for child spacing and child survival were observed by both husband and wife and maintained by strong beliefs in myths.<sup>175</sup>

This meant that husbands had power or authority over the sexual and reproductive functions performed by wives' bodies. This created an opportunity to abuse this authority or to exercise it in a manner representative of power relations in that relationship. On the other hand it may have served women well for some time, as men were forced to take responsibility for consequences of a couple's sexual and reproductive decisions. Unfortunately, this system in reproductive decision-making was maintained by myths, it has therefore disintegrated, as the myths have become known as such.

#### **5.1.1. Culture and Socialisation**

Respondents defined culture as the acceptable way of life in a given society. Most matters and infractions are unquestioned and condoned on the basis that culture permits them. Culture appears to be the primary factor in impinging on women's rights as it

---

<sup>175</sup> Munachonga, M. L., 1989. Socio-Economic and Cultural Determinants of Fertility in Zambia. 10.

prescribes gender norms, sets the parameters of femininity and masculinity, and defines appropriate socialisation and society's power structures and relationships. It is socially accepted as a legitimate reason for impinging on women's human rights.

It has been asserted that women are considered to be irresponsible persons who need to be controlled or as a source of salvation for a society that is sinking in its very self.<sup>176</sup>

This assertion highlights the fact that there is a cultural perception that women are guardians of a community's sexual morality and also the primary initiators of unchastity.

This perception compels women to make choices to conform and thereby compromising their autonomy.

Culture prescribes gender norms which determine what men and women should do and know about sexuality and other matters. Respondents indicated that there are set rules of culturally acceptable behaviour for each sex, precluding men and women from doing certain things or conducting themselves in a certain way. For example, it was said that it is culturally unacceptable for a woman to make sexual overtures towards a man or to propose marriage.<sup>177</sup> Culture therefore sets the parameters of male and female sexuality and therefore dictates how a woman is schooled to perceive herself, her sexuality and defines her relationships or interactions with the opposite sex, the broader family, society, authority and the law.

Culture was also said to prescribe the acceptable forms of sexual orientation, eroticism, pleasure, intimacy and reproduction and how these are to be expressed or exercised by members of society, thereby controlling women's lives.<sup>178</sup> Gender as the socially ascribed identity of what is male and what is female is thus defined by culture. Closely linked to sex which is biologically determined, gender is instrumental in defining masculinity and femininity in society. In this way culture defines the parameters of male and female sexuality. Culture not only defines the parameters of male and female sexuality and

---

<sup>176</sup> Women and Law in Southern Africa Research and Educational Trust-Mozambique, 2001. Power and Violence: Homicide and Femicide in Mozambique, 41-43.

<sup>177</sup> Focus group discussion, Mpunde (Kapiri Mposhi), 19.3. 2006.

<sup>178</sup> Focus group discussion, Mpunde (Kapiri Mposhi), 19.3. 2006.

gender, it also defines rights and the hierarchy of rights in society. It sets out what rights and duties men and women are entitled to or responsible for and which ones take precedence over others.

Culture also prescribes what men and women are socialised to in society and young members of the society are socialised into this culture from an early age, so that these cultural prescriptions, norms and beliefs are so deeply rooted and ingrained in people that they are often not questioned. Respondents said they held certain beliefs because that is what they were taught as they grew up. Puberty and premarital rites were said to ensure that young people had been fully and properly socialised to the acceptable cultural values, beliefs and practices. In the words of one respondent; ‘

We learnt from our grandmothers and mothers and have taught our children the same values and beliefs. It is our culture so we pass it on to the next generation. If we do not do so, society as we know it will disintegrate.<sup>179</sup>

Culture also relates to a society’s power structures and relationships and has enforcement mechanisms or sanctions for controlling and containing society, thus controlling women’s lives. Questioned as to why men were the heads of families even when the breadwinner was the wife, respondents explained that this is the culture. Culture has predetermined the power structures and set up various social structures and enforcement mechanisms that are used to ensure that members of society live in compliance with culture. Members of society are therefore inclined to comply with the existing socio-cultural perspectives as these constitute the norms of that society.

Therefore, culture sets the milieu in which women live their lives, impacting on the kind of choices women make. Zambian culture is patriarchal and patriarchy presupposes the superiority of men and the inferiority of women. It ranks the rights of men and women *a priori* with men’s rights ranking higher than those of women. Data shows that as a result of the socio-cultural dispensation, women are perceived and perceive themselves as inferior persons with fewer rights, authority and power than men. Culture sets restrictive

---

<sup>179</sup> Focus group discussions, Solwezi, 19.11.2006; Kabwe, 7.4. 2006 and Ndola, 10.4. 2006.

interpretations of beliefs and customs that curtail women's freedom of thought on sexual and reproductive issues.

Due to the existing cultural conceptualisation of and prescriptions on gender, sexuality and rights, there is little or no emphasis on the rights of women in the socialisation process. This does not encourage a consciousness of women's rights in society and among women themselves. Data shows that during the socialisation process, emphasis is placed on women's obligations and responsibilities in the community and family as opposed to their rights and entitlements. Girls interviewed said that they felt that they were being trained primarily to be wives, mothers and care givers by their families. They are constantly reminded in school, at home and in the community about their inferiority to boys and their duties towards their siblings. They felt that society does not perceive them as individuals with rights, entitlements and ambitions, but merely family members with duties and responsibilities.<sup>180</sup>

This emphasis on duties is exemplified by the contents of the rites of passage and the premarital counselling which play a major role in the socialisation process of women and girls. Rites of passage and premarital counselling are important junctions in the lives of women and girls.<sup>181</sup> They present a platform upon which the socialisation of many years is brought to a head and the social sanctions and enforcement mechanisms are revealed to the women and girls being counselled. These rites are also a test of the extent of internalisation of beliefs and values imparted during the socialisation process. Data shows that these are practiced in both urban and rural areas and are pivotal in indoctrinating and imparting information on sex, sexuality and marriage and disseminating the social expectations, duties, rights and the rules of conduct and acceptable sexual behaviour in society and marriage.

Data suggests that the whole social cultural system promotes men's entitlements to the disadvantage of women. Women indicated that much of the training during these rites is

---

<sup>180</sup> Women and Law in Southern Africa Research and Educational Trust-Zambia, 2006. Synthesised Report of the Girls Forums in Zambia. (Unpublished).

<sup>181</sup> Key informant interview, Traditional Counsellors Association, Lusaka, 28.3.2006.

focused on their duties and responsibilities towards their husband, family and society and not on their entitlements.<sup>182</sup> Traditional counsellors interviewed intimated that even premarital counselling for men, when it was done, mostly focused on the entitlements of men as opposed to the entitlements of a wife in the relationship.<sup>183</sup> Songs and rites that demean and emphasise women's low status and duties as opposed to their rights were noted during puberty and marriage rites observed in three sites. It is as if socialisation attempts to raise adult women who are subservient non-persons. Women therefore, have an inferiority complex which is constantly pitted against men's superiority complex and hinders their ability to make autonomous decisions relating to their rights or entitlements.

Culture also limits the scope of women's rights recognised and accepted by society. This again is ensured through the socialisation process. Premarital counselling, for instance, was said to inform women that as respectable women, they are precluded from expressing sexual pleasure and from initiating sexual intercourse even in marital relationships.<sup>184</sup> Hence, although society recognises that women have a right to sexual intercourse, as a conjugal right, this does not extend to the right to sexual pleasure and expression. Respondents also indicated that even though society recognises that married women have a right to have children, they do not necessarily have the right to decide the number of children.<sup>185</sup> Data also suggests that there are more social strictures on women's sexuality and rights as compared to men. This is a limitation on women's sexual rights and is an inhibition in the exercise or enforcement of their sexual and reproductive rights.

This limitation in the scope of women's rights is recognised and accepted by society and the emphasis on duties contributes to women's tolerance of and engagement in practices that violate their sexual rights. Male infidelity for example, was said to be a common practice that women are expected to tolerate. Yet it was said to be a very big source of worry on the part of women in respect of their sexuality. Respondents explained that infidelity affected their enjoyment of sexual intercourse, human bonding, social stability,

---

<sup>182</sup> Focus group discussions, Solwezi, 19.11.2006; Kabwe, 7.4.2006; Kapiri Mposhi 19.3.2006 and Ndola, 10.4.2006.

<sup>183</sup> Focus group discussion, Lusaka, 28.3.2006 and Ndola, 12.4. 2006.

<sup>184</sup> Key informant interview, Traditional Counsellors Association, Lusaka, 28.3.2006.

<sup>185</sup> Focus group discussions, Solwezi, 19.11.2006 and Kapiri Mposhi, 19.3. 2006.

spousal attraction, general intimacy, eroded their self esteem and diminished their standing in society.<sup>186</sup> Yet women appeared powerless against the problem as culture postulates that men are potentially polygamous and their occasional or regular adulterous behaviour should be forgiven and overlooked.

Women also engage in practices that violate their sexual rights in pursuit of the fulfilment of their sexual duties to their spouse or partner. One such practice is that of dry sex by application of traditional astringents in the vaginal cavity. It was said to be a common practice, although women said that it made sexual intercourse painful and not enjoyable for them.<sup>187</sup> It was also said to be a contributing factor to HIV infection in women. Yet women practice it because they have been socialised to believe that it is their responsibility to ensure their spouse's or partner's sexual pleasure.

This as a duty is expected to be fulfilled, even at the expense of the woman's pleasure and health. It is further sustained by the argument that if a woman does not practice it, their spouse or partner had a legitimate excuse for seeking sexual pleasure elsewhere. With the outbreak of HIV/AIDS infidelity and the practice of dry sex are a threat to women's physical and mental well being. Needless to say that infection of HIV/AIDS in such cases compromises the wife's rights to life and health.

Socialisation also determines what men and women should know about sex. Respondents said that it is inappropriate for women to be curious about sexual matters and even reproduction.<sup>188</sup> Thus, young women are constrained from getting more information on sexual matters while young men are at liberty to do so. Women are expected to be naïve about sex, sexuality, reproduction and other related issues and the seeking out of knowledge on these issues is frowned upon. Data shows that open communication about

---

<sup>186</sup> Focus group discussions, Solwezi, 19.11.2006; Kabwe, 7.4. 2006; Kapiri Mposhi, 19.3.2006 and Ndola, 10.4.2006.

<sup>187</sup> Focus group discussions, Solwezi, 19.11.2006; Kabwe, 7.4.2006; Kapiri Mposhi 19.3.2006 and Ndola, 10.4.2006.

<sup>188</sup> Focus group discussion, Lusaka, 28.3.2006 and Ndola, 12.4. 2006.

sexual matters in relationships is also not encouraged as a “good woman” is expected to be naïve about these matters.

The feminine ideal is thus characterised by women’s passivity and naivety of sexual matters. Most women are therefore unlikely to know much about or have accurate information on sexuality, reproduction and rights, so as to be able to exercise or enforce them. Knowledgeable and assertive women are believed to be loose and promiscuous. This limits women’s right to seek, receive and impart information. It also limits their right to thought and prevents them from seeking or acquiring information relevant for the exercise or enforcement of sexual and reproductive rights. The problem of lack of access to information is a long standing one. A 1994 study identified women’s lack of access to information on birth control methods and effects as a major challenge faced by women.<sup>189</sup>

### **5.1.2. Violence Against Women**

Another challenge is violence against women. Violence against women is defined as; “any act that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life”.<sup>190</sup> It includes sexual coercion which is defined as an act of forcing another individual through threats, verbal, insistent deception, cultural expectations or economic circumstances to engage in sexual behaviour against one’s will. It also includes cultural expectations requiring young women to marry and sexually interact with men not of their choosing. Women are entitled to be free from violence as a result of their sexual choices.<sup>191</sup> It has been argued that the touchstone of coercion is an individual woman’s lack of choice to pursue other options without severe social or physical consequences.<sup>192</sup>

Impact of violence on women’s sexual and reproductive lives include STDs and HIV/AIDS, unwanted pregnancy, abortion related injury, fear of or loss of pleasure,

<sup>189</sup> PANOS, Private Decision, Public Debate: Women, Reproduction and Population, 1994.

<sup>190</sup> United Nations 1995. Paragraph 113, Beijing Platform for Action and Beijing Declaration,

<sup>191</sup> Fried and Landberg-Lewis, Sexual Rights, 93.

<sup>192</sup> Heise, L., K. Moore and N. Toubia, 1995. “Sexual Coercion and Reproductive Health-A Focus on Research”, Population Council: New York. 8.

miscarriage and low birth weight from battering during pregnancy, violent sexual initiation, premature labour, gynaecological problems, inability to use condoms, genital mutilation, forced abortion of female foetuses, suicide or homicide related to stigma of sexual violence.<sup>193</sup>

WLSA-Lesotho asserts that violence makes women face a dilemma of whether to report acts of violence perpetrated against them.<sup>194</sup> This dilemma is attributed to the stigma attached to victims of sexual violence on the one hand and the perception of female victims as not entirely blameless in the incident or crime on the other. There is also a culture of silence around issues of violence. Attempts to report could lead to more violence. Women often choose to remain within the confines of custom and practice. Literature notes that; 'To strive to live and work outside the watchful gaze of the family and community is to risk becoming a target for male violent behaviour'.<sup>195</sup>

My research data shows that culture emphasises the tolerance of violation of women's rights by their spouses and partners. Assault, battery, incest, non-consensual marital sex and other violations are covered up within the family. They are treated as private issues that are not to be reported to outsiders except to specific elders who have recognised authority to counsel the male partner. Reporting matters of a private nature to outsiders on the grounds that such acts are a violation of rights is frowned upon and may lead to divorce.

This factor coupled with the pressure to ensure that the family unit survives and thrives, discourages women from enforcing their rights by reporting these infractions. Julia<sup>196</sup> intimated how she was divorced by her husband for sharing their marital problems with the church Pastor who was supposed to counsel them as their spiritual leader. This research also shows that some adolescents that have fallen pregnant as a result of

---

<sup>193</sup> Heise, L., Sexual Coercion, 9.

<sup>194</sup> Women and Law in Southern Africa Research and Educational Trust-Lesotho, 2002. Sexual Violence in Lesotho, Maseru.

<sup>195</sup> United Nations Special Rapporteur on Violence against Women, Violence against women-its causes and consequences, UN doc E/CN4/1997/47, 1997, paragraph 8 and 9.

<sup>196</sup> Not her real name. Individual interview, Lusaka, 24 .3. 2006.

defilement or rape opt to marry their assailants, as this is the ‘easier’ thing to do. This perception of rights violations and the consequences of seeking protection or other remedies inhibits women’s ability to exercise sexual and reproductive self determination.

