Zimbabwe, formerly called Rhodesia, is a land-locked country in southern Africa (see Figures 1 and 2). The country lies in the tropics but has a pleasant climate because of the high altitude associated with most of the country being a high plateau. See Figure 3 for a summary of various facts about Zimbabwe. Definitions of key terms can be found in Figure 4.

MULTIPLE COMPLEX FACTORS THAT INFLUENCE WOMEN’S HEALTH

Mwatambudzeni’s story is not an isolated incident. Her cause of death goes down in history as severe internal hemorrhage secondary to a ruptured uterus. She is not alone. According to the World Health Organization (WHO) (2006), Zimbabwean women are among the 10 countries with the least average life expectancy rates among women at 32.9 years. In Zimbabwe, maternal deaths are often attributed to the HIV/AIDS epidemic, but there is more to the problem than meets the eye. These health data do not tell the full story about the health and quality of life of a Zimbabwean woman from a human development perspective. The complete list of the health conditions that compromised Mwatambudzeni’s health are not included as causes of her death. For the purposes of health data collection, her cause of death is coded based only on the International Classification of Diseases (ICDs). Co-morbidities are seldom documented, and poverty is one of the major contributors to poor health among Zimbabwean women (Kanchense, 2005).

NATURE AND EXTENT OF POVERTY AMONG ZIMBABWEAN WOMEN

Rural Zimbabwean women (and their children) are at higher risk for poor health and quality of life as compared to urban women (Kanji, 1995). The predisposing factors include poor access to education and health care, and lack of self-efficacy in male-dominated and often abusive family relationships (Kerber, 1997). Self-efficacy describes an individual’s perception and conviction of his or her own ability to succeed in reaching a specific goal, such as self-care or health care utilization. The dynamics of lack of education and essential skills for meaningful employment (hence poor individual capital), abuse by male family members, and life in poverty force many single mothers into prostitution, a trade with deadly health consequences. Prostitution is virtually a prescription for contracting sexually transmitted infections in Zimbabwe (Kanchense, 2005). These infections include bacterial, viral, and other infections, each of which requires medical care (Watts, Ndlovu, Njovana, & Keogh, 1997). Yet, because they are so poor, health care ceases to
be a priority when they have children to feed.

In Zimbabwe, the situation is and severe that prenatal health care utilization trends bear testimony to the fact. During the mid-1980s, the Ministry of Health displayed a strong interest in the health of the nation. Health services expanded, and coverage of the population increased during that period. Well-established health units and/or mobile Primary Health Care teams provided health care to populations living in remote areas, in line with the principles of Primary Health Care and Safe Motherhood Initiatives. Additional programs included the Program for Control of Tuberculosis, the Zimbabwe Extended Program for Immunization, and the Program for Control of Diarrheal Diseases. As the coverage of prenatal care increased, there was a notable reduction in maternal mortality rates from about 145 per 100,000 live births in 1985 to about 73 per 100,000 live births in 1987. Prenatal coverage was highest during 1987/88, the first year of implementation for the Safe Motherhood Initiatives in Zimbabwe. During 1987-1988, 300 women per 100,000 pregnancies utilized prenatal care. In 1986, that number had been less than 100 (Zimbabwe Ministry of Health and Child Welfare, 1999).

However, rural women seldom access or utilize prenatal health care services. One reason is that many women in Zimbabwe are not self-reliant in the sense that they must depend on male family members to determine whether or when health services should be utilized (Kanchense, 2005). As a result of poor access and failure to utilize prenatal health care services, maternal mortality prevails. Of those affected, WHO asserts that 9 out of 10 deaths are preventable (The Inter-Agency Group for Safe Motherhood, 1999).

A combination of poor data collection systems and cultural norms that prevent women from reporting genitourinary health complications, especially those commonly associated with poor maternal outcomes, makes it difficult to account for many maternal morbidity and mortality rates (Kanchense, 2005). For example, a woman who develops a vesico-vaginal fistula during childbirth is at risk for developing repeated genitourinary infections. Repeated genitourinary infections increase the woman’s risk of developing renal failure. By the time she dies of renal failure, the root cause of the kidney failure is long forgotten, and she is reported as having died of chronic renal failure. A woman who develops severe malnutrition is at risk for developing unresolved genitourinary infections, among other problems. Anemia may also progress into heart failure. When she dies, she is reported as having died of heart failure.

The Zimbabwean government continues to profess its
Full name: Republic of Zimbabwe.
Land area/geography: 390,580 sq km; 150,804 sq miles (landlocked).
Population: 12.9 million (UN, 2005) including over 3 million living in the diaspora.
Capital: Harare.
Area: 390,759 sq km (150,873 sq miles).
Major language: English (official), Shona, Sindebele. English is the official Language. Shona (with 53 dialects, according to the Shona Companion, Ndebele, and Venda are the major native languages.
Major religions: Christianity, indigenous beliefs (for example, a blend of Christianity or Moslem and indigenous religious practices).
Major health problems: “Tuberculosis poses a huge threat – 60% of all new cases of tuberculosis are in HIV-positive patients, and tuberculosis is the leading cause of death among HIV-positive people.”
Average life expectancy: 39 years.
Monetary unit: 1 Zimbabwe dollar = 100 cents.
Economy/main exports: Tobacco, cotton, agricultural products, gold, minerals.
GNI per capita (average yearly income per person): US $340.
Percentage of urban vs. rural population: 75% rural and 25% urban.
Basic way of life: Peasant farming for the rural majority and informal trading for both employed and unemployed urbanites. The informal trading is generally referred to as “Ukopo-kopo,” or informal trading practices laced with dishonest practices for many. Ukopo-kopo means by hook and crook also known as fair or foul.
Form of government: Democracy.


Co-morbidity is the coexistence of a disease or diseases in a study participant in addition to the index condition that is the subject of study.

Gynecology is a medical specialty that focuses primarily on disorders of the female reproductive system excluding matters relating to pregnancy. Gynecology often overlaps with obstetrics (Royal College of Obstetricians and Gynaecologists, 2007). See definition of Obstetrics.

Health Policy refers to a formal statement or procedure within institutions (notably government) that defines priorities and the parameters for action (The New Zealand Health Strategy, 2000).

Human Development is a measure by an index. The United Nations (UN) Human Development Index (HDI) measures poverty, literacy, education, life expectancy, and other factors. It is a standard means of measuring well-being, especially child welfare. Factors, such as individual capital, social capital, life expectancy at birth, and quality of life, all play into the Human Development Index.

Morbidity refers to a diseased condition or state. It describes the incidence or prevalence of a disease or of all diseases in a population.

Mortality refers to the “number of deaths or expected deaths in a population” (Johns Hopkins Bloomberg School of Public Health, 2007).

Obstetrics is a medical specialty that is involved “principally with the management of pregnancy and childbirth” (Royal College of Obstetricians and Gynaecologists, 2007).

Poverty is often used to mean depravity or lack. It can only be described and explained, but it is seldom measured with accuracy. Some measures include social exclusion, while others focus on income.

