



“LOST WITHOUT KNOWLEDGE”

BARRIERS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION IN ZIMBABWE

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1. GLOSSARY

ADOLESCENT	Any person between ages 10 and 19 (the World Health Organization).
AU	African Union.
CHILD	Every human being below the age of 18 years (According to the Constitution of Zimbabwe and the definition of the United Nations Convention on the Rights of the Child). ¹
CHILD MARRIAGE	Marriage in which at least one of the parties is under the age of 18. ² This terminology, as used in this report, recognizes the importance that legal ages of consent for marriage are above 18, as confirmed by Zimbabwe's Constitutional Court (2016), ³ recognizing the obligations of African Charter on the Rights and Welfare of the Child, ⁴ and the Convention on the Elimination of All Forms of Discrimination against Women prohibit child marriage. ⁵
CURRENCY	In this report, ZIM \$1 = US\$1.
FORCED /EARLY MARRIAGE	Marriage in which one and/or both parties have not given their full and free consent. ⁶ Child Marriage is considered a form of forced marriage under the African Charter on the Rights and Welfare of the Child. ⁷ Where money, goods, land or other such exchanges and benefits for one of the arranging parties are involved, additional concerns would be raised about the scope for genuine free and informed consent. ⁸ Although boys also undergo forced or early marriage, it is most frequently young girls who are the victims.
HIV	Human Immunodeficiency Virus. HIV weakens the immune system, ultimately leading to AIDS.
MATERNAL MORTALITY	"The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (the World Health Organization).

1 Constitution of Zimbabwe Section 81 (1); Article 1 of the UN Convention on the Rights of the Child.

2 A/HRC/26/22, page 3 www.un.org/ga/search/view_doc.asp?symbol=A/HRC/26/22; Joint general recommendation/General Comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices CEDAW/C/GC/31-CRC/C/GC/18, 2014 (hereafter CEDAW and CRC Committees joint General Comment No. 31 and No. 18), para. 20.

3 Judgment No. CCZ 12/2015 Const. Application No. 79/14 *Loveness Mudzuru and Another v. Minister of Justice, Legal & Parliamentary Affairs and Others* (hereafter *Loveness Mudzuru and Another v. Minister of Justice and Others*) 2016

4 African Charter on the Rights and Welfare of the Child, Article 21 (2) which states that: "Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory."

5 UN Convention on the Elimination of All Forms of Discrimination against Women, Article 16(2). The Constitutional Court of Zimbabwe in *Loveness Mudzuru and Another v. Minister of Justice and Others* has clarified that when read with Article 1 of the UN Convention on the Rights of the Child, this prohibits marriages where one party is under the age of 18.

6 CEDAW and CRC Committees joint General Comment No. 31 and No. 18, para. 23.

7 See further, CEDAW and CRC Committees joint General Comment No. 31 and No. 18, paras 20, 21 and 23.

8 See further CEDAW and CRC Committees joint General Comment No. 31 and No. 18, paras 20 and 21.

MAPUTO PROTOCOL	Name widely used for the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
MOHCC	Zimbabwe Ministry of Health and Child Care.
MOPSE	Zimbabwe Ministry of Primary and Secondary Education.
SADC	Southern African Development Community.
SDG	United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals. ⁹
SEX WORK	Is used to mean the exchange of sexual services between consenting adults for some form of remuneration, with the terms agreed between the seller and the buyer. Amnesty International uses the term 'sex work' only for the consensual sale of sex between adults. ¹⁰ Children involved in commercial sex acts are victims of sexual exploitation, recognized by the International Labour Organization as one of the worst forms of child labour and a grave human rights abuse. ¹¹
STATE PARTY	A country that has ratified or acceded to a particular treaty, and is therefore legally bound by the provisions in the instrument.
UN	United Nations.
UNFPA	United National Populations Fund.
YOUNG PEOPLE	Persons between the ages of 15 and 24 (United Nations Department of Economic and Social Affairs). ¹²
ZDHS	Zimbabwe Demographic and Health Survey.

⁹ <https://sustainabledevelopment.un.org/>

¹⁰ Amnesty International, Policy on State Obligations to Respect, Protect and Fulfil the Human rights of Sex Workers POL 30/4062/2016 www.amnesty.org/en/documents/pol30/4062/2016/en/

¹¹ ILO Convention No. 182 (Worst Forms of Child Labour), 1999, Arts. 3(b) and 6(1) as cited in Amnesty International, Policy on State Obligations to Respect, Protect and Fulfil the Human rights of Sex Workers POL 30/4062/2016.

¹² United Nations Department of Economic and Social Affairs, fact sheet, 2016: www.un.org/esa/socdev/documents/youth/factsheets/youth-definition.pdf

2. EXECUTIVE SUMMARY

“It is high time that people accept that our children are getting involved [in sex] at a tender age so they have to accept and to teach us. It is a subject that is being taken for granted and it is affecting us a lot.”

Adolescent parent age 17.

Throughout the world, adolescent girls, those aged 10-19 years, are the group most at risk of dying or suffering serious injuries during pregnancy and childbirth. In many countries, adolescent pregnancy often results in girls experiencing discrimination, abuse and economic hardship. Many girls are forced into marriages by families hoping to avoid the stigma associated with pre-marital sex, or the cost of raising a child. Pregnancy too often also means the end of educational opportunities. Such outcomes perpetuate cycles of poverty and marginalization. They also represent the failure of governments to respect, protect and fulfil the rights of women and girls to life, health, equality, dignity, education and non-discrimination.

Amnesty International's research on adolescents' access to sexual and reproductive health services and information in Zimbabwe reveals one such significant case of failure by the government to meet its human rights obligations. Despite significant efforts to reduce the maternal mortality ratio (from 960 deaths per 100,000 live births in 2010 to 651 in 2016) and adopt policies to address critical maternal health issues, one fifth of maternal deaths occur among girls aged 15-19. National studies indicate that rates of adolescent pregnancy and HIV are increasing, coinciding with declining rates of knowledge related to sexual and reproductive health. Although Zimbabwe has one of the highest rates of contraceptive use in southern Africa, unmarried adolescents who want to prevent pregnancies are not accessing the contraceptives they need. Adolescents are also indicated to be at high risk of maternal morbidities, including obstetric fistula.

Amnesty International's research highlights four key areas of government failures, which directly and/or indirectly contribute to the barriers for effective access to sexual and reproductive health services, information and education in Zimbabwe: the existence of inconsistent laws and policies on age of consent for sexual and reproductive health services and information; entrenched taboos of adolescent sexuality; failures to provide comprehensive sexuality education in schools, and increasing costs for essential health care services to pregnant women and girls.

This report is based on desktop and field research conducted between February and May 2017. Desktop research included a comprehensive literature review, analysis of key laws and policies related to adolescent sexual and reproductive health and rights in Zimbabwe, and the most recent statistical health data. Field research was conducted in March and April 2017 when Amnesty International researchers visited four provinces in Zimbabwe: Harare, Manicaland, Mashonaland East and Masvingo. Through focused-group discussions and interviews, information was gathered from over 120 people, including 50 adolescent girls. Other participants included teachers, traditional leaders, volunteer community health workers, HIV counsellors, representatives of local NGOs and UN agencies.

Amnesty International shared its preliminary findings and requested further information from Zimbabwean authorities, including from the Ministry of Health and Child Care, the Ministry of Women Affairs, Gender and Community Development, and the Ministry of Primary and Secondary Education. At the time of publication of this report, Amnesty International has not received replies to its requests.

ISOLATED, UNINFORMED AND DEPRIVED OF CHOICES

“Both a man and a woman should wear a condom at the same time for extra protection”; “I heard that if you have never been pregnant and use pills they can damage you.”

Adolescent girls speaking to Amnesty International.

Zimbabwe's demographic health data reveals that nearly 40% of girls and 24% of boys are sexually active before they reach the age of 18. Despite this reality, Amnesty International's findings illustrate a disturbing context of isolation from sexual and reproductive health services and information that adolescent girls face in Zimbabwe. Almost all adolescent girls who spoke to Amnesty International demonstrated deeply concerning knowledge gaps regarding how to protect themselves from unintended pregnancies and sexually transmitted infections, including HIV.

Nearly all the adolescent girls told Amnesty International that they believe using modern contraceptive methods before they first had a pregnancy could result in infertility. Some also gave examples of alternative methods of preventing pregnancy that they had used, including "withdrawal method", "both a man and a woman to wear condom at the same time for extra protection", that women could insert cotton wool into their vagina before having sex with a condom so that if the condom broke the sperm would go into the cotton wool and prevent pregnancy or sexually transmitted infections, and a belief that condoms could sometimes be re-used.

Amnesty International's findings are consistent with Zimbabwe's Demographic and Health Survey (ZDHS) 2015, which indicate high rates of unintended and unwanted pregnancies. The ZDHS further highlights low rates of knowledge regarding emergency contraception and disparate rates of condom use among sexually active unmarried young people aged 15-24; only 50% of young women reported using a condom the last time they had sex, compared with 81% of young men. A government commissioned study also found that barriers to information and availability of condoms may lead to incorrect usage.

INCONSISTENT LAWS AND POLICIES

"I was scared of the law, because it says you have to be 18 before you can be sexually active."

Adolescent girl speaking to Amnesty International.

Zimbabwe's government has adopted specific health policies to improve adolescents' sexual and reproductive health. However, Amnesty International found widespread confusion amongst adolescents, parents, teachers and others regarding the age at which girls could receive sexual and reproductive health services. One of the girls told Amnesty International that "[you] can't go to the clinic if you are under 16; they will chase you away and insult you." Most community stakeholders emphasized that health care workers could "only talk to the ones who are pregnant." A secondary school teacher with 20 years' experience, explained to Amnesty International that even if she wanted to refer a 15 year old student to a clinic for sexual or reproductive health services or information, "I don't think the clinic would accept that."

As in many countries, Zimbabwe does not have a specific law to govern the age at which children may consent to medical procedures, including services related to their sexual or reproductive health. Existing laws which are directly or indirectly related to adolescents' access for sexual or reproductive health services and information do little to clarify confusions and break existing restrictions on access. Especially as debate rages on the appropriate age of consent for sex and marriage.

Under Zimbabwe's Constitution and the Legal Age of Majority Act (Act No. 15 of 1982), full legal capacity is attained at 18. The first section of the Public Health Act (Act No. 19 of 1924) on the other hand defines an adult as "a person of 16 years of age or over" and implies that anyone under 16 needs the consent of a parent or guardian for medical treatment. Furthermore, under the Sexual Offences Act (Acts No. 8 and 22 of 2001) the age of consent for sexual intercourse in Zimbabwe is 16. 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.

The government acknowledges that age of majority laws have been problematically interpreted as upholding the requirement for parental consent for adolescents' access to sexual and reproductive health services below the age of 18. But it is yet to take concrete steps to address existing legal and policy inconsistencies. While age of consent provisions may be intended to provide protection from child sexual abuse or early marriage, in practice they often result in denial of access to essential health services and information. As such, the government needs to take urgent steps to guarantee adolescents' access to sexual and reproductive health services and information without discrimination, restrictions due to age or marital status, or requirements of third party authorization (from a spouse, guardian, parents or others).

STIGMA OF ADOLESCENT SEXUALITY.

Amnesty International found that entrenched taboos of adolescent sexuality in Zimbabwe create barriers for adolescents to access the information and services they need to protect their health, and perpetuates gender discrimination. As result, girls experiencing unintended pregnancies face harsh consequences, including forced child marriage, stigma and difficulties continuing their education. Their health was also at risk as they delayed or were unable to access antenatal care services.

Community members and teachers interviewed by Amnesty International described pre-marital sex as a "taboo" and counter to cultural and religious values. They described girls who engaged in pre-marital sex with disdain, as "prostitutes", "lazy", "materialistic" and "lacking discipline". In contrast, adolescent boys' sexuality was more often acknowledged as "normal" and even respected.

Many parents explained to Amnesty International that they avoid speaking to their children about safer sex and relationships, for fear of condoning sexual activity. Traditional leaders, parents and teachers also expressed strong reservations in allowing adolescents to have access to sexual and reproductive health services and information before marriage or pregnancy for fear of condoning sexual activity, which was against their cultural and/or religious values. As one traditional leader in a focus group discussion explained: “We do not want adolescents to get condoms or contraception as it is then as if they are promoting sex, and sex is taboo.”

The widespread stigma, discrimination and resulting denial of access to much needed sexual and reproductive health information and services have dire consequences. Girls told Amnesty International how they bore sole responsibility for preventing pregnancy and how they struggled to find reliable information from parents, school or caregivers. Many girls in Zimbabwe are forced to resort to unsafe abortions, which are estimated to account for 20% of the country’s maternal deaths. Many adolescent girls are left to raise their children alone, without any support from their parents or the child’s father. Most girls face major challenges returning to school after a pregnancy, including as result of Zimbabwe’s School Re-entry policy, which requires that pregnant girl must drop out of school and re-apply after two years and re-enrolment is made subject to availability of space.

Human rights treaty bodies, including the CEDAW Committee, CRC Committee and the UN Human Rights Council have repeatedly called on Zimbabwe to eliminate stereotypes and harmful practices and take comprehensive action, including public education programmes, to address barriers to sexual and reproductive health services and information.

The government’s own adolescent sexual and reproductive health strategy 2016-2020 (ASRH Strategy) acknowledges the role of religious, cultural and social norms and beliefs as leading to “an environment that regards discussing or accepting adolescents’ sexual and reproductive [health] as taboo and where adolescents and young people who seek [adolescent sexual and reproductive health] services are stigmatized”. It also places emphasis on the importance of increasing adolescents’ knowledge of their sexual and reproductive health and rights as a pathway to reducing harmful religious, cultural and social norms and associated health risks. However, such policies have done little to address the issue and they also contrast to the government’s public messaging, which continues to promote abstinence and stigmatize adolescent sexuality.

COMPREHENSIVE SEXUALITY EDUCATION IN SCHOOLS.

“The fact that so many young girls are falling pregnant is indicative that they don’t understand.”

Teacher speaking to Amnesty International.

Zimbabwe has recently introduced a new educational curriculum which includes components of sexual and reproductive health and rights, within the examinable subject of Guidance and Counselling. However, Amnesty International’s findings indicate that the teaching of this subject continues to take an ‘abstinence-only approach’ and the conceptualization of adolescent sexuality and sexual behaviour remains predominantly negative.

Many stakeholders questioned the government’s commitment towards implementing comprehensive sexual education (CSE) in schools given the prevailing societal attitudes, limited training for teachers and other barriers. The Ministry of Primary and Secondary Education has previously been reported as promoting “a prohibition on all but abstinence education.” Implementation of the new curriculum also continues to rest upon individual decisions by teachers. Teachers retain wide discretion over choosing relevant content, potentially allowing them to avoid or drop lifesaving information due to personal discomfort or religious convictions. Teachers that Amnesty International interviewed explained they need support and training to deliver quality CSE. While some teachers may be specialized in Guidance and Counselling, others will be required to deliver the lessons with limited experience of how to discuss sensitive topics, or the skills necessary to ensure participation and the critical thinking required for changing attitudes and group norms.