### 5.1.3. *Lobola*

The findings of this study also show that the cultural practice of *lobola*<sup>197</sup> contributes to the poor status of women in heterosexual relationships and inhibits women’s ability to attain sexual and reproductive self-determination. *Lobola* which is now widely practiced in the country carries certain connotations. The research findings also show that in some cultures *lobola* gives unlimited powers to the husband including authority to chastise their wives as well as unlimited marital sexual rights.

It also gives exclusive authority to make decisions over and on behalf of their wives. In other cultures *lobola* was also said to signify the passing over of the woman’s reproductive capacity to the husband and his family. This was said to give power to the man and his family to decide on the number and spacing of the children. Women for whom *lobola* had been paid felt disempowered to make autonomous sexual and reproductive decisions.

Mrs. Phiri, interviewed in Kapiri Mposhi, narrated how her marriage broke down after her husband and family found out that she had a *bilateral tubal ligation*.<sup>198</sup> She is living with HIV/AIDS and had two children while on the prevention of mother to child treatment. After the birth of the second child, she was put on anti-retro viral therapy because her CD4 cell count had fallen below 200. She therefore, decided that she could not risk another pregnancy. Her mother in law travelled from eastern province to force her out of the matrimonial home and have her son file divorce proceedings. During the interview Mrs. Phiri wanted to know whether the operation could be reversed so that she could continue having children.

---

<sup>197</sup> This is bride price paid by the man and his family to the woman’s family in fulfilment of the marriage contract under customary law.

<sup>198</sup> Individual interview, Kapiri Mposhi, 19.3.2006.

The basis of this divorce action was that Mr. Phiri's family had paid six million Zambian Kwacha (approximately US\$1500) as *lobola* under Ngoni Customary Law. Under this customary law, reproductive capacity is transferred to the husband and his family upon payment of *lobola*. The husband and his family were therefore entitled to as many children as possible definitely more than two. The practice and concept of *lobola* is said to have been distorted over the years and has been reduced to a practice that disempowers women.

The amounts demanded by parents for *lobola* are said to be huge amounts that give the impression of purchase of the bride, as much as US\$5000 was paid for one young woman interviewed in Lusaka. Large herds of cattle, houses and motor vehicles are being demanded as *lobola*. In cultures where a portion of it is required to be returned on divorce, the inability to do so was said to force women to remain in bad or violent relationships, where their rights are violated in different ways. Data shows that society generally and women themselves believe that once *lobola* has been paid they no longer have the authority to make autonomous sexual and reproductive decisions.

## **5.2. The Legal Status of Women**

Against this cultural backdrop, women occupy a subordinate position in society and their status is that of a 'lesser being' with lower social standing. The social situation of women in Zambia maintains and legitimates this status quo and is reinforced by the poor legal status of women. McFadden, in her discourse on the absence of established and recognised norms of personhood and bodily integrity for African women, raises issues of women's legal status.<sup>199</sup> In analysing these, it is argued that women's reproductive rights cannot be fully evaluated without investigating women's legal status within society; that

---

<sup>199</sup> McFadden, P., 1997. "The Challenges and Prospects for the African Women's Movement in the 21<sup>st</sup> Century", 1 Women in Acton.

laws relating to women's legal status both reflect societal attitudes and have a direct impact on women's ability to exercise these rights.<sup>200</sup>

Women's rights as a class of rights are not defined or recognised in the domestic legislation. There is also a limited legislative framework for sexual and reproductive rights as a class of rights. There are few statutes that deal with the subject of women's sexual and reproductive rights. Apart from the Termination of Pregnancy Act, women do not have a legal basis upon which they can support their claim in respect of this class of rights. Perusal of court records revealed few cases brought before the court in an effort to enforce sexual and reproductive rights by women. Most of these applications originated in the local court and were made on the basis of unwritten customary law rather than statute or provisions of written law.

It was stated earlier that Zambia has a dual legal system that allows the application of customary law. Customary law is based on the conceptualisation of sexuality, gender and rights discussed above and permits discrimination. The exclusion of customary law and other personal laws from the non-discrimination clause in Article 23 of the Republican Constitution legalises this position and creates two justice paradigms. It has the very effect that the CEDAW was designed to eliminate.

Data showed that the majority of women interviewed in this study are married under customary law. All matrimonial disputes or applications arising from marriage under customary law are adjudicated by the local court which is a customary law court. Women who seek redress through these courts therefore face injustice on the basis of the application of biased customary law principles. Even though the Subordinate Courts have authority to declare customary law practices repugnant to natural justice and good conscience, and thereby make one justice paradigm superior to the other, they do not readily do so.

---

<sup>200</sup> The Centre for Reproductive Law and Policy, 1997. Women of the World: Laws and Policies Affecting their Reproductive Lives in Anglophone Africa, 102-106.

The Subordinate Courts endowed with this power are not nearly as accessible to women as the Local Courts that rely entirely on customary laws. Data suggests that the customary law courts (Local Courts and the traditional Chiefs Courts) actually act as enforcement mechanisms for women's compliance with the disempowering socio-cultural norms and expectations discussed above. The result is that women face discrimination and do not have the legislative tool required to upset the status quo and be able to enforce their rights.

Consequentially, data indicates that few women are prepared to assert their rights because there is no system to support them in doing so. The legal system was said to support men and prejudice women. Women indicated that it was almost pointless to sue in an effort to enforce rights as there is no fair law upon which the court will base its decision. Women respondents also claimed that the cost of litigation was high as fees are payable to the court and cost of transportation to and from court is high especially as the court often adjourns matters repeatedly. Women also indicated that they were uncomfortable with the adversarial method used in the courts and would prefer mediation or arbitration to litigation, which services are unfortunately uncommon outside Lusaka city.

### **5.3. Economic and Political Factors**

Data shows that even women with independent sources of income may have only limited autonomy over use of this income. This is especially true in respect of respondents interviewed in rural farming communities (Kapiri Mposhi, Monze and Kabwe). In focus group discussions women indicated that their money was a family resource over which the husband had authority. They said they could not just spend their money without consulting their husband. Even expenditure on medical expenses is subject to the husband's authorisation thereby affecting women's health seeking behaviour. Thus, women's ability to make choices and decisions is hampered by women's dependence on partners and spouses for their livelihood and income, especially if these are in conflict with the spouse's wishes.

It is also clear from data that sexual and reproductive decisions are made based on the concept that the man is the head and provider for his family. As stated earlier, 50% of husbands decide alone about the number and timing of children. The explanations for this were:

‘He is the head of the family so it is his right.’

‘He is the family provider so he knows he can afford them.’

‘He wanted more children, if I didn’t give him he would have got them elsewhere.’

It has been argued that the decision to get medical help is often made by husbands and marital families, who are often in control of family resources.<sup>201</sup> In discussing African women’s struggle to regain their identity, Patricia McFadden argues that African women have no personhood or bodily integrity as an established and recognised norm in their societies.<sup>202</sup> It would appear that for women, sexual and reproductive decision-making is determined by the extent of their empowerment and their status within the relationship. Sometimes these decisions are made unwisely without due consideration to the risk of disability or loss of income. Mwamba regretted allowing her husband to make this decision alone:

My husband wanted five children, so I had five children. Two years ago he was retrenched and now he drinks all the time and providing for the family has become my sole responsibility. With hindsight I should have had as many children as I can manage to provide for on my own. There are many eventualities in life and you need to plan for them. As it is, three of the children are no longer in school.<sup>203</sup>

Interestingly, women’s access to resources is often secured by their reproductive success. For example, under most of the Zambian customary law marriages women are not entitled to fifty percent or an equitable share of marital property. Thus, if the customary

<sup>201</sup> Centre for Reproductive Rights/Association des Jurists, 2000. Claiming Our Rights-Surviving Pregnancy and Childbirth in Mali, 35.

<sup>202</sup> McFadden, P., “The Challenges and Prospects for the African Women’s Movement in the 21<sup>st</sup> Century”, *1 Women in Action*, 1997.

<sup>203</sup> Individual interview, Ndola, 12.4.2006.

It is also clear from data that sexual and reproductive decisions are made based on the concept that the man is the head and provider for his family. As stated earlier, 50% of husbands decide alone about the number and timing of children. The explanations for this were:

‘He is the head of the family so it is his right.’

‘He is the family provider so he knows he can afford them.’

‘He wanted more children, if I didn’t give him he would have got them elsewhere.’

It has been argued that the decision to get medical help is often made by husbands and marital families, who are often in control of family resources.<sup>201</sup> In discussing African women’s struggle to regain their identity, Patricia McFadden argues that African women have no personhood or bodily integrity as an established and recognised norm in their societies.<sup>202</sup> It would appear that for women, sexual and reproductive decision-making is determined by the extent of their empowerment and their status within the relationship. Sometimes these decisions are made unwisely without due consideration to the risk of disability or loss of income. Mwamba regretted allowing her husband to make this decision alone:

My husband wanted five children, so I had five children. Two years ago he was retrenched and now he drinks all the time and providing for the family has become my sole responsibility. With hindsight I should have had as many children as I can manage to provide for on my own. There are many eventualities in life and you need to plan for them. As it is, three of the children are no longer in school.<sup>203</sup>

Interestingly, women’s access to resources is often secured by their reproductive success. For example, under most of the Zambian customary law marriages women are not entitled to fifty percent or an equitable share of marital property. Thus, if the customary

<sup>201</sup> Centre for Reproductive Rights/Association des Jurists, 2000. Claiming Our Rights-Surviving Pregnancy and Childbirth in Mali, 35.

<sup>202</sup> McFadden, P., “The Challenges and Prospects for the African Women’s Movement in the 21<sup>st</sup> Century”, 1 Women in Action, 1997.

<sup>203</sup> Individual interview, Ndola, 12.4.2006.

law under which a woman is married does not so allow, then the only way a woman can have access to an equitable share of the marital property is through the children. If she is awarded custody of the children the court may order that some of the property be given her for the children's use.

In relation to maintenance, women married under customary law may be awarded *compensation or maintenance after divorce over a period of three years after which it ceases*. However, the children are always entitled to maintenance and if the woman gets custody of the children she may be awarded maintenance for the children until they turn 18 years or graduate from college. Perusal of court records revealed that the courts were flooded with maintenance applications. The inheritance law in the country is another example of how women's legal status forces them to make choices that compromise their sexual and reproductive rights. Women generally do not inherit a deceased husband's estate, the children do.<sup>204</sup> Consequently not having children is not an option for women whose only or major access to resources is marriage.

In this way reproductive success helps women to access resources held by men that they are denied under customary laws. Respondents also felt that having children secured their position in the marital family as they were accepted and respected and the husband's relatives tend to support women with children when problems arise in the relationship. Consequentially, women feel obligated to fill this role and produce children to secure their position and access to resources. One respondent remarked during a focus group discussion of women, "there is nothing for you on divorce if you have no children during the marriage".<sup>205</sup> These factors obligate women to have children as a matter of necessity and financial survival. Since women feel obligated to have children, this amounts to lack of free will on their part in the decision. Such women cannot be said to have exercised self determination. Rather, they will have made a decision driven by the demands of economic and social survival.

---

<sup>204</sup>The Centre on Housing Rights and Evictions, 2004. Bringing Equality Home: Promoting and Protecting the Inheritance Rights of Women: A Survey of Law and Practice in Sub-Saharan Africa. See also the Intestate Succession Act Number 5 of 1989.

<sup>205</sup> Focus group discussion, Lusaka, 28.3.2006.

In examining why women commit the gendered offence of abortion, Women and Law in Southern Africa Research and Educational Trust –Zimbabwe<sup>206</sup> argue that men control women's sexuality through male dominated access to resources. That domination coupled with women's lack of access to these resources forces women to develop and maintain relationships that mediate their access to resources based on their status as wives, girlfriends or mothers but at the same time compromising their sexual and reproductive rights. That each of these relationships is created through women's sexuality and reproductive capacity. That in actual effect women's sexuality is controlled in this and other ways.

The subordinate position of women in society coupled with women's own perceived powerlessness in relationships and limited economic autonomy is also reflected in the low numbers of women in positions of decision making. Data shows that there are few women in these positions who meet the social cultural expectations of the ideal woman, which is a married woman, living under the control and supervision of a husband. Most women in these positions are either widowed or divorced, in other words unmarried single women who do not meet the ideal. In the study, of the eleven female members of parliament interviewed, only four of them were married women.

There is therefore an apparent absence of women in positions of power or public life who are role models of breaking the boundaries of these socio-cultural perceptions, expectations and limitations. Therefore, in women's own eyes power, public life, autonomous decision making and the ideal of womanhood are irreconcilable and mutually exclusive. Women therefore choose to conform to the stereotype of powerlessness and subordination instead of confronting these and asserting their rights. By so doing women are not in the positions of power that determine the culture, politics, economics and legal dispensation that impacts on their rights. Their participation is thus

---

<sup>206</sup> Women and Law in Southern Africa Research and Educational Trust-Zimbabwe, 2001. Pregnancy and Childbirth: Joy or Despair. Harare.

limited and has implications on the very recognition of women's rights generally and women's sexual and reproductive rights in particular.

#### **5.4. Religious Beliefs, Norms and Prescriptions**

It is a known fact that Zambians are predominantly Christian and so the majority of Zambian women interviewed in this study are Christians. Respondents defined Christianity as a lifestyle and a religion that prescribes how God would have humanity live. Christianity is unquestionable dogma whose 'dos' and 'don'ts' are recorded in the Bible. The church is a place of fundamental importance to women, in the words of one of the respondents:

The church is a place of belonging; a sanctuary from the harsh realities of life; a place where we find comfort and communion with friends and our creator. If you are not a member of a church you are really nobody in society and you are viewed with suspicion. If you have a bereavement, who will mourn with you? Who will bury your dead for you? Where will you find hope and strength to go on? It is in the church.<sup>207</sup>

The church is therefore not only of fundamental importance to women's spirituality but also to their social lives and social standing. Religious dogma is therefore almost as powerful and as fundamental as culture in women's lives. In fact it is part of the cultural milieu of women's lives. Obedience was said to be the cornerstone of Christianity. Believers or Christians are required to trust God and obey his commandments. Obedience is also required to the servants of God and their utterances treated as the message from God himself.<sup>208</sup> Data shows that most of the servants of God at the helm of churches are men rather than women. In some churches women cannot even be ordained as priests or pastors because as inferiors they cannot preside over men.

---

<sup>207</sup> Individual interview, Lusaka, 23.3.2006.