Urology is a medical specialty that deals with disturbances of the urinary (male and female) and reproductive (male) organs.
Given her individual predicament, there was no avenue through which Mwatambudzeni would even consider participating in and contributing to ensuring environmental sustainability. Considering any meaningful participation in global partnerships for development was not her priority. Mwatambudzeni needed the basics for survival; participation in global partnerships is a goal of the healthy and educated. For Mwatambudzeni, her contribution was as a statistic of maternal death.

In addition to extreme poverty and its immediate consequences on Mwatambudzeni’s health and quality of life, the

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**Figure 5. The United Nations Millennium Development Goals**

The Millennium Development Goals (MDGs) are eight goals proposed by the United Nations that respond to the world’s main development challenges. The anticipated year for meeting these goals is 2015. These goals will be measured by 18 targets with a total of 48 indicators. In 2005, the first 5-year summary of these goals was complied by the UN Secretary General and is available online on the UN Web site (http://www.un.org/millenniumgoals).

- **Goal 1:** Eradicate extreme poverty and hunger.
- **Goal 2:** Achieve universal primary education.
- **Goal 3:** Promote gender equality and empower women.
- **Goal 4:** Reduce child mortality.
- **Goal 5:** Improve maternal health.
- **Goal 6:** Combat HIV/AIDS, malaria and other diseases.
- **Goal 7:** Ensure environmental sustainability.
- **Goal 8:** Develop a Global Partnership for Development.

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**Figure 6. Primary Health Care Initiatives**

**Definition**

Primary health care means essential health care based on practical, scientifically sound, culturally appropriate, and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to and a central function of the country’s health system, and is the first level of contact with the health system (WHO, 1978).

**Objectives**

The overall objective is to improve equity and access to quality health services in the context of Primary Health Care for better health outcomes. Specific objectives are to:

- Strengthen community participation in health service delivery.
- Improve resource availability and allocation at operational level.
- Strengthen the managerial capacity of the district and sub-district health teams.
- Strengthen capacity for generation and use of information for decision-making.
- Improve health service quality and coverage.
- Strengthen coordination and partnerships among all stakeholders, especially public-private partnerships.

**Guiding Principles**

Revitalizing health services will be guided by a set of principles aimed at ensuring fair and appropriate health services to all in the context of Primary Health Care. They include:

- **Human rights.** All persons have the right to health, including access to basic quality care and services. Every person should have access (physical, financial, and cultural) to a defined minimum (essential) package of acceptable quality health care and services.
- **Efficiency and effectiveness.** All health interventions should be efficient and effective. The best possible use of resources should achieve the desired results of the given interventions.
- **Responsiveness.** Services should be tailored to the expectations of the clients, including social and human rights expectations.
- **Participation.** Primary Health Care depends very much on community participation and people’s involvement and ownership of health programs.
- **Intersectoral collaboration and partnership development.** Given the multi-sectoral nature of determinants of health and the increasing number of stakeholders in health, it is critical to strengthen collaboration between health and other sectors, and build partnerships with relevant stakeholders.

**Priority Interventions**

Community participation will be enhanced through:

- Establishing and strengthening community and health service interaction to enhance needs-based and demand-driven provision of health services.
- Empowering communities and strengthening community management structures, consumer activities and linkages to health service delivery systems.
- Providing guidelines for strengthening community participation.
- Reorienting the health service delivery system, including health staff, to reach out and support communities.

Availability of human, financial, and material resources will be improved through:

- Increasing availability and skills of human resources for health for delivery of quality priority interventions.

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*Source: WHO, 2006.*
health system proved incapable of delivering effective health care. Like Mwatambudzeni, many rural and some urban women do not access or utilize prenatal health care services (Zimbabwe Ministry of Health and Child Welfare, 1999). Many Zimbabwean women have resorted to using the services of traditional healers and traditional midwives. Quite often, the traditional midwife will insert her fingers and then a clenched fist to evaluate the birth canal. This is not a sterile procedure, and it may not even be a clean procedure. The traditional midwife does not assess the pelvis, but instead, assesses the elasticity of the vaginal wall, which is an inadequate assessment in itself. During these prenatal assessments, the pregnant woman risks developing cuts and infections from ungloved fingers, but the Zimbabwean culture requires that she submit to these assessments.

Should genitourinary complications, such as vesico-vaginal fistula, recto-vaginal fistula, rectocele, or cystoceles develop as a result of labor and delivery, the woman will seldom seek health care for a number of reasons.

- She is blamed for not complying with the passage-widening strategies as instructed by the traditional Zimbabwean midwife.
- It is culturally unacceptable for a woman to talk about genitourinary health problems. Those who do so often choose to discuss these issues with private doctors (if they can afford them).
- Many women do not feel comfortable discussing genitourinary health, even with nurses from the family planning services.
- Access to health care requires individual capital, which the majority of women simply do not have. They do not have money because they are unemployed. They are unemployed because they lack the necessary skills.

Those who are employed with little or no skills are employed based on the strength of their social capital (for example, “the institutions, relationships, and norms that shape the quality and quantity of a society’s social interactions” (World Bank Group Online, 2007). Increasing evidence shows that social cohesion is critical for societies to prosper economically and for development to be sustainable (The World Bank Group, 2007). Those who lack skills commonly have little or no education. They lack education because the education of females ceases to be a priority when family income is limited.

As seen in Mwatambudzeni’s story, this entire scenario creates a ripple effect readily observed in the plight of Zimbabwe’s women. Their situation grows worse every day as the country grapples with the World Bank imposed Economic Structural Adjustment Programs (ESAP) and a collapsed economy, characterized by runaway inflation due to repeated droughts and poorly planned land reform programs (Kanchense, 2005).

**HARMFUL CULTURAL PRACTICES**

Besides the health risks associated with utilization of the traditional healers and midwives, a number of other cultural factors contribute to poor genitourinary health among Zimbabwean women (Kanchense, 2005). These practices include *chiramu, kuroodza* (debt-bondage) *kugara nhaka* (wife inheritance), and *forced elongation of labia minora*.

*Chiramu* consists of a collection of privileges typically given to uncles and brothers-in-law. These allow them to fondle and even engage in sexual activity with younger girls in the family. Abortion is illegal in Zimbabwe except in cases of “proven” rape, incest, and danger to the mother. Social policy aggravates this; there is a lack of synchrony between the Zimbabwean social policy and its administration. Although Zimbabwe has a healthy-looking constitution committed to human rights and women’s advancement, women seldom utilize these policies for fear of further victimization by both her male family members and the legal system. For example, a pregnancy resulting from *chiramu* is seldom accepted as rape or incest, even though it is often both
(Kanchense, 2005). A woman who reports a rape through the **chiramu** practice is typically blamed for allowing the man to rape her. She is accused of being loose, inviting the rape via solicitous behavior, and being incapable of setting boundaries and maintaining them.