FAILURE TO UTILIZE AVAILABLE RESOURCES AND REDUCE COSTS BARRIERS

Zimbabwe is highly reliant on assistance from international partners to fund health services. The country’s health budget has consistently declined since 2012 and in 2017 represented only 8.2% of the total national budget. But most worryingly, Amnesty International’s findings indicate not just a declining budget allocation for the health sector, but also the government’s failure to utilize existing budget allocations. For instance, in 2017, the national budget allocation for the Ministry of Health and Child Care was reported to have decreased because the allocated funds for the Ministry in 2016 had not fully been spent. According to the government’s own consolidated statement of financial performance in 2017, this pattern appears to have continued. In the month of March 2017, for example, US\$780,000.00 was allocated for medical goods and services, but only US\$124,384.00 was spent.

One direct impact of the government’s failure to utilize available resources is on provision of free maternal health services. Despite the government’s policy of free maternal health care, fees for antenatal care and delivery continue to be charged in many public health facilities, to compensate for alleged shortfalls in government subsidy. The impact of such fees disproportionately disadvantages adolescents and, in many cases, has resulted in delayed access to maternal health services or not receiving care at all. Local civil society groups warn that the public health system is at risk of “imminent collapse” and that households will have to face financing their own health care needs. The MoHCC acknowledges that “out-of-pocket” cost contributions by the public to health care expenditures

remain unacceptably high and that it “presents household hardships especially for those who are poor and vulnerable.” A directive issued by the MoHCC in December 2017 has emphasised that fees should not be charged for maternity cases. Nevertheless, this does little to address inefficiencies in utilizing available resources to reduce or eliminate cost barriers.

KEY RECOMMENDATIONS

This report makes a number of recommendations to the government of Zimbabwe to address the identified barriers to adolescents’ ability to access sexual and reproductive health services and information and ultimately achieve progress towards reaching its development targets, including:

- Review and revise all laws related to adolescents’ sexual and reproductive health and rights in Zimbabwe to ensure that there are no inconsistencies related to the age at which adolescents’ can access sexual and reproductive health information, education, and services. This includes: the 1924 Public Health Act; the Children’s’ Act; Sexual Offences Act and the Criminal Law Codification Act and the Termination of Pregnancy Act;
- Provide clarification in all policies relating to sexual and reproductive health services, education and information, to ensure:
 - Adolescents have the right to access to sexual and reproductive health information, education and services, irrespective of their age, without parental consent, based on their evolving capacities, and
 - The age of consent to sexual activity and the minimum age of marriage are not linked to the age at which adolescents can access sexual and reproductive health information, education and services.
- Develop and urgently disseminate clear instructions for health care providers on adolescents’ right to sexual and reproductive health services and information without parental consent and according to the adolescent’s evolving capacities
- Ensure that all available resources are utilized efficiently to provide affordable, safe, effective and acceptable maternal, sexual and reproductive health services, especially for adolescents, including by strictly implementing the Ministry of Health and Child Care policies which provide for free maternal health services including antenatal care and skilled birth assistance, and move towards free sexual and reproductive health services, including modern contraceptive methods and services.
- Finalize and implement the School Health Policy by the end of 2017 to ensure that all young people, both in and out of school, have access to quality, age-appropriate, and evidence-based comprehensive sexuality education, and are empowered to take informed decisions about their sexuality and health, including through provision of information on:
 - Family planning and contraceptives, the prevention of HIV and the prevention and treatment of sexually transmitted infections;
 - The full range of sexual and reproductive rights, including the rights to be free from discrimination and violence, to information, to health, and to a remedy when rights are violated;
 - Gender equality, sexual diversity, and provide tools to challenge harmful gender stereotypes, and social norms and attitudes underlying gender based violence.

3. METHODOLOGY

This report is based on desktop and field research conducted between February and May 2017. Desktop research included a comprehensive literature review, an analysis of key laws and policies related to adolescent sexual and reproductive health and rights in Zimbabwe, and the most recent statistical data, including the Zimbabwe Demographic and Health Survey 2015.¹³

The field research was conducted in March and April 2017. Meetings were held with key staff working in NGOs and inter-governmental institutions who have chosen not to be named in this report. Amnesty International researchers also visited four provinces in Zimbabwe: Harare, Manicaland, Mashonaland East and Masvingo. Six research sites were selected to ensure a mix of rural, peri-urban and urban contexts, where adolescents experience a number of socio-economic challenges in relation to accessing resources, schooling, and opportunities¹⁴ and reflecting disparities in performance indicators in the area of maternal health and access to sexual, reproductive and maternal health services. Site selection also reflected the need that locations were accessible within the research timeframe. Interviews and focus group discussions were held in English and Shona, with facilitators fluent in both languages.

All interviews and focus group discussions were voluntary and conducted in accordance with Amnesty International's ethical standards, its protocol of informed consent and its guidelines for interviewing adolescents. The identities of participants and interviewees have been protected to ensure their right to privacy and to avoid any possible harmful consequences. All names used in the report are pseudonyms to ensure anonymity. Place names have also been excluded when they could be linked to testimonies. Community-based organizations have chosen not to be named to further protect the communities from identification and to protect their organization and their staff from any possible negative consequences.

Qualitative research methods included a series of 10 focus group discussions and two community dialogues as well as individual interviews. Four focus group discussions with community stakeholders were held to establish their views of adolescent sexual and reproductive health and rights. Stakeholders included parents, traditional leaders, teachers, HIV counsellors and volunteer community health workers who provide services in communities. In addition to Amnesty International's core methodology, key questions were developed in reference to the World Health Organization's *Quality Assessment Guidebook: A guide to assessing adolescent health services for adolescent clients*.¹⁵

Six separate focus group discussions were held with 50 adolescents, which aimed to establish participants' knowledge, beliefs and behaviour in relation to risk factors for pregnancy, sexually transmitted infections and child marriage. To comply with governmental regulations controlling health research in Zimbabwe, Amnesty's researchers did not visit any health facilities or undertake any interviews with health care professionals. Nevertheless perceptions and experiences of sexual and reproductive health services was gathered from adolescents. In addition to Amnesty International's core methodology, a series of open-ended, structured questions were adapted from the WHO recommended illustrative questionnaire for interview-surveys with young people.¹⁶ The questions are designed to be suitable for diverse groups of adolescents, including those who are attending school and those who have left school, and for individuals with experience of sexual intercourse and those without.

Ten follow-up interviews were conducted in May 2017 over Skype, with interviewees, including teachers and sexually active adolescent girls selected from two research sites in contrasting rural and peri-urban communities.

On 7 June 2017, Amnesty International wrote to Zimbabwe's Ministry of Health and Child Care, the Ministry of Women Affairs, Gender and Community Development and the Ministry of Primary and Secondary Education, requesting further information in relation to the

13 Zimbabwe Demographic and Health Survey 2015: Final Report. Rockville, Maryland, USA: Zimbabwe National Statistics Agency and ICF International, (hereafter Zimbabwe Demographic and Health Survey 2015) and Zimbabwe National Adolescent Fertility Study 2016.

14 Macleod, C. (2008). Developing principles for research about young women and abortion: a feminist analysis of difficulties in current South African studies. *Feminist Africa*, 11, 55-72 www.agi.ac.za/sites/agi.ac.za/files/fa_11_6_feature_article_3.pdf

15 WHO Quality assessment guidebook A guide to assessing health services for adolescent clients (2009) ref: 9789241598859, www.who.int/maternal_child_adolescent/documents/fch_cah_9789241598859/en/

16 John Cleland, Illustrative questionnaire for interview-surveys with young people (2001) World Health Organization, available: www.who.int/reproductivehealth/topics/adolescence/questionnaire/en/

provision of health and education services and in response to identified barriers to sexual and reproductive health information and services for adolescents. At the time of publication of this report, Amnesty International has not received a reply.

Amnesty International expresses deep thanks to the communities and the women and girls who agreed to share their often difficult accounts for this research. Amnesty International wishes to acknowledge the community of local researchers and civil society activists who provided valuable information and evidence.

4. BACKGROUND

4.1 HEALTH SYSTEM

Zimbabwe's high rates of maternal mortality and morbidity reflect how broader social, economic and gender inequalities negatively impact on women's and girls' health and rights.¹⁷ Zimbabwe's maternal mortality ratio (MMR) soared between 1994 and 2010, from 283 to 960 deaths per 100,000 live births.¹⁸ The period 2000-2008 witnessed intense political and related economic instability, resulting in a dramatic rise in household poverty.¹⁹ In parallel, the public health sector was significantly weakened, having previously reached 85% of the population.²⁰ By 2010, delays in seeking and accessing healthcare accounted for "about 67% of maternal deaths" in Zimbabwe.²¹

Zimbabwe has made significant progress in reducing its MMR by 43% since 2010.²² Key interventions have increased access to contraception,²³ skilled birth attendants, antenatal and postnatal care.²⁴ In 2011, the government secured international assistance to establish a Health Transition Fund to provide free maternal and child health services at all public health facilities²⁵ and has improved access to maternity waiting homes.²⁶ However, the rate of decline in the MMR is far more gradual among girls aged 15-19, at 21%,²⁷ indicating that adolescent girls have not benefited equally from the interventions.

Nearly 20% of Zimbabwe's maternal deaths occur among girls aged 15-19 years,²⁸ a significant proportion of which are linked to unsafe abortion.²⁹ Adolescents are also indicated to be at high risk of maternal morbidities, including obstetric fistula.³⁰ Although Zimbabwe has one of the highest rates of contraceptive use in southern Africa,³¹ demographic health data indicates that rates of adolescent pregnancy and HIV are increasing.³² Women and girls aged between 15 and 24 account for a disproportionate number of

17 In relation to HIV, see Dunbar et al. (2014) The SHAZ! Project: Results from a Pilot Randomized Trial of a Structural Intervention to Prevent HIV among Adolescent Women in Zimbabwe. *PLoS ONE* 9(11) the study focused on adolescent women, and highlighted that they 'face highly constrained access to educational and economic opportunities, and health services' which impact on high rates of HIV infection among girls and adolescent women.

18 UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Maternal Health.

19 Ministry of Health and Child Care (MOHCC), Neonatal, Maternal and Newborn Health Road Map 2007-2015 (hereafter NMNH Road Map 2007-2015), which also notes the period witnessed spiraling inflation rates and a shortage of foreign currency, collapse of the agricultural sector, massive unemployment, and widespread civil unrest.

20 NMNH Road Map 2007-2015, which further cites the HIV and AIDS pandemic, soaring inflation rates and a shortage of foreign currency, shortages of medical supplies, drugs and equipment, and an exodus of skilled medical professionals.

21 United Nations in Zimbabwe Periodic Publication, Issue Paper Series, Paper 1 2013, www.zw.one.un.org/sites/default/files/UN-ZW_IssuePaperSeries-1_MMR_June2013.pdf (hereafter UN Issue Paper Series, Paper 1 2013).

22 Zimbabwe Voluntary National Review (VNR) of SDGs for the High Level Political Forum Summary of Key Messages <https://sustainabledevelopment.un.org/content/documents/14894Zimbabwe.pdf>

23 MoHCC Zimbabwe National Family Planning Costed Implementation Plan 2016 – 2020; Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA) country report on Zimbabwe www.carmma.org/champion/rep-public-zimbabwe; in July 2017 the Zimbabwe MoHCC announced the country had reached a contraceptive prevalence rate of 67%; <http://healthtimes.co.zw/2017/07/15/zim-meets-global-family-planning-target/>

24 UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Maternal Health.

25 UNICEF notes that in 2012 the United Kingdom strengthened its partnership with UNICEF Zimbabwe and the MoHCC by announcing a £50 million (US\$78.4 million) injection into the Health Transition Fund, www.unicef.org/infobycountry/zimbabwe_61823.html; carmma.org/update/maternal-death-rates-fall-zimbabwe-36-percent

26 Voice of America November 20, 2014, Zimbabwe 'Waiting Homes' Aim to Improve Maternal Care', www.voanews.com/a/waiting-homes-improve-maternal-care-in-zimbabwe/2527767.html

27 The National Health Strategy for Zimbabwe 2016-2020 in which the MOHCC has recognized that "most of the sexual reproductive health indicators for youth are either deteriorating or remaining high" at page 27.

28 UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Maternal Health.

29 News Day 16 February 2017 '20% of maternal deaths due to abortion among young women and girls' the article quotes the MoHCC Secretary, Gerald Gwinji, appearing before the Parliamentary Portfolio Committee on Health and Child Care as stating '20% of maternal deaths were due to abortion.' www.newsday.co.zw/2017/02/16/20-maternal-deaths-due-abortion-among-young-women-girls/

30 www.fistulafoundation.org/countries-we-help/zimbabwe/

31 Zimbabwe Demographic and Health Survey data 2005/2010/2015; London Family Planning conference 2012, Family Planning 2020: www.familyplanning2020.org/

32 The National Adolescent Fertility Study, page xiv and xv; Zimbabwe National Family Planning Strategy 2016-2020, page 11.

new HIV infections.³³ Such outcomes coincide with reports of declining rates of knowledge related to sexual and reproductive health.³⁴ The Ministry of Health and Child Care (MoHCC) has recognized that sexual reproductive health indicators for young people are “deteriorating.”³⁵

It is of particular concern that the MoHCC has consistently been underfunded.³⁶ Despite calls from UN agencies and human rights treaty bodies that Zimbabwe substantially increase budget allocations in the areas of health, education and social services to adequate levels,³⁷ Zimbabwe’s budget allocations have remained below the 2001 Abuja Declaration, where governments committed to allocating at least 15% of their annual budget to the improvement of the health sector.³⁸ The budget allocation to health has been declining since a ‘high’ of 10.9% in 2012 and in 2017 represents 8.2% of the total national budget,³⁹ compared to the Sub Saharan Africa average of 11.3%.⁴⁰ In contrast, the budget allocations to Defense have remained above 9% during the same period.⁴¹ The health budget declined from US\$331 million in 2016 to US\$282 million in 2017.⁴² Decreased allocations have been linked to the MoHCC’s failure to utilize budget allocations in the past. The Auditor General has cited “financial leakages” and the failure of “Ministries to timeously report on and account for the collection and utilization of resources under their charge” as reasons for the limited release of funds from Treasury and the related compromise of health service delivery.⁴³

Approximately 80% of the health budget is allocated to employment costs, but vacancy rates remain high.⁴⁴ Doctors’ and nurses’ associations have taken part in strikes over unpaid wages and benefits in 2016 and 2017.⁴⁵ The MoHCC is reported to be over US\$80 million in debt to hospitals, including for reimbursements to health facilities for maternity care user-fees,⁴⁶ and health facilities are reported to be experiencing severe shortages of essential drugs.⁴⁷ The MoHCC acknowledges that per capita health funding is less than recommended levels; “currently \$24 per capita (2015 estimate) versus the recommended \$86.”⁴⁸ The Ministry’s costed intervention plan estimates that an annual spend per capita of \$88 from 2015-2020 would significantly reduce infant, child and maternal mortality.⁴⁹

The MoHCC remains highly dependent on international assistance and external agencies.⁵⁰ Despite efforts like Zimbabwe’s introduction of a tax on mobile phone airtime and data users to raise revenue for the purchase of “drugs and hospital equipment”, the Ministry acknowledges “98% of medicines [is] being procured by partners.”⁵¹ 85% of the national budget for HIV and AIDS health programmes is externally funded,⁵² including US\$177 million from the Global Fund.⁵³ In 2017 Zimbabwe received US\$45 million of funding for Maternal and Child Health Care from donors under the Health Development Fund, compared to US\$6.9 million from the

33 Zimbabwe Demographic and Health Survey 2015 page 273, noting also that HIV prevalence among young people aged 15-24 is also higher among young women (6.7% compared to 2.9% among males); Katswe Sistahood and Sexual Rights Initiative, Joint submission for the Universal Periodic Review of Zimbabwe, 26th Session November 2016.