<sup>208</sup> Individual interview with Pastor, Lusaka, 24 .3. 2006.

Respondents indicated that according to the Bible and Christian dogma, God made man first and then woman and that on this basis woman is inferior to man.<sup>209</sup> It was said that the husband was thus the head of the family and was entitled to make all key decisions. That according to the Bible the body of the wife is not hers as to do with as she pleases but it belongs to her husband. A good Christian woman can therefore not make decisions without her husband's involvement.

The bible is therefore used to justify the subordinate position of Christian women. Some respondents in a Pentecostal church explained that while women are subject to their husbands they are 'equal heirs to the throne of Grace'.<sup>210</sup> This means that even though subject to their husbands, they are entitled to an equal chance of inheritance as children of God together with men in the kingdom of God. This group of respondents also claimed that the headship of the husband includes the responsibility to love the wife and that love gives freedom and precludes abuse and therefore women are not denied their rights.

In religious circles, as under culture, submission to one's husband is thus the acceptable Christian standard conduct for married women. Respondents interviewed at churches cited Bible verses commanding wives to unqualified submission to their husbands. This was equated to a Christian person's submission to God as deity.<sup>211</sup> It also denotes that women have to defer their rights and needs to those of the husband as is the case with culture. Conduct in conflict with this was said to be tantamount to rebellion and is therefore sin. The fear of committing sin was noted as a major factor among Christian women in making choices and decisions, especially if such choices run contrary to the husband's will or the church doctrine.

Sex outside marriage is said to be sin. Therefore, single women are not allowed to get pregnant and this is a punishable 'offence' in the church. A single woman who gets pregnant outside wedlock is precluded from taking part in the rites of the church. For example, even though she is allowed to attend church service or mass, she cannot take

---

<sup>209</sup> Focus group discussion, Lusaka, 24.3.2006.

<sup>210</sup> Focus group discussion, Lusaka, 24 3. 2006.

<sup>211</sup> Focus group discussions, Lusaka, Mpunde, Ndola and Kabwe

part in the Holy Communion.<sup>212</sup> Such a woman is required to repent by undergoing certain rites among them penance and public declaration of having sinned and now repentant. She may also be required to appear before a committee of church elders or undergo ‘further instructions in the faith’. Respondents indicated that women who fall pregnant outside wedlock may also be suspended from attending church until after they comply with the repentance rituals.<sup>213</sup> A single woman thus has no right to start a family by having a child outside wedlock.

Churches were said to run premarital counselling for those who want to marry in the church. This counselling is based on the Bible and not on custom or culture. The fundamental aspect of a wife’s subjugation to her husband taught under custom is also taught under Christianity. The counselling emphasises the headship of the man over the wife and does not ascribe to the claims of women’s human rights.<sup>214</sup> One of the pastors who took part in a focus group discussion castigated women’s organisations as fanning rebellion among women and contributing to the disintegration of families; that a good wife must ‘walk in obedience and submission to her husband as the church walks in obedience and submission to Christ’.<sup>215</sup>

Participants in a focus group discussion at Catholic Churches in the research sites indicated that the issue of contraception was a difficult one for them as the church was against the use of modern methods of contraception. Use of condoms was said to be sinful and the only acceptable contraception was the rhythm or natural method of periodic abstinence. Women in this church admitted to secretly accessing contraception without the knowledge of the church or the husband if he was a staunch Christian. One respondent stated; “if your husband is a strict Christian he will help with the periodic abstinence but if he is not, he won’t and you could have an unwanted pregnancy, so you

---

<sup>212</sup> A rite where red wine or juice and unleavened bread are blessed by the priest or pastor to represent the blood and body of Jesus Christ and is taken in memory of the Covenant of Calvary between God and man through Jesus Christ. This is taken periodically and is believed to have healing and other powers. It is one of the most important and revered Christian rites.

<sup>213</sup> Individual interview with Pastor, Lusaka, 24 .3. 2006.

<sup>214</sup> Focus group with counsellors at a Catholic Church, the United Church of Zambia and Dutch Reformed Churches in Lusaka and Ndola.

<sup>215</sup> Pastor at Pentecostal Church in Lusaka, 24.3.2006.

might as well use contraceptives against the church's teaching". The findings show that the church ran hospitals either do not dispense modern contraceptives or dispense them only to married women.

Thus, religious dogma like culture has such a fundamental impact on women's lives that it restrains women from exercising or enforcing their rights when this contradicts the teaching of the church. The church is also patriarchal in its nature and has beliefs and prescriptions with the similar impact of restraining women's freedom of thought and ability to make autonomous decisions or choices. It requires women to comply and non-compliance carries certain sanctions. A respondent explained that the church has structures for dispute resolution that also have authority to discipline errant members.<sup>216</sup> The church, like culture therefore also has enforcement mechanisms used to ensure that its members comply with its rules.

Suzan a respondent interviewed in Ndola was a leader of the women's group in her Catholic Church. The Catholic Church does not permit the use of modern methods of contraception especially condoms. Suzan was found in possession of a box of male condoms by her husband who reported the matter to the Church Council Suzan had been on the pill for some time but found them out of stock on that occasion and in her words: "my husband never ascribed to periodic abstinence so I needed to use contraception, there was no avoiding it."<sup>217</sup> She was subjected to the committee which recommended her removal from her position as leader of the women's league.

Conclusively, while sexual and reproductive self determination postulates that one must decide for themselves on sexual and reproductive matters, women are seriously constrained from doing so. The social cultural constructions of gender, sexuality and rights impact on people's value systems and have serious implications for women's ability to exercise or enforce their rights. Intricately weaved into the lives of women from childhood, they form a pattern of disempowerment of women, which is passed on from

---

<sup>216</sup> Individual interview with Pastor, Lusaka, 24 3.2006

<sup>217</sup> Not her real name. Individual interview in Ndola, 12.4. 2006.

generation to generation. Closely controlling women's sexuality, they create an internalised barrier to the exercise of women's human rights generally and women's sexual and reproductive rights in particular.

Therefore, women live in a value system that disempowers them and does not encourage a valuing of the self by women themselves. This also leads them to subject themselves to practices that further violate their sexual and reproductive rights. Women are constrained in making autonomous sexual and reproductive decisions and choices because they believe they do not have the right or power to do so. The value system also ensures that women believe that they and their conduct are responsible for sustaining marriage and the family which are fundamental to society. This is a factor that weighs heavily on women and is an inbuilt mechanism that inhibits them from making autonomous decisions that appear to jeopardise or destabilise the continued existence of the marriage or family unit. The cumulative effect of all this is to disempower women so that they are unable to exercise or enforce their rights.

Not only is the value system disempowering, but it also has serious implications on the status of women in society. As a result of the existing value system, women are relegated to second class citizens with limited rights; little or no financial autonomy; and limited access to positions of decision making. In true pluralist style, the status quo is maintained not only by statutes or lack of legislative safeguards but by a system of social sanctions and unwanted consequences imbedded in culture.

## CHAPTER SIX

### 6. UNWANTED CONSEQUENCES AND THE WOMAN'S DILEMMA

The principle of sexual and reproductive self determination denotes that women's sexual and reproductive decisions and choices should be made not only autonomously but also free of coercion, discrimination and violence. This principle is based on women's right to bodily integrity and security of the person which in this case includes security from sexual violence and assault by one's intimate partner or other person, and other forms of violence or threats thereof; freedom from medical interventions related to their sexual and reproductive health without their full, free and informed consent; right to be free from externally imposed fear, shame, guilt, beliefs based on myths and other psychological factors inhibiting one's sexual responses or impairing their sexual relationships and threats thereof; and freedom from coerced pregnancy, sterilization and abortion.

In the previous chapter data showed how inadequate legislative provisions, women's socialisation, societal attitudes and women's own perceived powerlessness create emotional, economic, legal, cultural and social barriers for women that prevent them from or limit them in exercising or enforcing their rights. There is need to understand why women choose to comply with the strictures that conspire against their enjoyment of rights. Women's complicity with these norms and beliefs that disempower them and portray them as non-persons, incapable of autonomous decision-making, is due partly to the consequences they may face if they refuse to comply. Making autonomous sexual and reproductive decisions and choices may carry serious and unwanted consequences for women or put women's relationships, economic security and physical safety at risk.

This reality places women in a dilemma where they are forced to choose between suffering unwanted consequences and making the unwanted sexual and reproductive choices demanded of them by society and family. Women are pushed between a hard place and a rock and have to choose between two unwanted choices. This dilemma is a

crossroads for women's sexual and reproductive rights and one that women need help to overcome. In essence it is not a choice as both options are unwanted to most women.

Further, women's complicity is ensured by social entities that have a rule generating and rule upholding capacity that act as social enforcement mechanisms. These entities police women's lives and punish those that do not comply with accepted social norms. These entities are important to this discussion because the study takes a legal pluralist approach. It was indicated in chapter two that even though the legal administrative system consists of one formal legal system designed to apply a multiplicity of laws, there is in fact a plurality of normative orders affecting women's lives, the choices and decisions they make as well as a plethora of arenas where these are made. This chapter presents findings on the unwanted consequences women may face in making these decisions or choices, the social enforcement mechanisms that force them to comply and the dilemma they face.

## **6.1. Unwanted Consequences**

The consequences women may face in making autonomous sexual and reproductive choices and decisions or in refusing to comply with social strictures, norms and beliefs that impinge on their right to sexual and reproductive self determination, include ridicule, public humiliation, accusations of infidelity, and different forms of violence, divorce, and withdrawal of maintenance, loss of custody of children, loss of access to resources, neglect, exclusion and criminal charges. Given the importance of family and the poor social, economic and legal status of women, the mere threat of these consequences is enough to deter them from making the autonomous choices and decisions that may lead to these consequences.

### **6.1.1. Violence and Related Consequences**

The term violence against women means any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women including threats of such acts coercion or arbitrary deprivation of liberty whether

occurring in public or private life.<sup>218</sup> It includes physical, sexual and psychological violence occurring in the family, within the general community or perpetrated by the state, including battering, sexual abuse of female children in and outside the household, dowry related violence, sexual harassment and intimidation at work, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence, trafficking and forced prostitution and violence related to exploitation.

The fact that a large number of women, at least over 50%, have been said to have suffered violence from their intimate partners,<sup>219</sup> signifies that this is a widespread and common problem. Although a lot of this violence is as a result of many reasons, some of it results from women's insistence in exercising their sexual and reproductive rights or refusing to comply with demands that violate these rights. Sometimes male dominance and control is expressed as sexual coercion and violence. Data shows that sexual coercion sometimes takes the form of non-consensual marital sex, which was said to be common because according to custom, women have no right to deny their husbands the conjugal right of sexual relations.

The findings suggest that there is no requirement for men to seek consent for sexual relations from their wife. Consequentially, married women have no right to say no to sex. Non-consensual marital sex is not a recognised criminal offence and the only legal recourse available is a civil application for damages or divorce based on customary law principles before the local court. Respondents stated that rights generally and let alone sexual and reproductive rights are not a subject for discussion in their relationships.<sup>220</sup> It was said that a discussion on such a matter, often results in violence.<sup>221</sup> Respondents also stated that the situation of women subjected to non-consensual marital sex often worsens if they fight and it sometimes results in divorce. Respondents indicated that sometimes

---

<sup>218</sup> United Nations department of Public Information, 1996. The Beijing Declaration and the Platform for Action, New York, 73.

<sup>219</sup> Central Statistics Office, Central Board of Health, ORC Macro, 2003. Zambia Demographic and Health Survey, 2001-2002: Lusaka.

<sup>220</sup> Focus group discussion, Lusaka Civic Center Clinic, 22.3.2006.

<sup>221</sup> Focus group discussions, Lusaka, 22<sup>nd</sup> - 28<sup>th</sup> 3. 2006; Kabwe, 6<sup>th</sup> -7<sup>th</sup> .3.2006; Ndola, 10-12.4. 2006

non-consensual marital sex is used to punish women or to show “who is the boss” in the relationship.

As stated elsewhere *lobola* often transfers women’s sexual and reproductive capacities to the husband and/or the marital family thereby passing the right to sexual and reproductive decision making to them. Failure or refusal to meet the desired sexual and reproductive desires of the husband is grounds for divorce. The story of Mrs. Phiri of Kapiri Mposhi referred to in chapter five illustrates the implications of this kind of *lobola*. Cases of divorce arising from women’s failure or refusal to have children or more children were found in all sites. Local court justices indicated that married men and women were entitled to have children and failure or refusal to do so was a ground for divorce.

The findings also indicate that *lobola* related violence is common. It was said that women remain in abusive and violent relationships because they lacked capacity to return *lobola* and because of its binding nature.<sup>222</sup> Among the Tonga of Monze district for example, part of the *lobola* has to be returned in the event of a divorce. Marcia<sup>223</sup> a 26 years old woman had recently divorced her first husband for cruelty and returned to her natal home. Her family were however unable to return the *lobola* due as a result of the dissolution of this marriage. Marcia’s family collected *lobola* for a second marriage without her consent so that they could use part of it to repay the first husband who had sued them for same. The local court held that the sexual intercourse between Marcia and her assailant did not amount to rape as the second marriage was binding under Tonga customary law. Not only was Marcia treated cruelly in her first marriage because of the *lobola* but it became the basis for her abuse in the purported second marriage.

Other cases of violence arising from women’s exercise of sexual or reproductive rights encountered during data collection related to violence against women for deciding not to have any more children, deciding to have another child, using contraception; deciding to have a termination of pregnancy or refusing to submit to sexual intercourse with an

---

<sup>222</sup> Individual interview, Monze, 15.11.2006.

<sup>223</sup> Not her real name.

intimate partner. During data collection, several women were met at hospitals and police stations complaining of different forms of violence. Mary<sup>224</sup> was found hospitalised at Monze Hospital after being assaulted by her husband. The reason for the assault was that she was found in possession of contraceptive pills collected from the local clinic without his consent or knowledge. Mary was 25 years at the time of the interview and had already had six children.

Tarrah another respondent interviewed in Monze narrated how her husband started calling her a prostitute at every occasion he had, causing her to suffer emotional violence and public humiliation, after she came home with a box of male condoms.<sup>225</sup> Tarrah could not take oral contraceptives due to a high blood pressure. Her local clinic referred her to Monze hospital where she could get an intra-uterine device inserted. Meanwhile, the clinic advised that she should use condoms for contraception till after the device was inserted. In addition to being assaulted by her husband she was accused of infidelity and publicly humiliated by her husband. The community thereafter viewed her as a woman of questionable morals and life has never been the same for her.