**Kuroodza** is a custom wherein a family in need typically receives help from another family, on the condition that the family receiving assistance commits to giving a girl child, or bearing a girl child, and giving it to the donor family. In this practice, a girl up to about age 19 years is provided in a form of debt bondage. The family in need of financial or material support exchanges a girl child for needed resources at the time of the arrangement (Kanchense, 2005).

**Kugara nhaka** is the practice of wife inheritance. It takes two principal forms: a woman whose husband has died may be given to a surviving brother-in-law to marry, or a man whose wife has died is given a young girl from his wife’s family to marry. The practice of kugara nhaka purports to be a way of “protecting” the widow, yet it violates her fundamental rights to self-determination, and can pose major physical and mental health threats (Kanchense, 2005). In the second instance, the girl could either be a sister of the wife or the wife’s niece. This often happens with a son-in-law in good standing, and more often one who is rich, so that the wife’s biological family continues to benefit from the wealth.

**Forced elongation of labia minora** is a cultural expectation among Zimbabwean females. Typical Zimbabwean females are required to lengthen their labia minora in preparation for sex in marriage (Gelfand, 1967, 1973; Williams, 1969). For the young and so-called modern females, older women force this practice on them. This forced elongation of labia minora is seldom documented as a form of female genital mutilation, probably because no instrument is used, save for one’s fingers. Although no instrument is used, long labia minora are potential breeding grounds for microorganisms for a number of reasons. The labia fold and form warm pockets where bacteria thrive. Also, men touch the labia as part of foreplay during sex. Depending on how clean the man’s hands are, there is a risk of infection being transmitted from the man’s hands to the labia and then migrating to the rest of the genitourinary tract.

Cultural practices such as **chiramu**, **kuroodza**, **kugara nhaka**, and **forced elongation of labia minora** all have negative health consequences, which range from sexually transmitted infections, pelvic inflammatory diseases, poor maternal outcomes, and other health problems. For example, many women living in poverty prefer older men because they provide money; yet, many of these older men are infected with HIV (Kanchense, 2005).

**Chiramu**, **kuroodza**, and **kugara nhaka** can prevent girls and women from progressing socially, occupationally, academically, and physically through the various aspects of their lives. **Chiramu** and related practices can have potentially obstructive social effects and limit opportunities for girls and women. These effects ripple through the population of Zimbabwean women and result in ill-health from genitourinary infections, loss of educational opportunities through unwanted pregnancies, and the social stigma that accompanies pregnancy out of wedlock. Moreover, a girl who becomes pregnant under these conditions has many challenges ahead of her. If she becomes pregnant while in school, she risks losing opportunities for education. Without education, she seldom uses her legal and human rights, including health services, because she does not understand her rights or how to claim them. The very tradition that allows the men to play the **chiramu** sexual games will condemn the girl for losing her virginity, for getting pregnant outside wedlock, and even for being too close to her sister’s husband (Kanchense, 2005). They risk contracting disease-causing pathogens that can have long-term and detrimental effects on their lives, and cause girls and women to lead fearful lives. They live in fear because often their abuser, such as a brother-in-law or uncle, will always be there as a reminder of the traumatic experience (Kanchense, 2005).

With little or no education, a...
woman’s probability of employment decreases, thereby forcing the woman to market the only item that she has: her vagina. She goes into prostitution, where a new vicious cycle of social circumstances awaits her, jeopardizing her quality of life and health. Alternatively, she may opt to work as a general laborer when opportunities permit, resulting in a situation whereby her income is often below the minimum wage, which is insufficient to support even one individual, let alone a family (Kanchense, 2005).

The social system does not support these victims of the ripple effects of its culture, despite the creation of the Social Dimensions Fund designed by the government to support the needy. The inadequate use and benefit from the fund is complicated by events and practices in a larger circle whose epicenter is in culture. There is a large yet neglected group of girl and women laborers that constitute many of these working poor who live destitute lives. Women who were forced to Porta Farm on the outskirts of the city of Harare ranked their priorities as hunger/shortages of food, health/HIV/AIDS, water and sanitation, and housing. These represent basic needs for human survival, much less than the elements of a flourishing life.

**POLICY ISSUES THAT INFLUENCE UROLOGIC HEALTH**

The Zimbabwean government has committed to multiple international human development protocols in which the common goal is to improve the health and quality of life of the people. Examples of women-specific conventions include commitment to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (see Figure 8) and the Safe Motherhood Initiatives. Zimbabwe has also professed support for the Primary Health Care Initiatives, MDGs, and Universal Primary Education, and has a constitution built on universal human rights.

However, these conventions lack the necessary implementation of administrative policies to enable Zimbabweans to realize the goals therein. The government has agreed to this publicly, but it has taken limited steps within the country to comply with the programs. The international community, including the United Nations, has done little to ensure that Zimbabwe holds to its stated intentions, in an attempt to respect the country’s national sovereignty. The Zimbabwean government ratified the CEDAW, but violence against women remains a social disease among Zimbabweans. The Zimbabwean government has maintained the traditional dominance of females by males. Politically sanctioned rape and other forms of violence have been documented in Zimbabwe since the liberation war of the 1970s (Amnesty International, 2005). Gender issues have been documented as well. The male-dominated Zimbabwean government has consistently used human rights violations to silence the opposition. The same is true of male family members who apply harmful traditional practices on their female family members.

The primary health care initiatives were implemented to ensure health care is available, accessible, and affordable to all Zimbabweans. In reality, only the elite have access to beneficial health care. They utilize international health care services in other countries, such as South Africa, the United Kingdom, and the United States of America. The Zimbabwean health care system collapsed during the early 1990s and has precipitously declined ever since. Rural women and their children are especially vulnerable to this deteriorated health care system because their husbands typically have access to health care services through employer-sponsored mechanisms. Although the use of pre-natal care services rose during the late 1980s, it declined after 1990, in part due to charges for these services instituted under the ESAP (Kanchense, 2005).

Likewise, access to educational resources and academic achievements rose in the late 1980s and declined in the 1990s. This, too, may be related to the withdrawal of international funds under ESAP (Kanchense, 2005). The World Bank recommended ESAP to Zimbabwe as part of globalization of the world economy, and the country entered the program in 1991. However, it has been reported that globalization of the economy has affected the livelihoods of Zimbabweans in a negative way. For example, one Zimbabwean researcher remarked, “While economic globalization has had an influence on the labor market, particularly through economic reforms such as the ESAP, colonial legacies continue to influence education and training in Zimbabwe” (Nherera, 2000).

Again, these influences have a significant effect on the women in the country.

Even in the absence of scientific evidence regarding the increased maternal mortality rates, inferences can be made as the results of the exponential increase in the number of orphans and households headed by children. Despite the link between pregnancy and maternal death, this increased number of orphans creates a negative opportunity for young girls who head their orphaned households. These girls are at risk for contracting sexually transmitted infections, being forced into early marriage, experiencing premature death, and creating another generation of orphans in this economically ravaged country. Moreover, the MDGs have remained national goals but not necessarily national accomplishments.

