Kafswe Sistahood

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EDITION

WHAT YOU NEED TO KNOW!

A Policymaker's Guide to Outstanding Legal & Policy Issues on SRHR & SGBV

List of Acronyms

ACHPR	African Charter on Human and Peoples Rights
AGYW	Adolescent Girls and Young Women
ASRH	Adolescent Sexual and Reproductive Health
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
ESA	East and Southern Africa
GBV	Gender-Based Violence
HIV	Human Immuno-Deficiency Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
PEP	Post-Exposure Prophylaxis
RMNCH-N	Reproductive, Maternal, Newborn, and Child Health and Nutrition
SADC	Southern Africa Development Community
SGBV	Sexual and Gender-Based Violence
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization
ZDHS	Zimbabwe Demographic Health Survey

Context and Background

Women, SRHR and GBV in Zimbabwe

Women and girls make up 52% of the total population in Zimbabwe[1]. Despite constituting a majority of the population, women in Zimbabwe are disproportionately affected by poverty and disease while they, at the same time, remain largely underrepresented in decision making owing to several socio-cultural and economic factors, among others. As a result, Zimbabwe ranks lowly in the gender equality ranking.[2]

Although indicators for the status of women and gender equality generally point to a state of disempowerment among women, the SRHR indicators are untenable. According to UNAIDS[3], women in Zimbabwe constitute nearly 61% of the total number of people living with HIV while, when compared to their male counterparts, new infections are more than double among young women aged 15-24 years.[4] Additionally, knowledge levels of STIs and HIV prevention are low among AGYW, probably, a cause of the high transmission and prevalence of the epidemic among this group. Studies indicate that only less than half (46.3%) of AGYW have comprehensive knowledge on HIV[5].

Other SRHR indicators for this group are equally bad. Nationally, on average, a third of AGYW will marry before they turn 18[6], 22% of adolescents will fall pregnant as teenagers while only 47.5% of female adolescents 15-19 years report using some form of contraception in their last sexual encounters[7]. Sexual and Gender Based Violence also remains a huge problem affecting women and girls in Zimbabwe. According to the Spotlight Initiative [8] project documents, 1 in 3 women in Zimbabwe is affected by GBV, 35 percent of girls and women 15-49 years have experienced violence since the age of 15. Major factors sustaining such negative SRHR outcomes among women include poverty, socio-cultural factors as well as the absence of gender-sensitive and youth friendly services[9].

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1 *Inter-censal Demographic Survey: Zimstat and UNFPA, 2017*
2 *The Zimbabwe National Gender Policy: Ministry of Women Affairs, Gender and Community Development*
3 *https://www.unaids.org/en/regionscountries/countries/zimbabwe*
4 *https://www.unaids.org/en/regionscountries/countries/zimbabwe*
5 *The Zimbabwe Demographic Health Survey (2015)*
6 *Multiple Index Cluster Survey, 2019*
7 *The National Fertility Study, 2016*
8 *The Spotlight Initiative is an inter-agency initiative of UN organizations to pool efforts towards elimination of sexual and gender-based violence.*
9 *The Girls' and Young Women's Empowerment Framework: Danida & the Ministry of Women Affairs, Gender and Community Development, 2014*

The Policy Context

This section reviews the major laws, policies, strategies that are in place at international, regional and national levels to promote SRHR.

Regional and International Commitments for SRHR

1. Inter-censal Demographic Survey: Zimstat and UNFPA, 2017
1. The Zimbabwe National Gender Policy: Ministry of Women Affairs, Gender and Community Development
2. https://www.unaids.org/en/regionscountries/countries/zimbabwe
3. https://www.unaids.org/en/regionscountries/countries/zimbabwe
4. The Zimbabwe Demographic Health Survey (2015)
5. Multiple Index Cluster Survey, 2019
6. The National Fertility Study, 2016
7. The Spotlight Initiative is an inter-agency initiative of UN organizations to pool efforts towards elimination of sexual and gender-based violence.
8. The Girls' and Young Women's Empowerment Framework: Danida & the Ministry of Women Affairs, Gender and Community Development, 2014

Once the ICPD Programme of Action was adopted in 1994, heralding a human rights-based approach to SRH, many commitments were made at the international and regional level to promote SRHR, especially for vulnerable groups such as women, children and young people. Although such instruments may not be binding on governments, they do reflect international consensus on issues and provide details on actions that can be taken by governments to meet their commitments. Zimbabwe is a signatory to a number of these commitments:

- The International Conference on Population and Development (ICPD) Programme of Action (1994);
- The Millennium Declaration (2000);
- The Abuja Declaration (2001);
- The Regional Child Survival Strategy for the African Region developed by WHO, UNICEF and the World Bank and adopted by the 56th Regional Committee of Health Ministers in August 2006;
- The Maputo Plan of Action (2006);
- Ouagadougou Declaration (2008) on Primary Health Care and Health Systems in Africa;
- The United Nations Commission on Life-Saving Commodities for Women and Children;
- The 2010 African Union initiated Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA);
- WHO and the African Union Commission commitments on universal health coverage and ending preventable maternal and child deaths by 2030 (April 2014)
- Agenda 2063 – The Africa we want: with 7 common aspirations including "An Africa whose development is people driven, especially relying on the potential offered by its women and youth"
- Global Strategy for Women's, Children's and Adolescents' Health (2016 – 30), which is particularly pertinent to this Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Strategy.