Serena,<sup>226</sup> a nurse at a rural health centre is living with economic violence in her home. She wanted a fourth child and her husband didn't. Before the couple resolved the matter Serena fell pregnant. Even though she explained to her spouse that the pregnancy was due to contraceptive failure, he did not believe her. He demanded that she have an abortion. Serena contended that as the body involved in the pregnancy was hers and it was her life at risk from a termination the decision to terminate or not was hers to make and not his. She carried the pregnancy to full term and her husband did not accept the child and provides no maintenance for him. Serena indicated that the situation in the family was tense and uncomfortable and the larger family and community they live in were suspicious that the reason for her husband's non-acceptance of this child was due to infidelity on her part.

---

<sup>224</sup> Not her real name. Individual interview, Monze, 15.11.2006.

<sup>225</sup> Not her real name: Individual interview, Monze 15.11.2006.

<sup>226</sup> Not her name. Key informant in Solwezi, 19.11.2006.

Polygamy coupled with loss of family income, loss of custody of children and loss of marital consortium were identified as other consequences of women's refusal to comply with dictates that infringe upon their rights or for insistence on their rights. Presenting her case to a mobile legal clinic, Winola lamented that her husband spent all his time at the new wife's homestead; was not regularly contributing to the maintenance of her children; and threatened to take the children from her. Winola had two live births after four miscarriages and decided she was not going to have any more children. Her husband who wanted more children ended up having two children from an extra marital relationship.

Women also face unwanted consequences when they exercise their right to be free from the restrictive interpretation of religious texts, beliefs and philosophies that curtail freedom of thought on sexual and reproductive health care and related issues. Some churches have restrictive interpretations of religious texts, beliefs and philosophies on the use of contraceptives and women are expected to use the natural method of birth control. Abortion is another right not recognised by the church; in fact abortion is tantamount to murder in the church. Women who break religious strictures on use of contraceptives or abortion may be punished by the church for doing so. The consequences could extend to suspension from important church rites or even excommunication from the church depending on how serious the breach is.

Religious institutions have their own social structures that act as enforcement mechanisms with power to discharge or excommunicate people from such fellowships or suspend from the enjoyment of church rites such as the Holy Communion. Apart from staff at the Catholic desk under the Catholic Centre for Justice, Development and Peace, none of the members of staff who dealt with women's complaints in the other churches visited were trained in human rights. They therefore gave advice on the basis of religion to the exclusion of human rights standards. This means that women who present a complaint related to the violation of their sexual and reproductive rights will receive a remedy based on religious beliefs. Thus, if the church does not permit the use of contraceptives a woman found in possession of same is guilty of a religious infraction.

Suzan, referred to above, was not only forced to resign her position in the church. She also suffered exclusion and public humiliation. Notices for Residents Development Committee meetings, for example, where she was the committee secretary, were deliberately not delivered to her to avoid her attendance; the larger family excluded her from family consultations and events; and she was also no longer hired as a premarital counsellor in her community.

Sometimes consequences are less public but still result in psychological or emotional trauma. Cecile had an abortion procured on her by deception because she had decided to carry her pregnancy to full term. Cecile, a 17 year old student fell pregnant by her boyfriend and when she told him he demanded that she have an abortion as he was not ready to have a child. She refused and later he took her for a 'medical examination' at a large Hospital in Lusaka to allegedly 'establish the truth of her claim'.

After the examination she was given medication through the medical practitioner who examined her under the pretext that she needs it. Later, she began to bleed and her boyfriend took her back to the hospital where she was told that she had lost the baby. She later found out that her boyfriend had connived with the doctor to procure an abortion on her without her knowledge or consent by the administration of an oral drug. Cecil complained of suffering from grief and guilt following this incident. She felt violated and abused although she decided not to take legal action.

### **6.1.2. Unsafe illegal abortion**

A woman may fail to prevent pregnancy through no fault of her own as this may be due to lack of knowledge about contraception, lack of access to contraceptives or due to contraceptive failure as in Serena's case. It was said that many women face the threat of stern action by an intimate partner, violence, economic deprivation, social exclusion or other unwanted consequences as a result of an unwanted or unplanned pregnancy. When this happens, such a woman may be forced to procure an abortion to secure her position or protect herself from the unwanted consequences. Women's sexual and reproductive rights denote that a woman must decide of her own free will whether to carry a pregnancy

to full term or to terminate it. However, women are sometimes coerced into deciding to terminate a pregnancy.

As stated earlier lawful termination of pregnancy may only be done in accordance with the provisions of the Termination of Pregnancy Act. In chapter four, the problems surrounding women's access to safe abortion services were noted as including inadequate and inaccessible health units; inadequate trained staff; unaffordable private services; restrictive legal and administrative requirements; lack of modern methods and appropriate equipment, pharmaceuticals and supplies; and lack of information, education and communication materials for the public regarding the availability of these services. Most women interviewed were shocked to hear that the law permitted abortion in certain circumstances and they could go to the hospital and have it done in a clean safe environment. They had no knowledge of this and had never come across any brochure or poster giving such information. Safe and legal abortion is thus an unknown and inaccessible option for many women in Zambia.

Women, especially those in rural sites said they were familiar with traditional methods for termination of pregnancy and that many women resorted to use these methods when faced with an unwanted or unplanned pregnancy. This was said to be a quick and effective solution after which the woman can present herself to the hospital with incomplete abortion for treatment. Some of these methods are unsafe and poorly administered. Unsafe and poorly performed abortions are a major cause of maternal mortality in Zambia.<sup>227</sup> A 1993 research showed the seriousness of the problem of illegal abortions.<sup>228</sup> The study shows that 17,977 women were treated in hospitals for complications arising from illegally induced abortions while doctors in Zambia's hospitals performed only 1,164 legal abortions in the same year. This gives an indication

---

<sup>227</sup> Castle, M., Likwa, R., and Whittaker, M., 1990. "Observations on Abortion in Zambia". In *Studies in Family Planning*, 21(4): 231-235.

<sup>228</sup> Likwa, R. and Whittaker, M., "The Characteristics of Women Presenting for Abortion and Complication of Illegal Abortions at the University Teaching Hospital, Lusaka, Zambia: An Explorative Study". Presented at the Conference on Unsafe Abortion and Post Abortion Family Planning in Africa, Mauritius, and March 1994.

of the extent of the problem of illegal and unsafe abortions and the risk it poses to women's lives.

Therefore, the combination of the desire for economic, social and cultural survival in the midst of many social, cultural and economic strictures; the challenges to sexual and reproductive self-determination and access to health services; and the fear of unwanted consequences forces women to undergo not only unwanted but unsafe terminations of pregnancy that put their lives at great risk. Many women interviewed were averse to termination of pregnancy but indicated that they would procure one if they felt that it threatened the wellbeing of their lives or put their marriage, social and economic situation in jeopardy.

### **6.1.3. Criminal Charges**

Women who fail to prevent pregnancy due to lack of knowledge about contraception, lack of access to contraceptives or due to contraceptive failure, in circumstances such as those described above, may be forced to procure an illegal termination of pregnancy. Similarly, women who may not wish to carry a pregnancy to full term for whatever reasons may not be able to procure a lawful termination of the pregnancy due to the many obstacles of doing so. These circumstances force women to unwittingly commit an unlawful and criminal act for which they may face criminal charges and punitive measures. Apart from unlawfully procured termination of pregnancy, some of the other gendered offences that women are charged with due to the violation of their reproductive rights or in their attempts to exercise these rights are infanticide, concealment of birth, and child destruction.

Women who are unable to obtain either a legal or an illegal abortion and are forced to carry the pregnancy to full term and deliver the child, often suffer psychological, mental or emotional trauma that may lead to infanticide. In Patricia's case the pregnancy was a result of a gang rape. Patricia a 19 year old university student met at the Lusaka Central Police Station had this to say about her situation:

My drink was laced with something at a party and I was gang raped. I was so devastated and embarrassed that I did not report the incident. Two months later I realised I was pregnant and went to my aunt to terminate the pregnancy. She gave me some medicine that made me really sick but the pregnancy was not terminated. I did not know that I could have obtained a legal abortion at UTH so I carried it to full term and when the baby was born I could not keep it... I couldn't stand it... I didn't even know which one of the rapists was the father...<sup>229</sup>

Women have sometimes carried a pregnancy to full term and concealed the birth for a variety of reasons. Where a woman delivers a child and conceals the birth by any secret disposition of the dead body whether the child died before, at, or after its birth, she may be charged with the offence of concealing the birth of a child under section 220 of the Penal Code. During a focus group discussion in Lusaka the researcher was informed of a case where a student at Lusaka's Evelyn Hone College was charged with concealing the birth of the child by dumping it in the sewerage soak away at the college. Women who do not have the intention to commit criminal acts are therefore forced to do so and consequently face criminal charges with stiff punishment if caught. The punishment for these offences is fourteen years for attempt to procure an abortion; seven years for procuring an abortion and life imprisonment for infanticide and child destruction.

## **6.2. The Woman's Dilemma**

Women therefore face violence, ridicule, public humiliation, accusations of infidelity, and different forms of violence, divorce, loss of maintenance, custody of children and of access to resources, neglect, exclusion and criminal charges due to the violation of their sexual and reproductive rights and for attempting to exercise their rights. The restraints on their ability to exercise self determination and the consequences that they may face in

---

<sup>229</sup> Not her real name. Individual interview, Lusaka, 25.3.2006. Patricia was charged with infanticide under section 203 of the Penal Code. Infanticide is the killing of a child below twelve months by the mother by act or omission, where the balance of the mind of the mother was at the time of the act or omission disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child.

either exercising this right or refusing to comply with norms or requirements that violate their sexual and reproductive rights, puts women in a dilemma. Women are forced to choose between suffering these consequences and complying with unwanted sexual and reproductive norms and strictures. This is hardly a choice at all, but is the reality of many women's lives.

Further, in prescribing gender roles, culture ascribes reproductive roles to women and the social epitomes of womanhood and motherhood exalt marriage and parenting as the primary functions and responsibilities of women. Women find self actualisation in motherhood, marriage and intimacy and these are important to many women. However, women also find self actualisation in productive roles of economic, professional and religious pursuits. As Ayesha Imam, a Nigerian Feminist observes, women should not be seen as passive breeders but also as economic agents, active in creating new developments.<sup>230</sup>

Therefore, while mother hood, marriage and intimacy are important to women, other pursuits may be equally important to them. Sometimes the reproductive roles interfere with the productive pursuits and women may need to regulate the reproductive roles so as to find time to pursue their productive interests. Regulating the reproductive roles entails exercising ones sexual and reproductive rights and thereby stepping out of the sphere of societal expectations. This stepping out often causes conflict that leads to unwanted consequences creating a vicious circle for women.

It was stated earlier that in the eyes of many women power, public life, autonomous decision making and the social ideal of woman hood and motherhood are irreconcilable and mutually exclusive. The pursuit of interests that conflict or do not comply with the ideal is alien to most women and a difficult thing to achieve. Women interviewed indicated how they try to be all things, such as being engaged in productive remunerating

---

<sup>230</sup> McFadden, P., "Issues of Gender Developments from an African Feminist Perspective", Women's World, African Women's Voices, 2000, [www.wworld.org](http://www.wworld.org). Last visited November 2005.

pursuits, meeting the reproductive roles of wife and mother, and being available for church, family and other social responsibilities.

### **6.3. Social Enforcement Mechanisms**

The combination of the non-recognition of this class of rights as human rights in the law; restrictive legal and administrative requirements for legal abortion; inadequacy of social and public services; and the legal administration system all work towards the creation of a legal dispensation that supports women's disadvantaged position in respect of sexual and reproductive rights. It was stated in chapter two that even though the legal administrative system consists of one formal legal system designed to apply a multiplicity of laws, there are a plurality of normative orders affecting women's lives, the choices and decisions they make, as well as a plethora of arenas where these are made.<sup>231</sup> This means that there are semi- autonomous social fields which are social entities that have a rule upholding and rule generating capacity at play in women's lives. These form the various social enforcement mechanisms that ensure that women comply with the requirements or dictates of family, society or custom and tend to keep women within their dilemma.

These derive their authority from the socio-cultural order of the society. They decide what amounts to a wrong within that society, what remedies are available for victims or what punishment is due to a person who commits a wrong. They are informal institutions with no written rules or precepts and no legal backing in the formal legal system. As shown in chapter two, these make their determinations based on a variety of considerations, among them practical considerations, common sense, and knowledge of the law however skewed, religious norms<sup>232</sup> and customs and practices. Their rule upholding power is social and often not enforceable by legal provisions. They are relatively powerful entities handing out social sanctions.

---

<sup>231</sup> Benzton, A., 1989. Pursuing Grounded Theory in Law, 40.

<sup>232</sup> Benzton, A., 1989. Pursuing Grounded Theory in Law, 40.

The family is one of the most powerful of these social institutions. If a complaint is brought before the family, a family council may be convened to deal with the complaint or problem. The council consists of relatives and counsellors. Where the complaint or problem involves two families, such as between husband and wife, the council will consist of relatives from both sides. These family members are often senior persons in the family or persons who were involved in the contracting of the marriage of the involved parties. These are often members of the extended family or trustworthy family friends.

Unfortunately, the extended family in particular enforces culture, the same culture that supports women's subordination discussed in the previous chapter. One of the roles of the family is to ensure that culture is kept alive by enforcing it within the larger family unit and ensuring that family members live in compliance with it. As a result the remedy given by the family may not be just, as it is based on discriminatory cultural beliefs or precepts that do not protect the rights of women, and actually work towards maintaining their subordinate and underprivileged position or compels them to accept the status quo. Women settle for the decisions of these institutions because of what is important or a matter of priority for them at any given time. Where women are forced to choose between maintaining familial relations and enforcing a right, it is sometimes more important to them to maintain the relationships than to enforce a right that antagonises the family relationships. This however, is a decision arrived at not by free will but by the coercive system in operation in the lives of women.

Although the family has methods to compel both men and women to comply with norms as these relate to the complaint or problem brought before it, or to desist from acts that violate the other's rights, it has only a few and rather ineffective means of doing so against men. For example, data shows that if a child dies during childbirth or early infancy or suffers from a cough, (called *chidulo* in Nsenga), the father may be accused of infidelity during the wife's pregnancy. Also in cases where the wife dies in child birth the family council may accuse the husband of infidelity (called *inchila* in Bemba) and require the man to pay a fine before the body of the deceased can be buried. This rule is generated to ensure fidelity and foster good health and avoid infectious diseases to the

pregnant woman, thereby securing her right to survive pregnancy and childbirth. Unfortunately, such precept is easy to ignore because it is based on a myth that has since been proved to be such by society.