Human rights violations have played a role in obstructing progress toward the MDGs. Basic
human rights (for example, the right to life, education, and health care), are two opposing, yet very powerful, characteristics laid along a continuum. On one end, human rights violations take away human lives through premature deaths (killing is an act of denying another her or his right to life). Denying access to education kills another through the consequences of ignorance. Lack of access or poor access to health care precipitates poor health and quality of life. A combination of poor access to education and health care is a prescription for premature death. Human rights violations are a major obstacle to achieving MDGs.

Conversely, when human rights prevail, they act as an enabling factor that enhances human and social development. MDGs can be achieved when people enjoy basic human rights. People who know their basic human rights and how to claim them are capable of negotiating the social system in a healthy way. Educated individuals are employable, and employed people have access to health care. People who utilize health care experience better quality of life. People with good quality of life are less likely to die prematurely, except in genuine accidents or as a result of war between nations. For example, universal primary education was accomplished during the 1980s when Zimbabwe received funds from the international community. But thereafter history repeated itself; fewer girl children accessed education because of poverty, or were orphaned by the HIV/AIDS epidemic and the gender inequity described previously.

Today, a majority of Zimbabwean females continue to experience a sharp and progressive decline in their ability to enjoy their basic human rights. The progressive increase in the number of orphans and street children bears testimony to a poverty cycle exacerbated by human rights violations. In fact, according to Elder (2006), one in four Zimbabwean children is an orphan. As discussed earlier, statistics show that girls are the first to drop out of school during social and economic crisis, but UNICEF’s Head of Education in Zimbabwe, Cecilia Baldeh, argues that this is a social and economic mistake. Baldeh explains, “Educated girls can protect themselves from HIV and AIDS, they can contribute to reduce infant and maternal mortality rates, and they can foster economic growth. As the World Bank has noted, educating girls yields a higher rate of return than almost any other investment available in the developing world” (Elder, 2006). However, until the poverty cycle and human rights violations end, meeting the MDGs will remain a far-fetched dream in Zimbabwe.

**Counter-Progressive Government Policies**

Despite its commitment to the international human development protocols, several distinctively counter-progressive policies have exacerbated the situation in Zimbabwe. The government must preside in a multicultural country, where a combination of Roman Dutch law and traditional laws operate simultaneously. In the justice system, rape is a punishable crime. Debt bondage is a crime. Inheritance laws do not approve of wife inheritance. However, traditional laws perceive these practices as a way of sustaining cultural identity. This problem fuels the perpetuation of harmful cultural practices that contribute to gynecologic and urologic health problems among females because traditional law often supersedes the constitution. Table 1 is an illustration of the parallels between the Criminal Law (Codification and Reform) Act [Chapter 9:23] Act 23/2004 that replaced Roman Dutch Law in 2004, and traditional laws in Zimbabwe.

Another counter-progressive policy is the problem of government sanctioned internal migration of the poor, a majority of whom are female. Examples include the aforementioned forced removal of homeless from the streets of Harare to Porta Farm in 1980 (Amnesty International, 2006; International Monetary Fund, 2001) followed by a second forced removal from Porta Farm to Caledonia farm in 2004 (Wines, 2006). The forced eviction of laborers from farms previously owned by white farmers beginning in 2000 is another example (Wines, 2006). A final example is the forced removal of poor people from cities during Operation Murambatsvina in 2004 (Wines, 2006). The poor were removed to make way for the elite to build mansions or establish businesses. The elite have money and can bribe officials to bend laws, but the poor must relocate to undeveloped places where access to health care, education, safe water, sanitation, and other essential basics for survival are scarce. Victims of internal migration cannot fight for their right to live lives that are free of harassment and abuse because they have no money. They have no money because they are unemployed. They are unemployed because they have no education. Their children have no education because the parents are poor. And the cycle of poverty is sustained.

These economic factors merely exacerbate an already vulnerable population. Although the Zimbabwean public health system received recognition from the WHO in 1985, by 1998, the Zimbabwean public health system was reported to be “in shambles” (Ncayiyana, 2005). The Safe Motherhood Initiatives proved effective only in some parts of Zimbabwe during the mid-1980s. Thereafter, commitment to the Safe Motherhood Initiatives vanished, as evidenced by increase of preventable maternal deaths. Although life expectancy at birth improved significantly until 1990, rising from 52.5 years at political
### Table 1.
Illustration of Constitutional Law vs. Traditional Laws that influence Women’s Health and Quality of Lives in Zimbabwe

<table>
<thead>
<tr>
<th>CHAPTER V: Crimes Against The Person</th>
<th>Examples of Harmful Practices in the Name of Sustaining Traditional Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Criminal Law (Codification and Reform) Act [Chapter 9:23] Act 23/2004</td>
<td>Chiramu and wife inheritance breach the sexual crimes listed under Division B. Both fall under crimes committed in the name of culture.</td>
</tr>
<tr>
<td>Division B: Sexual Crimes</td>
<td>Forced elongation of labia minor is a form of indecent assault.</td>
</tr>
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<td>65. Rape</td>
<td>Chiramu, wife inheritance and pledging of female persons contribute to the deliberate infection of another with a sexually transmitted disease, all of which are crimes committed in the name of culture.</td>
</tr>
<tr>
<td>66. Aggravated indecent assault</td>
<td>Chiramu is a form of coercing or inducing persons for the purpose of engaging in sexual conduct, a crime committed in the name of culture.</td>
</tr>
<tr>
<td>67. Indecent assault</td>
<td>Kuroodza – pledging of a female person – is a crime committed in the name of culture.</td>
</tr>
<tr>
<td>68. Unavailable defences to rape, aggravated indecent assault, and indecent assault</td>
<td>Wife inheritance <em>(kugara nhaka)</em> and pledging of a female person <em>(kuroodza)</em> often result in bigamy, a crime committed in the name of culture.</td>
</tr>
<tr>
<td>69. Cases where consent absent or vitiated</td>
<td>Women who attempt to claim their rights to own property or land are regarded as rebels. The president told women who solicited his support in their quest for their right to jointly own land with their husbands by saying, “Mapanduka,” meaning you have become rebellious, you are moving away from culture and tradition (Taylor, 1992).</td>
</tr>
<tr>
<td>70. Sexual intercourse or performing indecent acts with young persons</td>
<td>Women who attempt to claim their rights to own property or land are regarded as rebels. The president told women who solicited his support in their quest for their right to jointly own land with their husbands by saying, “Mapanduka,” meaning you have become rebellious, you are moving away from culture and tradition (Taylor, 1992).</td>
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<tr>
<td>71. Sexual crimes committed against young or mentally incompetent persons outside Zimbabwe</td>
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<td>Division D: Transmitting HIV Deliberately or in the Course of Committing Sexual Crimes</td>
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<td>Division E: Crimes Relating to Prostitution or the Facilitation of Sexual Crimes</td>
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<td>Division E, Part V: Crimes Involving Infringement of Liberty, Dignity, Privacy or Reputation</td>
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<td>94. Pledging of female persons</td>
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<tr>
<td>Division E, Part V: Crimes Involving Infringement of Liberty, Dignity, Privacy or Reputation – Crimes Relating to Prostitution or the Facilitation of Sexual Crimes</td>
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<tr>
<td>PART VII</td>
<td></td>
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<tr>
<td>104. Bigamy</td>
<td></td>
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</tbody>
</table>

Chapter III of the Zimbabwean constitution on which laws are built is “The Declaration of Rights” (Parliament of Zimbabwe, 1979).