34 Zimbabwe Demographic and Health Survey 2015, page 239; National Adolescent Fertility Study Technical Report 2016.

35 National Health Strategy for Zimbabwe 2016-2020.

36 MoHCC NMNH Road Map 2007-2015; United Nations in Zimbabwe Periodic Publication, Issue Paper Series, Paper 1 2013, www.zw.one.un.org/sites/default/files/UN-ZW_IssuePaperSeries-1_MMR_June2013.pdf

37 In 2016 the CRC Committee recommended that Zimbabwe should: “Facilitate access to free maternal and child health services, reduce the incidence of maternal, child and infant mortality; CRC/C/ZWE/CO/2 para 59 (b). The Committee also raised concern regarding the insufficiency of trained health professionals para 15(a). at page 50; Aljazeera 9 February 2014 *Zimbabwe’s maternal mortality crisis* www.aljazeera.com/indepth/features/2014/02/zimbabwe-maternal-mortality-crisis-20142561739198301.html); See also the UN raised concerns that per-capita spending under the 2013 health sector budget was US\$18, about half of the recommended US\$34 by the National Health Strategy (2009-2013) UN Issue Paper Series, Paper 1 2013; CRC Committee Concluding Observations Zimbabwe para 15(a).

38 Abuja Declaration on HIV/AIDS, Tuberculosis, and other related infectious diseases, www.un.org/ga/aids/pdf/abuja_declaration.pdf,

39 Community Working Group on Health (CWGH) Post Budget Analysis – Health Sector Allocations 2017 (hereafter CWGH post budget analysis 2017).

40 UNICEF Zimbabwe 2016 Health and Child Care Budget Brief www.unicef.org/zimbabwe/Zimbabwe_2016_Health_and_Child_Care_Budget_Brief.pdf

41 As calculated based on Military expenditure figures from the World Bank www.data.worldbank.org/indicator/MS.MIL.XPND.CN?locations=ZW as a proportion of Zimbabwe’s national budget in 2013 -2017 available www.zimra.co.zw/index.php?option=com_content&view=article&id=1869:2013-national-budget-statement&catid=4:story&Itemid=85

42 lol 14 February 2017 Zimbabwe braces for crippling doctors’ strike www.iol.co.za/news/special-features/zimbabwe/zimbabwe-braces-for-crippling-doctors-strike-7760685
43 Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page viii.

44 National Health Strategy for Zimbabwe 2016-2020 page 52, noting: “Vacancy levels are as high as 89% for midwives, 64% for government medical officers and 49% for nursing tutors” page 47 and “The vacancy rate for specialists at hospitals is at 65%” page 50.

45 Zimbabwe Independent 22 February 2017 Zimbabwe deploys army at hospitals after doctors’ strike www.theindependent.co.zw/2017/02/22/zimbabwe-deploys-army-hospitals-doctors-strike/; The doctor’s strike in February 2017 called for increased ‘on-call’ allowances and implementation of tax deductions on imported cars for doctors as agreed by the government in 2016.

46 Zimbabwe Human Rights NGO Forum October 2016, Quarterly Political and Human Rights Violations Report July - September 2016 (hereafter Zimbabwe Human Rights NGO Forum Quarterly Report 2016); News Day 16 February 2017 20% of maternal deaths due to abortion among young women, girls www.newsday.co.zw/2017/02/16/20-maternal-deaths-due-abortion-among-young-women-girls/

47 Zimbabwe Human Rights NGO Forum Quarterly Report 2016 which notes “Harare and United Bulawayo hospitals also suspended surgical operations due to drug shortages.” Community Working Group on Health Press Statement 23 August 2017 “Urgent need to address the Arv stock-outs” www.cwgh.co.zw/urgent-need-to-address-the-arv-stock-outs/

48 National Health Strategy for Zimbabwe 2016-2020 page 12.

49 National Health Strategy for Zimbabwe 2016-2020, noting: “a mean cost per capita of \$88 over the entire period, would have the following impact in 2020: Decline in infant mortality from 45 per 1000 (2015) to 36 per 1000 live births in 2020; Decline in child mortality from 70 per 1000 (2015) to 60 per 1000 live births in 2020; Decline in maternal mortality ratio from 614 (2015) to 514 per 100,000 live births in 2020; and 101,984 life years gained by ART and PMTCT interventions by 2020” page 64.

50 National Health Strategy for Zimbabwe 2016-2020 page 11.

51 National Health Strategy for Zimbabwe 2016-2020 page 52; see also Community Working Group on Health post budget analysis 2017.

52 MoHCC Zimbabwe Country Report January 2014 – December 2014 (accessed via UNAIDS website), the report notes that domestic spending for the AIDS response increased by 40% between 2011 and 2014 but Zimbabwe’s AIDS response remains 85% externally funded. AVERT notes, the Zimbabwean government collects an AIDS levy, which is made up of 3% payee and corporate tax which contributes considerably to the domestic share of funding for the national HIV response.

53 CWGH, noting HIV and AIDS related costs include anti-retroviral, medicines and training of health care workers.

MoHCC budget.⁵⁴ However, the Zimbabwean government has failed to secure necessary funding for increasing access to contraceptive commodities.⁵⁵

In this context, out of pocket expenses for health services are increasing.⁵⁶ Hospital fees are reported to provide US\$35 million towards drugs and equipment.⁵⁷ The Community Working Group on Health (CWGH), a network of health advocacy organisations in Zimbabwe, warns that the health system is at risk of “imminent collapse” and that “households will mostly finance their own health care needs.”⁵⁸ The MoHCC has acknowledged that “Out-of-Pocket Expenditure contributions remain unacceptably high” and “presents household hardships especially for those who are poor and vulnerable.”⁵⁹ These costs have grave implications for access to sexual and reproductive health services for marginalized women and girls. For example, although Zimbabwe has increased access to skilled birth attendants,⁶⁰ the national figures mask stark inequities; a significant proportion of women without education (50%) and living in poverty (38%) continue to give birth without skilled assistance.⁶¹ These outcomes risk further decline as Zimbabwe weathers another period of economic instability and recovers from severe drought.⁶²

4.2 ADOLESCENT PREGNANCY

High prevalence of adolescent pregnancy is linked to Zimbabwe’s high rates of child marriage, barriers to education⁶³ and related geographic and economic inequalities.⁶⁴ Nearly one quarter of Zimbabwean girls aged 15-19 are currently married or in unions similar to marriage, but this figure increases to 40.2% in rural areas.⁶⁵ Pregnancy rates among girls in rural areas are three times higher than among their urban counterparts.⁶⁶ Adolescent pregnancy rates are also more than five times higher among girls in poverty (than in wealthiest quintile) and twice as high among those with only primary education.⁶⁷

Section 75 of the Constitution states that every citizen and permanent resident of Zimbabwe has a right to a basic state-funded education, including adult basic education. Through its own resources and with assistance from development partners, the government has reported making efforts to provide funding for school fees requirements for children from vulnerable families.⁶⁸ However, it has highlighted severe funding shortages for this programme, which reached only 10,817 students in 2015, compared to 460 239 in 2012.⁶⁹ The report of the Auditor General on the 2016 financial year, noted concern that “Treasury released \$1 570 000 out of a total budgeted figure of \$10 000 000 for the programme.”⁷⁰ Challenges of paying basic school fees continue to be widely reported.⁷¹

54 Government of Zimbabwe, Ministry of Finance 2017 Budget Highlights, “Pushing Production Frontiers Across all Sectors of the Economy” page 3.

55 Zimbabwe National Family Planning Costed Implementation Plan 2016–2020 noting the need to “increase the health budget proportion of the national health budget allocated to the family planning programme from 1.7 percent to 3 percent” page 3; Zimbabwe National Family Planning Strategy 2016-2020, page 10.

56 National Health Strategy for Zimbabwe 2016-2020 which notes “In 2009, per capita expenditure was \$9 and this is estimated to have increased to \$24 in 2015.”

57 CWGH post budget analysis 2017.

58 CWGH post budget analysis 2017.

59 National Health Strategy for Zimbabwe 2016-2020 page 8 and 10.

60 Zimbabwe Demographic and Health Survey 2015 noting an increase to 78% of births in 2015 up from 66% 2010-11, page 145.

61 Zimbabwe Demographic and Health Survey 2015 notes “Wealth is also correlated with delivery assistance: 62 percent of births to mothers in the lowest wealth quintile were attended by a health professional compared with 96 percent of births to mothers in the highest wealth quintile” at page 146.

62 Zimbabwe Voluntary National Review (VNR) of SDGs for the High Level Political Forum July 2017 notes that “Of the 6.3 million children in Zimbabwe, 78 per cent (4.8million) live in consumption poverty and 26 per cent (1.6 million) live in extreme/food poverty”, page 7 and that the “El Nino-induced drought of 2015/16 which left over 4 million people food insecure, 51 per cent of whom are women”, page 10 and that “Endemic poverty afflicts the majority of youths and women in rural areas and in the informal economy where they work with little or no incomes” page 20.

63 Zimbabwe Demographic and Health Survey 2015; National Adolescent Fertility Study Technical Report 2016.

64 UNFPA Adolescent Sexual and Reproductive Health Zimbabwe Demographic and Health Survey 2015 Key Findings notes: “Adolescent pregnancy...is more than twice as high among girls with primary education than among those who attended secondary school” and that “Teenage Pregnancy has Dropped in Urban Areas but not in Rural Areas.”

65 Zimbabwe Demographic and Health Survey 2015, page 66, Table 4.1 Current marital status; ZIMSTAT Multiple Indicator Cluster Survey (MICS) report, cited in Financial Gazette 9 July 2015 ‘Child marriages rampant’ by Andrew Kunambura, Political Reporter www.financialgazette.co.zw/child-marriages-rampant/; Further inequalities are visible in divergent sexual and reproductive health outcomes between provinces, including rates of child marriage (Mashonaland Central province has the highest rate of child marriages, see further, NMNH Road Map 2007-2015.) teenage pregnancy (Teenage pregnancy rates: Matebeleland North (31%), Mashonaland Central (30%) and Manicaland (27%), see further Zimbabwe National Family Planning Strategy 2016-2020 page 15; Zimbabwe Demographic and Health Survey 2015, Key Indicators, notes domestic violence rates also vary, “there are notable differences by province, ranging from 23 percent in Matabeleland to 45 percent in Mashonaland East” page 44.

66 Zimbabwe Demographic and Health Survey 2015 Key Indicators, page 9, noting “Early childbearing among teenagers is almost three times higher in rural than in urban areas (27% versus 10% respectively). By province, early childbearing is highest in Mashonaland Central and Matabeleland South (31% and 30%, respectively) and lowest in Harare (10%); see also Zimbabwe National Family Planning Strategy 2016-2020. Note also that although 67% of Zimbabwe’s 14 million population lives in rural areas, two thirds of medical posts are located in urban areas, The NMNH Road Map 2007-2015, notes further that medical posts in the cities of Harare and Bulawayo account for ‘nearly 90% of the urban quota’.

67 Zimbabwe Demographic and Health Survey 2015 Key Indicators, noting: “More than twice the number of teenagers with primary education (38%) have begun childbearing compared with teenagers who have a secondary education (17%). The proportion of teenagers who have begun childbearing decreases as wealth increases: five times more teenagers in the lowest wealth quintile (34%) have begun childbearing compared with teenagers in the highest wealth quintile (6%)” page 10.

68 Human Rights Council Working Group on the Universal Periodic Review Twenty-sixth session 31 October–11 November 2016, National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21* Zimbabwe at para.s 48 & 49 A/HRC/WG.6/26/ZWE/1(hereafter HRC Working Group UPR, National report Zimbabwe)

69 Ministry of Finance and Economic Development, Zimbabwe Interim Poverty Reduction Strategy paper 2016-2018, noting that under the Basic Education Assistance Module “Students receiving assistance declined from 460,239 in 2012 to a mere 10 817 students in 2015, consistent with the decline in the resources” page 45.

70 Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page 26.

71 Sunday Mail 16 April 2017 ‘Pay school fees with goats, labour’ www.sundaymail.co.zw/pay-school-fees-with-goats-labour/

According to the Zimbabwe Vulnerability Assessment Committee, “at least 63% of the children experienced being turned away for non payment of school fees.”⁷² The participation rate for girls at upper secondary level remains at 44%.⁷³

The last two decades have also seen the rapid rise of apostolic religions in Zimbabwe.⁷⁴ Over a third of women currently belong to apostolic faiths, which preach against using formal health services.⁷⁵ There is significantly higher risk of maternal mortality among women of apostolic faith,⁷⁶ as the religion has been found to promote gender inequality, “high fertility, early marriage, non-use of contraceptives and low or non-use of hospital care.”⁷⁷ Both the UN Committee on the Rights of the Child (2016) and the Committee on the Elimination of Discrimination against Women (CEDAW Committee) (2012) have expressed ‘[S]erious concern about the persistence of harmful norms, practices and traditions, patriarchal attitudes and deep-rooted stereotypes, regarding the roles, responsibilities and identities of women and men in all spheres of life, as well as the State party’s limited efforts to address such discriminatory practices directly.’⁷⁸

72 Zimbabwe Vulnerability Assessment Committee (ZimVAC) 2017 Rural Livelihoods Assessment Report https://docs.wfp.org/api/documents/WFP-0000019918/download/?_ga=2.154151416.1726182025.1502809067-1193031492.1502809067

73 HRC Working Group UPR, National report Zimbabwe at para. 53.

74 Munyaradzi et al. (2016) Praying until Death: Apostolicism, Delays and Maternal Mortality in Zimbabwe. PLoS ONE 11(8): e0160170. page 2/9 (hereafter Munyaradzi et al.)

75 OPHID Apostolic Birth Attendants 2014 noting that among the Apostolic faith, the ‘healer is described as someone that can channel the will of the Holy Spirit and perform divine intervention’ page 22.

76 Munyaradzi et al.; OPHID Apostolic Birth Attendants 2014.

77 Munyaradzi et al.

78 CEDAW Committee Concluding Observations Zimbabwe para. 21; CRC Committee Concluding Observations Zimbabwe 2016 para. 46.