Society tolerates male infidelity and violence and therefore offers no or few sanctions against men.<sup>233</sup> Data therefore shows that whereas there are few sanctions that the family can effectively implement against men, it has powerful means of exclusion and ridicule against women that may compel a woman to comply. It would appear that the family is thus more effective in implementing sanctions against women rather than men. The family is the place where women are socialised into the disposition of subordination and it is the enforcement or compliance with these suppressive dispositions that the family council often sees as the solution to conflicts. In essence the family council, even when the woman is the complainant or aggrieved party, will often enforce the cultural norms that disadvantage women or violate their rights as recognised under international human rights law.

It was stated earlier that women see themselves not as individuals with individual rights but as part of the family, they define themselves by the roles they play in the family and are socialised to believe that the burden of sustaining the family unit lies with them. Women's desire to maintain family relation is of course not only for social reasons or responsibility but also for economic survival. Therefore, they are more likely to desire to maintain family relations than men and are more affected by family imposed sanctions than men. It was said that whereas most men assert their rights and ignore sanctions imposed by the family council, few women were said to do so. This illustrates how the family remains not only a place of identity, belonging and alliances for women<sup>234</sup> but also a place of struggle for many women. Data also shows that in spite of this situation, the family council is still the first institution that women turn to for help and conflict resolution.

---

<sup>233</sup> Copelon, R., Intimate Terror: Understanding Domestic Violence as Torture. In Coomarsawamy, R., In Cook, R.J., 1994. Human Rights of Women: National and International Perspectives 40-42.

<sup>234</sup> Mvududu, S. and P. McFadden, 2001. Re-conceptualizing the Family in a Changing Southern African Environment, Women and Law in Southern Africa Research and Educational Trust, 18.

Further, the family often colludes with other semi autonomous social entities such as the church and society generally to create a powerful mechanism for policing women and controlling women's sexuality. This is evident in the case of Suzan who was punished by the church, ostracised by the family and excluded and shunned by society. Collusion may also be between family and a legal institution as was the case in Mrs Phiri's story where she was bundled out of the matrimonial home by the marital family and their action defended and legitimated by the local court that granted the divorce.

The traditional courts in rural areas are another form of enforcement mechanism with rule generating and enforcing power. Presided over by the headmen or even chiefs, they are not recognised at law and therefore are unregulated. In Monze, the trend was to send women back into abusive or violent relationships after admonishing them to obey their husbands. Only in one case observed was the husband ordered to pay a goat as compensation to his wife for battering her for being in possession of contraceptives without his knowledge. The husband was also admonished to give his wife time to rest in between pregnancies or to take a second wife if he felt disadvantaged.

This situation is reinforced by existing legal standards and concepts that disadvantage women and maintain the status quo. The dual legal standard in Article 23 of the Constitution disadvantages women in that it expressly allows for the practice of customary law even when that law is discriminatory. The law further requires that a practice can only be declared repugnant to natural justice and good conscience by a court of competent jurisdiction. As a result the family council and traditional courts continue to enforce practices and laws that disadvantage women. Unless a woman can get her complaint into a court of competent jurisdiction, then she may have to settle for a resolution that is unjust and that may not comply with the notion of sexual and reproductive rights. Further, the law itself neglects to make express provisions that secure women's sexual and reproductive rights. For example, the Penal Code does not specifically criminalise acts such as non-consensual marital sex, a provision that would have given women grounds to exercise their right to decide when to have sex.

## **CHAPTER SEVEN**

### **7. THE COMPLEXITIES SURROUNDING WOMEN'S SEXUAL AND REPRODUCTIVE RIGHTS AS INDIVIDUAL RIGHTS**

#### **7.1. Prerequisites to the Exercise of Rights**

The nature and enormity of the challenges and the dire consequences that women face in exercising and enforcing their sexual and reproductive rights raise the question whether women's sexual and reproductive rights are mere theoretical assertions that cannot be exercised or enforced fully. This chapter discusses the impact of the challenges and consequences on women's sexual and reproductive rights as a class of rights and women's ability to exercise or enforce these rights. It posits that there are certain prerequisites to the exercise or enforcement of women's sexual and reproductive rights that are missing and contribute to the challenges and consequences that constrain the exercise or enforcement of these rights. The chapter also examines the complexities surrounding women's sexual and reproductive rights as individual rights.

These prerequisites include knowledge of rights and their inherent nature; and desire to assert, claim or demand these rights. This chapter also examines two aspects—the difficulties surrounding the exercise and enforcement of these rights as individual rights and the State's responsibility towards the promotion, respect and fulfilment of these rights. It argues that conflicting interests; inadequate health care facilities and services; and the lack of a legislative framework and enforcement mechanisms for these rights makes it impossible for women to exercise or enforce these rights fully.

##### **7.1.1. Knowledge of rights**

A key prerequisite to the full exercise or enforcement of any rights is the knowledge of those rights. The holder of rights must know these rights, what they are, what they entail,

the extent and scope and how to assert them.<sup>235</sup> The women's rights perspective presupposes that women are 'knowers' because knowing these rights allows women an opportunity to define their rights within their social context or in opposition to its boundaries. However, data shows that few women know about these rights and this impacts on whether they ultimately exercise or enforce these rights or not and this lack of knowledge defines their social relationships.

The rights holder must also have understanding that she is entitled to these rights not as a privilege bestowed by the State or any other person or entity, but as an inherent part of her being.<sup>236</sup> Above all, she must perceive this entitlement as hers as an individual or in the case of group rights, as part of a group or other entity. Data however suggests that women do not perceive themselves as individuals with individual entitlements but as people linked to family. They perceive themselves as daughters, wives and mothers, existing in relation to others as opposed to being autonomous individuals. This position is reinforced by the societal ideals of woman hood and mother hood.

The epitome of womanhood is passivity, naivety and even ignorance in matters of sexuality and dictates that a good woman defers her rights to her husbands' needs and interests. Similarly, the epitome of motherhood dictates that the rights of children supersede those of the mother. Consequentially, the whole concept of personhood which is the basis of individualistic and autonomous action eludes women. The concept of personhood helps women to appreciate themselves and their strength in improving their personal conditions and thereby exercising their autonomy. It negates the 'definition of women as the private property of males, located in male headed households',<sup>237</sup> and exalts the idea of women as independent individuals capable of making sexual and reproductive decisions and any other decisions affecting their lives.

---

<sup>235</sup> Cook, R., 2004. "International Protection of Women's Reproductive Rights", 24 New York University Journal of International Human Rights Law and Politics, 625.

<sup>236</sup> Cook R.J. and F. F. Mahmoud, 2005. "Advancing Reproductive Rights Beyond Cairo and Beijing". In Askin, D.K., and Dorean M. Koenig, (eds.), Women and International Human Rights Law, vol.3.

<sup>237</sup> McFadden, P., "The Challenges of Sexuality, Patriarchy and Globalisation in Africa", African Women's Voices -Women's World, 2001, [www.wworld.org](http://www.wworld.org), last visited October 2006.

In chapter five we saw the interplay between various social, religious, cultural, economic, legal and political factors that constrain women from asserting their sexual and reproductive rights. These factors create a continuum of subordination that affects women's ability to exercise and enforce their rights.<sup>238</sup> They constitute and sustain the patriarchal social structure and define the social cultural context that controls every aspect of women's lives.

Data suggests that this social cultural context of women's lives does not encourage a free development of personality. Thus, women cannot develop their sexuality or any other aspect of their lives in a manner more acceptable to themselves, but in a manner that conforms to social norms. These social norms that women are expected to comply with do not always ascribe to international human rights standards or law or the conceptualization of sexual and reproductive rights as individual rights. Hence the social cultural context itself does not support or favour women's human rights or women's sexual and reproductive rights.<sup>239</sup>

Chapter five also shows the social cultural context of women's lives as a patriarchal social structure that promotes an asymmetrical model of rights in society, with men's entitlements at the top. Data shows that as a result of this asymmetrical model of rights in society, women are socialized as duty bearers and perceive themselves as such rather than as rights holders. Women are not socialized to know their rights and the inherent nature of these rights. The central socialization centre for women is the family. It ensures that women grow up to define themselves by the roles and duties that society ascribes to them, that is, as duty bearers. The social ideals of motherhood and womanhood are by products of this model of rights and contribute to its continued existence.

Naïve and socialized as duty bearers rather than rights holders, and devoid of a sense of personhood and individualism, women have little or no consciousness of the rights that

---

<sup>238</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. "Sexual Rights: From Concept to Strategy", in Askin K.D. and D.M. Koenig, (eds.), Women and International Human Rights Law, volume 3. 91.

<sup>239</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. "Sexual Rights".

inhere in them as individuals.<sup>240</sup> Data shows that few women know what their human rights are, or understand that these inhere in them and are not given as a privilege. There were even fewer women able to conceptualize sexual and reproductive rights as individual rights. Like other rights, sexual and reproductive rights are to a certain extent individual rights whose enjoyment requires both a consciousness of rights and a perception of the self as an entitled individual. Even though women constantly referred to their rights during data collection, it was almost always in reference to their rights as wives or mothers rather than as individuals.

Data further suggests that many women do not perceive others as duty bearers towards them in respect of rights. A husband or intimate partner bears a duty towards their wife or partner in respect of physical integrity, for example, but respondents in the study never identified this. The duty identified was in respect of social and economic maintenance and other duties relating to conjugal rights. Women's position as rights holders is overshadowed by women's position as duty bearers to others. Therefore, women have little consciousness of the duty others owe them. Devoid of this knowledge of the duty others bear towards them and with little or no consciousness of themselves as rights holders, women are unlikely to claim or assert their sexual and reproductive rights.

### **7.1.2. Conflicting Interests**

The second key prerequisite is the desire to assert these rights. Although human rights are inherent, they carry a duty of participation and inclusion on the part of the individual who is the holder of such rights. In other words human rights have to be asserted by the individual in whom they inhere. Women are thus expected to be active agents in the realization of their rights. Further, the concept of personhood denotes that people are principal actors and decision makers in matters affecting their lives, therefore subjects and not mere objects. It follows that to exercise or enforce sexual and reproductive rights, women are expected to be independent, free, endowed with knowledge of rights and

---

<sup>240</sup> Cook, R., 2004. "International Protection of Women's Reproductive Rights", 24 New York University Journal of International Human Rights Law and Politics, 625.

rational agency. The reality however is that women are dependent and severely constrained members of the family with little or no consciousness of rights or individual agency. They are therefore constrained from being principal actors and decision makers in matters affecting their lives.

Not only are women faced with lack of consciousness of rights, but they also face a serious tension that creates difficulties in the exercise or enforcement of rights.<sup>241</sup> Individual rights denote that sometimes the interests of the self will conflict with those of others including spouses and children. Thus, the interest of a woman in respect of her sexual and reproductive rights might conflict with those of her husband or partner. It was earlier stated that patriarchy promotes an asymmetrical model of rights in society whose effect is inequality between men and women. The exercise or enforcement of individual rights of women, at the bottom of the rights model, that are in conflict with those of men in such a set up, is therefore not a norm.<sup>242</sup> It challenges the status quo and creates a tension.<sup>243</sup> The desire to exercise or enforce sexual and reproductive rights is compromised by this tension and what it may entail.

Further, the existing rights model emphasizes women's duties as opposed to rights. Exercising rights that may be in conflict with those of the husband also challenges the order of women's duties and rights. It entails the departure from what is expected of women, that is, to discharge their duties. It changes the socially accepted priority of women's duties above their rights. Therefore, the conflicting interests between a couple that arise as a result of the notion of individual rights, in an environment with an asymmetrical model of rights, creates a serious tension between individual rights and social duties for women. There is thus a two fold conflict that arises as a result of the hierarchy of rights of men and women in society and the emphasis of women as duty bearers rather than rights holders. The one being a conflict between the hierarchies of

---

<sup>241</sup> Coomarsawamy, R., To Bellow like a Cow: Women, Ethnicity and the Discourse of Rights. In Cook, R.J., 1994. Human Rights of Women: National and International Perspectives 40-42.

<sup>242</sup> Schlafly, P., 1987. Not by Law Alone. In Mackinnon C, 1987. Feminism Unmodified, Harvard University Press, Cambridge, 21.

<sup>243</sup> Cohen, J.L., 1999. About Women and Rights. In Cohen, J.L. and C. F. Epstein,, (eds.),1999. Women and Rights, 369.

rights of men and women and the other being a conflict between individual rights and societal duties.

The unwanted consequences of making choices in favour of the self and the burden of sustaining the family unit join together in women's lives. There is therefore a combined effect of the social enforcement mechanisms that force women to aspire to the socially accepted ideals of womanhood and motherhood.<sup>244</sup> Women are placed at a crossroads of exercising individual rights or executing duties, a fundamental and difficult choice to make for many women. This explains why even women, who are conscious of the human rights that inhere in them and are relatively financially autonomous, also face similar challenges in asserting their rights as women with little or no consciousness of rights or financial autonomy. This situation is generally disempowering for women and also compromises their ability to develop the necessary consciousness and personhood required for the exercise and enforcement of these rights.

The asymmetrical model of rights and the tensions arising from the conflict between the hierarchies of rights and individual rights and societal duties also breed an ideological resistance to the concept of women's human rights.<sup>245</sup> The exercise or enforcement of women's sexual and reproductive rights threatens the asymmetrical order of rights and therefore, the general order of society. It is not a welcome disruption in the social order of things and is met with resistance by society. Social resistance of women's rights ideology appears essential to the male retention of power and maintenance of the status quo. This resistance is manifest in the consistency of the social mechanisms that force women to comply. The ideological resistance to women's human rights is not only by society as a whole, but also by women themselves.

The idea of putting themselves before others so as to assert their rights is alien to many women. The ideology of women's human or individual rights therefore, appears to threaten to alienate them from that which is most important or fundamental in their lives.

---

<sup>244</sup> Coomarsawamy, R., To Bellow like a Cow: Women, Ethnicity and the Discourse of Rights. In Cook, R.J., 1994. Human Rights of Women: National and International Perspectives 40-56

<sup>245</sup> Cook, R. J., 1994. Human Rights of Women: National and International Perspectives, 5-31.

