Universal Periodic Review of Zimbabwe
26th Session
November 2016

Joint submission by:

Katswe Sistahood
www.katswesistahood.org

&
Sexual Rights Initiative
www.sexualrightsinitiative.com

Key Words: abortion, decriminalization, sex work, access to contraception, comprehensive sexuality education, rape

Executive Summary

1. This report presents key issues of concern, and recommendations on three main themes, i.e. access to sexual and reproductive health and rights (SRHR) information and services for adolescents and youth, particularly contraception; sex work; and abortion.

2. Access to SRHR services remains a challenge for many young Zimbabweans. Many young people do not have access to comprehensive information about SRH issues and services, including contraception. Service providers tend to deny adolescents and unmarried youth access to contraception, due to their own personal prejudices and biases about adolescent sexuality, opting instead to place emphasis on abstinence-only messages, or to demand parental consent.

3. Women and girls seldom access safe abortion services, even in instances where abortion is legal and should be performed in accordance with the law i.e. if a pregnancy is as a result of rape, or incest, or if the woman's health is under threat as a result of the pregnancy.

4. Sex work is illegal in Zimbabwe. Sex workers often face different forms of violence from clients, and the police. They face discrimination from health workers, and active denial of health services, such as treatment for sexually transmitted infections.

Access to SRHR information and Services: Contraception

Legal Context

5. Section 76 of the constitution on the Right to Health Care states that every citizen and permanent resident of Zimbabwe has the right to have access to basic health care services, including reproductive health care services.

Policy Context

6. The government developed the Life Skills, Sexuality, HIV & AIDS strategic plan (Ministry of Primary & Secondary Education 2013), and the Adolescent Sexual and Reproductive Health (ASRH) Strategy, to respond to adolescent SRHR needs. Although the legal age of sexual consent in Zimbabwe is 16 years, the National Family Planning Guidelines stipulate that all adolescents who are sexually active should be offered a contraceptive method of their choice.

Problem Identification

7. According to the latest national survey, 16 percent of young married women in Zimbabwe reported having an unmet need for family planning, and 32 percent of sexually active unmarried women reported having an unmet need. This translates into more than 103,000 women with unmet need — an

estimated 93,000 married and 10,400 unmarried women[1]. One outcome of high unmet need is unplanned pregnancies. In Zimbabwe, 31 percent of pregnancies among married women ages 15 to 24 are unplanned.

8. According to the UNAIDS Gap Report of 2014, 1.4 million people are living with HIV in Zimbabwe- a 15% prevalence rate, of which 720,000 are women. Zimbabwe is experiencing 69,000 new infections per year. The bulk of the new infection are occurring among young girls aged between 15-24 years.

9. The Zimbabwe's National Statistics Agency in the 2014 Zimbabwe Multiple Indicator Cluster Survey, found that approximately 1 in 3 girls in Zimbabwe are married before their 18th birthday.

10. Access to SRHR services remains a challenge for many young Zimbabweans. Many young people do not have access to comprehensive information about SRH issues and services, including contraception. The Ministry of Education, though it has a Life Skills, Sexuality, HIV & AIDS strategic plan, fails to provide contraceptive information and services to sexually active adolescents, leaving girls exposed and resulting in high rate of teenage pregnancies. Besides, the Ministry of Education insists on only teacher-led comprehensive sexuality education processes for in-school youths. However, the pupils tend to fear their teachers, posing a great barrier to open communication about their sexual experiences and SRHR needs as adolescents. Service providers below the head office level have limited knowledge of ASRH related laws, policies and strategies that govern their work. Adolescents themselves have little or no information of legal and policy provisions in place to protect their sexual and reproductive health and rights. Rural adolescents are particularly affected by this lack of information.

11. Even when adolescents have information about SRH, they continue to face multiple barriers when they attempt to access these services. Service providers tend to deny adolescents and unmarried youth access to contraception, due to their own personal prejudices and biases about adolescent sexuality, opting instead to place emphasis on abstinence-only messages, or to demand parental consent. Further, inadequate availability of services particularly in rural areas hinders access.

12. Generally, Zimbabwean society is more liberal about boy's sexuality and this allows boys to access information, and openly discuss sexual matters, without facing much stigma. In recent years, boys are further supported with targeted information services, for example, as part of the package for the Voluntary Male Circumcision programmes on HIV prevention. Besides, the school life expectancy for boys is higher than that for girls, meaning that boys will be targeted with school based ASRH programmes for a longer period.

[1] http://www.prb.org/pdf15/unmetneed-factsheet-zimbabwe.pdf

13. On the other hand, girls face many restrictions when it comes to accessing SRHR information and services. Girls are generally viewed as sex objects, and often sexually abused. According to UNICEF, 32% of women/girls first sexual encounter is by coercion. Yet girls are not encouraged to openly discuss sexual matters. It is also often difficult for girls to report this abuse as they are often dismissed as promiscuous and attention seekers.