5. BARRIERS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION, EDUCATION AND SERVICES

5.1 ISOLATED, UNINFORMED AND DEPRIVED OF CHOICES

Zimbabwe's obligation to respect, protect and fulfil human rights – including the right to the highest attainable standard of health – requires ensuring that all adolescents can access confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education.⁷⁹

Despite the development of policies aimed at improving the sexual and reproductive health of adolescents and young people,⁸⁰ adolescent girls in Zimbabwe continue to experience high rates of unintended pregnancy and remain at disproportionate risk of maternal mortality and morbidity and HIV infection.⁸¹

Amnesty International's findings illustrate a disturbing context of isolation from the health services, information and education that adolescent girls face in Zimbabwe. Key barriers were related to confusion and inconsistent interpretations of laws and policies relating to the age at which girls were able to access sexual and reproductive health services without parental consent. This situation was also compounded by intense stigma towards the sexual activity of adolescents and the lack of comprehensive sexuality education at schools. Reliable information from health professionals was also not accessed; none of the adolescent girls who participated in Amnesty International's research had visited a health care provider for sexual or reproductive health information or modern contraceptive services from before they had sex for the first time.⁸²

The girls who participated in the research demonstrated deeply concerning knowledge gaps regarding how to protect themselves from unintended pregnancies and sexually transmitted infections, including HIV.⁸³ Nearly all of the interviewees and participants in focus group discussions believed that using modern contraceptive methods before they first had a pregnancy could result in infertility.⁸⁴ Girls also gave examples of alternative methods of preventing pregnancy that they had used. Two reported relying on the “withdrawal method” before they had become pregnant.⁸⁵ One participant suggested that “both a man and a woman could wear a condom at the

79 CRC Committee General Comment 20 para 59.

80 Including the National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020.

81 See above Background section, pages 14-17.

82 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescent girls on 27 May 2017.

83 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescent girls on 27 May 2017.

84 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Macheke 6 April 2017, Caledonia 7 April 2017 and individual interviews on 27 May 2017.

85 One participant of Amnesty International's focus group discussions with adolescent girls in Hopley 1 April 2017, one participant of Amnesty International's focus group discussions with adolescent girls in Caledonia 7 April 2017. 'Withdrawal' is described as 'A man can pull out of a woman before climax' in the WHO Illustrative questionnaire for interview-surveys with young people.

same time for extra protection.”⁸⁶ Another said that condoms could sometimes be re-used.⁸⁷ One suggested that women could insert cotton wool into their vagina before having sex with a condom so that if the condom broke the sperm would go into the cotton wool and prevent pregnancy or sexually transmitted infections.⁸⁸ All of the girls also lacked information about emergency contraception,⁸⁹ and they had either never heard about it or did not know how it works.⁹⁰

Most of the girls generally believed that condom use was an effective method of preventing both pregnancy and HIV,⁹¹ and they agreed that condoms were suitable for casual relationships. However, nearly all revealed that they were not always able to access or use condoms.⁹² Girls described feeling too embarrassed to obtain condoms themselves from shops or clinics, citing a lack of privacy and fear of stigma. One interviewee explained that condoms were kept at the public reception area of her local clinic, but that “If they see you take them they will say you are a bitch.”⁹³

Shuvai’s experiences illustrate some of the barriers:

SHUVAI’S EXPERIENCE

“Shuvai” is 16 and in her third year of secondary school. She should be in the fourth year, but after her father died in 2016 she missed a year in order to work and help her mother save the school fees for herself and her younger sister. Shuvai explained: “I worked as a maid but the husband started to abuse me because he knew my situation, he took advantage of me...I left that work and stayed with my mother. I did odd jobs but men would come and lie...some promised they would send me to school and I could not say no [to having sex with them].” “Sometimes, they would refuse to use a condom, they would overpower me and they were much older, some were married.”

Shuvai is one of the few who had received sexual and reproductive information from an NGO and she took courage to visit a local clinic for condoms. She recounts one of her experience at the clinic: “I knew I had to protect myself. The condoms used to be put in the [clinic] toilet but [are] not there anymore. So now you have to see the nurses...[they] asked how old I was, I told them I was 15, and they started calling me names, bad names and abusing me, but I wanted the help so I gave them deaf ears and they gave me the condoms...” The humiliation she faced is on-going. Shuvai returned to the clinic for more condoms and faced similar mistreatment: “It wasn’t any better [but] I got used to the shouting and mocking.”

Shuvai has not used any other form of modern contraception, due to misconceptions and cost: “At school I read that pills had side effects, like you can stop giving birth at an early age. [The] nurse just gives condoms because the pills are sold. She reflected, “I could have been a mother, God help me.” Shuvai has not tested for HIV: “I am afraid of the worst.”⁹⁴

In interviews and focus group discussions, girls told Amnesty International researchers that they felt women and girls bore the responsibility for preventing pregnancy.⁹⁵ Girls emphasized that condom use was dependent on the agreement of their male sexual partners. Condoms were also regarded as unsuitable for committed long-term relationships and within marriage.⁹⁶ Girls elaborated that the “guy will go if you don’t give unprotected sex,”⁹⁷ and “you’ll lose the guy, [you] need to be agreed that condom use is for a short time, before marriage.”⁹⁸ Participants also related the excuses that male partners had given for not wanting to wear condoms, including “condoms cause cancer” and that they cause testes to enlarge.⁹⁹ Several participants also expressed a lack of confidence in using

86 Amnesty International focus group discussion in Epworth 28 March 2017.

87 Amnesty International focus group discussion in Epworth 28 March 2017.

88 Amnesty International focus group discussion in Epworth 28 March 2017.

89 The WHO describes emergency contraception as “methods of contraception that can be used to prevent pregnancy in the first five days after sexual intercourse.” It is intended for use following unprotected intercourse, contraceptive failure or misuse (such as forgotten pills, or breakage or slippage of condoms), rape or coerced unprotected sex.

90 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescents on 27 May 2017. One participant of the Hopley focus group discussion noted she had heard something about emergency contraception on the radio. Another participant said she thought that emergency contraception was ‘only for other people’.

91 One participant in Amnesty International’s focus group discussion in Caledonia on 7 April 2017 had become pregnant as a result of a condom breaking and was adamant that condoms were unreliable as a method to prevent pregnancy.

92 One participant in Amnesty International’s focus group discussion in Hopley on 1 April 2017 noted she was ‘no longer ashamed’ to be seen purchasing condoms; one participant in Amnesty International’s focus group discussion in Caledonia on 7 April 2017 noted she was shy to take condoms but one day ‘took the whole box’ [from a clinic] and nobody knows.

93 Amnesty International interview on 27 May 2017.

94 Amnesty International interview on 27 May 2017.

95 Amnesty International focus group discussion in Hopley 1 April 2017, Epworth 28 March 2017, and Caledonia 7 April 2017, and individual interviews 27 May 2017.

96 Consensus from Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Macheke 6 April 2017 and Caledonia 7 April 2017.

97 Participant of Amnesty International focus group discussion in Epworth 28 March 2017.

98 Participant of Amnesty International focus group discussion in Epworth 28 March 2017.

99 Amnesty International focus group discussion in Epworth 28 March 2017.

condoms, with two girls reporting they had become pregnant after it broke.¹⁰⁰ A significant number of girls disclosed that they had sold sex to get money for school fees or other essentials.¹⁰¹ Condom use was described as being difficult to negotiate in these contexts.¹⁰² (See Shuvai's case study above.)

Amnesty International's findings are consistent with Zimbabwe's Demographic and Health Survey (ZDHS) 2015, which reports that an estimated 40% of girls and 24% of boys have sex before the age of 18,¹⁰³ and nearly one in 10 adolescent girls give birth every year.¹⁰⁴ The ZDHS and other studies also indicate high rates of unintended and unwanted pregnancies,¹⁰⁵ yet contraceptive use by adolescents - especially those who are unmarried - remains low.¹⁰⁶ The ZDHS further highlights low rates of knowledge regarding emergency contraception¹⁰⁷ and disparate rates of condom use among sexually active unmarried young people aged 15-24; only 50% of young women reported using a condom the last time they had sex, compared with 81% of young men.¹⁰⁸ A government commissioned study also found that barriers to information and availability of condoms may lead to incorrect usage.¹⁰⁹

A number of girls interviewed by Amnesty International also reported incidents of sexual violence and coercion.¹¹⁰ "Kudzai" became pregnant after her boyfriend raped her when she was 16. It was the first time she had sex. They had been dating for six months, having met at school. At school, Kudzai was not given basic sexuality education, or told about contraception. She did not tell anyone what happened with her boyfriend, and is still traumatised from the experience; she told Amnesty International "now I hate to be in a relationship".¹¹¹ Kudzai has limited knowledge about contraception and did not have any information about emergency contraception. Had she known, she noted "I would have got it".¹¹² On disclosing her pregnancy, Kudzai's mother shouted at her and beat her. Her boyfriend has denied paternity and has not made any contribution to the care of his six month old daughter. Kudzai is studying at afternoon classes and also helps her mother selling sweets and biscuits.

Data from Zimbabwe indicates that Kudzai's experience is all too common. According to the government's National Gender Policy 2013-2017; "51.3% of girls aged 19 years and below have their first sexual experience forced against their will."¹¹³ The National Adolescent Fertility Study 2016 also found, "the contribution of sexual violence to sexual initiation and adolescent pregnancy is significant in Zimbabwe,"¹¹⁴ the study's baseline data reflects that 43% of the participants aged 13-17 who had sexual intercourse for the first time in the 12 months preceding the survey, had "unwanted" first sexual intercourse.¹¹⁵

A 2016 study commissioned by the Ministry of Public Service, Labour and Social Welfare found that gender norms, including perceptions of masculinity "in which a real man does not use protection" and that girls "lack agency in making sexual decisions" and "fear rejection by boys," negatively influenced contraception use.¹¹⁶ The study also highlights Zimbabwe's high rate of adolescent relationship violence in the form of sexual violence.¹¹⁷ The report indicates prevalent social norms of forced sex, driven by gender

100 One participant in Amnesty International's focus group discussion in Caledonia on 7 April 2017 and one participant in Amnesty International's focus group discussion in Hopley on 1 April 2017.

101 Local NGOs reported to Amnesty International that poverty was so severe in some peri-urban (high density areas) that girls sold sex for US\$25 cents or "US\$1 for two"; On the economic context of young people selling sex see further www.economist.com/news/middle-east-and-africa/21713866-less-stigma-more-competition-decriminalising-sex-trade-zimbabwe; <http://www.herald.co.zw/govt-acts-on-child-prostitutes/>; and on access barriers to health services, J. Busza et al. Underage and underserved: reaching young women who sell sex in Zimbabwe *AIDS CARE*, 2016 VOL. 28, NO. S2, 14-20 which notes that young women in Zimbabwe who sell sex were both unaware of health services and reluctant to use them.

102 Amnesty International interviews with adolescent girls 27 May 2017.

103 Zimbabwe Demographic and Health Survey 2015 pages 63-34 and Table 4.5.

104 UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings Adolescent Sexual and Reproductive Health; see also the Zimbabwe Demographic and Health Survey 2015 which notes that, "teenagers in rural areas are almost three times as likely as their urban peers to begin childbearing: 27 percent of rural teenagers have begun childbearing compared with 10 percent of urban teenagers," at page 80 and table 5.11.

105 Zimbabwe Demographic and Health Survey 2015 page 106, Table 6.5 Fertility planning status, indicating 36.1% of births to women aged under 20 years were unintended ('wanted later') and 1.5% were 'wanted no more'; see also: McCoy SI et al. (2014) Unmet Need for Family Planning, Contraceptive Failure, and Unintended Pregnancy among HIV-Infected and HIV-Uninfected Women in Zimbabwe. *PLoS ONE* 9(8), the study found of 8,797 births, "3,090 (35.1%) were reported as unintended", including "2,282 (25.9%) unwanted" pregnancies.

106 The National Adolescent Fertility Study page 8; Zimbabwe Demographic and Health Survey 2015 page 127, Table 7.9.2; UNFPA Zimbabwe Demographic and Health Survey 2015 Key Findings ASRH.

107 Zimbabwe Demographic and Health Survey 2015 noting "emergency contraception is the least-known modern contraception method among women and men (28% and 33% respectively)" page 110.

108 Zimbabwe Demographic and Health Survey, page 247 and Figure 13.10.

109 Fry, D., Hodzi, C. and T. Nhenga, Addressing Social Norms that Underpin Violence Against Children in Zimbabwe: Findings and Strategic Planning Document. Harare: Ministry of Public Services, Labour and Social Welfare, 2016 (hereafter Fry et al. Addressing Social Norms 2016) noting the finding from the qualitative research within the study that "young people spoke at length about the difficulties and barriers accessing contraceptives" and noting concern that "Since adolescents do not necessarily have proper information on condom use, the condoms may be reused or not applied properly" at page 19.

110 Interview with Amnesty International 27 May 2017.

111 Interview with Amnesty International 27 May 2017.

112 Interview with Amnesty International 27 May 2017.

113 Zimbabwe Demographic and Health Survey 2010/11 page 6.

114 National Adolescents Sexual and Reproductive Health Strategy II: 2016 page 2.

115 ASRH Strategy II 2016 page 2, and clarifies "unwanted first sexual intercourse" as: "they were either forced, pressured, tricked, or threatened to engage in sexual intercourse", citing: Zimbabwe National Statistics Agency (ZIMSTAT), United Nations Children's Fund (UNICEF) and Collaborating Centre for Operational Research and Evaluation (CCORE), 2013 National Baseline Survey on Life Experiences of Adolescents, 2011. Harare, Zimbabwe; see also Zimbabwe Demographic and Health Survey 2015 and UNFPA Gender Based Violence 2015 Key Findings, noting "more than one in three women in Zimbabwe have experienced physical violence since the age of 15."

116 Fry et al. Addressing Social Norms 2016, at page 19.

117 Fry et al. Addressing Social Norms 2016, at page 27, noting "adolescent relationship violence in the form of sexual violence is also the highest in Zimbabwe when compared to other countries that have undertaken similar surveys."

stereotypes and stigma of female adolescent sexuality,¹¹⁸ including a finding that 75% of the participants were reported to “believe girls say no to sex even when they want to have sex.”¹¹⁹

EVOLVING CAPACITIES

As children mature, they experience physical and social changes and develop their reasoning skills and individual identity.¹²⁰ Human rights law, including under the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, (ACRWC) protects children’s right to be heard as part of the obligation that the best interests of the child shall be the primary consideration in all actions concerning a child.¹²¹ The CRC Committee have emphasized, that the principle of best interests includes ensuring “that appropriate weight is afforded to the views of adolescents as they acquire understanding and maturity.”¹²²

Although adolescents’ sexual development is a natural and important part of the transition from childhood to adulthood,¹²³ as this report demonstrates, their individual agency in relation to decisions over their sexual and reproductive health, is often contested when it clashes with cultural or societal norms and taboos. Attitudes towards sexual development are further complicated by the negative association of early sexual activity with broader health and social risks, such as high rates of maternal deaths and injuries among adolescents.¹²⁴ Development goals under the SDGs and the AU’s Agenda 2063 include targets to significantly reduce maternal mortality ratios¹²⁵ HIV incidence,¹²⁶ and to “eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.”¹²⁷ Related interventions to improve sexual and reproductive health outcomes often demonstrate a tension between paternalistic approaches, aimed at “protecting children” and those which seek to “empower adolescents” to make their own responsible decisions.