Individual agency is thus alien to many women and challenges the unequal power relations in heterosexual relationships. It questions the norm and threatens the delicate balance of things. Although the direction a woman chooses to take at the crossroads of exercising individual agency and fulfilling familial obligations, ultimately depends on what is important to her at that point in life, placed at such a crossroads many women would choose the latter. For many women the ideology of women's human or individual rights cannot even compete against the ideology of maintaining familial relationships because of how they have been socialized.

Many women find fulfilment, enhanced self esteem and self actualization in marriage and parenthood.<sup>246</sup> Marriage is central to women's social status and acceptance in society. We saw how girls are taught of its importance and socialized to believe that it is the ultimate end for them. An aspect of marriage is that a good woman keeps her marriage going whatever the cost and produces children in that marriage. Family ideology is thus important to many women and sustaining cohesive and successful family units is an important aspect of women's lives. Marriage and parenthood therefore, assume so fundamental a position in women's lives that they fail to see the point at which these cease to be fulfilling and become a threat to their wellbeing and fulfilment of rights.

Therefore, most women perceive their empowerment as manifesting through familial ideology as opposed to rights ideology.

They are therefore, wary of taking action that is likely to upset the precarious arrangements of their lives and families and often choose to be content with their lot. Further, human beings are by nature social beings and this fact combined with the fundamental position of family in women's lives makes the fulfilling of societal or family expectations a matter of prime importance to women. The rejection of the rights ideology and embracing of familial ideology constrains women from accepting the rights inherent in them. Women are thus unable to exercise or enforce their sexual and reproductive rights.

---

<sup>246</sup> Women and Law in Southern Africa Research and Educational Trust-Swaziland, 1998. Family in Transition: The Experience of Swaziland, Manzini.

Further, that the woman's body is the only site of pregnancy and childbirth is an issue of power and the patriarchal society closely controls women's sexuality so as to be in possession or control of this power. Rights are about power and exercise or enforcement of women's sexual and reproductive rights often implies a power shift, where women acquire or decide to use their power to make choices autonomously.

A woman, who decides to exercise her right to prevent pregnancy by using modern contraception without her husband's consent or knowledge in the existing order of rights, puts her right above that of the husband. She thus takes some of the power the man has to control her body and assumes individual agency. This denotes a proportional loss of power on the part of the man. It also denotes a shift in the asymmetrical model of rights in that relationship and therefore in society. Individual agency and patriarchy thus assume the position of oppositional interests.

## **7.2. State's Obligation to Women's Sexual and Reproductive Rights**

In chapter four it was stated that one of the major challenges to women's exercise of sexual and reproductive rights is limitations in the sexual and reproductive health services. They are far from where women are located and they are sometimes inadequate and under resourced. As a result of which women have limited access to sexual and reproductive health care and services. Even if the prerequisites of knowledge and desire to assert rights discussed above were present, full exercise of women's sexual and reproductive rights would be compromised by the challenges women face in the area of health services.<sup>247</sup> Hence the extent of provision of public health services by the State has implications for women's human rights.

### **7.2.1. Provision of Adequate Health Services**

The challenges related to sexual and reproductive health care have implications for human rights because international human rights instruments create a triple obligation on

---

<sup>247</sup> Centre for Reproductive Law and Policy, 2001. Surviving Pregnancy. New York.

the part of the State Parties towards its citizens, to promote, respect and fulfil human rights.<sup>248</sup> The obligation to fulfil human rights requires the State to take active steps to put in place prerequisites necessary for citizens to enjoy their human rights. This includes policies, programs, legislation, institutions, procedures and resources that enable people to enjoy their rights. These active steps must be capable of realizing the targeted goal. Thus, the State has an affirmative duty to facilitate human rights not only through legislative and enforcement mechanisms, but also through resource allocation.<sup>249</sup> In other words, the State must in its national budget and priorities allocate resources aimed at providing the things necessary for women to enjoy sexual and reproductive rights.

In respect of women's right to sexual and reproductive health care, this means that the State is obligated to ensure that the challenges to women's sexual and reproductive health care are removed. This includes the provision of institutions and facilities or health units that provide sexual and reproductive health services to deal with the problem of accessibility; and resources to acquire requisite equipment and contraceptives and recruit sufficient human resource to deal with the problem of lack of service availability and acceptability.

Given the resource limitations of women in the country, the challenges to women's sexual and reproductive health care can only be overcome if the State meets its obligations in respect of provision of adequate public health services. This would create the necessary environment in which women can fully exercise their right to sexual and reproductive health care. It is highly unlikely that women will attain a resource level where they can all afford to access private health services. Private services are currently not only unaffordable to most women but are also unavailable in rural areas.

### **7.2.2. Lack of an Appropriate Legislative Framework**

Finally, for these rights to be fully enjoyed there is need for a legislative framework that

---

<sup>248</sup> Cook R.J., B.M. Bernard, and M.F. Fathalla, 2003. Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law, 148-215.

<sup>249</sup> Byrnes, A., Women, Feminism and International Human Rights Law-Methodological Myopia, Fundamental Flaws or Meaningful Marginalisation, 12 Australian Year Book of International Law, 205.

supports human rights.<sup>250</sup> There is need for legislation that provides for and protects human rights and provides for mechanisms of enforcement. As stated in the law and policy review, in Zambia human rights are provided for in the Bill of Rights to the exclusion of economic, social and cultural rights. The area of sexual and reproductive rights is largely unregulated or provided for in the law. In the absence of a legislative provision stipulating these rights, women have nothing to lean on in exercising or enforcing such rights. There is no instrument for women to apply in an effort to exercise or enforce these rights. The law does not intervene in the private arena where women's sexual and reproductive rights are actually located and often violated. A good example is the case of non-consensual marital sex to which the definition of rape in the Penal Code does not extend.

Where a person has interests or entitlements that are rights there is a corresponding duty that binds another to respect those rights. Therefore, a claim holder (or right holder) has a legal entitlement while the duty bearer holds a corresponding legal duty or legal obligation to fulfil that entitlement. In other words wherever there is a right, there is someone with an obligation. The interest of a woman to control her fertility for example, creates a corresponding duty that binds her partner to respect this interest. This corresponding duty is binding legally or morally.

Thus, the empowering nature of human rights lies in the fact that they provide means by which people can legitimately assert their interests, morally or legally. The problem with women's sexual and reproductive rights is that this corresponding duty is only binding morally and not legally. In the absence of a legally binding duty on sexual and reproductive rights, there is no *locus standi* on which to enforce them. Therefore, the State needs to ensure that the moral obligation of private individuals with respect to women's sexual and reproductive rights are transmitted into legal obligations that can be enforced.

---

<sup>250</sup> Ghai, Y., and Cottrell J, (eds.) 2004. The Role of the Courts in Protection of Economic, Social and Cultural Rights, InterRights, 58.

It was stated earlier that human rights impose triple obligations on the State to promote, protect and fulfil rights. Therefore, the corresponding duty to women's sexual and reproductive rights also extends to the State. The State should thus be compellable to execute its obligation towards citizens, which is what it has pledged to in the international human rights instruments.<sup>251</sup> The principles of accountability and rule of law denote that States and other duty bearers are answerable for the observance of human rights, and where they fail to do so; aggrieved rights holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by the law.<sup>252</sup> The State should therefore be compellable to meet its domestic and international obligations in respect of women's sexual and reproductive rights.<sup>253</sup>

In the South African case of *Minister of Health and others v. Treatment Action Campaign and others*,<sup>254</sup> Treatment Action Campaign took out an action to compel the state to comply with its Constitutional obligations and implement a reasonable program for the Prevention of Mother To Child Transmission of HIV (PMTCT). It was possible to take out this litigation because the South African State is obligated in the Republican Constitution to fulfil the right to health. The Constitutional Court therefore ordered the State to implement this program. This order *inter alia* worked towards the enforcement of women's rights to the benefits of scientific progress and to plan and have a family.

Unfortunately, this may not be tenable in Zambia because enforcement of rights can only be done in an existing legislative framework and the extent of enforcement is limited within that framework. In Zambia, the State not only maintains a dichotomy between civil and political rights on one hand and economic and social rights on the other, but actually relegates social and economic rights to non-justiciable guidelines for state policy. The right to sexual and reproductive health care and services is derived from the right to health which is classified as a non-justicable policy guideline in the Zambian

---

<sup>251</sup> Fried, S. T. and I. Landsberg-Lewis, 1996. "Sexual Rights".

<sup>252</sup> Ghai, Y., and Cottrell J, (eds.) 2004. The Role of the Courts in Protection of Economic, Social and Cultural Rights InterRights 58.

<sup>253</sup> Ghai, Y., and Cottrell J, (eds.) 2004. The Role of the Courts, 61.

<sup>254</sup> *Minister of Health and others v. Treatment Action Campaign and others*, CCT 8/02.

Constitution.

The right to health is not guaranteed in the bill of rights of the Republican Constitution and citizens can therefore not compel the State to provide health services. Based on the non-justiciability of the right to health, it is highly unlikely that women in Zambia would succeed in an action such as *Minister of Health and Others v. Treatment Action Campaign and Others*. Further, the provisions of international human rights instruments are not part of the domestic legislation and so the State cannot be compelled to comply with these.

### 7.2.3. Lack of Deliberate Strategies for Empowerment

Human rights and the theory of State responsibility obligate the State to make strategies of empowerment which support rights holders with power, knowledge, capabilities and resources to ensure that they can have individual agency and can exercise and enforce their rights.<sup>255</sup> Human rights imply special attention to marginalized or minority groups and to the elimination of disadvantage and vulnerability in the exercise or enforcement of rights.<sup>256</sup> Therefore, the factors that undermine women's power and ability to make autonomous sexual and reproductive decisions are matters requiring the State's attention and action in its attempt to empower citizens to exercise and enforce their human rights.<sup>257</sup>

The State has neglected, refused or failed to meet this obligation. Therefore, it can be implicated in the continued construction of gender subordination and inequality, and the resultant systematic disempowerment of women.<sup>258</sup> The State can also be accused of perpetuating this subordination, maintaining patriarchy and neglecting the socio-economic structures in which the subordination of women occurs. This neglect relegates

---

<sup>255</sup> The CEDAW and the Protocol to the African Charter on Women's rights are key instruments in this regard.

<sup>256</sup> Ghai, Y., and Cottrell J, (eds.) 2004. The Role of the Courts in Protection of Economic, Social and Cultural Rights InterRights 58.

<sup>257</sup> Romany C, 1994. "State Responsibility Goes Private: A Feminist Critique of the Public/Private Distinction in International Human Rights Law". in Cook R, Human Rights of Women: National and International Perspectives, 85

<sup>258</sup> Askin and Koenig, (eds.), Women and International Human Rights Law, volume 3.

women's basic rights to life, dignity and integrity as construed in the discourse on women's sexual and reproductive rights, to a sphere where State intervention is not ordinarily expected, i.e. the private sphere.<sup>259</sup> If women are to fully exercise or enforce their sexual and reproductive rights, the State needs to interpret and define the scope of the rights located in the private sphere of women's lives which is also the primary site of human rights violations against women.

The State ascribes to a human rights framework that construes civil and political rights of individuals as being in the public sphere of life, and neglects to protect the infringement of those rights located in the private sphere of familial relationships.<sup>260</sup> The rights to life, dignity, information and physical integrity are civil and political rights that imply women's special interests that constitute their sexual and reproductive rights. When these are interpreted in the public sphere, they extend only to the traditional scope that excludes women's special needs to enjoy these rights. For example, when women's right to life is interpreted in the public sphere, it extends only to the arbitrary deprivation of the right to life by the State or private actors, and does not cover the special needs of women to enjoy their right to life by being able to survive pregnancy and childbirth.

This private and public divide thus translates into the regulated and unregulated spheres of women's lives. Although the State has to a certain extent regulated the private sphere of family life with laws on marriage, divorce, maintenance and custody, it has however neglected to extend this regulation to the areas that liberate women from their social cultural subordination. In Zambia, familial relations conducted under customary law remain largely unregulated. For example, although the Marriage Act sets the minimum marriage age in marriages contracted under the Act at 21 years, child marriages are contracted under customary law without legal restraint. This poses a big problem in a society which sanctions marriage as the only approved setting for the enjoyment of sexual and reproductive rights.

---

<sup>259</sup> Cook, R., 2004. "International Protection of Women's Reproductive Rights", 24 *New York Journal of International Law and Politics*, 645.

<sup>260</sup> Romany C, 1994. State Responsibility Goes Private, 85.

The State has neglected to outlaw marital practices such as forced and early marriages of girls, resulting in the legitimization of child marriages where the girls are coerced or unduly influenced.<sup>261</sup> This is contradictory to the principle of the best interest of the child as provided for in the Convention on the Rights of the Child. Further, women have a right to control their fertility, but are coerced into pregnancy by threats to their status quo or physical integrity. This coercion amounts to violation of rights and takes place mostly in the privacy of familial relationships.

Due to the State's refusal, failure or neglect to intervene, the violations in the private sphere continue to thrive in a well protected system of patriarchy with insufficient protective legislation for victims or punitive legislation for offenders. Therefore, non-State actors especially individuals are able to violate women's rights in the private arena with impunity. The State ignores the necessity of these measures and maintains a blind eye to the crippling power relations and rights violations in marriage and other familial relations. Yet, the State's obligation to respect and promote rights extends to the prevention and punishment of the violation of rights by non-State actors.

Although not recognized as an active subject of international law, the individual is a subject of domestic law. States should thus be held responsible for violations in the private sphere because of failing to provide legislative protection for women from private actors. Women's human rights infringed by private actors, such as male domestic violence against women, should therefore be attributable to the State. There is need to recognize that the problem lies partly in the State's failure or refusal to put in laws, mechanisms and processes in relation to women's sexual and reproductive rights at domestic level. This keeps these rights as a preserve of international law, thereby preventing women from accessing these rights under domestic law.

Therefore, neglect, refusal or failure by the State to respond to women's sexual and reproductive rights and the State's relegation of these rights to the unregulated private

---

<sup>261</sup> Cook, R., 2004. "International Protection of Women's Reproductive Rights", 24 *New York University Journal of International Human Rights Law and Politics*, 625.

sphere is tantamount to the State's complicity in rights violation. It makes the State an accomplice to these acts. The failure or refusal to put in place provisions for prevention and punishment of violation of women's rights in the private sphere, also results in the State's denial of women's right to equal protection of the law. There is unequal protection of the law when a section of society (in this case the woman) is not protected by existing legislation. General recommendation 19 of the CEDAW monitoring committee obligates State Parties to legislate against wrongs through criminal penalties or civil remedies and to ensure that this legislation is effective through judicial mechanisms. Zambia does not have an appropriate legislative framework or mechanisms to facilitate the enforcement of women's sexual and reproductive rights.

