Gender Equity Efforts

**Context and political will**

Zimbabwe has made progress in reducing gender inequities, although it remains a patriarchal society, with men occupying most prominent positions in politics and education and acting as the main decision-makers within households. One study conducted in a school showed that 90% of participating male students indicated that women should obey their husbands.2

Prior to its independence in 1980, Zimbabweans experienced inequality in the health sector with higher social classes and white people controlling where health infrastructures were instituted.2 Health equity was not a consideration during this era.3 After independence, President Robert Mugabe ruled for 37 years. Social justice and gender equity issues were among the top priorities during the independence struggle, but the new government failed to meet expectations on time, delaying progress for women’s rights.4

Dependent on agriculture, Zimbabwe’s economy experienced a decline in the years leading to 1982 due to drought, insecurities, inequalities among farming communities, and land resettlement policies. These challenges led to high unemployment, especially for women, and mass migration to urban areas.5 By 1990, the economy was starting to recover, but in 1992, another drought struck, resulting in consequences that reverberated for many years. The country struggled with inequitable land distribution, high inflation, and economic sanctions.5,6 Despite these setbacks, policymakers made some progress in addressing gender inequalities, including land reforms that granted women the right to own land.7

As a result of the Government’s land reform program in 2000, many people received access to land in their own right, 18% of whom were married, single or widowed women.8 Despite the economic hardship caused by high inflation, the land reform program contributed to women’s social-economic transfor-
Since 2008, Zimbabwe's economy has grown, with a remarkable increase in agricultural production in 2020. However, worsening agricultural productivity and price volatility due to COVID-19 slowed the economy, and inflation is expected to remain in double digits through 2024.

In 2017, it was noted that 52% of women owned bank accounts compared to 59% of men. In June 2018, the government opened a women’s bank known as the Zimbabwe Women's Microfinance Bank to empower women financially. The bank provides financial literacy education services and outreach to women, including women in rural areas. Within the first six months of operation, the bank opened a total of 38 new accounts. One hundred seventy loans were issued to women in the agricultural sector, disbursing close to $350,000.

Access to mobile phones is high (85%) and is equally high for men and women.

Media: Women’s presence in media is low. Studies conducted by media monitoring services in Zimbabwe show that women are less likely to be sources of information in stories of violence, local government, and constitutional issues. Women are also underrepresented in media professions. For instance, none of the major newspapers is owned by a woman, and progress in promoting women leadership in media has been slow, despite the inclusion of women leadership in media in national gender policies and signed frameworks.

Policy and regulatory framework

Over the last few decades, the government of Zimbabwe has ratified several international frameworks that promote women’s rights and gender equality. These include the Convention on the Elimination of All Forms of Discrimination against Women (usually known as CEDAW, or the Women’s Convention), signed in 1979, and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, signed in 2003. These frameworks require the government to treat men and women equally in the distribution of resources and opportunities, which included the land resettlement schemes. Since 2004, the government of Zimbabwe has enacted the National Gender Policy to streamline gender in all development programs. This policy was revised in 2013 and again in 2016 to prioritize eight areas from the Beijing Platform for Action, namely: 1) gender, constitutional and legal rights; 2) gender and economic empowerment; 3) gender, politics and decision-making; 4) gender and health; 5) gender, education and training; 6) gender-based violence (GBV); 7) gender and the environment; and 8) gender, media and information, communications and technology (ICT).

Furthermore, in 2013, Zimbabwe amended its constitution to recognize women’s rights, economic empowerment, and the inclusion of women. The enactment of the new constitution has been a major milestone in women’s rights because it consolidates equality of men and women before the law and requires equal access to resources and opportunities.

In the same year, the Gender-Responsive Economic Policy Management Initiative (GERPMI) was created to ensure that “economic policies are formulated, designed and implemented in a manner that considers the different roles and needs of all women, men, girls and boys in the country.” United Nations agencies in Zimbabwe endorsed this initiative by providing technical assistance to help achieve GERPMI’s goals.

Under the Zimbabwean constitution and Labor Act, women are entitled to a minimum of three months of maternity leave plus a minimum of 60% of their earnings. After returning from maternity leave, employers are required to allow either one hour or two half-hours during the workday for employees to attend to postpartum needs.