In the context of adolescent sexual and reproductive health, the WHO highlights that laws and policies which “mandate adolescent access to contraceptive information and services irrespective of their age or marital status could improve contraceptive use by adolescents and reduce teenage pregnancies.”¹²⁸ Improving access to modern contraception information, services and goods is also demonstrated to reduce maternal deaths.¹²⁹ The WHO recommends that “fostering autonomy, for example, by empowering adolescents to access health services, is a protective measure, since timely access to services could protect them from potential harm.”¹³⁰ Similarly, in the context of addressing harmful cultural practices, the CRC and CEDAW Committees have emphasized that “girls need to be equipped with the skills and competencies necessary to assert their rights, including to make autonomous and informed decisions and choices about their own lives.”¹³¹

In contrast, paternalistic interventions usually focus on controlling adolescents’ individual behaviour, such as requiring abstinence, laws prescribing age of consent for sexual activity and age of marriage, or the criminalization of consensual sexual activity between adolescents.¹³² Such approaches often fail to respect adolescent’s right to autonomy, commensurate with their evolving capacities and risk stigmatizing adolescents who fall outside “accepted behaviour”.

Paternalistic approaches also overlook social and economic inequalities¹³³ and the range of structural factors – including access to education or poverty status – which impact on decision-making, especially for adolescents

118 Fry et al. Addressing Social Norms 2016, at page 27.

119 Fry et al. Addressing Social Norms 2016, at page 28-29.

120 CRC Committee General Comment 4.

121 African Charter on the Rights and Welfare of the Child Article 4 (1); CRC Article 3; CRC Committee General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1).

122 CRC Committee General Comment No 20 para 22.

123 CRC Committee General Comment 4.

124 WHO News Release ‘More than 1.2 million adolescents die every year, nearly all preventable’ <http://who.int/mediacentre/news/releases/2017/yearly-adolescent-deaths/en/>

125 UN Agenda 2030 Goal 3.1

126 UN Agenda 2030 Goal 3.3 and indicator 3.3.1

127 UN Agenda 2030 Goal 5.3. AU Agenda 2063 The Africa We Want, 2015. ASPIRATION 6: An Africa whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children para 51:

128 WHO Guidelines for Preventing Early Pregnancy and Poor Reproductive Outcomes 2011, as cited by as cited by Fry et al. Addressing Social Norms 2016 page 26.

129 See for example: UNFPA and Guttmacher Institute, Adding it up: Costs and benefits of contraceptive services estimates for 2012, June 2012,

www.guttmacher.org/pubs/AIU-2012-estimates.pdf; UNFPA, State of world population 2005: The promise of equality, page 6, www.unfpa.org/publications/state-worldpopulation-

130 WHO Global Accelerated Action for the Health of Adolescents 2017 Summary page 8.

http://africahealthforum.afro.who.int/IMG/pdf/the_global_accelerated_action_for_the_health_of_adolescent_aa-ha_implementation_guidance.pdf

131 CEDAW and CRC Committees joint General Comment No. 31 and No. 18 para 61.

132 Report of the Special Rapporteur on the right to health 2016.

133 Wendy Graham et al. Diversity and divergence: the dynamic burden of poor maternal health, Lancet, 2016; 388: 2164–75 Published Online September 15, 2016

in vulnerable situations.¹³⁴ Behaviour change approaches have also been found to be more expensive and less sustainable than investment in structural changes.¹³⁵ In contrast, implementation approaches which seek to empower adolescents, through prioritizing policies that provide access to health services, education and social support are likely to have longer term success.¹³⁶ For example, programmes supporting girls to complete secondary school education, have demonstrated reduced rates of HIV infection and adolescent pregnancy,¹³⁷ and in Zimbabwe, reduced early marriage among orphan girls.¹³⁸ Also in Zimbabwe, a social cash transfer program implemented by UNICEF is credited for “a positive impact on delaying marriage and sexual debut, as well as decreasing the likelihood of early pregnancy among female youth in large households... positively [impacting] condom use at first sex as well as the probability of lifetime reports of forced sex.”¹³⁹

Public health and human rights experts have made a number of clear, evidence based, recommendations for improving the sexual and reproductive health outcomes of adolescents. These include the need for states to ensure that legal, policy and regulation frameworks protect, promote and fulfil adolescents’ right to health.¹⁴⁰ Such laws or regulations should explicitly guarantee adolescents access to sexual and reproductive health services and information, free from discrimination or barriers,¹⁴¹ including restrictions due to age or marital status, or requirements of third party authorization (from the spouse, guardian, parents or others).¹⁴² Furthermore, states are obliged to provide comprehensive sexuality education¹⁴³ and take immediate measures to tackle negative gender stereotypes and stigma that prevent access to sexual and reproductive health information and services.¹⁴⁴

The Office of the UN High Commissioner for Human Rights (OHCHR), has emphasized that barriers to adequate sexual and reproductive health services and information that result in “[d]elays in the decision to seek care or opting out of the health system entirely” should not be “treated not as idiosyncratic, personal choices or immutable cultural preferences but as human rights failures.”¹⁴⁵ The following sections of this report highlight four key areas of government failures which were found to undermine access to sexual and reproductive health services, information and education for adolescents in Zimbabwe, including: failures to ensure consistent laws and policies regarding adolescents’ access to sexual and reproductive health information and services; failures to address the high prevalence of negative attitudes and stigmatization against adolescents’ right and eligibility to access sexual and reproductive health services; failures to provide comprehensive sexuality education in schools and failures to regulate out of pocket costs for maternal health services and ensure they do not impede accessibility of care for marginalized women and girls.

5.1.1 INCONSISTENT LAWS AND POLICIES

Human rights bodies emphasize that realizing adolescents’ sexual and reproductive health and rights requires States parties to put in place laws, policies and programmes to support adolescents’ autonomous decision-making and non-discrimination.¹⁴⁶ This requires ensuring there are no barriers to health-related information, education and services, such as restrictions due to age or marital status, or requirements of third party authorization (from the spouse, guardian, parents or others).¹⁴⁷ Public health research and human rights treaty bodies recognize that adolescents – especially those most at risk of marginalization – are unlikely to access health services and

134 CRC Committee General Comment 4 at para. 30;

135 MoHCC National Adolescent Sexual and Reproductive Health Strategy II, at page 8; CRC Committee General Comment 4 at para 34.

136 See further: A. Yamin and V. Boulanger, Embedding sexual and reproductive health and rights in a transformational development framework: lessons learned from the MDG targets and indicators *Reproductive Health Matters* Volume 21, Issue 42, November 2013, Pages 74-85; UN The Millennium Development Goals Report 2015, page 42.

137 Cluver L et al. Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity-score-matched case-control study, *Lancet Glob Health* 2013;1: e362–70; Cluver L et al. Combination social protection halves HIV-risk behaviour incidence amongst female and male South African adolescents. 20th International AIDS Conference, Melbourne, abstract MOAC0104, July 2014.

138 UNICEF-ESARO/Transfer Project (2015), ‘Social Cash Transfer and Children’s Outcomes: A Review of Evidence from Africa’.

139 Johns Hopkins Bloomberg School of Public Health Review of ASRH Strategy I 2015.

140 CESCR Committee General Comment 22 para. 28; CRC Committee General Comment 20; ACHPR General Comment 2 on article 14 of Maputo Protocol para. 35; UNPFA Harmonizing the Legal Environment for ASRHR 2017; WHO Global Accelerated Action for the Health of Adolescents 2017.

141 ACHPR General Comment 2 on article 14 of Maputo Protocol Para 29.

142 CESCR Committee General Comment 22 para 41; Maputo Plan of Action which advises governments to ‘Remove legal, regulatory and policy barriers limiting access to SRH commodities, programmes and services’;

143 CRC Committee General Comment 15 paras 31, 59; CRC, CRC Committee General Comment 4 paras 7, 26, 28, 39(b); CRC Committee General Comment 20 para. 60; CRC Committee Concluding Observations Zimbabwe 2016; Report of the United Nations Special Rapporteur on the right to education, on the topic of the right to sexual education, 23 July 2010, A/65/162 para. 63; Human Rights Council, Report of the Special Rapporteur on the right to health 2016 at para 91; ACHPR General Comment 2 on article 14 of Maputo Protocol para 26 and 51.

144SADC Gender Protocol, article 4(3) includes obligations that “States Parties shall by 2030 adopt and implement gender sensitive educational policies and programmes addressing gender stereotypes in education and gender based violence”; OHCHR Commissioned Report ‘Gender Stereotyping as a Human Rights Violation’ 2013; for further information on legal standards see the section in this briefing on international human rights standards and for further guidance Page X.

145 UN OHCHR Technical Guidance, para. 56.

146 CESCR Committee General Comment 22; CRC Committee General Comment 20 para 39.

147 CESCR Committee General Comment 22 para. 41; CRC Committee General Comment 20 para 39.

information without such guarantees.¹⁴⁸ For adolescent girls, the impact of such barriers may be injury or even death related to pregnancy.¹⁴⁹

As in many countries, Zimbabwe does not have a specific law to govern the age at which children may consent to medical procedures, including services related to their sexual or reproductive health.¹⁵⁰ Although there are a number of laws in Zimbabwe which are related, directly or indirectly, to the provision of sexual or reproductive health services and information for adolescents, these are increasingly creating confusion and inconsistent interpretations on adolescent's access to services related to their sexual or reproductive health.

Under Zimbabwe's Constitution¹⁵¹ and the Legal Age of Majority Act (1982),¹⁵² full legal capacity is attained at 18. The Public Health Act (1924) on the other hand defines an adult as "a person of 16 years of age or over"¹⁵³ and implies that anyone under 16 needs the consent of a parent or guardian for medical treatment. PLAN International's analysis of Zimbabwe's Children's Act highlights its failure to "specify an age at which children can consent to medical treatment or access health services without parental consent" and silence regarding "reproductive health matters."¹⁵⁴ Furthermore, the age of consent for sexual intercourse in Zimbabwe is 16.¹⁵⁵ Until recently, it was also possible for girls to consent to marriage from the age of 16 (boys from 18).¹⁵⁶

In 2016, the Constitutional Court ruled that Section 22 of the Marriage Act was unconstitutional and set the legal age for marriage as 18 for both girls and boys.¹⁵⁷ However, the government has yet to amend the Marriage Act or related legislations to comply with the court's judgment in order to prevent or prosecute subsequent cases of child marriage. In community discussions facilitated by Amnesty International, adolescent pregnancy was considered to be one of the main drivers of child marriage; as a means of mitigating both the "shame" of pre-marital sex and the economic burden of raising a child.¹⁵⁸ Many stakeholders expressed concern about the legal situation as a result of the judgment that the age of consent for sex remains at 16 (under the criminal law) yet the legal age for marriage is 18.

The MoHCC acknowledges that age of majority laws have been problematically interpreted as upholding the requirement for parental consent for adolescents' access to sexual and reproductive health services below the age of 18.¹⁵⁹ Various public health studies have also found confusion among stakeholders, including health services providers, parents, community members and adolescents themselves regarding adolescents' rights to access these health services.¹⁶⁰

Amnesty International interviewed adolescents and community stakeholders to assess their understanding as to the age or circumstances when adolescents would be able to access sexual or reproductive health services and information. The findings highlight profound confusion and knowledge gaps. Some identified 16 as the age at which girls could access services, but many interviewees and participants of focus group discussions emphasized that health care workers could "only talk to the ones who are pregnant."¹⁶¹ A secondary school teacher with 20 years' experience, including as the Head of the Guidance and Counselling department at a secondary school in Harare, explained to Amnesty International that even if she wanted to refer a 15 year old student to a clinic for sexual or reproductive health services or information, "I don't think the clinic would accept that."¹⁶²

148 Delany-Moretwe S et al., Providing comprehensive health services for young key populations: needs, barriers and gaps *Journal of the International AIDS Society* 2015 18(Suppl 1):19833, (hereafter Delany-Moretwe et al. Providing comprehensive health services for young key populations 2015) which notes: "In [young key populations], the effects of stigma, discrimination and violence are exacerbated by policy and legal barriers related to the age of consent for sex as well as selected medical interventions, further limiting access to a range of health services"; UNAIDS 12 August 2016, Breaking Down the Barriers on International Youth Day – Young People Need Better Access to HIV services www.unaids.org/en/resources/presscentre/featurestories/2016/august/20160812_international-youth-day; CRC Committee General Comment 20, para. 62; UNFPA Harmonizing the Legal Environment for ASHRs 2017; WHO Guidelines for Preventing Early Pregnancy and Poor Reproductive Outcomes 2011; WHO HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV 2013; UN Special Rapporteur on the right to health 2016 para. 59.

149 UN Special Rapporteur on the right to health 2016 para.5.

150 The WHO recognizes that many countries have 'patchwork' legal frameworks relating to when adolescents may 'exercise their right to independent decision-making' WHO HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV 2013.

151 Constitution of Zimbabwe S81 (1).

152 Legal Age of Majority Act (Act No. 15 of 1982); The Act conferred full legal capacity on every Zimbabwean aged 18 years and above.

153 Public Health Act of Zimbabwe (Act 19 Of 1924), Interpretation section (1). www.chr.up.ac.za/undp/domestic/docs/legislation_56.pdf

154 PLAN International, In-depth review of legal and regulatory frameworks on child marriage in Zimbabwe, 2016 (hereafter PLAN Zimbabwe legal review 2016), citing by comparison the South African Children's Act of 2005, page 43.

155 The Sexual Offences Act 2001.

156 Section 22 of the Marriage Act sets the minimum age of marriage at 16 years for girls and 18 years for boys.

157 *Loveness Mudzuru and Another v. Minister of Justice and Others* 2016.

158 Amnesty International Community discussions in Mutare 4 April 2017 and Masvingo 5 April 2017.

159 Such barriers are recognized as problematic in the National Adolescent Fertility Study, page 12, citing MoHCC. National Adolescent Sexual and Reproductive Health (ASRH) Advocacy Package and Implementation Plan: 2014 – 2015 for Zimbabwe; see also Guttmacher Institute, Background assessment for adolescent reproductive health project: results from interviews with representatives of 15 national and international health organizations and agencies, Sept. 11–14, 2011, Harare, Zimbabwe, unpublished report, New York: Guttmacher Institute, 2011 www.guttmacher.org/report/sexual-and-reproductive-health-needs-adolescents-zimbabwe#20; Guttmacher Institute, In Brief, 2014 Series No 3, Sexual and Reproductive Health Needs of Adolescents in Zimbabwe, at page 4.

160 Johns Hopkins Bloomberg School of Public Health Review of ASRH Strategy I 2015; National Adolescent Fertility Study 2016; Müller et al. (2016) "You can see there is no harmony between policies": service providers' knowledge on the law and policy framework governing adolescent HIV and sexual and reproductive healthcare in Zimbabwe (Research Brief). Cape Town: GHJRU, UCT (hereafter Müller et al, Research Brief: "You can see there is no harmony between policies").