Table 04

The table below provides an overview of some of the major commitments and their key SRHR provisions as well as status of ratification and implementation in Zimbabwe.

Key Provisions, Status of Ratification and Implementation of International & Regional Commitments

International Treaties related to SRHR and their Provisions	Signed	Ratified/ Acceded/ Declared	Comments on status of implementation in Zimbabwe
Convention on the Rights of the Child protects children's right to access sexual and reproductive health services and their rights to substantive equality and nondiscrimination.	Yes	(r) 11th September 1990 (no reservations)	Constitution of Zimbabwe (2013) made great strides in adopting furthering children's SRHR. The Children Act also forms a concrete basis for SRHR. Gaps in the current law on SGBV will be addressed through the Child Justice Bill currently before Parliament.
Convention on the Elimination of all forms of discrimination against women: Has the clearest and most specific articulation with respect to family planning information and services. In addition, it also contains the most direct articulation of reproductive autonomy of any human rights treaty through Article 12.	Yes- with reservations	13th May 1991	The Domestic Violence Act and Domestic Violence Council have continued to promote gender mainstreaming in all SRHR planning and implementation processes. The Constitution and landmark rulings on child marriage by the Constitutional Court have contributed to the implementation of CEDAW
The International Conference on Population and Development (ICPD) Programme of Action: Marked the genesis of expanding SRHR packages beyond family planning.	Yes	1994	Has informed the National Reproductive Health Policy, the ASRH Strategy among other key sector policies.
The Millennium Declaration: The Millennium Development Goals (MDGs) were set at the 2000 Millennium Summit to accelerate global progress in development. Sexual and reproductive health is a prerequisite of all goals, particularly those related to gender and health.	Yes	2000	Provided guidance for the development of interventions that Zimbabwe is implementing to reduce maternal and child mortality rates, whilst recognizing the role of family planning.

International Treaties related to SRHR and their Provisions	Signed	Ratified/ Acceded/ Declared	Comments on status of implementation in Zimbabwe
Regional treaties on SRHR			
Africa Youth Charter (Banjul Charter): The Banjul Charter ensures that "...every individual shall have the right to enjoy the best attainable state of physical and mental health... which would and does include sexual and reproductive health.			Informed development of the National Youth Policy.
African Charter on Human and Peoples Rights (ACHPR): Recognizes the right to SRH especially for women.	Yes	(r) 30th May 1986	A human rights approach to SRHR programming has been adopted to a certain extent. Sexual rights remain a thorny issue. Constitutional provisions on Health provide guidance on the realization of SRHR
African Charter on the Rights and Welfare of the Child: a holistic view of children's' health and protection and the right to education and information. This holistic view states that every child (below 18 years) has the right to enjoy the best attainable state of physical, mental and spiritual health.	Yes	(a) 19th January 1995	Child-centered approaches on SRHR, through the Children's Act, have been used.
Convention Governing the Specific Aspects of Refugee Problems to Africa: Recognizes SRHR as a key issue for displaced people and provides guidance on addressing such.	Yes	28th September 1985	Most key SRHR strategic documents have established mechanisms for humanitarian response as well as SRH programming for refugees. Funding remains a constraint.
Cultural Charter for Africa: Calls for cultural sensitivity in addressing SRHR issues.	Yes	5th July 1988	Zimbabwe strives to ensure that SRHR strategies are culturally sensitive and competent. This sometimes creates conflict with the rights discourse.
The Abuja Declaration: 15 percent of the total national budgets should be allocated to health.	Yes	2001	Government yet to meet the target pledging poor economic growth.
Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR): Adopted in January 2006 and endorsed by heads of state. Priority areas of this framework include Sexual & Reproductive Health legislation, Integration of SRH services into Primary Health Care, Budgeting of SRH activities, among others.	Yes	2005	Ongoing incorporation in various strategies and programmes.

Table
04

International Treaties related to SRHR and their Provisions	Signed	Ratified/ Acceded/ Declared	Comments on status of implementation in Zimbabwe
The Maputo Plan of Action: Provides a framework to achieve universal access to comprehensive sexual and reproductive health rights (SRHR) and services in Africa.	Yes	2006	Informed the development of the Zimbabwe Maternal and Newborn Health Road Map: 2010 - 2015
Regional Child Survival Strategy	Yes	2006	Informed the development of the 2010 National Child Survival Strategy for Zimbabwe.
Ouagadougou Declaration on Primary Health Care and Health Systems in Africa	Yes	2008	Informed development of the National Health Strategy: 2010 - 2015
SADC Protocol on Gender and Development: Recognizes the gendered nature of SRHR.	Yes	2009	Guide the efforts of the Domestic Violence Council in gender mainstreaming
The African Union initiated Campaign on Accelerated Reduction of Maternal Mortality In Africa (CARMMA)	Yes	2010	Strengthened advocacy work towards SRHR, repositioning of family planning and the need to focus on adolescents and youth
The United Nations Commission on Life-Saving Commodities for Women and Children	Yes	2010	Helped towards development of an SRH Commodity Security strategies
Agenda 2063: The Africa we want: Considers health and SRHR a key issue for the development agenda of Africa.	Yes	2013	Informed the development of the ZimAsset: 2013 – 2018, a government blueprint for development.
Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA)	Yes	Affirmed 2013	Informed the development of the National ASRH Strategy II, development of the new curriculum framework and the school health policy
Global Strategy for Women's, Children's and Adolescents' Health (2016 – 30)	Yes	2016	Its launch coincided with the development of the RMNCH-N: 2017 – 2021, ASRH Strategy II: 2016 – 2020, Cervical Cancer and Control Strategy and Family Planning Strategy: 2016 – 2020
SADC Model Law on Eradication of Child Marriages	Yes	2016	Informed the development of the Marriage bill