Women who attempt to claim their rights to own property or land are regarded as rebels. The president told women who solicited his support in their quest for their right to jointly own land with their husbands by saying, “Mapanduka,” meaning you have become rebellious, you are moving away from culture and tradition (Taylor, 1992).
independence in 1980 to 62 in 1990, this gain was followed by a decline to about 57 years by 1996, and 42 by 2004 (Zimbabwe Ministry of Health and Child Welfare, 1999). In April 2007, average life expectancy at birth in Zimbabwe was one of the lowest in the world at only 39 years of age (Central Intelligence Agency [CIA], 2007).

A woman’s life expectancy is often lower than a man’s, due partly to inadequate health care services and facilities, which result in untreated complications during pregnancy and childbirth. The maternal mortality ratio became 2,000 per 100,000 live births, or 2% (United Nations Development Program, 2004). The situation became so dire that in 2004, the government resorted to using ox-drawn carts to transport pregnant women during obstetric emergencies (BBC News, July 13, 2004). Nurse aides were running “43% of the country’s rural clinics….” (Zimbabwe Sunday Mail, July 4, 2004), and the government resorted to utilizing primary care nurses who received only 18 months of training (Zimbabwe Herald Online, November 1, 2004).

Few, if any, scholars have conducted research in Zimbabwe, particularly in the last decade due to policies and restrictions implemented by Zimbabwe’s President Robert Mugabe. Any writing about Zimbabwe is closely guarded and edited by the government, including journalistic works. Voices that critique the administration are often silenced. The situation in Zimbabwe has so deteriorated that even scholars with the best intentions have not had opportunities to conduct research in the country. Many journalists have resorted to underground reporting and publishing their works online.

Through the media, it became apparent that in early 2005, patients were increasingly utilizing traditional healers for health care. Harare Hospital, a quaternary level facility, was in such a deteriorated state that it was described as “fighting for life” (News24.com [SA], January 29, 2004). There was a critical shortage of oxygen, and the elevators, laboratory, dialysis unit, and toilets were no longer operational. By March 2005, Chitungwiza Hospital used fire trucks to ferry patients, while “some pushcart operators are making brisk business by ferrying patients to hospitals and clinics in many areas” (Southern African Migration Project, 2004). The crippled Primary Health Care and Safe Motherhood programs provided poor quality health care services, fewer women accessed health care, and more women died as a result.

Ironically, Zimbabwe continues to profess commitment and adherence to progressive human development initiatives such that on September 8, 2005, the Herald reported that the government launched the Millennium Development Goals in line with the WHO’s principles of Primary Health Care and the Safe Motherhood Initiatives. This commitment remained so strong that on March 10, 2005, less than 3 weeks before the 2005 parliamentary elections, the government-owned Herald newspaper reported the Minister of Health as having stated that “the Government intends to establish a health system that is efficient, well-managed, and manned by an adequate and professional human resource base….” Again on September 8, 2005, the Herald reported that the government launched the Zimbabwe Millennium Development Goals (MDGs) in line with the United Nations, with poverty eradication, gender equality, and the fight against HIV and AIDS being the main priority areas. President Robert Mugabe emphasized, “Through a unity of purpose and the support of our development partners, our people will enjoy improved living standards as we work to achieve the expectations of the millennium declaration.”

However, such goals for Zimbabwe’s health care system seem like an unlikely reality, when a large number of Zimbabwe’s women do not even have adequate access to sanitary wear, a basic essential for feminine hygiene. One female member, Misihairabwi-Mushonga, of the opposition party, Movement for Democratic Change (MDC), was humiliated for proposing that the government reserve foreign currency for importing sanitary wear for the benefit of females (Wines, 2006). Yet, it is common knowledge that these products are in short supply. When one takes this deficiency into account, the establishment of an “efficient, well-managed” health system seems a grand and extraordinary goal.

The post-colonial public health policy and administrative systems continue to obstruct the pursuit of the MDGs. For example, even though economic resources are scarce, the government has for many years focused on regime preservation rather than governance. The result is that the health system had a “medical staff deficit of 70%” by May 2006 (Staff Reporter, NewZimbabwe.com, November 3, 2006). However, “Mugabe, in power since independence from Britain in 1980, denies responsibility for Zimbabwe’s economic woes, and accuses local and foreign opponents of sabotaging the country’s wealth.”

The lack of set benchmarks for ongoing program and outcome evaluations, poor resource management, and the skewed resource distribution patterns have not only affected women’s health and quality of lives. The whole society has been reduced to a vicious cycle of self-destruction (see Figure 10):

- Poor women’s health leads to morbidity.
- Morbidity leads to a reduction in agricultural productivity in particular.
• Reduced agricultural productivity results in less food.
• Less food means increased malnutrition and infant mortality, as well as increased maternal morbidity and mortality rates.

When considered in a more general societal sense, one might make the connection that poverty and inequality lead some members of the society to be less food secure than their more wealthy counterparts. In turn, many of Zimbabwe’s poor turn to risky survival activities in order to earn money to buy food. Not only are they engaging in risky survival activities, but they are often malnourished due to food insecurity. Thus, many of these people contract HIV/AIDS, and they are either too weak to work and/or they leave their children as orphans, putting the children at greater risk to repeat the cycle (Oxfam International, 2002). Today, there are over 800,000 children in Zimbabwe who are orphans due to HIV/AIDS (Elder, 2006).

PATHOPHYSIOLOGICAL CONSEQUENCES OF POVERTY, CULTURAL PRACTICES, AND HEALTH AND SOCIAL POLICIES

In Zimbabwe, the term poverty is often used to mean depravity or lack. Factors that are included in this definition are a lack of access to education and health care, financial and material resources, and a lack of individual and social capital. Poverty affects human life across the life span, from birth to death. For example, a child born into a poor family has a high probability of death from infant or childhood diseases. Illnesses in mothers often affect children’s health because mothers are the nurturers. In addition, a child born into a poor family has a high probability of death from infant or childhood diseases. Illnesses in mothers often affect children’s health because mothers are the nurturers. In addition, an unhealthy mother will deliver an unhealthy child with poor probability of survival. Diseases include preventable conditions, such as measles and malnutrition. Childhood malnutrition, especially among girls, increases the risk for anemia. Malnutrition and endemic diseases cause undocumented morbidity. Their impact on health is so common that it has been “accepted” as normal. Examples include anemia and hematuria that result from bilharzias (schistosoma haematobium) and malarial infections.