161 Amnesty International focus group discussion with community members, Mutare 4 April 2017.

162 Amnesty International Interview with secondary school teacher 27 May 2017.



TENDAI'S EXPERIENCE

Tendai, now 18, had sex for the first time when she was 15. Her friends advised her to find a boyfriend who could give her financial support. "I come from a poor family and I wanted money to go to school." She has since had more than 20 sexual relationships. Tendai explained she was afraid to visit a government health facility for information or services because of her perception of the law;

"I was scared [to go] because I was young... I was scared of the law, because it says you have to be 18 before you can be sexually active."

Tendai relied on boyfriends to provide condoms as they were too expensive for her to buy [US\$50c each].

Tendai's first visit to a clinic was when she was eight months pregnant, aged 17;

"The nurses shouted at me because I was late to be registered, [but I] had to pay US\$25, I was doing small jobs like laundry [to get the money]. I was feeling bad while pregnant because I [thought I] was doing the wrong things."

Tendai needed to give birth at a hospital in Harare. It cost her \$US20 for the ambulance to get there, and US\$85 in fees for the delivery, injections and surgery to repair an injury sustained while giving birth. Tendai is still paying back the money she borrowed. She has received no support from the child's father and lives with her mother. She feels people see her 'as a failure' and 'don't respect' her. "It's difficult living there for me".

Perceived age barriers were found to have dire implications. Two adolescent girls who described selling sex told Amnesty International they had been barred from the clinic because of their age.¹⁶³ As one of the girls explained, "[you] can't go to the clinic if you are under 16; they will chase you away and insult you."¹⁶⁴ Another girl had been told by friends she needed to be 18 to access health services. She explained that despite having 20 sexual relationships, her first visit to a health facility was at eight months pregnant; "I was scared of the law, because it says you have to be 18 before you can be sexually active."¹⁶⁵ Another girl similarly explained that because of her age she had never visited a health clinic before she became pregnant aged 17; "I knew that I was too young."¹⁶⁶

Such views were confirmed by an HIV counsellor in a different location who highlighted that girls under 18 do not come to the clinic where she works for contraception services.¹⁶⁷ Furthermore, when Amnesty International asked representatives of NGOs working on programmes related to adolescent sexual and reproductive health about their experience of providing such health services to adolescents, they explained their understanding that they were unable to provide contraceptive or HIV testing services to adolescents under the age of 16 without parental consent.¹⁶⁸ The NGO representatives highlighted this age barrier as major a concern in contexts of possible sexual exploitation of children. Other studies also reveal the widely held belief that the MoHCC requires written parental consent for HIV testing for anyone aged under 16, and that the legal definition of statutory rape prohibits service providers delivering adolescent sexual and reproductive health information, education and services to under-16s.¹⁶⁹

Zimbabwe's key policies on adolescent sexual and reproductive health seek to improve access to 'Youth Friendly' services. However, they fail to address increasing levels of ambiguity and confusion surrounding adolescents' right to access these services and information, and how health care providers should apply the principles of evolving capacities and the best interests of the child.¹⁷⁰ To the contrary, some of the policies fuel the conflation of ages of consent for health services with debate surrounding the age of consent for marriage and sexual intercourse.

163 Amnesty International focus group discussions in Epworth on 28 March 2017.

164 Participant in Amnesty International focus group discussion in Epworth on 28 March 2017.

165 Amnesty International Interview 27 May 2017.

166 Amnesty International Interview 27 May 2017.

167 Amnesty International Interview with HIV Counsellor 7 April 2017 (location removed to maintain anonymity).

168 A number of organizations supported events described as 'join in circuits' where adolescents were provided with integrated HIV and sexual and reproductive health information and services. In meetings with Amnesty International one organization specifically highlighted the low take up of family planning services among girls aged 15-19.

169 Johns Hopkins Bloomberg School of Public Health Review of ASRH Strategy I 2015; these findings are supported by ZDHS data, as cited by UNFPA ZDHS 2015 Key Findings ASRH, which indicates adolescents are less likely than adults to be tested for HIV and less likely to be linked to services, whether they test positive or negative, and further nearly half of '15-24 year old men and one third of 15-24 year old women have never tested for HIV.

170 See for example, the guidance from IPPF "The application of the best interests of the child implies that all available alternatives for a child to decide autonomously have been exhausted. • As a minimum health professions must: (1) have provided full and accurate information that is understandable to minors and (2) answered their questions and concerns (3) in a friendly context, committed to their specific needs, with a guarantee of confidentiality and privacy, (4) respecting their opinions, comments, concerns and worries and (5) promoting the exercise of the minor's autonomy by all means available, according to the nature of the concrete case." IPPF Sexual and Reproductive Rights of Young People: Autonomous decision making and confidential services, page 20.

Amnesty International reviewed three key national sexual and reproductive health policies in order to assess their responses to the existing legal inconsistencies.

NATIONAL GUIDELINES ON HIV TESTING AND COUNSELLING GUIDELINES 2014

The National Guidelines on HIV Testing and Counselling (HTC Guidelines) set national standards to govern all HIV Testing and Counselling (HTC) services in the country.¹⁷¹ Significantly, the Guidelines recognize the importance of a human rights-based approach to HTC and emphasize the need to guarantee the right to health and related rights to privacy, confidentiality and informed consent.¹⁷² However, the HTC Guidelines set 16 as the age of consent for HIV testing and treatment services¹⁷³ and stipulate that the “consent of a parent or caregiver is required before performing an HIV test on a child who is below 16 years of age.”¹⁷⁴

Nevertheless, the HTC Guidelines do provide for exceptions in cases where children can be considered “mature minors.”¹⁷⁵ This includes children who are “married, pregnant or a parent,” - who are automatically deemed capable of informed consent regardless of their age - and children who can “demonstrate that he or she is mature enough to make a decision on their own.”¹⁷⁶ Although the “mature minor” exception is important, the HTC Guidelines have been criticized for creating a perverse situation in which HTC services, necessary to empower adolescents aged under 16 to make decisions to protect their sexual and reproductive health, are available as standard only after pregnancy or marriage.¹⁷⁷

The MoHCC recognizes that Zimbabwe has one of the highest HIV infection rates in sub-Saharan Africa.¹⁷⁸ In generalized epidemics, the WHO recommends HTC services with links to prevention, treatment and care for all adolescents.¹⁷⁹ Zimbabwe has made great progress in increasing coverage of HIV testing since 2005.¹⁸⁰ However, according to ZDHS 2015 data, while 15.2% of women aged 20-24 have never tested, this rises to 52.1% for adolescents aged 15-19,¹⁸¹ reflecting that “[s]eeking an HIV test may be more difficult for young people than adults because many young people lack experience in accessing health services; and there are often barriers to young people obtaining services.”¹⁸²

Health experts, including UNAIDS, the WHO and UNFPA, have warned that age of consent requirements for HIV testing and treatment are a significant barrier for adolescents, many of whom will be afraid or unable to seek parental consent.¹⁸³ UNFPA have recently recommended that states; “[s]et the age of consent to 12 years for HIV testing, pre- and post-counselling and contraceptives without parental consent.”¹⁸⁴

NATIONAL GUIDELINES ON CLINICAL ADOLESCENT AND YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION 2016

Access by adolescents to contraceptive services is governed by Zimbabwe’s National Guidelines on Clinical Adolescent and Youth-Friendly Sexual and Reproductive Health Service Provision 2016 (Clinical YFSP Guidelines). These guidelines are addressed to health service providers and are intended to benefit all adolescents, by ensuring they “receive effective and youth friendly” sexual and reproductive health services.¹⁸⁵ The guidelines do not specify a particular age of consent for services, but follow WHO’s recommendations and expressly provide that age should not be a barrier in cases where an

171 Zimbabwe National Guidelines on HIV Testing and Counselling 2014.

172 Zimbabwe National Guidelines on HIV Testing and Counselling 2014, throughout Chapter two.

173 Zimbabwe National Guidelines on HIV Testing and Counselling 2014, page 5, states: “Any child who is aged 16 years or above, or is married, pregnant or a parent, who requests HTC is considered able to give full informed consent.”

174 The Guidelines provide that if a parent or caregiver will not or cannot give consent for a child below 16 years of age, the health worker can exercise the ‘best interest of the child’ principle and seek approval from the person in charge of the clinic or hospital to perform the HIV test.” Zimbabwe National Guidelines on HIV Testing and Counselling 2014, page 5.

175 Zimbabwe National Guidelines on HIV Testing and Counselling 2014 refers to “mature minors” who are under age 16 but pregnant, married or who are parents or heading a household or living independently from a parent/guardian to access HIV testing. Such “mature minors” are considered to have assumed responsibility for their own lives and can therefore consent to HTC, at page 22.

176 Zimbabwe National Guidelines on HIV Testing and Counselling 2014.

177 Women’s Action Group (WAG) in the Zimbabwe Gender Challenge Initiative (GCI) report for PEPFAR, *Promoting social dialogue to inform Sexual Reproductive and Health Rights (SRHR) program strategies for addressing SRHR issues affecting pre-adolescent and adolescent boys and girls in Guruve district*, April 2015; See also: State of Denial, 2003 by the Center for Reproductive Law and Policy Child and Law Foundation in Zimbabwe.

178 Zimbabwe National Guidelines on HIV Testing and Counselling

179 WHO Global Accelerated Action for the Health of Adolescents 2017, page 49, the report Annex 3, refers to South Africa’s legislative provision for reduced age of consent for HIV testing (from the age of 12 under the Children’s Act) as a best practice example.

180 Zimbabwe Demographic and Health Survey 2015 notes an increase from 22% of women aged 15-49 who have ever been tested for HIV and received the result in 2005-06 rising to 80% in 2015, p 243, Figure 13.5 Trends in HIV Testing.

181 Zimbabwe Demographic and Health Survey 2015 Table 13.9.1 Coverage of prior HIV Testing: Women, page 259.

182 Zimbabwe Demographic and Health Survey 2015 page 247.

183 WHO, HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV; UNAIDS The Gap Report 2015; Delany-Moretlwe et al. Providing comprehensive health services for young key populations 2015 ; UNFPA Harmonizing the Legal Environment for ASRHRs 2017.

184 UNFPA Harmonizing the Legal Environment for ASRHRs 2017; The WHO similarly praise South Africa’s Children’s Act which legislates for children to consent to HIV services from the age of 12, see further WHO Global Accelerated Action for the Health of Adolescents 2017 Annex 3.

185 MoHCC National Guidelines on Clinical Adolescent and Youth-Friendly Sexual and Reproductive Health Service Provision 2016 (Clinical YFSP Guidelines) page 25.

adolescent is sexually active and under the age of 16.¹⁸⁶ The Clinical YFSP Guidelines further require that: "Health service providers should be aware that adolescents requesting contraceptives have a right to receive these services regardless of age or marital status."¹⁸⁷ The Clinical YFSP Guidelines also recognize the importance of integrating sexual and reproductive health and HIV services.

"Although the legal age of consent to sexual activity in Zimbabwe is 16 years, all adolescents who are sexually active should be offered a contraceptive method of their choice."

2016 Clinical YFSP Guidelines

However, the Guidelines do not extend a similar presumption of access, regardless of age or marital status, to HIV counselling and testing. It therefore appears that the age of consent for these HIV services remains at 16, with the exceptions for "mature minors" as per the HTC Guidelines.¹⁸⁸ For example, under the Clinical YFSP Guidelines a 15-year-old who is sexually active should be able to access contraceptive services, without parental consent, but may not be able to test for HIV.

Implementation of both Guidelines depend on the discretion of health service providers. They both require that health service providers consider the "best interests of the child" when deciding whether to provide services to a child who is under the age of 16.¹⁸⁹ Unlike the national HTC Guidelines, however, the Clinical YFSP Guidelines do not provide guidance as to the factors that should be taken into account in making decisions on providing services to a child without parental consent.¹⁹⁰ In this regard, "determining whether or not a young person is eligible for a particular sexual or reproductive health service remains complex, especially when providers are reminded that their decision must also comply with ten additional national regulations."¹⁹¹

UNFPA have recommended the need for regulatory frameworks to "Clearly state that health-care providers need to respect the views and opinions of the adolescent or young person accessing a service and their right to confidentiality." And that "The law should guide health-care providers on how they can assess this maturity."¹⁹²

THE NATIONAL ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH STRATEGY II: 2016-2020

Amnesty International also reviewed Zimbabwe's National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016-2020, which was launched in March 2017.¹⁹³ The ASRH Strategy is a national policy document designed to provide guidance on the implementation of sexual and reproductive health services and related initiatives.¹⁹⁴

The ASRH Strategy identifies the need to "harmonise policy and legal framework to facilitate implementation of ASRH programmes."¹⁹⁵ And it expressly recognizes that "inconsistencies in the law, in defining a child, the age of consent to sex, and the age of consent to marriage...continues to pose problems to both young people and service providers."¹⁹⁶ However, the Strategy fails to clarify adolescents' rights to access sexual and reproductive health services and information without age, marital status or third party consent limitations. Rather, it focuses on the need to strengthen laws and processes in Zimbabwe which deal with issues of child sexual abuse, including enforcement of age of consent for child marriages and sexual activity.¹⁹⁷ Such singular framing risks conflation of the different ages of consent: for sexual intercourse, marriage and access to health services.¹⁹⁸ While age of consent provisions may be intended to provide protection from child sexual

186 Here the 2016 Clinical YFSP Guidelines repeat the framing of the Family Planning Guidelines (2007); "Age alone should not constitute the sole reason for denying medical service to adolescents. Although the legal age of consent to sexual activity in Zimbabwe is 16 years, all adolescences who are sexually active should be offered a contraceptive method of their choice."

187 Zimbabwe Clinical YFSP Guidelines 2016.

188 The "mature minors" as noted above, footnote 196.

189 Clinical YFSP Guidelines, including at page 39; HTC Guidelines at page 6.

190 The HTC Guidelines require that a HIV Counsellor "should consider the following factors in determining whether a child or adolescent should be treated as a mature minor: The minor's ability to appreciate the seriousness of HTC and the test result and to give informed consent; The minor's physical, emotional and mental development; The degree of responsibility the minor has assumed for his or her own life, such as heading a household or living independently from a parent/caregiver", at page 6.

191 2016 Clinical YFSP Guidelines listing other guidelines on page 46, including: Family Planning Guidelines 2007; Maternal and neonatal Health roadmap 2007-2015; HTC Guidelines 2014; Guidelines for Antiretroviral therapy for the Prevention and treatment of HIV 2013; National Case Management and System for the Welfare and Protection of Children in Zimbabwe (undated); Child Participation and Protection Guidelines 2010; Guidelines on Voluntary Medical male Circumcision 2014; management of Sexually transmitted infections and Reproductive tract Infections in Zimbabwe 2012; Psychosocial Support Guidelines for Children living with HIV and AIDS 2009; National Guidelines for Comprehensive Abortion Care in Zimbabwe 2014.

192 UNFPA ESA Harmonisation 2017.

193 Government of Zimbabwe, Ministry of Health and Child Care National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision, 2016 and Government of Zimbabwe, Ministry of Health and Child Care, National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020.