The Country Constitutional and Legal Environment

Zimbabwe has a protracted struggle for constitutional reform that has taken decades from the late 90s. Pressure groups and various sectors have argued, over the years, that Zimbabwe needed a new constitution. The SRHR sector – youth and women, as well as the general health sector has always been fighting for the acknowledgement of the right to health.

The 2013 constitutional reform process witnessed an expansion in the bill of rights compared to the previous one. Although there is no express mention of SRHR, the right to health was, for the first time, enshrined in the constitution. Despite its progressive nature, the struggle for SRH rights in Zimbabwe is yet to be considered a case closed with further need for constitutional recognition of some rights as well as the outstanding task of alignment of various pieces of legislation to the new constitution. In some cases, the new constitution regressed on key rights.

Table 01

It is important, however, to note that the country has promulgated and implemented several policies and legal instruments to promote the SRHR of women and girls as well as to address the sexual and gender-based violence (SGBV) scourge affecting the same. In this guide, we explore some of the outstanding legal and policy issues in the area of SRHR and SGBV with a focus on key actions that policy makers can take.

Outstanding legal provisions for SRHR

Constitutional/ Legal/Policy Provision	Analysis on Gaps
Age of consent	The Public Health Act (Act No. 11 of 2018) defines an adult as "a person of 18 years of age or over" and implies that anyone under 18 needs the consent of a parent or guardian for medical treatment. Under the s70 as read with s65 of the Criminal Law (Codification and Reform) Act the age of consent for sexual intercourse in Zimbabwe is 16. However, Zimbabwe's Children's Act (as amended by Act No.23 of 2001) also fails to specify an age at which children can consent to medical treatment or access health services without parental consent. As such, the age of consent for access to HIV testing services has been set at 16 years. Service provider attitudes and inference from these set ages often results in young people who are sexually active before the age of 16 years being denied access to services. Yet evidence shows that unplanned pregnancies, illegal abortions and STIs are quite high in this area. There were failed calls to get the Public Health Bill to lower the age of consent to access services to 12 years. However, the dilemma comes at lowering age of consent for services while increasing age at marriage, as this is interpreted by communities to giving permission to adolescents to engage in sex before marriage.
Criminalization of Child Marriages	While the Domestic Violence Act and the ruling by the Constitutional Court invalidated child marriages, Zimbabwe still has no law that criminalizes and punishes offenders.
Gay Rights	The constitution actively prohibits same sex marriages with the country having active laws that criminalize man-to-man sex through the 'The crime of sodomy'. In this case, the law takes a moralistic view. To get reforms in this area, there is need for the constitution to provide for this right.
Sex work	Laws that prohibit soliciting for sex have the effect of criminalizing sex workers, this limits their access to SRHR and SGBV and/or leave them open to abuse and rape as they fear to report perpetrators.
Termination of Pregnancy Act	The new constitution expanded the right to life to cover fetuses thereby further limiting the circumstances under which women and girls can seek legal abortion. There ToP Act provides a narrow definition of health as a ground for termination, several sexual offences including statutory rape are not included as a ground for termination. Procedure for termination excludes health professionals other than doctors from providing the service.
Criminalization of willful transmission of HIV	Calls to repeal the law on willful transmission of HIV are based on difficulties in enforcement. The law promotes stigma and does not have a place in modern society where HIV is no longer a death sentence. Worse, there is no way to prove who was infected first between two parties. The provision to decriminalize willful transmission in a marriage set up is included in the Marriages Bill currently under consideration by Parliament.

Abortion

Introduction and Background

Abortion is defined as the termination of pregnancy before its full term. Across the world, different jurisdictions have different definitions in terms of the number of weeks and conditions surrounding which abortion can be carried out, if at all it is allowed. In Zimbabwe, abortion is legally permitted only under limited circumstances, including if the pregnant woman's life is in danger or in cases of rape, incest or foetal impairment.

However, in practice, it is extremely difficult to obtain a legal abortion; as a result, most abortions are clandestine and potentially unsafe, often resulting in loss of life. One in ten pregnancies end in an induced abortion. The biggest challenge when it comes to abortion, today, is to ensure that women and girls are afforded an opportunity to do so in a safe way with the attendance of medical professionals. This can only happen if national laws and socio-cultural attitudes are permitting or when the services are available and accessible. However, this often not the case. In several countries globally, abortion is outlawed while religious and cultural beliefs remain a key obstacle to legalisation and acceptance of the practice. Where abortion is legal, in some cases, the services are expensive, unavailable or involve unnecessary bureaucratic delays. In the end, women and girls resort to unsafe abortion away from the eyes of the law and society. Unfortunately, unsafe abortion often results in higher risk of disability or death.