Actors and implementers

Local gender participants and implementers include the gender focal persons in all line ministries, departments and agencies, the Zimbabwe Gender Commission, and women’s groups. The Zimbabwe Gender Commission and the Ministry of Women Affairs, Gender and Community Development (MWAGCD) are responsible for promoting gender equity in ed-
ucation, welfare, and health.\textsuperscript{15} The Ministry of Primary and Secondary Education (MoPSE) has reduced gender inequalities in education through the Education for All policy, implemented after the country’s independence. The MoPSE also passed a policy allowing pregnant women to remain in school and offers scholarships that mainly target women.\textsuperscript{19} In addition, the Ministry of Public Service, Labor, and Social Welfare created a national social protection policy framework that promotes a systems approach to social protection by addressing gender inequalities.\textsuperscript{20}

There are 670 registered non-governmental organizations (NGOs) in Zimbabwe, 100 of which focus on women’s rights.\textsuperscript{21} For example, Women and Land in Zimbabwe was created in 1988 and has promoted and economically empowered women by providing them with information on their rights and entitlement to land along with capacity strengthening to improve land productivity.\textsuperscript{22} Also created in 1988, the Musasa Project fights domestic violence against women. The Musasa Project offers counseling services, legal advice, and shelter for women who are victims of domestic violence. In 2022 alone, the Musasa Project reached nearly 30,000 people through its call center, one-stop centers, district offices and shelters.\textsuperscript{23} Another influential organization is the Zimbabwe Lawyers for Human Rights,\textsuperscript{24} formed to promote a “culture of human rights, equality and respect for the rule of law for a just and democratic society”.\textsuperscript{25}

Many international bodies have worked to promote equity and to improve the economy of Zimbabwe. For example, the United Nations Children’s Fund (UNICEF) established its presence in Zimbabwe in 1982 and has continued to promote equity through women’s rights and welfare.\textsuperscript{29} The United Nations Education, Scientific and Cultural Organization (UNESCO) focuses on people’s development through education, science, and information while USAID supports the Zimbabwe economy by providing food security and health services and by upholding democracy.\textsuperscript{12} The World Bank Group, alongside other governments, especially Canada, the European Union, Norway, Sweden, Switzerland, and the United Kingdom, have provided crucial support to the government of Zimbabwe to address development challenges and more recently those posed by COVID-19.\textsuperscript{10}

\textbf{Sexual and gender minorities}

Both past and present governments of Zimbabwe prohibit same-sex sexual acts and ban same-sex marriage, with culture and religion contributing to current perspectives.\textsuperscript{30} In recent years, attacks against sexual and gender minorities (SGM), such as hate speech, have diminished alongside an increase in tolerance, but the struggle for equity remains.

The Gays and Lesbians of Zimbabwe (GALZ) is an organization whose mission is to promote human, economic and social rights for SGM. Alongside operating a resource center that provides counseling, education and entertainment opportunities for the LGBTI+ community, GALZ also works with the constitutional Parliamentary Committee of Zimbabwe to fight for inclusion in the constitution.\textsuperscript{31}
Education and Employment

Women in the workforce

Most occupations in Zimbabwe remain gender-biased due to cultural beliefs that relegate women to small and medium enterprises and refuse leadership to women. Though evidence suggests that women outperform men in managerial responsibilities, such as organizing and monitoring the work of others, as well as formulating and expressing organizational vision, women are less likely to be in managerial positions. Cultural beliefs and social norms continue to be determining factors for choosing a career path in Zimbabwe. Women are typically employed in agriculture, mining, forestry, and farming while men tend to be employed in more competitive positions. Overall, women are less likely to be in leadership positions in CSOs/NGOs that are not women’s groups. This gendered structure systematically leads to women earning less than men.

Women are considered the “poorest of the poor” in Zimbabwe, especially women who are heads of household, such as widowed women and single mothers. In 2017, female-headed households faced higher multidimensional deprivation than male-headed households (19% versus 13.3%, respectively). Furthermore, women mainly provide domestic labor, spending more time in unpaid labor and less time in paid labor, as culture demands. This unequal distribution of responsibilities between men and women, in addition to limited access to resources and opportunities, plays an important role in keeping poverty levels high among women. For instance, although the land reforms increased land ownership by women, for families with larger land size, women experience a greater workload so large land size may not necessarily result in poverty reduction.

Women in the health workforce

Within the health workforce, most nurses are women (76%), and most physicians are men (72%).

Women in government

In 2021, women occupied 31.7% of the seats in Parliament and 12% of the elected seats in deliberative bodies of local government. In 2018, women occupied 34% of the seats in the lower house of Parliament and 48% in the upper house. Prior to this, the proportion of seats held by women in national parliaments doubled between 2012 (15%) and 2013 (31%). Women’s representation in civil service overall increased from 18% in 2010 to 25% in 2014. Further, as a result of enabling policy and legislative provisions, 46% of Supreme Court justices were women although women’s representation remained low in other areas of law and enforcement.

Data Availability

Inclusion of gender in health data collection and analysis

In Zimbabwe, health data on women remain limited. To promote gender equity in health, the government put more emphasis on collecting sex-disaggregated data, which was made publicly available through the Zimbabwe National Statistics Agency (ZIMSTAT). The Zimbabwe Ministry of Women Affairs and Youth, in partnership with UN Women, established the Gender Equity and Women Empowerment Monitoring and Evaluation program to monitor and evaluate sex-disaggregated data collection.