194 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020, page xvii.

195 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020.

196 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020, page 5.

197 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020, page 25. This debate has also highlighted concern regarding high rates of sexual violence and abuse of children in Zimbabwe and the failure of the criminal justice system to secure access to justice and redress for survivors, alongside which confusion over the provisions of the criminal law which have been interpreted as accepting 'consent' of a child aged between 12 and 16 as a mitigating factor in such cases;

www.crin.org/en/library/news-archive/zimbabwe-courts-are-seeing-consenting-sex-over-12s-unproblematic-activists-say

198 See further the Zimbabwe National Adolescent Fertility Study, 2016 which recommends that "the Child Marriages Act and the Legal Age of Consent...require urgent harmonisation. At present a girl can consent to sex at the age of 16 but cannot be married until she attains 18 years despite being pregnant" page 99, and warns; "children are having sexual intercourse outside of marriage. The age of consent remains at 16 years and there is a possibility of an increase in childbearing outside marriage as the men

abuse or early marriage, they can also be used to unfairly suppress, regulate or prosecute consensual sex between adolescents. This focus on protection from harm rather than consent and empowerment can have unintended consequences as well as serious implications for adolescents' ability to realize their human rights.

Human rights standards are clear that while setting a minimum age for sexual consent is part of States' obligations,¹⁹⁹ it should not create barriers "to commodities, information and counselling on sexual and reproductive health and rights."²⁰⁰

Indeed, in failing to clarify the necessity of a human rights based approach to ensuring adolescents have access to sexual and reproductive health services and information, the ASRH Strategy risks undermining the development and implementation of strategies to address Zimbabwe's high rate of child marriage. The government has recently announced plans to criminalize marriage under the age of 18 through a proposed amendment to the Children's Act.²⁰¹ Zimbabwe's Constitutional Court is clear that "pregnancy can no longer be an excuse for child marriage."²⁰² The government's (draft) National Action Plan to End Child Marriage 2016-2018 acknowledges the need to address adolescent pregnancy as a driver of child marriage through improving access to sexual and reproductive health services and information.²⁰³

Amnesty International was unable to speak with health care providers to hear how they interpret and implement the laws and policies regarding age of consent for sexual and reproductive health services.²⁰⁴ However, a 2016 study of service providers' knowledge on the law and policy framework governing adolescent HIV and sexual and reproductive health care in Zimbabwe, revealed that "providers have inconsistent knowledge of the laws and policies, especially around the ages of consent to access to HIV and SRH services."²⁰⁵ Similarly, the 2016 National Adolescent Fertility study found health service providers may use their discretion to restrict access, especially for unmarried adolescents.²⁰⁶

Indeed, Amnesty International's findings highlight that ages of consent for health services, to sexual intercourse and to marriage have become conflated in public debate and risk proper policy implementation. Legal and policy inconsistencies on the provision of sexual and reproductive health services, information and education must be clarified as a matter of urgency. As recently highlighted by UNFPA, the prevailing "uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent."²⁰⁷ The CRC Committee, in its concluding observations to Zimbabwe in 2016, also recommended that the government needs to "[e]nsure the alignment of legislation with the Constitution to prevent discrimination against adolescents on the basis of marital status, particularly with regard to their access to reproductive health services without the consent of a parent or a guardian."²⁰⁸

TACKLING TABOOS OVER ADOLESCENT SEXUALITY

The Zimbabwean authorities have an obligation to take all appropriate measures to address negative gender stereotypes, inequalities and related social or cultural norms concerning sexuality and reproduction, which lead to gender and other forms of discrimination and denial of human rights.²⁰⁹ Human rights treaty bodies have recognized the harmful outcomes of such norms and stereotypes for girls, including as barriers to sexual and reproductive health services and information²¹⁰ and as a driver of child marriage.²¹¹

try to avoid prosecution by rejecting the responsibility of pregnancy" page 78; Müller et al, Research Brief: "You can see there is no harmony between policies" 2016, further indicates that the government's delay in clarifying laws related to child marriage since the Constitutional Court judgment has fueled confusion among health service providers regarding ages of consent to health services, noting "All providers knew about the recent constitutional court judgment setting the legal age for marriage at 18. However, many felt uncertain about the implications." The study recommends that "implications of the Constitutional Court judgment setting the legal age for marriage at 18 should be discussed in detail with NGO and healthcare service providers to avoid misinterpretation of the judgment."; See also Zimbabwe Chronicle, 'Age of consent now 18: Lawyers' 22 January 2016 www.chronicle.co.zw/age-of-consent-now-18-lawyers/

199 CRC Committee General Comment No. 4 para 5.

200 CRC Committee General Comment 20 which notes that States parties are obliged under article 4 of the CRC to take appropriate legislative, administrative and other measures for the implementation of the rights recognized para. 60; UNFPA's report Harmonizing the Legal Environment for ASRHs 2017, highlights that the age of consent for access to sexual and reproductive health services should not be higher than the age of consent for sex.

201 www.herald.co.zw/act-to-criminalise-child-marriages/

202 *Loveness Mudzuru and Another v. Minister of Justice and Others* 2016 at Page 53

203 Government of Zimbabwe, National Action Plan to End Child Marriage 2016-2018 (DRAFT seen by Amnesty International in May 2017), which notes the Plan "has been developed with a view to catalyse, coordinate and strengthen national efforts to end child marriage and child pregnancy by 2030", page 1.

204 See methodology section.

205 Müller et al, Research Brief: "You can see there is no harmony between policies."

206 The National Adolescent Fertility Study page 11.

207 UNFPA ESA Harmonisation 2017.

208 CRC Committee Concluding Observations Zimbabwe 2016 para. 60 (d). Note that The CRC Committee have previously called upon states to recognize adolescents as rights holders, and not to impose strict "age of consent" requirements in CRC Committee General Comment 4 (Adolescent Health), 2003, paras 7, 6, 9, 12.

209 CEDAW and CRC Committees joint General Comment No. 31 and No. 18 paras 6 and 31 and citing CEDAW articles 4 (1) 14; art. 5 (a); and art. 16 (2); see also CESCR Committee General Comment 22 para 35.

210 CRC Committee General Comment No. 4, paras 26 and 27.

211 CEDAW and CRC Committees joint General Comment No. 31 and No. 18 para 6.

Amnesty International found that entrenched taboos of adolescent sexuality in Zimbabwe create barriers for adolescents to access the information and services they need to protect their health, and perpetuates gender discrimination.²¹² Community members and teachers interviewed by Amnesty International described pre-marital sex as a “taboo” and counter to cultural and religious values. They described girls who engaged in pre-marital sex with disdain; as “misbehaving”,²¹³ “lazy”, “disinterested in school” and “materialistic”,²¹⁴ and lamented the “lack of discipline”.²¹⁵ In contrast, adolescent boys’ sexuality was more often acknowledged as normal and even respected.²¹⁶

Most participants felt that allowing adolescents to access sexual and reproductive health services and information was akin to their condoning sexual activity, which was against their cultural and/or religious values.²¹⁷ As one traditional leader in a focus group discussion explained: “We do not want adolescents to get condoms or contraception as it is as if they are promoting sex, and sex is taboo.”²¹⁸ This view was supported by a female teacher who agreed: “It is taboo for girls to have sex before marriage – so if a girl gets Jadelle [contraceptive implant] it means saying OK to have sex before and it is not OK.”²¹⁹

Similar views were expressed by parents, who explained that they felt unable to speak to children about safe sex and relationships as they feared such discussions carried an implicit approval: “[we] can’t teach a child to prevent, it is giving them permission.”²²⁰ Another mother expressed further: “[the] problem is that...culture plays a role and for mothers to say use condoms or contraception, no, families can’t say that, you would be communicating that it is OK [to have sex] so [we] need to find someone else to communicate.”²²¹ Participants acknowledged that “now there is no one to give young people direction.”²²²

Most adolescent girls interviewed by Amnesty International indicated they would prefer obtaining information about relationships and reproduction from their mothers or female relatives,²²³ yet found it very difficult or impossible to speak about sexual relationship with their parents.²²⁴ Some also noted that friends and family members gave them misinformation.²²⁵ An adolescent who had a six-month-old baby explained “parents don’t talk about preventing pregnancy. [They] just say ‘don’t get pregnant’ but don’t tell you straight.” She felt such attitudes had left her “lost without knowledge”.²²⁶ As noted above, none of the adolescent girls who participated in Amnesty International’s interviews and focus group discussions had accessed sexual or reproductive health information or modern contraceptive services from a health care provider before they had sex for the first time. They had also not received this necessary information from school (see below).

The National Adolescent Fertility Study raises “[n]egative attitudes regarding sexual activity before marriage” as contributing to the lack of knowledge of contraceptives among young women.²²⁷ The ASRH Strategy II (2016-2020) also identifies the role of harmful religious, cultural and social norms and beliefs as leading to “an environment that regards discussing or accepting adolescents’ sexual and reproductive [health] as taboo and where adolescents and young people who seek ASRH services are stigmatized.”²²⁸ Commendably, the ASRH Strategy places emphasis on the importance of increasing adolescents’ knowledge of their sexual and reproductive health and rights as a pathway to reducing harmful religious, cultural and social norms and associated health risks.²²⁹ However, these policies contrast with the government’s public messaging, which continues to promote abstinence and stigmatise adolescent sexuality.²³⁰

212 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescents on 27 May 2017.

213 Village Health Worker (aged 54 Female) participant of Amnesty International focus group discussion in Mutare with community leaders 4 April 2017.

214 A grandmother and older male speaking to Amnesty International during community discussion in Mutare 4 April 2017.

215 Negative reference to ‘child rights’ emerged in Amnesty International community discussions in Mutare 4 April 2017 and in Masvingo 5 April 2017; with suggestions that adolescent pregnancy was related to parents no longer being allowed to ‘beat’ children.

216 Amnesty International community dialogues and focus group discussion in Mutare and Masvingo 4 and 5 April 2017, for example, as one of the community leaders participating in a focus group discussion in Mutare on 4 April 2017, explained; “He can have four children and still be a hero.”

217 Amnesty International community dialogues and focus group discussions with traditional leaders, community health care workers and teachers in Masvingo and Mutare April 4 and 5 2017.

218 A traditional leader participating in Amnesty International focus group discussion with community leaders and teachers in Mutare 4 April 2017. Traditional leaders in Zimbabwe perform important roles in the public life and governance of communities.

219 Amnesty International focus group discussion with community leaders and teachers in Mutare 4 April 2017.

220 Amnesty International focus group discussion with community leaders and teachers in Mutare 4 April 2017.

221 Village health care worker: Amnesty International community discussion in Masvingo 5 April 2017.

222 Village health care worker: Amnesty International community discussion in Masvingo 5 April 2017. Parents and community members participating in Amnesty International community dialogues and focus group discussion in Mutare and Masvingo also explained that traditionally, giving guidance to children about sex and relationships would have been a role for extended family members, such as aunts and uncles, or advisors in the church to perform. However, such processes were often no longer in place. See further, Ngwenya S. Communication of reproductive health information to the rural girl child in Filabusi, Zimbabwe. *Afri Health Sci* 2016;16(2): 451-461.

223 Amnesty International researchers asked adolescents about the sources of information they had access to for learning about puberty, reproductive systems and relationships. In relation to puberty, adolescents mentioned a range of sources, including: parents, aunts, sisters, school, church and NGOs. They reported that ‘school’, was the most important source of information on reproductive systems, followed by ‘friends’. Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescents on 27 May 2017.

224 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescents on 27 May 2017.

225 Amnesty International community dialogues and focus group discussion in Mutare 4 April 2017 and Masvingo 5 April 2017.

226 Participant of Amnesty International focus group discussion in Caledonia 7 April 2017.

227 The National Adolescent Fertility Study page 8.

228 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020 page 17.

229 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020 page 16-17.

230 For example, the Minister for Health and Child Care, David Parirenyatwa, is quoted as saying his ministry will push for “total abstinence from sex before marriage” to tackle unsafe abortions and unwanted teenage pregnancies; Gift Phiri for Al Jazeera <http://www.aljazeera.com/indepth/features/2014/02/zimbabwe-maternal-mortality-crisis-20142561739198301.html>.

Implementation of the policies risk failure unless the government also takes steps to address wider societal gender norms and stereotypes which numerous studies in Zimbabwe have found underpin such views.²³¹ The CESCR Committee has called on states to address “discriminatory stereotypes, assumptions and norms concerning sexuality and reproduction, which...undermine the realization of sexual and reproductive health.”²³² Such action is long over-due. In 2012 the CEDAW Committee noted with “serious concern” that Zimbabwe had “not taken sustained measures to modify or eliminate stereotypes and harmful practices” which discriminate against women and girls.²³³ The Committee called for a “comprehensive strategy”, including public education programmes, to be “[p]ut in place, without delay”.²³⁴ However, the National Gender Policy 2013-2017 fails to make any substantive reference to addressing patriarchy, cultural norms or stereotyping, which underlie Zimbabwe’s profound gender inequality.²³⁵

In 2016, the CRC Committee again highlighted Zimbabwe’s failure to take “sustained measures to modify or eliminate stereotypes and harmful practices” and highlighted serious concerns regarding “the situation of girls, in particular adolescent girls, [in Zimbabwe] who suffer marginalization and gender stereotyping which compromise their educational opportunities, and who are more vulnerable to sexual violence, abuse and HIV/AIDS.”²³⁶ The CRC Committee called on the government to “carry out comprehensive public-education campaigns to prevent and combat all forms of discrimination, including gender stereotyping.”²³⁷ Concerns regarding Zimbabwe’s failure to sufficiently address gender inequality were also highlighted by States party to the ICCPR at Zimbabwe’s Universal Periodic Review before the Human Rights Council in 2017.²³⁸

The ASRH Strategy further references to a draft MoHCC communication tool to support parents with skills and information to better talk to children about sex and relationships.²³⁹ On 7 June 2017, Amnesty international wrote to the Ministries of Health and Child Care and of Primary and Secondary Education to request further information regarding development of this tool, but had not received a response at the time of publication.²⁴⁰

STIGMA RELATED TO ADOLESCENT PREGNANCY AND ITS CONSEQUENCES

In community discussions, community members explained that pregnant girls may be victimized in their homes, labelled “prostitutes” and treated as outcasts.²⁴¹ A teacher explained: “some parents may chase the girl away, some girls may commit suicide, they will have low self-esteem.”²⁴² Tatenda’s experience highlights some of the challenges that stigma creates for adolescent mothers:

231 Fry et al. Addressing Social Norms 2016; PLAN International, Counting the Invisible, Girls’ Rights and Realities, Technical Report – Zimbabwe 2017.

232 CESCR Committee General Comment 22 (2016), para 35.

233 CEDAW Committee Concluding observations Zimbabwe 2012 (ref CEDAW/C/ZWE/CO/2-5) para. 22.

234 CEDAW Committee Concluding observations Zimbabwe 2012 (ref CEDAW/C/ZWE/CO/2-5) para. 22.

235 The National Gender Policy 2013-2017 makes only three references to Stereotyping, once within the Definition of Terms, and twice in the context of educational subject choices, pages 4 and 17.