Unsafe abortion

occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. – World Health Organization

Developing countries, including Zimbabwe, spend a lot of their limited resources treating complications that result from unsafe abortions with 7 million women being admitted to hospitals annually as a result of unsafe abortion. This makes abortion, both, a public health concern in addition to being a human rights concern.

Why Women and Girls Seek Abortion Services?

Women should be afforded a right to decide what they do with their bodies. It is important to understand that women seek abortion services due to several and complex reasons. Worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing. The second most common reason—socio-economic concerns—includes disruption of education or employment; lack of support from the father; desire to provide schooling for existing children; and poverty, unemployment or inability to afford additional children. In addition, relationship problems with a husband or partner and a woman's perception that she is too young, constitute other important categories of reasons. Women's characteristics are associated with their reasons for having an abortion; with few exceptions, older women and married women are the most likely to identify limiting childbearing as their main reason for abortion. This evidence was gathered through research. [1]

1 *Reasons Why Women Have Induced Abortions: Evidence from 27 Countries | Guttmacher Institute*

Abortion in Zimbabwe: What You Need to Know!

As a policymaker you need to appreciate that circumstances under which abortion is permitted in Zimbabwe remain limited – only permitted in cases when the pregnant woman's life is in danger or in instances of rape, incest or foetal impairment. Women, however, face many obstacles including inordinate delays and bureaucratic requirements making it almost impossible to obtain an induced abortion even in circumstances when they are within their legal right according to the national laws.

Although circumstances under which abortion is permitted are limited in Zimbabwe, the Ministry of Health and Child Care promotes and provides post-abortion care services as a strategy to reduce the unsustainably high rates of maternal deaths that the country experiences. In this case, women who would have had an illegal induced abortion may still present at health facilities and get life-saving health services without questioning or prosecution.

Despite this progressive position on post-abortion care, challenges remain:

- Due to lack of money or transport, many who need post-abortion care services delay reaching the health facility.
- Most primary health care facilities which serve rural areas do not offer post-abortion care services.
- Sometimes women are asked to pay for post-abortion care prior to treatment even when facilities are supposed to provide the service at no cost.
- Sometimes facilities lack the necessary medication and equipment.
- Societal attitudes on abortion, shaped by religion and culture, often prevent women and girls who need services from presenting at the health facility.
- Service providers may be judgemental.
- Many women and girls lack knowledge on the availability of these services.

Facts and Statistics About Abortion in Zimbabwe[1]

- In 2016, an estimated 65,300 induced abortions occurred in Zimbabwe. This translates to a rate of 17 abortions for every 1,000 women aged 15–49.
- Abortion rates in Zimbabwe vary greatly across the country. The highest rates are in the Mashonaland provinces and Harare (21 per 1,000 women aged 15–49) and lowest in the Manicaland and Masvingo provinces (12 per 1,000 women).
- Among women treated for post-abortion complications in 2016, 78% had mild or moderate complications and 19% had severe complications. Three percent died or nearly died from complications.
- Women who experience complications even during an illegal abortion are entitled to health care services. However, cost, distance and ill-equipped facilities a major reason why about half of all women who need post-abortion care services do not access such.
- Women end up seeking abortion because they do not have access to contraceptives. In Zimbabwe, one in 10 married women and two in 10 sexually active unmarried women reported wanting to avoid a pregnancy but were not using any contraceptive method.
- Gender norms also, sometimes, disempower women from negotiating for safer sex and leave them vulnerable to rape and abuse resulting in unwanted pregnancy.

A Call to Action!

As a policymaker, you have a role to play:

- Sponsor or support the enacting of laws that broaden the circumstances under which abortion is legally permitted.
- Hold public institutions and service providers, including the Ministry of Health and Child Care as well as the Ministry of Justice, accountable for accessible, timeous and less bureaucratic access to abortion, when legally permitted and, always for post-abortion care
- Advocate for increased funding to the health sector in the national budget to ensure public health facilities are equipped and workers are trained to provide abortion and post-abortion care services.
- Support public health campaigns to educate the public about the availability of post-abortion care services.
- Support legal initiatives that seek to expand access to contraceptives, especially for unmarried girls and young women (see section on contraception).

1 *Adapted from a Factsheet by the Guttmacher Institute*

Child Marriages - Forced Marriages

Introduction and Background

Child marriage is any marriage where at least one of the parties is under 18 years of age. Forced marriages are marriages in which one and/or both parties have not personally expressed their full and free consent to the union. A child marriage is considered to be a form of forced marriage, given that one and/or both parties have not expressed full, free and informed consent.

According to Plan International, globally, 12 million girls get married off before their 18th birthday every year. Such practices are driven by poverty, gender inequality, religious and cultural practices, among other reasons. In many instances and cultures, child marriages are practiced because of misconceptions that girls benefit from such, for example, through protection from violence. In reality, girls who are married off early miss out on school, are exposed to gender-based violence and, often, lack decision making powers pertaining to their sexual and reproductive health and rights. As a result, there is a growing wave of national laws that prohibit such marriages although in many contexts these laws are not fully enforced for a variety of reasons.