Social rights are premised on the availability of State resources.<sup>262</sup> Unlike the ICCPR, the ICESCR has no "respect and ensure" clause. There is only an undertaking by State Parties to take steps with a view to achieving progressively the full realization of the rights recognized in the covenant.<sup>263</sup> Hence, in the example of the South African case<sup>264</sup> above, even though the South African Constitution guarantees the right to health, as a justiciable right, the Constitutional Court ordered that the government provide the PMTCT program where facilities have the capacity to do so, and plan a phased rollout of comprehensive services to those areas where capacity did not yet exist.

This was in recognition of the principle of progressive realization of social, economic and cultural rights. The State can therefore only provide these rights in progression with resource availability. However, in Zambia women cannot get a court order for the progressive realization of the right to health as it is *non-justiciable*. As discussed earlier, enforcement of rights can only take place in a legislative framework that has provisions under which an applicant can make an application before a court.

---

<sup>262</sup> An-Na'im. A., 2004. To Affirm the Full Human Rights Standing of Economic, Social and Cultural Rights. in: Ghai, Y., and Cottrell J, (eds.) 2004. *The Role of the Courts*, 7.

<sup>263</sup> An-Na'im. A., 2004. To Affirm the Full Human Rights Standing, 7.

<sup>264</sup> *Minister of Health vs. Treatment Action Campaign*.

#### 7.2.4. Non-Recognition of the Indivisibility and Interrelatedness of Human Rights

An interesting fact of the dichotomy between civil rights and economic rights is that it defeats the notion that human rights are indivisible and interdependent.<sup>265</sup> The interdependence or interrelatedness of human rights means that the realization of one right often depends on the realization of others. For instance, the realization of the right to life may depend on the realization of the right to health. In the Zambian context, the right to survive pregnancy and child birth which is the full extent of women's right to life cannot be enforced because it is dependent on the right to health which is a *non-justiciable* right.

The indivisibility of human rights also means that all rights have equal status and cannot be ranked in a hierarchical order as is the case in the Republican Constitution. The demarcation of civil and political rights as justiciable rights on one hand and social and economic rights as non-justiciable rights on the other divides rights and ranks them *a priori*.<sup>266</sup> Civil and political rights thus become more important than economic and social rights. In a system where this interrelatedness is ignored, civil rights whose fulfilment depends on that of economic and social rights may not be fulfilled. The full extent of civil rights as they pertain to women's sexual and reproductive rights is thus limited.

It goes without saying that there is need to secure rights to sexual and reproductive health care and services, by the provision of appropriate and adequate services. There is also need for deliberate and urgent efforts to end crippling challenges related to women's sexual and reproductive self determination if women are to fully exercise and enforce their rights. Viewed in a framework that does not promote social, economic and cultural rights, these rights remain in the background of the discourse on human rights at domestic level. Women's sexual and reproductive rights therefore, remain hanging in the balance as mere international human rights law based assertions that cannot be fully

---

<sup>265</sup> Budlendor, G., 2004. Justiciability of Economic, Social and Cultural Rights. In: Ghai, Y., and Cottrell J, (eds.) Economic, Social and Cultural rights in Practice, InterRights 33.

<sup>266</sup> Lester, 2004. The Effective Protection of Socio-Economic Rights. in: In: Ghai, Y., and Cottrell J, (eds.) Economic, Social and Cultural rights in Practice, InterRights 17.

exercised or enforced in Zambia.

## CHAPTER EIGHT

### 8. CONCLUSIONS AND RECOMMENDATIONS

#### 8.1. Conclusions

At the start of the study the problem was identified as being the fact that even though sexual and reproductive rights are recognized human rights, they are not a reality in women's lives. Women continue to die from causes that can be prevented by the exercise or enforcement of sexual and reproductive rights. The study identifies several challenges that women face in asserting or enforcing this class of rights and several conclusions can be drawn from the data collected and analysed in respect of these challenges.

The findings show that the social, political, legal and economic milieu in the country is a result of a combination of social-cultural prescriptions, norms, beliefs and the social and legal status of women which constitutes the culture of a society. It has a major impact on women's behaviour, including their ability to exercise or enforce their rights. Its impact subjects even relatively independent or privileged women to serious insecurities, restricting women's capacity to change their lives and limiting alternatives and their exposure to these alternatives. These social-cultural prescriptions, norms, beliefs and the social and legal status of women in society render women powerless or incapable to either exercise or enforce their rights especially rights as personal as sexual and reproductive rights.

Women are subjected to sexual harassment, externally imposed fear, shame, guilt or beliefs based on myths and other psychological factors inhibiting their sexual responses or impairing their sexual relationships. The right to protection from restrictions on grounds of thought, conscience and religion such as restrictive interpretation of religious texts, beliefs, philosophies and customs that curtail freedom of thought on sexual and reproductive issues is non-existent in this milieu.

This milieu prescribes femininity and sets the boundaries within which women can express and enjoy their sexuality and reproduce, thereby determining women's sexual and reproductive behaviour. It sets up strictures on women in respect of sexuality and reproduction thereby limiting women in the way they express their sexuality and in their reproductive decision making. Not only is the social, political, legal and economic milieu limiting for women as individuals but it also establishes an asymmetrical model of rights where women are perceived and perceive themselves as inferior persons with fewer rights, authority and power than men.

African feminists have argued that colonialism had significant impact on social systems and social fields, because it enshrined the headship of a man at household level enjoying immense benefits and responsible for little.<sup>267</sup> Consequently, there is no equality between men and women and women are disempowered by the existing model of rights in society. The concept of rights as individual rights is premised on the equality of individuals, a reality that is missing in Zambian society. Women's human rights as understood under international human rights do not form part of this dispensation and this asymmetrical model of rights has become the norm. Summarily, social, cultural, economic, legal and religious factors posit a patriarchal structure of society that objectifies women. It limits their expression and enjoyment of their sexuality and control over their reproductive capacities by supporting an asymmetrical model of rights. In this way constraining women's ability and desire to make autonomous decisions and choices related to their sexuality and reproductive capacities.

Although the principle of inalienability of human rights denotes that the person in whom the rights inhere cannot voluntarily give them up, nor can others take them away from him or her, fulfilment, protection and respect for human rights require the participation of the individual in whom they inhere. The findings in this study show that women are in effect not participating in the assertion of their rights thereby permitting the violations of these rights. Women appear to embrace the familial ideology which emphasises the

---

<sup>267</sup> Pereira, C., 'Where Angels Fear to Tread?', *Feminist Africa*: Issue 2, 2003; [www.feministafrica.org/fa%202/02-2003/sp-charmaine.html](http://www.feministafrica.org/fa%202/02-2003/sp-charmaine.html)

location of women as duty bearers in respect of others as opposed to the rights ideology locating women as rights holders. Consequently, women are unable to view themselves as individuals, fail, neglect or refuse to perceive their personhood as holding rights and find themselves unable to participate in the enforcement and exercise of their rights. From women's own perspective, they are powerless and are devoid of individual agency.

This powerlessness lies in the fact that men hold most of the power in heterosexual relationships. Using Weber's classifications of power,<sup>268</sup> men have coercive, reward and referent power and dominate women's lives. Coercive power because men and society have the power to induce women to make certain choices by the negative consequences women may face for non-compliance; reward power because more men have control over productive resources as opposed to women who are compelled to make or desist from making certain choices so as to be rewarded. Reproductive success often helps women to access these resources thereby making women's reproductive choices non-autonomous and leading to men holding and wielding reward power over women. Further, in the face of negative socialisation and multiple manipulations, women face pressure to aspire to the social ideals of womanhood and motherhood subjecting them to referent power.

The order of things also contributes to women's absence in the positions of power that determine the culture, politics, economics and legal milieu that impacts on their lives. Therefore, women are not only unable to make autonomous sexual and reproductive choices and decisions in the privacy of their personal lives, but are further unable to contribute to the decision making processes in the public sphere that impact on their lives, including the enjoyment of their sexual and reproductive rights. Women's lives are thus characterised by a sense of powerlessness in relationships and in public life, different forms of subjugation or multiple manipulations.

This position is sustained by the subjection of women to unwanted consequences coercing women to choose to comply with the strictures that conspire against the

---

<sup>268</sup> Weber, M., 1919. Authority and Autonomy in Marriage. In M. Weber, *Frauenfrage und Frauengedanke*. Tübingen, Ger.: J.C.B. Mohr: 67

enjoyment of their rights. Failure to comply with the dictates of society tends to put women's relationships, economic, security and physical safety in jeopardy. These consequences range from social exclusion to violation of women's physical integrity. Further, society has several entities that have a rule generating and rule upholding capacity that are used as mechanisms to ensure women's conformity to the prescriptions, norms and beliefs that restrain them from asserting their rights. These include the church and the family.

The existing model of rights in Zambian society is not always challenged by women partly because of these many negative or unwanted consequences of doing so. The ignorance of rights and lack of acceptance of the rights ideology by women themselves also contributes to the failure or refusal to challenge this model. The absence of a challenge to the rights model is also however due to the fact that sexual and reproductive rights are a concept that brings to the fore the issues of power and inequality between men and women. There are difficulties for women in confronting these challenges because this entails upsetting a system that has existed from time immemorial. Fear, ignorance and lack of support by government systems keeps women shackled to the norms that subjugate them and restrain them from asserting their rights.

Perhaps the critical point about women's sexual and reproductive rights is that they challenge the traditional boundaries of the human rights discourse of sexual and reproductive rights as rights of couples. This challenge brings the entire discourse on rights to new limits that confront the status quo. Both men and women can only reproduce in heterosexual interactions where the rights of each of the two individuals are involved. Women's sexual and reproductive rights are therefore also rights of couples because sex and reproduction are social functions that involve two individuals. The question of whose rights take precedence thus becomes a subject for debate and a power struggle.

The plurality in the legal system works to the disadvantage of women maintaining a social system that recognizes few rights of women. The normative order that women

choose to use to enforce their rights is often one that is likely to provide them with a remedy far less than what the statute, where available, provides. The solution offered by such a normative order is also not in conformity with women's sexual and reproductive rights. Women are likely to choose a normative order that does not challenge the order of things in their lives but makes peace within the existing order of things.

In addition to internalised inhibitions and the social, political, legal and economic environment, women's limitations in exercising and enforcing these rights are further worsened by the state of the public health system. Women's sexual and reproductive rights can only be fully enjoyed in an environment where relevant health services are available, accessible and acceptable. The public health system does not seem to be coping with the needs of women in this area, especially those located in rural areas. The state of the public health system is a major challenge for women seeking sexual and reproductive health services.

The problems in the public health sector limit women's access to benefits of scientific progress, freedom from treatment amounting to torture or cruel or inhuman treatment, confidential health services, health care and health protection. Women are restrained in their ability to exercise or enforce their sexual and reproductive rights fully by limited access to healthcare services. The challenges that women face in respect of their right to self determination also have an impact on women's health seeking behaviour so that even where health services are available, women may shun them.

Human rights and the socio-cultural, legal, political and economic milieu necessitates the State's deliberate intervention in overturning the deeply rooted social, legal, economic and political structures that impact on women's ability to exercise or enforce rights. Unfortunately, the state has ignored its responsibility in this respect, neglecting to put in place the essential requisites for the fulfilment, respect and protection of women's sexual and reproductive rights, namely, an appropriate legislative framework that recognises women's rights as human rights; an enforcement framework; adequate, accessible and acceptable health services; and programs and strategies of empowerment that support

rights holders with power, knowledge, capabilities and resources necessary for the exercise and enforcement of their rights.

Conclusively, there are two factors that impact on women's ability to enforce or exercise their sexual and reproductive rights. These include firstly, the myriad of social, legal, economic and political factors that lead to unwanted consequences, conflicting interests for women and a sustained ignorance of rights and perceived powerlessness on the part of women. Secondly, the limited extent of State compliance to women's human rights, inadequate health care facilities and services, the absence of appropriate legislative framework and enforcement mechanisms for these rights. This combination makes it difficult for women to exercise or enforce these rights fully. In fact, to expect women to exercise or enforce individual rights that they do not even realize inhere in them is to expect the impossible.

The working hypothesis at the start of the study was that these rights are not mere theoretical assertions as the factors restraining women from asserting them are not so enormous and so beyond women's control; that given an enabling environment, information and life skills women can exercise and enjoy these rights without facing any unwanted consequences. The findings show that the problems surrounding the full exercise or enforcement of women's sexual and reproductive rights are complex and push the frontiers of the human rights discourse to new levels. The enabling environment for the full exercise and enforcement of these rights requires more than the provision of information on or knowledge of these rights. To achieve this, a socio-cultural revolution needs to take place that will change the tide towards acceptance of women's rights and overthrow the existing socio-cultural and legal structures that maintain the status quo.

## **8.2. Recommendations**

The real challenge therefore is to develop a consciousness of rights in the general mass of ordinary grassroots women, remove the existing conflict and tensions and overthrow the ideological resistance to women's rights. The state would therefore, be required to lead

the process into the deconstruction of the concepts that are at the root or are fundamental to the perceptions, understanding, interpretation and construction of women's rights. This would entail the engagement of both men and women into a deliberate exercise where citizens begin to start creating positive cultural influences.

This effort would also include the deliberate and systematic dismantling of the asymmetrical model of rights which puts the rights of men and women in a hierarchical order. Women are the vectors of culture and practices. As such they may be a powerful entity in its reconstruction. Women can lead the shift in the paradigms of negative cultural beliefs and values and as well as the development of positive and empowering ones. This kind of revolution need not wait for a catastrophe in society but can be started by a deliberate process. The outbreak of HIV/AIDS is a great opportunity for this Cultural Revolution and the State needs to take advantage of it to push the frontiers on women's sexual and reproductive rights.

The process to deconstruct concepts that are at the root or are fundamental to the perceptions, understanding, interpretation and construction of women's rights should not be done in isolation. It is recommended that the state accompanies these with measures that equip women as rights holders with power, knowledge, capabilities and resources to challenge the status quo and that give them individual agency to exercise and enforce their rights. The government machinery should lead this process which civil society organisations and other private actors are likely to support.

The privacy of domestic life makes women's concerns invisible in the domestic sphere and entrenches women's inequality. Equality must therefore be moved from the peripheries of human rights discourse in the country and the private and family spheres and be made more central and mainstream. The state is thus required to take action to protect and impose sanctions when women's sexual and reproductive rights are violated or threatened. This includes putting appropriate legislation in place and taking positive actions against third party actors.