Paleness and lack of energy are symptoms of anemia that are so common they have become a sign of pregnancy for many (Kanchense, 2005). The terms kwashiorkor and AIDS have become everyday language for many. Sexually transmitted diseases are so common that they appear to have become rites of passage for many adolescents and young adults.

As mentioned earlier, anemia is one of the major health conditions that influence maternal outcomes among Zimbabwean women (Zimbabwe Ministry of Health and Child Welfare, 1999). Anemic individuals tend to have lowered immunity, thereby increasing their risk for contracting infections, many of which have genitourinary consequences. A combination of lack of access to prenatal care and cultural beliefs against Caesarean section predisposes women to obstetric complications, such as ruptured uterus, vesico-vaginal fistulae, rectovaginal fistulae, cystocele, rectoceles, urinary and fecal incontinence, maternal morbidity, and preventable maternal deaths. If the girl or woman contracts HIV, then she has been effectively sentenced to death. Maternal morbidity and mortality in Zimbabwe are associated with poverty, lack of education, and lack of access to health care. Because of poverty, many young girls engage in risky behavior by marrying or having sex with older men in order to secure food and shelter. The older men also prefer younger girls, believing they are virgins. In addition, they abuse young girls and women to fulfill their so-called Coolidge effect, a subjective arousal affecting especially older men (O’Donahue & Geer, 2003). These men target young girls to
satisfy their sexual desires at the expense of their own sexual health, as well as the health of the young girls’ and the men’s spouses by increasing the risk of sexually transmitted infections and their implications on health, wellness and quality of life. Although they seldom use the term “Coolidge Effect,” a majority of Zimbabwean women and men justify and condone promiscuity among middle-aged and older men, believing that men must continue to have sex even though middle-aged and post-menopausal women are expected to be celibate. Because they control both the legal and traditional norms and values, men justify this behavior to a point whereby a majority of women perceive this behavior as normal and acceptable. This behavior puts the lives of both the young girl and the wife at risk with consequences that go beyond the man and his sexual partners.

There is a common belief among these older HIV-positive men that sex with virgins will cure them from the infection. If the girl is “lucky” and escapes the HIV virus, she may be infected with other sexually transmitted diseases, such as gonorrhea, syphilis, and genital herpes. If the girl contracts the HIV virus, she is at risk for other infectious microorganisms, such as malaria and tuberculosis (Kanchense, 2005). In fact, WHO (2005) cited that 60% of new tuberculosis cases are HIV-positive, and tuberculosis is the leading cause of death among HIV-positive people in Zimbabwe. Regarding the urgency for alleviating this complex problem, WHO emphatically argues that “HIV and TB form a lethal combination, each speeding the other’s progress” (WHO, 2005).

Chlamydia and gonorrhea are the two top causes of pelvic inflammatory diseases (PID) among Zimbabwean women, and it is the most prevalent gynecological health problem among Zimbabwean women (Zimbabwe Ministry of Health and Child Welfare, 1999). If the girl or woman contracts gonorrhea, she risks developing complications that include scar formation in the genitourinary tract. These scars can lead to stricture formation in the urethra, which in turn leads to voiding problems. Poorly managed complications of urological or gynecologic health problems can predispose a woman to develop cervical cancer, weak pelvic floor muscles, pelvic inflammatory diseases, and urinary incontinence. Urinary incontinence predisposes the affected woman to repeated genitourinary infections, stress, and depression, further comprising her immunity system and thereby creating another vicious cycle.

In addition, the human papilloma virus (HPV) appears to work synergistically with the vaginal herbs that have previously been associated with cervical cancer among Zimbabwean women (Chokunonga et al., 2000). The incidence of cervical cancer has increased notably during the last decade. Epidemiologic studies have shown another association between AIDS and cervical cancer among Zimbabwean women (Chokunonga et al., 1999). Although HPV is preventable with a vaccine (Gardasil®) and barrier methods, this option is out of reach of the ordinary rural Zimbabwean woman, especially when considering the evident lethal combination of poverty and lack of access to essential medications. The poor cannot afford the cost of these medications. In addition, “many health systems in sub-Saharan Africa, as in other poor regions [including Zimbabwe], are over-stretched, under-funded and unable to deliver these complex services” (Lush, 2001, p. 491). As a result, only individuals who are rich or who have powerful connections gain access to life-prolonging treatment and care. Therefore, cervical cancer may soon join tuberculosis and HIV/AIDS as a leading cause of morbidity and mortality among Zimbabwean women.

Scars that form in the genital tract as a result of sexually transmitted diseases can lead to the obstruction of the fallopian tubes, where fertilization then occurs during conception. Obstructed fallopian tubes may lead to failed conception or to an ectopic pregnancy. A ruptured ectopic pregnancy is one of the causes of early maternal death, primarily because of the subsequent blood loss and shock (Kanchense, 2005). Ectopic pregnancy, with possible fatal consequences, is complicated by poor access to medical care. Ectopic pregnancy ranks 9th out of the 12 top causes of pregnancy-related deaths among Zimbabwean women (Zimbabwe Ministry of Health and Child Welfare, 1999). Embolism, herbal poisoning, and meningitis also rank 9th, thus making the conditions that rank 1 to 9 the top 12 causes of maternal death.

Undoubtedly, a number of maternal deaths are not counted among ectopic pregnancy-related deaths because the actual or immediate cause of death is likely to be identified as something else. For example, ruptured ectopic pregnancy, embolism, and meningitis could all be complications of an ectopic pregnancy in some women, but these conditions are instead documented as the “actual” cause of death rather than the ectopic pregnancy itself. This lack of, delayed, and even inadequate medical care often leads to septicaemia or toxic shock. Toxic shock may result from lack of treatment or from the use of feminine hygiene products for routine menstrual care.

In regard to reporting maternal death, this situation arises from the use of the ICD codes in relation to pathophysiology of ectopic pregnancy and its complications. For example, a woman who suffers ectopic pregnancy and dies as a result of septicaemia, or even a brain abscess arising from septicaemia secondary to ruptured ectopic pregnancy, does not count among the deaths from ectopic pregnancy (Kanchense,
A woman who experiences a ruptured ectopic pregnancy may not have transportation to take her to the nearest health center. This delays emergency obstetric care and increases her risk of dying from complications. She may have severe internal bleeding and pain, both of which can lead to shock. If the woman is lucky, she is transported to the nearest district hospital, which is usually more than 20 kilometers (16 miles) away, as was the case with Mwatambudzeni.

However, even the health care provided at district hospitals is often inadequate. Regrettably, the main consumers of rural and district health services are women and children, as many of the men benefit from industrial health care provided by their employers whose main goal is to ensure a healthy workforce for healthy profits (Kanchense, 2005).