Child marriages is a gendered problem, affecting more girls than boys. However, it is still a violation of human rights regardless of the sex of the victim. There are several international and regional instruments and commitments signed by the Zimbabwean government to eradicate child marriages. In the SADC region, the SADC Model Law on Eradicating Child Marriages is such an example,

Effects of Child Marriages

When girls are married off as children, there are many negative impacts they experience at a personal level:

- Child marriages violate the human rights of children, especially the rights of the girl child to health, education, equality, non-discrimination and the right to live free from violence and exploitation.
- When children marry, they drop out of school and miss out on opportunities for social and economic advancement. Girls who drop out of school are also likely to marry early, research shows.
- Marrying early has physiological effects on girls, especially considering that they are likely to start bearing children early which predisposes them to birth complications. Maternal mortality rates are higher among young mothers, below 18 years, compared to other age groups.

Child Marriages in Zimbabwe: What You Need to Know!

Zimbabwe is among the countries with the highest prevalence of child marriages in Africa. Approximately, one in three girls are married off before turning 18, with most of such marriages being formalised through customary procedures.

The country-specific drivers of child marriage, according to Girls not Brides[1] are:

- ***Poverty:*** Daughters are sometimes married off to reduce their perceived economic burden, with their bride price (lobola) used by families as a means of survival.
- ***Level of education:*** Girls from Zimbabwe's poorest households are more likely to marry before the age of 18 than girls living in the richest households.
- ***Religion:*** Some members of the indigenous apostolic church reportedly encourage girls as young as ten to marry much older men for "spiritual guidance". Men in the church are reportedly entitled to marry girls to shield them from pre-marital sex.
- ***Traditional customs:*** Virginity testing is still practiced in parts of Zimbabwe by the apostolic church and some sections of society. Girls who are found to no longer be virgins are shamed into wearing a mark on their forehead and are required to find another virgin for their husband to marry as compensation.
- ***Family honour:*** If a girl engages in pre-marital sex, is seen with a boyfriend or returns home late, she is sometimes forced to marry to mitigate the shame. Some girls who fall pregnant choose to enter customary marriages because they are afraid their family will abuse them for dishonourable behaviour.

In 2016 Zimbabwe's Constitutional Court outlawed child marriage, so that no one

1 https://atlas.girlsnotbrides.org/map/zimbabwe/

may enter into any marriage before the age of 18. The ruling includes marriages under the Customary Marriages Act which had previously not had a minimum age requirement. There is a Marriages Bill yet to be signed into law that will absolutely prohibit child marriages.

A Call to Action!

As a policymaker, you have a role to play:

- Expedite the adoption of the Marriages Bill into law, ensuring that the new law does not only outlaw child marriages but also provides sanctions for perpetrators.
- Support policies that promote the re-integration, into school, of girls who are pregnant or who have been rescued from child marriages.
- Hold the relevant public institutions accountable for their roles in ending child marriages.

Consent

Introduction and Background

In the field of sexual and reproductive health and rights (SRHR), consent is often discussed in the context of accessing services or agreeing to having sexual intercourse. However, specifically to sexual and gender-based violence (SGBV), consent is discussed in relation to rape (see sections on date rape or SGBV).

We have noted that in the field of SRHR, consent is often associated with sexual intercourse as well as accessing services such as contraceptives and treatment. Often the big question is on the age at which individuals can consent. This is often referred to as the age of consent.

Age of consent

is the age from which someone is deemed capable of consenting to sexual activity or access to SRHR services such as contraceptives, HIV testing and treatment, safe abortion and post-abortion services, HPV vaccines, cervical cancer screening as well as antenatal care, among other key services.

What is the Right Age of Consent?

Ongoing debates, especially in the region, are centred on ensuring that the age of consent to accessing services be set at an age low enough not to deny adolescents who are sexually active such services when they need them. Without a clear age of consent that is low enough, service providers often use their discretion based on cultural, religious and parenting attitudes to judge adolescents who are sexually active and, sometimes, to deny them the services they need.

On the other hand, there must be clear laws that balance a number of concerns when it comes to age of consent for sexual intercourse. Activists in the fields of SRHR and child protection agree on the following considerations in setting up the right age of consent to sexual intercourse:

- It must be high enough for the protection of children from paedophiles and adult sex predators who intend on preying on minors.
- That such an age is low enough to acknowledge the fact that adolescents and young people who are engaging in sexual activity early enough are not criminalised or feel stigmatised or made to feel like they are committing a crime when they want to access services. A good way of balancing such is to have the so-called 'Romeo and Juliet' clause. This is a provision at law that allows adolescents and young people who are close to each other in age to have sexual intercourse among themselves while prohibiting adults to engage in sexual activities with them.

Age of Consent and Societal Attitudes towards the Sexuality of Young People

It is also important to note that although the age of consent is often defined by law or policy, it is usually influenced by social factors and attitudes. Many parents, communities and policy makers do not believe that young people should have sex before marriage. As a result, setting ages of consent to sexual intercourse or contraception lower than the age of marriage is mistakenly viewed as a tacit approval of sex before marriage.

Age of Consent in Zimbabwe: What You Need to Know!

Below are the different ages for consenting to sexual intercourse as well as various SRHR services:[1]

- Age of Consent for sexual intercourse in Zimbabwe is 16 years, while any sexual intercourse with a person under the age of 12 years is illegal. Currently those aged 12-14 years can consent to sex if capable of doing so. There is ongoing discussion on revising this age in line with the factors discussed above.