14. Comprehensive sexuality education, improved youth-friendly services, marked by positive service provider attitudes will restore young people's confidence in the health system and they will not be afraid to seek help, support, and protection when they need it. This could help save girls and young women's lives. Youth-friendly health services will help effectively deal with the increasing HIV infection rates among young girls, increase in unwanted pregnancies, and consequently unsafe abortions which have dire consequences for the girls' lives.

Access to safe abortion services

Legal Context

15. The Termination of Pregnancy Act of 1977, was enacted while the country was still known as Rhodesia and run by the white minority. The law permits the procedure when "the life of the woman is endangered, the child may suffer a permanent physical or mental defect, or the fetus was conceived as a result of rape or incest."

16. The Criminal Law Codification and Reform Act states that: "Any person who intentionally terminates a pregnancy or terminates a pregnancy by conduct which he or she realises involves a real risk or possibility of terminating the pregnancy shall be guilty of unlawful termination of pregnancy and liable to a fine not exceeding level ten or imprisonment for a period not exceeding five years or both."

Policy Context

17. Zimbabwe is a signatory to the Maputo Plan of Action on SRHR, which places emphasis on the need to legalise abortion and ensure safe abortion services for all women and girls to the fullest extent of the law.

Problem Identification

18. Women and girls seldom access safe abortion services, even in instances where abortion is legal and should be performed in accordance with the law i.e. if a pregnancy is as a result of rape, or incest, or if the woman's health is under threat as a result of the pregnancy.

19. Research points to early sexual debut among adolescents, yet young people continue to be denied access to contraception information and services, resulting in unintended pregnancies. Contraceptive failure is also a reality. Many women have reported falling pregnant while on contraception. This includes both unmarried and married women. Many of these women turn to unsafe abortion, risking their lives, because unplanned pregnancies also fuel stigma and domestic violence.

20. Research has also reveals that for most girls, about 32%, the first sexual encounter is by coercion.[2] Very few of these (rape) cases are reported due to negative attitudes of police, and a dysfunctional court system, that is prejudiced against girls and young women. Many just opt not to report due to the fact that often, the courts make it victim's prerogative to prove the rape, which is often difficult given the barriers in communication, distance to police stations and clinics, fear, etc. The problem is further compounded by poor forensic processes within the police department. Hence, many genuine cases of rape are never prosecuted. Many rape survivors do not benefit because abortion can be accessed legally only when the rape is **proved**.

21. When rape is not reported, the survivor does not receive information about contraceptive options, such as emergency contraception, or services; hence, the rape may result in an unintended pregnancy. Many survivors of rape resort to backstreet unsafe abortion services, even though the law provides for safe and legal abortion in their case.

22. Political violence and polarization: Many women are also raped during the election period, and these cases of rape are sometimes tolerated as politically motivated violence, and not gender based violence, with many service providers refusing to provide services to the victims due to fear.

23. For the year 2009, Zimbabwe recorded 11903 illegal abortions. Sometimes these abortions result in serious gynecological complications or even death as many of the abortions as performed using dangerous material such as sticks, iron rods, or herbs. These procedures are performed in unhygienic conditions and in many cases very late into the pregnancy. In 2008, complications from unsafe abortion resulted in 35% of maternal deaths in Zimbabwe [MOHCW 2009]. Hospital based studies suggest that as many as 28% of maternal deaths in Zimbabwe are due to unsafe abortion, and this is an underestimation of the problem because the figures represent only those who have had contact with the health delivery system [MOHCW 2006].

24. Complications from unsafe abortion cost the health care system a tremendous amount in terms of hospital space, providers' time, antibiotics, blood, and supplies. Experts note that "It is not uncommon for the majority of beds in emergency gynecology wards to be occupied by women suffering abortion complications … Treating a patient with abortion complications can cost upward of five times the annual per capita health budget[3]." Indeed the Zimbabwean government has functional health facilities offering post abortion care. Dealing with consequences of backyard unsafe induced abortions is more costly than offering safe abortion services from the onset.

[2] National Baseline Survey on Life Experiences of Adolescents (NBSLEA), 2011

[3] http://www.policyproject.com/pubs/policymatters/pm-01.pdf

25. Up-to-date information on abortion is not available, i.e. numbers of safe and legal abortions accessed in accordance with existing legal provisions; illegal backstreet abortions; and the effects they have on girls and women's lives etc. Such evidence would push policy makers to review policies.

Sex Work

Legal Context

26. Sex work is illegal in Zimbabwe. The Criminal Law (Codification) Act 2004:152 came into effect in 2007, replacing the Sexual Offences Act of 2001. Section 81 to 84 criminalizes solicitation, living off the earnings of sex work, procurement, and brothel keeping. Section 81 of the Act makes it illegal to solicit, imposing a maximum prison sentence of up to six months. Section 82 prohibits 'living off or facilitating prostitution', and 83 prohibits 'procuring' sex, imposing a maximum prison sentence of two years.