It is recommended that the State fully assumes its responsibility to promote, protect and fulfil women's rights through a deliberate policy that will lead to deconstruction of negative attitudes and beliefs on women's rights; usher into being an acceptance of the rights ideology; and provide a legislative framework that recognises and promotes the equality of men and women. The Bill of Rights must recognise women's sexual and reproductive rights as individually held and legislation must provide for enforcement mechanisms. The state must domesticate international law for the benefit of women at domestic level.

The African Charter on Human and Peoples' Rights shifts away from the western concept of individual rights and highlights the tension between individual rights and social duties. The Charter focuses on peoples rights and emphasises the duties of individuals towards their families, the community the state and the international community. This is reflected in the society by the emphasis on women's duties as opposed to their rights.

Few of the provisions of the Charter focus on women. This explains the necessity for the development of the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa. The Protocol moves the Charter to another level, one where the sexual and reproductive rights of women are perceived as individual rights. It is recommended that the government take a similarly bold step and recognises women's sexual and reproductive rights as individual rights provided for in the law.

As the full exercise and enforcement of women's sexual and reproductive rights is also dependent on the access of women to sexual and reproductive health services, it is imperative that these be provided in the country. It is therefore recommended that the state puts in place a program to progressively increase and improve women's sexual and reproductive health services and accompanying information and education on sexual and reproductive health.

These institutions and services must be located and provided in a manner that encourages service utilization by citizens. Therefore clinics must provide services that encourage

utilization by women, which in turn makes it possible for them to exercise their right to health and specifically sexual and reproductive health. Services must also be provided in a manner that ensures non-discrimination of marginalized groups of women, such as women living with HIV/AIDS and women with disabilities.

## BIBLIOGRAPHY

1. Armstrong, A., (ed.) Perspectives on Research Methodology, WLSA Working Paper no. 2.
2. Askin K.D. and D.M. Koenig, (eds.), 1998. Women and International Human Rights Law, volume 3.
3. Beatie K.,T. A.,J. P. Christou Raymond and K. Starmer QC, 2005. Human Rights Manual and Source Book for Africa. British Institute for International and Comparative Law, London.
4. Bentzon, A.W., A. Hellum, J. Stewart, W. Ncube and T. Agersnap, 1998. Pursuing Grounded Theory in Law: South-North Experiences in Developing Women's Law, North-South Legal Perspectives, Series No. 1.
5. Berer, M., 2000. "Reproductive Rights, Advocacy and Changing Laws". Reproductive Health Matters, volume 18 number 16.
6. Bbuku-Chuulu, M., E. Muyovwe, E. Mbozi, P.M. Musanya, W. Mwenda, S. Kasonde-Ngandu, 1997. Inheritance in Zambia.
7. Bbuku-Chuulu, M., P.M. Chileshe, H. Ntalasha, A. W. Chanda, 1999. Justice in Zambia: Myth or Reality. Women and Law in Southern Africa Research and Educational Trust-Zambia.
8. Byrnes, A., "Women, Feminism and International Human Rights Law-Methodological Myopia, Fundamental Flaws or Meaningful Marginalisation? Some Current Issues". 12 Australian Year Book of International law.
9. Castle, M., Likwa, R., and Whittaker, M., "Observations on Abortion in Zambia, "Studies in Family Planning, 21(4): 231-235. 1990.
10. Convention of Civil and Political Rights /C/85/D/1153/2003.  
<http://www.reproductiverights.org>,
11. Central Statistics Office,/Central Board of Health/ORC Macro, 2003. Zambia Demographic and Health Survey, 2001-2002: Lusaka.
12. Centre for Reproductive Law and Policy, 2000. Reproductive Rights are Human Rights. New York.

13. Centre for Reproductive Law and Policy, 1997. *Women of the World: Laws and Policies Affecting their Reproductive Lives in Anglophone Africa*.
14. Centre for Reproductive Rights/International Planned Parenthood Federation, 1996. *Charter on Reproductive Rights. Briefing Papers*. New York.
15. Centre for the Study of Human Rights, 1994. *Twenty-Five Human Rights Documents*. 2<sup>nd</sup> ed. New York: Columbia University.
16. Centre on Housing Rights and Evictions, *Bringing Equality Home: 2004. Promoting and Protecting the Inheritance Rights of Women: A Survey of Law and Practice in Sub-Saharan Africa*.
17. Choike, P., "Sexual and Reproductive Rights in the Political Arena", [www.choike.org/nuevo\\_eng/informes/1393.html](http://www.choike.org/nuevo_eng/informes/1393.html)
18. Committee on Elimination of Discrimination Against Women 27<sup>th</sup> Session, *Report of the Government of the Republic of Zambia Country Report*, June, 2002.
19. Cohen, J.L., *About Women and Rights*, 1999. In: Cohen, J.L., and Cynthia F. Epstein,, (ed.), *Women and Rights*.
20. Cook, R. J. "International Protection of Women's Reproductive Rights". 24 *New York University Journals of International Law and Politics*.
21. Cook R.J., (ed.), 1994. *Human Rights of Women: National and International Perspectives*. Pennsylvania Studies in Human Rights.
22. Cook, R.J., B.M. Bernard, and M.F. Fathalla, 2003. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford University Press, New York: Faculty of the University of Toronto.
23. Dahl, .S.T., 1987, *Women's Law: An Introduction to Feminist Jurisprudence*. Oslo: Norwegian University Press.
24. Dahl, S.T., 1988. 'Towards an Interpretative Theory of law-The Argument of Women's Law'. *Studies in Women's Law*, 27 Institute of Public and International Law Publication, series no 7/1988.
25. DenguZvogba, K., B.R. Donzwa, E.C. Gwaunza, J.L. Kazembe, W. Ncube, J.E. Stewart, 1994. *Inheritance in Zimbabwe*. Harare: Women and Law in Southern Africa Research and Educational Trust-Zimbabwe.

26. Filshie, G.M., 1999. "Sterilisation: Risk Management". In: *The Obstetrician and Gynaecologist*, vol 1.
27. *Feminist Africa: Issue 2 of 2003*
28. Forum for African Women Educationalists in Zambia (FAWEZA), 2004. *An Analysis of Traditional and Statutory Laws on Female Reproductive Rights*. Lusaka.
29. Fried, S. T. and I. Landsberg-Lewis, 1996. *Sexual Rights: From Concept to Strategy*, in: Askin K.D. and D.M. Koenig, (eds.), *Women and International Human Rights Law*, volume 3.
30. Ghai, Y., and Cottrell J, (eds.) *Economic, Social and Cultural rights in Practice, InterRights*
31. Ghai, Y., and Cottrell J, (eds.) 2004. *The Role of the Courts*.
32. Heise, L., *Sexual Coercion*.
33. International Conference on Population and Development, *Program of Action*. [www.reproductiverights.org](http://www.reproductiverights.org).
34. Likwa, R. and M.Whittaker, , 1994. "The Characteristics of Women Presenting for Abortion and Complication of Illegal Abortions at the University Teaching Hospital, Lusaka, Zambia. An Exploratiye Study". Presented at the Conference on Unsafe Abortion and Post Abortion Family Planning in Africa. Mauritius.
35. McKinnon, 1982. "Feminism, Marxism, Method and the State: An agenda for theory". *Journal of Women in Culture and Society*, Volume 7 no 3.
36. Ministry of Health, 2004. *Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines*
37. Munachonga, M. L., 1989. *Socio-Economic and Cultural Determinants of Fertility in Zambia*.
38. Munachonga, M. L., 1989. "Socio-Economic and Cultural Determinants of Fertility in Zambia". Report of the National Commission for Development Planning.
39. Mvududu, S. and P. McFadden, 2001. *Re-conceptualizing the Family in a Changing Southern African Environment*. Harare: Women and Law in Southern Africa Research and Educational Trust.

40. Mwananshiku, P., 2002. Understanding God's Blueprint for Long Life and Sexual Fulfilment. Lusaka: Aquila Printers.
41. Non-Government Coordinating Council (NGOCC), 2007. Gender Analysis of the 2006 National Budget. Lusaka.
42. Nsemukila, B., 1998. Situational Analysis of Maternal Mortality in Zambia. Lusaka: Ministry of Health.
43. Obondo, A.E., 2003. Sexual and Reproductive Rights, [www.whrnet.org/doc/issue-sexual rights.html](http://www.whrnet.org/doc/issue-sexual%20rights.html)
44. Ogunidipe, L., 2001. 139 Moving the Mountains.
45. PANOS, Private Decision, Public Debate: Women, Reproduction and Population, 1994.
46. Romany C, 1994. "State Responsibility Goes Private: A Feminist Critique of the Public/Private Distinction in International Human Rights Law". In Cook R, Human Rights of Women: National and International Perspectives.
47. Schlafly, P., 1982. Not by Law Alone, Stanford.
48. Stewart, J., (ed.), 1997. Paving a Way: A Review and Research Primer of WLSA Research Methodologies, Harare: Women and Law in Southern Africa Research and Educational Trust.
49. United Nations Special Rapporteur on Violence Against Women, 1997. Violence Against Women-Its Causes and Consequences, UN doc E/CN4/1997/47, paragraphs 8 and 9.
50. United Nations Department of Public Information, 1994. Harmful Traditional Practices Affecting the Health of Women and Children. Fact Sheet 23.
51. United Nations Department of Public Information, 1994. Universal Instruments. U.N. Sales No.E.94.1.29
52. United Nations Department of Public Information, 1995. A Compilation of International Instruments, volumes 1, Parts 1 and 2. Geneva: United Nations Publications.
53. United Nations Department of Public Information, 1995. The United Nations and the Advancement of Women, 1945-1995. U.N.Doc.DPI.1679, U.N. Sales No.E.95.1.29.

54. United Nations Department of Public Information, 1996. Platform for Action and Beijing Declaration. New York.
55. United Nations, 1984. Report of the International Conference on Population. Doc.E/CONF.76.19.
56. United Nations, 1997. The World Conferences: Developing Priorities for the 21<sup>st</sup> Century. United Nations Briefing Papers, Sales No. E.97.1.5. New York: United Nations Publications.
57. Weber M., *Frauenfrage und Frauengedanke*. Tübingen, Ger.: J.C.B. Mohr
58. White S.V., D. Kaunda-Kamanga, T. Kachika, A.L. Chiweza, F. Gomile-Chidyaonga, 2002. *Dispossessing the Widow: Gender Based Violence in Malawi*, Blantyre: Women and Law in Southern Africa Research and Educational Trust.
59. Women and Law in Southern Africa Research and Educational Trust, 2002, *Lobola: Its Implications for Women's Sexual and Reproductive Rights*. Harare.
60. Women and Law in Southern Africa Research and Educational Trust- Mozambique *Asymmetrical model of rights: Power and Violence*.
61. Women and Law in Southern Africa Research and Educational Trust- Mozambique, 2001. *Power and Violence: Homicide and Femicide in Mozambique*
62. Women and Law in Southern Africa Research and Educational Trust-Swaziland, , 1998. *Family in Transition: The Experience of Swaziland*. Manzini.
63. Women and Law in Southern Africa Research and Educational Trust-Zambia, 2006. *Report of the Girls Forums in Zambia*. Lusaka.
64. World Health Organisation, 1999. *Training Manual: Gender and Rights in Reproductive Health*. New York. .

**LIST OF CASES REFERRED TO**

*Chibwe v. Chibwe S.C.Z., Appeal No. 38 of 2000*

*KL v. State of Peru, CCPR/C/85/D/1153/2003*

*Minister of Health and others v. Treatment Action Campaign and others, CCT 8/02.*

*Mwiya v. Mwiya (1977) Z.R. 115*

*Rosemary Bwalya v. ZCCM and two others, S.C.Z. Appeal No. 164 of 2003*

**LIST OF STATUTES**

The Constitution of Zambia, Chapter 1 of the Laws

The Marriage Act, Chapter 50 of the Laws of Zambia

The Nurses and Midwives Act, Chapter 300 of the Laws of Zambia

The Public Health Act, Chapter 295 of the Laws of Zambia

The Termination of Pregnancy Act, Chapter 304 of the Laws of Zambia

The Penal Code, Chapter 87 of the Laws of Zambia

The Criminal Procedure Code, Chapter 88 of the Laws of Zambia

**APPENDIX****Summary of Data Collection Instruments****a) Guide for Key Informants Interviews-Health Workers and Local Court Magistrates**

1. Personal data of the informant-position, qualifications, age
2. Number of staff at clinic or hospital
3. Availability or provision of family planning or contraceptive services at clinic or hospital
4. Availability of Infertility Treatment and Cancer Cytological Testing Services
5. Availability of necessary infrastructure for service provision
6. What contraceptives or kind service provided
7. Availability of Counseling/abortion services
8. Basis of provision of these services/cost if any
9. Most preferred method by clients
10. Provision of adolescent reproductive services
11. Provision of HIV prophylaxis in mother to child
12. Availability of information for staff and clients/what kind
13. Limitations in service delivery
14. Nearest referral center

**b) Guide for Focus Group Discussions (men and women generally).**

1. Personal data -names, sex, age, marital status
2. Understanding of sexual and reproductive rights
3. Traditional interpretations on reproductive roles
4. What are rights and duties of partners in marriage or intimate relationships
5. Who makes reproductive decisions in a couple
6. Is childlessness an option for women
7. Do women talk about sex and reproduction/do they talk about these things with men
8. Do women suffer violence in relationships

9. What are the causes of conflict in relationships
10. Are there any practices related to sexuality and reproduction
11. How do men and women learn about sex and reproduction
12. Do women talk about sex and reproduction/do they talk about these things with men
13. Are there any marriage rites
14. Puberty and premarital rites/ Rites of passage
15. Knowledge of sexual and reproductive health services

**c) Guide for in-depth individual interviews**

1. Personal data -names, sex, age, marital status
2. Understanding of sexual and reproductive rights
3. Rights and duties of partners in marriage or intimate relationships
4. Decisions on number of children
5. Decision on choice of contraception

**d) Guide for Key Informants Interviews-** traditional counselors and traditional birth attendants

1. Personal data of the informant
2. Training if any
3. Nature of services rendered
4. Puberty and premarital rites/ Rites of passage
5. Knowledge of rights
6. Requisites used in service provision
7. Availability of requisites
8. Any values, beliefs, myths and practices

**Guide for Perusal of Court records**

1. Court level
2. Jurisdiction limits  
Fees for services
3. Knowledge of rights
4. Training
5. Distances of courts from people
6. Challenges
7. Nature of cases on women's sexual and reproductive rights