1 *Age of Consent: Legal Review, Zimbabwe Country Report, SRHR Africa Trust*

- In Zimbabwe, access to contraceptives that are a form of barrier method are available to persons of any age without parental consent. Contraceptives that are a form of medication (such as emergency contraceptives) can only be provided to persons under 16 years of age with parental consent.
- Abortion is only permitted in very limited circumstances (see the Abortion section). Persons under 16 years of age would require parental consent to obtain a lawful abortion.
- There are guidelines for ART and treatment of HIV in Zimbabwe provide for treatment of children, but do not mention Age of Consent. In practice, a child under the age of 16 will still require parental or guardians consent as with any other medical treatment.
- Age of Consent for the Human Papillomavirus (HPV) vaccines is 10 years.
- Age of Consent for cervical screening is 16 years without parental consent. An individual younger than 16 years does not require parental consent if he/she is considered to be a 'mature minor'.
- HIV test results will be reported directly to the patient from the age of 16 years, or on assessment of maturity by the health service provider if the individual is under the age of 16 years.

A Call to Action!

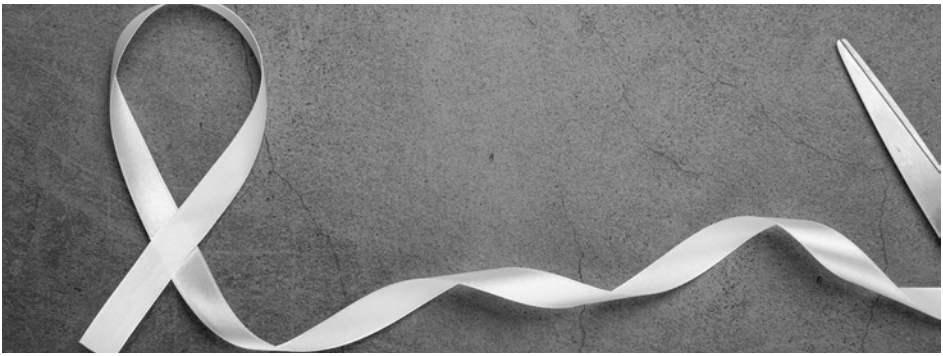
The Katswe Sistahood's position is to review Age of Consent laws as follows:

- Age of Consent to Sex to be set 18 with Romeo and Juliet clauses.
- Age of Consent to Marriage to be set 18 for both girls and boys.
- Age of Consent to reproductive and other health services should be open for all young people who are sexually active to decide for themselves.

Sexual and Gender Based Violence

Introduction and Background

Gender-based violence (GBV) is defined as 'any harmful act that is perpetrated against a person's will, based on socially-ascribed differences between males and females.[1] These socially ascribed differences are what is termed 'gender'.



Gender

refers to the social interpretations and values assigned to being a woman, a man, a boy or a girl. Gender is about social relationships. Gender is an analytical concept. It is socially determined and not based on the sex of the individual. Gender is socially constructed through a process called socialization, a function of ideas, attitudes and norms of the societies in which individuals are brought up in. We grow up with these and they can, and do, change over time. To such an extent, it is possible to change gender norms and relations.

1 *This definition is according to the Inter Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action 2015*

Gender-based violence is sometimes referred to as sexual and gender-based violence (SGBV).

Because gender-based violence affects women more, it is sometimes defined as 'violence that is directed against a woman because she is a woman or that affects women disproportionately.' [1]

Also, important to include in the definition is the alternative but narrower concept of domestic violence which is any behaviour the purpose of which is to gain power and control over a spouse, partner, girl/boyfriend or intimate family member.

Types of GBV

GBV can be classified into five categories[2]:

- Sexual violence which includes rape, sexual assault and sexual harassment.
- Physical violence which includes such violence such as beatings, sometimes even with fatal consequences such as murder.
- Emotional violence (psychological abuse).
- Economic violence (denial of resources or livelihoods).
- Harmful traditional practices (forced marriages, female genital mutilation).

Effects of GBV

GBV has several impacts covering the social, economic and political impacts:

- Women and girls may end up with unwanted pregnancies, unsafe abortions, STIs including HIV.
- Physical injuries and disabilities.
- Mental health and psychosocial consequences e.g. stress and depression
- Social effects include stigmatisation following violation for both survivors and their families.
- Huge investments in health and social welfare services to help survivors cope have a cost on the economy. In addition, GBV often prevents women from participating in economic activities.
- Affects performance of children in school as well as affects their growth and development.

Services Required by Survivors of GBV

People who have experienced violence may be affected in many ways. It is important that survivors of violence have access to some help that get them in a position where they can live normal lives again. The following are some of the key services that people who have experienced violence, must access:

- Clinical services, especially for those who have experienced sexual violence, physical violence and, in some cases, harmful traditional practices.
- Legal services: all forms of violence go against the principles of human rights that every individual must enjoy. Zimbabwe has put in place various laws that protect citizens against the various forms of GBV. When there is threat of violence or repeated violation, the legal system can provide

1 *According to the Zimbabwe Red Cross: Zimbabwe Country Case Study; Effective Law and Policy on Gender Equality and Protection from Sexual and Gender-based Violence in Disasters*
2 *UNFPA, Facilitator's Guide to Reporting on Gender-Based Violence*