**SUMMARY: LINKING POVERTY TO HUMAN DEVELOPMENT AND POOR HEALTH**

The narrative of Mwatambudzeni’s life as a lover, mother, and worker characterizes the typical rural Zimbabwean woman’s life. A constant interplay of malnutrition, workload, energy expenditure on agricultural and domestic chores, and stress typifies her life, health, and quality of life. She did not grow to experience adolescence, and achieve physical and mental maturity. Malnutrition and anemia increased her susceptibility to infections, thereby compromising her reproductive health. Had she lived to adulthood, morbidity would have characterized her life, with little or no attention to her post-menopausal health. Had she lived, a myriad of gynecologic and urologic health problems awaited her.

Urinary tract infections are a common condition that affects pregnant women, and compromised genitourinary health is typical among Zimbabwean women. The prevalence of urethritis, cystitis, pyelitis, pyelonephritis, and peritonitis are interwoven in pelvic inflammatory diseases and their sequelae, which include scar tissue formation, secondary infertility, ectopic pregnancies, and their complications. In Zimbabwe, many cases of PID progress to peritonitis for a variety of reasons such as those experienced by Mwatambudzeni:

- Poor access and poor health care utilization.
- Delayed access to health care services.
- Delayed utilization of health care services.
- Inadequate drug supplies in the country.
- Poor quality of health care.
- No emergency services.
- No reliable telecommunication systems.
- No reliable transportation system.
- Essential drugs beyond the reach of many if and when available.

**DISCUSSION/COMMON THEMES**

The developing world aspires for holistic health and wellness, which are key to being self-suffi-
cien
t, independent, and partici-
pating individuals in society. Achieving the MDGs is a pathway to achieving holistic health and wellness. Holistic health and wellness will contribute to a reduction in the current prevalence of genitourologic health problems among Zimbabwean women. MDGs are potentially improving health and quality of life in several developing countries.

However, the MDGs are organized in such a manner that they can be intimidating, especially in poor countries and in those countries that blindly follow global development initiatives. This was the case when Zimbabwe assumed the Primary Health Care and Safe Motherhood Initiatives, and Land Redistribution program. There was not a plan with benchmarks for measuring and rectifying potential obstacles. The MDGs can not only be intimidating, but they also adopt the top-bottom approach; this phenomenon is a manifestation of government attempts at maintaining power and control. Many sociological researchers believe this approach

<table>
<thead>
<tr>
<th>Millennium Development Goal (MDG)</th>
<th>Mwatambudzeni’s Experience</th>
<th>Proposal to Reorganize MDGs to Support an Affordable, Appropriate, Acceptable, and Achievable Approach to Ameliorating these Issues in Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1: Eradicate extreme poverty and hunger</td>
<td>Mwatambudzeni experienced extreme poverty and hunger.</td>
<td>Goal 2: Achieve universal primary education. This is the first step toward gender equity. The infrastructure is there. President Mugabe is very supportive of education (United States Agency for International Development [USAID], 2007).</td>
</tr>
<tr>
<td>Goal 2: Achieve universal primary education</td>
<td>Mwatambudzeni could not complete primary school.</td>
<td>Goal 3: Promote gender equality and empower women, so both females and males have equal access to education, health care, available resources, equal employment opportunities, etc.</td>
</tr>
<tr>
<td>Goal 4: Reduce child mortality</td>
<td>Mwatambudzeni contracted HIV from Tapfumiswa. Therefore, Tapfumiswa had a high probability of developing AIDS within the next 5 years. His death would leave Tapfumiswa (Jr.) without a parent and add to the fast-growing society of orphans.</td>
<td>Goal 5: Improve maternal health. Women who do not depend on men are self-sufficient. With self-sufficiency comes self-efficacy, resulting in improved maternal health.</td>
</tr>
<tr>
<td>Goal 5: Improve maternal health</td>
<td>Mwatambudzeni experienced poor maternal health.</td>
<td>Goal 6: Combat HIV/AIDS, malaria, and other diseases. Self-efficacious women can set boundaries regarding sexual practices without fear of being denied access to food, shelter, and other basic essentials for survival.</td>
</tr>
<tr>
<td>Goal 7: Ensure environmental sustainability</td>
<td>Mwatambudzeni had no means by which she could contribute to environmental sustainability even at such a micro-level as her daily life.</td>
<td>Goal 7: Ensure environmental sustainability. Healthy communities can afford to think about and take appropriate action to save and sustain their environments.</td>
</tr>
<tr>
<td>Goal 8: Develop a Global Partnership for Development</td>
<td>Mwatambudzeni’s life was riddled with obstacles to her own health and wellness, making it unlikely she could move beyond that to a global stance.</td>
<td>Goal 8: Develop a Global Partnership for Development. Healthy communities become their own advocates on the global arena. Only then can they participate in global partnerships for development.</td>
</tr>
</tbody>
</table>

Table 3. Mwatambudzeni’s Life from the Perspective of the Millennium Development Goals
is not only ineffective because beneficiaries desire a voice in matters pertaining to their welfare. Below is an outline that illustrates Mwatambudzeni’s life in relation to the UN approach to addressing the MDGs per the WHO report on May 13, 2005 (WHO, 2005). The outline that follows puts Mwatambudzeni’s priorities in perspective.

I. Peace and Security and Disarmament
This approach is beyond Mwatambudzeni. Mwatambudzeni needed education, food, shelter, and access to education and health care so she could take care of her own health. Mwatambudzeni never used a weapon, except maybe a stick to kill a snake.

II. Development and Poverty Reduction
Mwatambudzeni needed education to increase her chances on the job market. Only when she was employed would she be in a position to think about ways to eradicate poverty. Mwatambudzeni was not employed. However, she worked more than 18 hours per day, even though she was not labelled a slave.

III. Protecting Common Environment
For Mwatambudzeni, protecting the environment would be the last thing to come to her mind, if she had any knowledge about the environment at all. Mwatambudzeni needed shelter, food, and water, as well as participation in her own health care before she could think of protecting trees, grass, and wild animals – the very things she could access to survive.

IV. Human Rights, Democracy, and Good Governance
Only the educated and financially sound individuals with powerful social capital can dream of human rights issues in Zimbabwe. Mwatambudzeni needed education and health care so that she would not only be healthy but also be able to take good care of her children.

V. Protecting the Vulnerable
Social advocates and human rights activists will first want to know which would effectively protect vulnerable persons to the likes of Mwatambudzeni, when international, national, and family relations resemble being on an uneven playing field where goals are constantly shifted and rules are constantly changed. Zimbabwean women have a first-hand experience of such tactics, as follows:

a. Zimbabwe is vulnerable to the international community. Mwatambudzeni’s father, husband, and brothers are vulnerable both in the international community and the Zimbabwean double-sided social policies.

b. Mwatambudzeni’s mother, aunt, and mother-in-law are all vulnerable to the international community, social policy in Zimbabwe, and male family members. Mwatambudzeni is vulnerable to older females in her life (for example, her biological and marital families).

c. Mwatambudzeni is vulnerable to all of the above; hence, she is not only unable to be her own advocate, but she was also unable to be an advocate to her child.