Policy Context

27. The Zimbabwe National Strategic Plan on HIV & AIDS III acknowledges sex workers' health needs as a Key Population to target in HIV prevention.

Problem Identification

28. Zimbabwe's economic situation drives many women into transactional sex and sex work. According to research by Katswe Sistahood, sex workers in Zimbabwe often face different forms of violence from criminals, clients, or even the police, yet they often do not report these cases of abuse, for fear of being arrested themselves. Often, these sex workers are denied protection by the police who opt instead, to open charges against them when they go to the police station to make a report. Many sex workers have said some clients or sexual partners refuse condom use, or force them to have unprotected sex (rape), or deliberately take off the condom during sexual intercourse. However, they do not report to the police, for fear of being arrested themselves, because sex work is criminalized.

29. When they go to clinics, sex workers face further discrimination i.e. they have been asked; 'How can a sex worker be raped'. Often, health workers treat these women as criminals who should be punished for their offences and immorality. Katswe Sistahood's survey reveals that sex workers who reported rape by clients, or who have had condoms removed during sex, did not access post-exposure prophylaxis (PEP) for HIV because the nurses and police often ask – 'Can a sex worker be raped?'

30. Beyond that, many sex workers are generally looked down upon as criminals hence they also face discrimination at different service points, including in government clinics. PEP is only administered for rape cases and for those working in risky settings in the event of an accident that could lead to the risk of HIV transmission, and sex workers are not included in this category, although their occupation, compounded by the criminalization of sex work, places them at a much higher risk of contracting HIV.

31. Sex workers are being deprived of different kinds of health services. Because sex work is criminalized, health workers sometimes impose sanctions on them. According to a survey by Katswe Sistahood, many sex workers reported that some clinics now only treat them for sexually transmitted infections (STIs) thrice. *'If you come back for the fourth time, you are simply shouted at and simply sent away. They say it is because recurrent STIs is evidence that one is not serious about staying alive'.* This is in contravention of Section 29 of the constitution; on Health Services; which stipulates that i) The State must take all practical measures to ensure the provision of basic, accessible, and adequate health services throughout Zimbabwe. Failure to treat recurring STIs may result in health complications. Negative attitudes of health workers force many sex workers to default on their anti-retroviral therapy, which may lead to drug resistant HIV.

Recommendations for action by the Government of Zimbabwe:

32. Remove policy and procedural barriers to access to contraception for adolescents and unmarried youths.

33. Ensure that service providers study, publicize and promote the country's family planning guidelines, which dispel the commonly held misperception that age criteria—and related parental or spousal consent requirements—exist for accessing family planning services. The guidelines[4] clearly specify that "age alone does not constitute a medical reason for denying any method to adolescents" and that those "who are sexually active should be offered a contraceptive method of their choice."

34. Promote comprehensive sexuality education and services that are non-discriminatory; address service provider attitudes towards unmarried youths to enable access to contraceptives and other essential SRHR services; and introduce youth-friendly service provider sections in Primary and Tertiary Health Care Centres.

35. Urgently Review the Marriage Act, and the Criminal Codification Act (on sexual offences), in accordance with the new Constitution of Zimbabwe, adopted in 2013, which places emphasis on equality of all genders, citizens' right to health, and the need to recognize and protect all children, and children being anyone below the age of 18.

36. Implement existing laws and policies to ensure that survivors of rape, including date rape, access treatment, care & support; intensify efforts to ensure roll out of post-exposure prophylaxis (PEP), emergency contraception and safe abortion for survivors of rape; and ensure that court procedures are victim friendly so as to enable reporting and prosecution.

37. Expand PEP rollout to cover non-rape scenarios, inclusion provision to sex workers as needed.

[4] Ministry of Health and Child Welfare, *Family Planning Guidelines for Zimbabwe: A Guide to Essential Practice*, Harare, Zimbabwe: Ministry of Health and Child Welfare, 2011.

38. Review the Termination of Pregnancy Act to guarantee free safe abortion services to all women, on demand.

39. Decriminalize sex work in Zimbabwe to ensure sex workers' bodily integrity and autonomy, and reduce their vulnerabilities.

40. Demonstrate political will through allocation and disbursement of the 15% Abuja commitment to the Health budget- from the current 12%; this allocation should be used to address inequalities in health service access i.e. the rural urban dichotomy; prioritise adolescents- and women-friendly SRH programmes; and support infrastructure – road and communication – development especially in rural and resettlement areas.

41. Develop strong budget and indicator tracking mechanisms to ensure that available resources reach the service points.