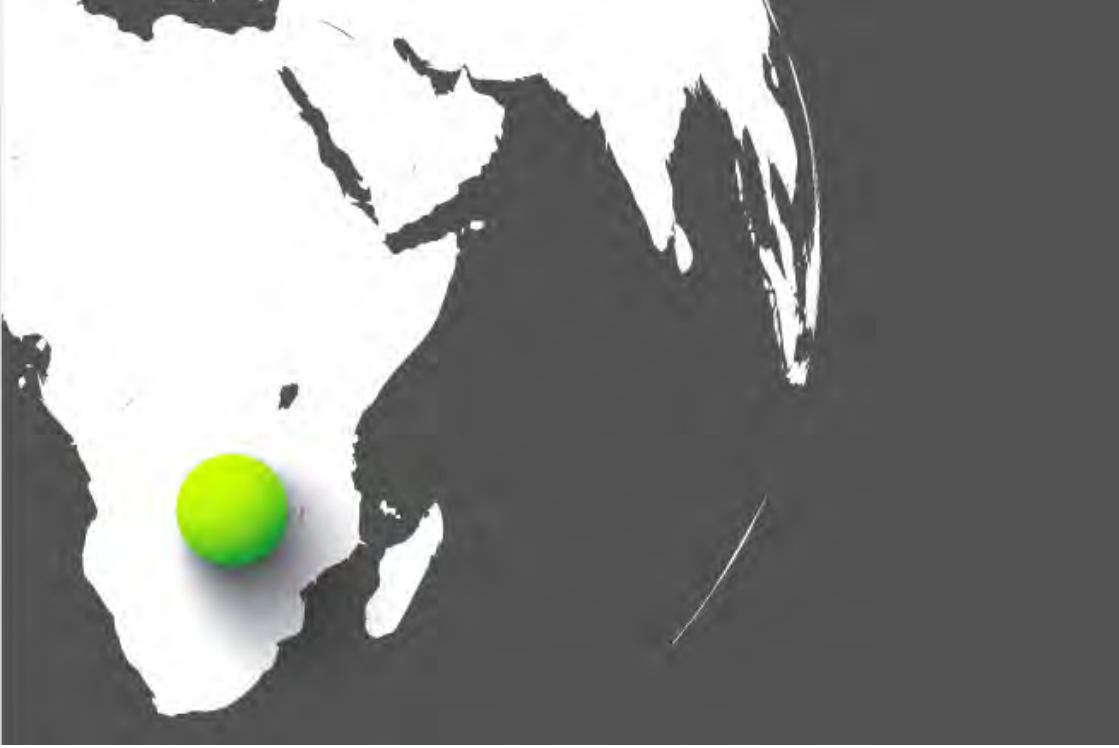
protection orders as a prevention measure.

- Psychosocial services are important not only for people that have gone through emotional violence but for all survivors of GBV because violence leaves emotional scars on victims.
- Economic support: Many, especially women and children experience the different forms of GBV at the hands of the people they depend on for survival or are made vulnerable to violence due to poverty. It is important that such survivors of violence are empowered with means of survival in order to allow them to fend off violence. In cases where survivors depend on the perpetrators for survival, cases are not reported to the policy.
- Welfare Services: In some cases, it is necessary to remove people experiencing violence from their homes/communities. Some of the welfare services they require include food, shelter, clothing etc.

GBV in Zimbabwe: What You Need to Know!

In Zimbabwe, GBV arises from social, cultural, and religious practices that subordinate women to men and do not allow men and women to go out of the socially defined roles of what is normal for men and women. Some of the contributing factors to high prevalence of GBV in Zimbabwe include:

- Societal norms on sexual rights and perceptions on what is considered a real man or woman.
- Harmful traditional practices that include child pledging, forced virginity testing as well forced and child marriages.
- Commercialization of the lobola/roora practice.
- Children (girls and boys) are brought up to accept myths about gender as a fact.
- Many Zimbabweans are socialised to view violence as acceptable for one reason or another e.g. it is okay to fight if you don't agree or beat up a child if they do wrong.
- The dependence of women on men for survival and women's lack of access for productive resources such as land makes them vulnerable to violence.
- There are fewer women in decision making and leadership positions.



Sexual Violence

Sexual violence is one of the most prevalent forms of violence against women in Zimbabwe. According to the Criminal Codification and Reform Act (chapter 9: 23), offenses that are related to sexual and gender-based violence include, rape, aggravated indecent assault, indecent assault, deliberately infecting another with a sexually transmitted disease, soliciting, procuring, sexual crimes against a young person or mentally incompetent person, sexual intercourse within a prohibited degree of relationship, kidnapping or unlawful detention, pledging of female persons, deliberately infecting another with HIV and or sexual transmitted diseases[1], soliciting for purposes of prostitution[2], having sexual intercourse with a young person[3], having sexual intercourse within a prohibited degree of relationship[4], coercing or inducing persons for purposes of engaging in sexual conduct[5], detaining a person for purpose of engaging in unlawful sexual conduct[6], permitting the living off or facilitating prostitution[7], and allowing a child to become a prostitute[8].