Health data allow for the assessment of health behaviors, living conditions, and policy that impact the health and general wellbeing of a given population. While these assessments may provide insight on how to tackle gender health inequities, some factors, such as Parliament decisions and inadequate tools for data collection,
hinder gender-based data collection. For example, an initiative dubbed “Informatics Project” started in 2001 to develop a database of socio-economic data to inform the work of Parliament. Despite the potential for positive change, this project did not lead to the expected results owing to inadequate support, limited capacity, and computer literacy barriers.41

In 2017, to represent the voice of women in health, the Zimbabwe Ministry of Women Affairs and Youth, in partnership with UN Women, established the Gender Equity and Women Empowerment Monitoring and Evaluation program to monitor and evaluate sex-disaggregated data collection.42 The program includes 141 gender indicators that are further divided into sectoral ministries to track areas where the government is making progress in closing the gap on health inequity. Trainings are then conducted to close gaps in gender-responsive monitoring and evaluation.42

In 2022, 53.3% of the indicators monitored by the Women Count Data Hub SDG Dashboard were still missing.38

Gender and Health Outcomes

Since its independence, the government has put several mechanisms in place to reduce health inequities.12 Although some progress has been made in improving health outcomes, gender health disparities still exist in: HIV, food security, healthcare access, mortality and GBV. For instance, 69.5% of the adult female population report severe food insecurity, affecting personal and household health and well-being.38 In addition, high poverty among female-headed families may increase vulnerability to other health risks, including HIV/AIDS, and children from these households may experience increased mortality and stunting-related morbidities.8

Gender and access to healthcare

The constitution grants everyone above 18 years of age the right to determine their own healthcare treatment, though culturally, approval from the husband is important in making reproductive health decisions, including the use of contraceptives.43 The National Health Strategy guarantees every patient, regardless of gender, the right to quality healthcare.12 However, individuals in rural areas have limited access to healthcare or receive care from untrained care providers. Children and women in rural areas suffer the most from this health inequity. Most women in rural areas perceive that healthcare services are not “girl-friendly” and therefore find it challenging when seeking care.43

Due to fear of stigma and shame, most SGM do not seek medical care.44

Life expectancy and maternal and child mortality

In 2020, the life expectancy in Zimbabwe was 63 years for women and 60 years for men.9 Zimbabwe made remarkable strides in reducing maternal and child mortality over the last two decades. According to the civil registration, vital statistics, and medical records on deaths of women of reproductive age, the maternal mortality ratio fell from 657 to 217 deaths per 100,000 live births between 2007-2008 and 2018-2019.45 The infant mortality rate was 38 deaths per 1000 live births in 2020 compared to 51 deaths per 1000 in 2010. Under-five mortality reduced from 81 to 54 deaths per 1000 live births between 2011 and 2020.9

Gender-based violence

Gender violence is common in Zimbabwe, and at least 35% of ever-married women report physical or sexual violence by a male partner; among them, 37% report physical injuries.43 The government has launched several initiatives to address GBV, including the Zero Tolerance 365 National Program on GBV Prevention and Response in 2010. In addition, the National GBV Strategy (2012-2015) provides a guiding framework for a coordinated response, engagement of traditional leaders to promote the message of zero GBV, and engagement of men in GBV-related activities.12
Reproductive healthcare

Child/adolescent marriage is a common practice in Zimbabwe. Reports conducted by ZIMSTAT in 2014 show that one in four women between the ages of 15-19 is married.43

Government policies recommended abstinence during the HIV/AIDS epidemic to prevent pregnancy and sexually transmitted infections.46 However, these recommendations resulted in no improvement in the infection rate. In 2010, to decrease the rate of infection, the government established new policies that included funding and services to educate women. Through the Ministry of Health and Child Welfare, the government provided free healthcare for children and pregnant women, including family planning options. In 2015, 84.8% of women had their contraceptive needs met. In 2017, the adolescent fertility rate was 107.9 births per 1000 women aged 15-19, a slight decrease from 110 per 1000 in 2014.47

Non-profit organizations such as the Talia Women’s Network48 supply girls with hygiene products to end period poverty and improve quality of life.

HIV/AIDS

Zimbabwe continues to experience high morbidity and mortality from HIV/AIDS. Women have the highest prevalence of HIV, with a 15.3% infection rate compared to a 10.2% infection rate among men.49 Pregnant women are also at higher risk for HIV compared to other women.50 Though the prevalence is still high, over the last two decades the government and the National AIDS Trust Fund have made remarkable strides in controlling the spread of HIV/AIDS. Between the years 1997 and 2013, considerable efforts resulted in a dramatic decrease from 29% to 15% of women in Zimbabwe living with HIV/AIDS.51 This reduction in prevalence has been associated with changes in sexual behaviors and access to treatment.52

The Gender Equity Unit would like to thank the following for their crucial contributions to this report:

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