VI. Meeting the Needs Of Africa
International sympathy toward Africa, without action, is synonymous with a healthy-looking Zimbabwean constitution without the appropriate implementation to achieve social development among females in Zimbabwe.

VII. Strengthening the United Nations
The UN and its appendages, such as the International Monetary Fund, The World Bank, the Food and Agricultural Organization, and the World Health Organization, all provide funding and support to less-developed countries.

a. Failure to comply with the funding guidelines results in punitive action against the beneficiary nation.

b. UN representatives have the power of veto: the power to tell developing nations to comply with guidelines.

c. Like any funding agency, the IMF has encouraged developing countries to conform to IMF requirements or these countries may not be eligible for needed financial support, resulting in a situation whereby only those developing countries that cooperate with the IMF may access IMF funds. The Zimbabwean government has categorically refused to cooperate with the IMF. For resisting this arm-twisting tactic, Zimbabwe was declared as “ineligible for IMF funds” [author’s emphasis] in 2001 (International Monetary Fund, 2001).

Mwatambudzeni’s circumstances could have been ameliorated through the implementation of the MDGs and using a holistic bottom-up approach. Only then could the likes of Mwatambudzeni dream of experiencing holistic health and wellness, an idea implied in the principles of Primary Health Care. Holistic health and wellness refer to a quality of life that is whole, meaning that it is characterized by physical, mental, emotional, and spiritual aspects as interdependent parts of human existence. When the MDGs are used to analyze Mwatambudzeni’s life, it becomes clear that she was destined to die. Table 3 illustrates Mwatambudzeni’s life from the MDGs’ perspective.

CONCLUSIONS AND RECOMMENDATIONS
Despite their government’s stating a commitment to the
Ndaramo Wellness Initiatives

Our Mission
To helping women to recognize their inherent power and use it responsibly.

Vision: Develop and sustain healthy and happy families

Who we are: The Ndaramo Wellness Initiative is a grassroots movement led by women to help alleviate poverty in rural Zimbabwe. We are dedicated to addressing issues that impoverish women. We address the underlying link between education, poverty, and health. We educate women about the effects of poverty on the health and wellbeing of their families and communities, and how support one another in introducing and implementing low-cost and innovative solutions at the local level.

Our Motto
Women – The Foundation for Healthy and Happy Families (Mwana Ndirmai; Musha Mukadzi)

Who We Are
Ndaramo Wellness Initiatives connects Zimbabwean rural women with individuals and organizations interested in Human Development, such as educational, public health, and funding professionals and organizations.

In collaboration with such organizations, Ndaramo facilitates learning and provides material support for women interested in helping themselves through:

- Encouraging rural women to use available resources and improve the health and quality of the lives of their families.
- Assisting rural women to develop and manage small income generation projects.
- Encouraging grassroots organizations to work collaboratively with relevant governmental and non-agencies with similar interests.

What We Do
At Ndaramo Wellness Initiatives we strive for excellence in improving quality of life through Holistic Self-Management Education and Support.

Core Values
Excellence
Quality
Client focused
Respect
Communication

Strategic Principles
Mutual Support
Stewardship
Self Development
Meeting Participant Learning Needs

Clients
Ndaramo Wellness Programs are available to individuals who do not have easy access to education, but are interested in learning how to enhance the health and quality of lives of their families and communities. Most educational services are provided at little or no cost to the participating individual.

Research and Development:
Ndaramo Wellness Initiatives trains its trainers, data collectors, and other program personnel.

Data collected from the Ndaramo Wellness Initiatives is used for program enhancement.

Evidence obtained from research is shared with stakeholders, sponsors, and other interested parties.

Learning and Partnerships
We encourage the development of cooperative and collaborative working relationships with individuals and organizations with an interest in improving the health and quality of lives of especially women and children in Africa.

Should you require staff from Ndaramo Wellness Initiatives to facilitate learning for your organization, Ndaramo Wellness Initiatives is willing to support similar initiatives.

Do You Have Questions about Ndaramo Wellness Initiatives?
Ndaramo Wellness Institute works with adult education and public health professionals on a broad range of activities including:

- Curriculum design and development.
- Development of teaching/learning materials.
- Outsourcing material and financial resources.
- Program Planning and Evaluation.
- Using research literature to develop and support evidence-based programming.

Contact us at:
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E-mail: Info@Ndaramo.org

Ndaramo Wellness Initiatives is governed and supported and funded by its member organizations: Engineers without Borders, Sustainable Village, Nebraska Methodist College, Creighton University, and University of Nebraska Medical Center.

If you are interested in learning more about the Ndaramo Wellness Initiatives, please contact:

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Convention on the Elimination of All Forms of Discrimination Against Women, the Primary Health Care initiatives, Safe Motherhood Initiatives, Millennium Development Goals, basic human rights, and a seemingly healthy-looking constitution, Zimbabwean women continue to strive for basic survival. A combination of harmful cultural practices; an ineffective, inefficient public health system; and existing social policies exacerbate the situation. Meaningful human development for holistic health and wellness remains a far-fetched dream among the majority of Zimbabwean women. The reasons behind the gynecologic and urologic health epidemic among Zimbabwean women may appear complex to understand, but it is simple to address. Women need to be empowered to take charge of their health. This goal can be achieved by doing things differently, rather than doing different things.

Recommendations for improving the situation begin with allowing women to recognize their inherent power and use it responsibly. A newly developed model of
public health, Holistic Self-Management Education and Support (HSME & S) has been proposed as a possible solution to this problem:

Holistic self-management education and support is a capacity-building philosophy that ensures active involvement of consumers of health care in the planning, and implementation and evaluation of health care services. It helps consumers of health care to achieve the desired improved quality of health and life in managing and sustaining their health at the grassroots level. The care model addresses disease management ideals of the in the original primary health care model (Kanchence, 2006, p. 62).

A pilot project, the Ndaramo Wellness Initiatives, a wellness program that focuses on helping girls and women to recognize their iner power and how to use it responsibly, is currently being developed to test the effectiveness of the HSME & S model in the Chitakatira village outside Mutare, Manicaland Province, Zimbabwe. Help for realizing this dream includes financial, human, and material resources to support the construction of the first building at the Ndaramo Wellness Institute and for implementing the “training of trainers” program. Interested public health and social development professionals will receive training on how to implement the HSME & S model. The trainers will in turn facilitate Holistic Self-Management Education to village women and provide the women with ongoing support until they are capable of taking care of their health and be their own advocates in social matters with an emphasis on human rights. This help can be facilitated through the creation of linkages with established organizations such as universities, professional health and education-related associations, human rights organizations, and individuals interested in helping Zimbabwean women.

Finally, financial and technical assistance to develop a video about Mwatambudzeni’s story as a teaching tool would help in creating awareness regarding the plight of the Zimbabwean woman. See Appendix 1 for a copy of the Ndaramo Wellness Initiatives brochure.

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Role of Poverty

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