However, due to some cultural and societal norms most cases of sexual violence go unreported as the criminality thereof is not appreciated. There is also a worrying trend as to how these cases are being handled by the courts. Most of the few cases that are reported are acquitted by the courts on prosecution. Cases are acquitted, mainly because,

1 *Section 79 of the code*
2 *Section 81 of the code*
3 *Section 70 of the Code*
4 *Section 75 of the Code*
5 *Section 84 of the Code*
6 *Section 85 of the Code*
7 *Section 82 of the Code*
8 *Section 87 of the Code*

Statistics on GBV in Zimbabwe

- About 1 in 3 women aged 15 to 49 years have experienced physical violence and about 1 in 4 women have experienced sexual violence since the age of 15.
- According to the ZDHS, most women and girls suffer violence at the hands of their intimate partners. 32% of ever-married women have experienced spousal emotional violence.
- 6 % of women who have been pregnant reported that they experienced violence during one or more of their pregnancies, thereby affecting the health of mothers and the unborn children
- 43% of girls (13-17 years) report that their first incident of sexual intercourse was unwanted.

the courts are clouded by the fact that the parties would have been in a relationship, and in most cases the complainant consent is implied by what she does prior to the act. For example, if the girl willingly goes to the accused's house or consents to kissing, she is deemed to have accepted the sexual encounter that ensues. This form of rape is often related to date rape.

Date Rape

Date rape is an increasing form of sexual violence yet one that is not clearly addressed at law.

Rape is sex that one doesn't agree to, including forcing a body part or object into one's vagina or anus. Rape is not about sex. It is an act of power by the rapist, and it is always wrong.

The Criminal Law (Codi fication and Reform) Act Chapter 9:23 describes rape as follows: If a male person knowingly has sexual intercourse or anal intercourse with a female person and at a time of the intercourse:

i. the female person has not consented to it.

ii. he knows that she has not consented to it or realizes that there is a real risk or possibility that she may have not consented to it.

In cases of males being violated, the crime is referred to as indecent sexual assault.

Date rape specifically refers to a rape in which there has been some sort of romantic or potentially sexual relationship between the two parties. Date rape also includes rapes in which the victim and perpetrator have been in a non-romantic, non-sexual relationship, for example as co-workers or neighbours.

Date rape occurs when a perpetrator uses physical or psychological intimidation to force a victim to have sex against his or her will.

Sexual Harassment

Sexual harassment is any form of unwelcome sexual behaviour that is offensive, humiliating or intimidating. Unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when submission to or rejection of this conduct explicitly or implicitly affects an individual's living, learning or employment etc. i.e. unreasonably interferes with an individual's performance or creates an intimidating, hostile or offensive environment. Sexual harassment can occur in a variety of circumstances, including the public and private life of an individual while the victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.

Sexual harassment highly prevalent, especially in public spaces, including the streets, in schools and the workplace. However, the magnitude of the sexual harassment crisis is understated if one considers the fact that research[1] indicates that a significant majority (69%) of college female students who are sexually harassed may not be able to recognize that they are being sexually harassed with only 7% of such cases reported to authorities. This scenario, sadly, represents the general outlook for sexual violence, especially sexual harassment, and IPV-related sexual violence – many victims are not aware of their rights and/or are limited by societal attitudes, among other reasons, from reporting the same.

Although there is the labour law protects women from sexual harassment at the workplace, to some extent, women and girls remain unprotected from sexual harassment in many private and public spheres.

1 *Thelma Dhlomo et. al. Perceived Sexual Harassment Among Female Students at a Zimbabwean Institution of Higher Learning, 2010 [accessed 27 April 2021]*

A Call to Action!

Sexual and gender-based violence cases encompass a number of offenses and human rights violations, especially against women, children and other key populations (e.g. sex workers and sexual minorities). As a result, to completely eradicate SGBV, the following recommendations are worth taking up for policymakers:

- A clear, cross-sectorial government policy on sexual harassment.
- Expediting the formulation and implementation of the national sexual harassment law
- Guaranteeing recourse for survivors by intensifying penalties for sexual harassment perpetrators to ensure they do not enjoy impunity.
- Adopting minimum mandatory sentencing for sexual offences clause in our criminal laws.
- Expand conditions for legal abortion and remove obstacles (legal and procedural requirements) for women who qualify for legal abortion. The new constitution expanded the right to life to cover foetuses thereby further limiting the circumstances under which women and girls can seek legal abortion. Survivors of many forms of sexual violence are, often, forced to carry their pregnancies to full term because of legal restrictions.
- Decriminalise sex work to increase access to services and reduce violence against this key population. Laws that prohibit soliciting for sex prevent sex workers from accessing services and/or leave them open to abuse and rape as they fear to report perpetrators.
- Parliamentarians as policy makers can influence budgetary allocations by establishing a budgeting process which includes a gendered and child rights perspective and specifies clear allocations to women, children and young people in disadvantaged or vulnerable situations. This will ensure availability of resources for providing services to survivors of SGBV.
- Avail PEP on demand to women and adolescents for effective prevention of HIV for survivors of SGBV.
- Raise age of consent to sex (for both boys and girls) to 18 years to protect girls especially from sexual exploitation by adult sexual predators. This can be done by changing the definition of a young person in s61 of the Criminal Code to mean any person below 18 years. Sexual intercourse between minors should not be criminalised.

Katswe Sistahood

22 Suffolk Road, Strathaven Harare

Phone: **024 2308622**

Toll Free: **080805306**

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