236 CRC Committee Concluding Observations 2016 paras 46 and 26.

237 CRC Committee Concluding Observations 2016 para 27.

238 For example, “Ghana encouraged Zimbabwe to put in place a comprehensive strategy to modify or at best eliminate patriarchal attitudes and stereotypes that discriminate against women, in particular”, Zimbabwe accepted the recommendations related to improving gender equality, including: A - 131.20 Tunisia; A - 131.56 Thailand; A - 131.57 Maldives; A - 131.58 Republic of Korea; A - 131.59 Mexico; A - 131.60 Japan, see further UPR Info, Zimbabwe, Second Review Session 26 Review in the Working Group: 2 November 2016 Adoption in the Plenary: 16 March 2017 www.upr-info.org

239 National Adolescent and Youth Sexual and Reproductive Health Strategy II: 2016-2020.

240 Amnesty International letters to MoHCC and MoPSE dated June 7 2017.

241 Amnesty International focus group discussion Mutare 4 April 2017 and Masvingo 5 April 2017.

242 Female teacher, Amnesty International focus group discussion with community members Mutare 4 April 2017.

TATENDA'S EXPERIENCE AS AN ADOLESCENT PARENT

"Tatenda" is 17 years old and became pregnant at 15. As a single parent, she has experienced stigma and discrimination and feels very isolated. She explained: "[People] treat you like you are a whore. Like maybe they think I got myself into this situation. I was with one guy, but people think I was indulging. It's difficult for my relatives and they are just neglecting me."

Tatenda's mother died when she was eight years old. Her father died when she was 13 and two of her older sisters shortly afterwards. Tatenda developed a relationship with a boy from school who was two years older than her. "We became best friends to one another. It was hero syndrome...I needed a shoulder and he was my friend...he was my exile." They were together for two years. Tatenda was 15 when they had sex for the first time. She never went to a clinic for advice or information about reproductive health. She explained she had only "the basic info" about sex from school. "They told us to abstain, that there should be no sex before marriage and 'don't indulge', but he was my friend and he had my trust and I thought I was the only one." When she found out she was pregnant, her boyfriend rejected her, and she left school. Some friends told her to abort, "but I felt that [abortion] would be a mistake".

Tatenda later returned to school to take her exams, "I was actually a good student, so I had a scholarship that paid for my fees. I had a stepping stone. I came out with five subjects but I could have done better. [I] had so many challenges. It was difficult but I had to make do because there was no choice." She hopes to be able to continue with school. In the meantime, she has created a small business. "I am grateful to God that I can do work on my own, I bake and cook samosas to sell at school markets, I'd like to work more but I am afraid to leave my daughter. Now I have a baby, I have to be careful and be there for her."

Tatenda recommends that "it is high time that people accept that our children are getting involved at a tender age so they have to accept and to teach us. It is a subject that is being taken for granted and it is affecting us a lot."²⁴³

UNSAFE ABORTION

In the context of pregnancy-related stigma, high rates of unsafe abortion among adolescents were raised as community concerns.²⁴⁴ Many girls considered aborting their pregnancies,²⁴⁵ knowing cases of unsafe abortion and of girls abandoning babies immediately after birth.²⁴⁶ One participant in a focus group discussion explained that she knew "how to insert something inside her" to make the baby come out.²⁴⁷ Abortion is criminalized in Zimbabwe, with narrow exceptions.²⁴⁸ Unsafe abortion is estimated to account for 20% of maternal deaths in Zimbabwe.²⁴⁹ The ACHPRs has called on States parties to decriminalize abortion and improve access to safe abortion.²⁵⁰ The CRC Committee have called on Zimbabwe to "Take urgent measures to reduce maternal deaths relating to teenage abortions and ensure children's access to safe abortion and post-abortion care services, in law and in practice."²⁵¹

ABUSE

Adolescent girls who had experienced pregnancy told Amnesty International how stigma increased the social and economic disadvantages they already encountered. The experiences of "Janet" and "Maidei" illustrate the problem.

"Maidei" is 17 years old and seven months' pregnant. When she discovered she was pregnant, her boyfriend denied paternity. Despite this, her mother sent her to live with him and his family, where she was beaten, made to sleep outside and called names. Maidei reported their abuse to the police and her mother allowed her to return home.²⁵²

243 Amnesty International interview 27 May 2017.

244 Amnesty International focus group discussions: Mutare 4 April 2017 and Masvingo 5 April 2017.

245 Amnesty International interviews 27 May 2017.

246 Amnesty International focus group discussion with adolescents in Caledonia 7 April 2017.

247 Amnesty International focus group discussion with adolescents in Epworth 28 March 2017.

248 Termination of Pregnancy Act (1977), allows abortion when it is necessary to save the life of the woman, to preserve her physical health, when there is foetal impairment and when the conception is the result of rape or incest, noting abortion outside of those exceptions is criminalised under the Criminal Law Act (2007).

249 www.newsday.co.zw/2017/02/16/20-maternal-deaths-due-abortion-among-young-women-girls/; Note that persistent barriers to safe abortion have also been highlighted in the context of the 2014 Supreme Court judgement *M. Masingure vs. Minister of Home Affairs & others* HC455/07 Case by Zimbabwe Women Lawyers Association, see further Nyasha Chingore, SALC, Judgment in *Masingure v The State: A Step Forward for Women's rights or a Token gesture*, 8 April 2017, www.southernafricalitigationcentre.org/2014/04/08/judgment-in-masingure-v-the-state-a-step-forward-for-womens-rights-or-a-token-gesture/; The WHO is clear that access to safe abortion is a key step for avoiding maternal deaths and injuries, see further: WHO Safe Abortion: Technical and Policy Guidance for Health Systems 2012, pp. 23, 47-49. The WHO defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both; UNFPA Harmonizing the Legal Environment for ASRHR 2017, noting further that "The narrow and unclear legal exceptions for abortion are often at the discretion of health-care providers. This creates additional challenges for those who fall under the categories for which exceptions are made" page 13.

250 ACHPR General Comment 2 on article 14 of Maputo Protocol.

251 CRC Concluding Observations Zimbabwe 2016 para 61 (c).

252 Interview with Amnesty International 27 May 2017.

“Janet” is also 17. She was 15 when she became pregnant and her mother was very angry and sent her to live with her boyfriend’s family. “I went to his house by myself and when I got there they accepted me. [But] when I was living there the mother started to treat me badly, saying that her son was not old enough to have a pregnant woman and sometimes I could not eat, she would say ‘this is my son’s food.’”²⁵³ Janet was able to return home when a friend reported to her mother that she was being ill-treated and was losing weight.²⁵⁴

In most cases, however, adolescent girls were found to be raising their children without any support from the child’s father. Girls reported suffering severe financial and social disadvantages as a result of being abandoned by their male partners during their pregnancies.²⁵⁵ The CESCRC Committee have emphasised the importance of Family and Child support benefits²⁵⁶ as an intervention to address social and economic challenges for parents. The CRC Committee has also acknowledged the disadvantages many adolescents face when they are heads of households and responsible for children.²⁵⁷ The Committee has urged states to introduce social protection interventions to respond to the “specific requirements of adolescent caregivers.”²⁵⁸

BARRIERS TO CONTINUING EDUCATION

Barriers to education and employment opportunities for girls were raised as major concerns by the adolescents interviewed by Amnesty International. Most girls interviewed had left school because of lack of money for school fees,²⁵⁹ and nearly all expressed a desire to return to school. However, barriers to continuing with their education were greatly increased for adolescent girls with children. Of the 22 girls who had experienced pregnancy, only three had been able to return to school; one had saved money by selling sex, one had the financial and childcare support of her mother and the third had received a scholarship.²⁶⁰

Zimbabwe’s Constitutional Court has emphasized that:

*“The effect of the protection under...the Constitution, is that a girl remains a child regardless of her pregnancy status until she attains the age of 18. Whilst she is a child all the fundamental rights of a child protect her from being subjected to any form of marriage. The pregnant girl is entitled to parental care and schooling just as any other child is entitled.”*²⁶¹

UNESCO, UNFPA and UNAIDS report that Zimbabwe has a School Re-entry Policy, to ‘protect’ pregnant learners; “Policy Circular 35, which provides that the young mother (former pupil) may be re-enrolled at the same school, in the same grade/form in which she was before she took leave.”²⁶² However, the National Adolescent Fertility Study has highlighted limitations, noting Zimbabwe’s School Re-entry policy also requires that “a pregnant girl must drop out of school and re-apply after two years and re-enrolment is made subject to availability of space.”²⁶³ Teachers in both urban and rural areas informed Amnesty International that in many cases, the lack of another school nearby would effectively mean girls could not return at all due to transport barriers.²⁶⁴ The National Adolescent Fertility Study further criticizes poor implementation of the School Re-entry policy, suggesting a “lack of political will to make it happen as the Policy is not being popularised.”²⁶⁵ UNFPA have highlighted that punitive approaches towards pregnant schoolgirls include “policies that ban learners from returning to their former school [or] exclude them for a specific pre-determined time frame” and that such approaches are not in line with international obligations.²⁶⁶

Teachers emphasized to Amnesty International that most adolescents do not return to school once they have a baby because they cannot afford child care or cannot count on the financial support of their families. In the minority of cases when they can return, teachers reported that stigma towards them from other students was a major barrier to their continuing.²⁶⁷ As one teacher explained:

“If girls are pregnant they usually drop out of school. You don’t find them the next year. They are allowed [to come back] but it is embarrassing for them, they are stigmatised by their peers, ignored, laughed at. We don’t see it. I had one two years back – she

253 Interview with Amnesty International 27 May 2017.

254 Interview with Amnesty International 27 May 2017. Two participants of the Amnesty International focus group discussion in Hopley on 1 April 2017 reported they had married after getting pregnant, but the circumstances of the marriage were not discussed.

255 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescents on 27 May 2017.

256 CESCRC Committee General Comment 19 on the right to social security ref: E/C/R/GC/19 4 February 2008, para. 18.

257 CRC Committee General Comment 20 para 55.

258 CRC Committee General Comment 20 para 55.

259 For example, in Amnesty International’s focus group discussion in Hopley on 1 April 2017, all six participants had attended secondary school, but all had left between the second and third years (in forms 2 and 3).

260 Interview with Amnesty 27 May 2017.

261 *Loveness Mudzuru and Another v Minister of Justice and Others* 2016, page 53 of the judgment.

262 UNESCO, UNAIDS and UNFPA, Fulfilling Our Promise to Young People Today, 2013-2015 Progress Review The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people, 2016. <http://youngpeopletoday.net/wp-content/uploads/2016/07/ESA-Commitment-Report-Digital.pdf> (hereafter UNESCO Progress review of ESA Commitment) page 95.

263 National Adolescent Fertility Study page 12.

264 It appeared, however, that this requirement may not be strictly enforced in all school, as the teachers from two schools (in Masvingo and Harare) indicated their schools did not impose it. Interviews with Amnesty International on 5 April and 27 May 2017.

265 National Adolescent Fertility Study page 79.

266 UNFPA Harmonizing the Legal Environment for ASRHR 2017, which further argues “An accommodating approach, which has general principles guided by a rights-based framework and takes into account an individual learner’s needs and circumstances, is more appropriate.”

267 UNFPA have recommended that policies should “[i]nclude measures aimed at de-stigmatizing pregnancy among adolescents and use the opportunity to inform and educate other learners on the importance of obtaining services to prevent unplanned pregnancy.” UNFPA Harmonizing the Legal Environment for ASRHR 2017 page 17.

dropped out and came back but she only lasted one term. No one wanted to be friends with her, I would see her at break, just by herself. ²⁶⁸

The Committee on the Rights of the Child has recognized the impact of such stigma as a cause of “depression and anxiety” and has urged States parties to “foster positive and supportive attitudes towards adolescent parenthood and to develop policies that will allow adolescent mothers to continue their education.”²⁶⁹

Amnesty International’s findings are supported by larger-scale studies, which also highlight the impact of stigma towards adolescent sexuality and pregnancy and discrimination resulting from it. The National Adolescent Fertility Study 2016 emphasizes the high rate of girls leaving school from the age of 15, noting that the “main reason cited for not attending school was the inability to afford the fees.”²⁷⁰ The ZDHS 2015 data similarly reflects a sharp decline in school attendance rates between primary and secondary school; while 91% of Zimbabwean children aged 6-12 attend school, only 50% of children aged 13-18 attend secondary school. The decline is significantly more rapid among girls from the age of 16.²⁷¹

Amnesty International wrote to the Ministry of Primary and Secondary Education on 7 June 2017 to request clarification on the policies in place to ensure that pregnant girls can continue with their education, including by addressing the stigma of adolescent pregnancy, and by supporting girls who are mothers to return to school. No reply had been received by the date of publication.

5.1.2 COMPREHENSIVE SEXUALITY EDUCATION

UNESCO defines comprehensive sexuality education (CSE) as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information.”²⁷² CSE has been found to boost adolescents’ decision-making skills and to contribute to “the prevention of unintended pregnancy, violence and abuse, and gender-based violence.”²⁷³ CSE is also recognized as a key strategy for tackling the related root causes, including “gender and social norms, on stereotypes around masculinity and femininity, and on how these norms and stereotypes can affect young people’s lives and relationships.”²⁷⁴ CSE programmes which address gender or power dynamics have been found to be significantly more effective in targeting unintended pregnancy and sexually transmitted infections.²⁷⁵

As part of its obligation to uphold the right to health, Zimbabwe must provide comprehensive sexuality education to all children and adolescents, both in and out of school.²⁷⁶ In 2013, Zimbabwe’s Ministers for Health and Education signed a regional commitment for eastern and southern Africa, to support young people’s access to sexuality education and to sexual and reproductive health services.²⁷⁷ The Commitment includes time-bound targets, to “deliver comprehensive sexuality education and youth-friendly Sexual and reproductive health services” in response to the HIV epidemic, sexually transmitted infections, early and unintended pregnancy and child marriage.²⁷⁸

Despite these legal and political commitments, Amnesty International’s findings indicate that CSE continues to take an ‘abstinence only approach’, focuses predominately on ‘biological’ information and fails to address gender inequality and related taboos surrounding adolescent sexuality.

268 Interview with teachers, 27 May 2017.

269 CRC Committee General Comment 4 para 27.

270 The National Adolescent Fertility Study page 46, reasons cited for not attending school was the inability to afford the fees, (45%), followed by having completed O’/A’ levels (35%). Seven percent got married (4% aged 15-17 years and 0.4% aged 10-14 years) while 5% became pregnant (4% aged 15-17 years and 2% aged 10-14 years).

271 Zimbabwe Demographic and Health Survey 2015, page 17.

272 <http://youngpeopletoday.net/sexuality-education/>

273 UNESCO summary, noting The African Commission-led Maputo Plan of Action (2006) and Maseru Declaration on the Fight Against HIV/AIDS in the SADC Region (2003) page 8.

274 UNESCO Progress review of ESA Commitment; UNFPA Operational Guidance for Comprehensive Sexuality Education 2014 notes, “Integrating a gender perspective into sexuality education is not only a matter of human rights: It matters urgently for young people’s sexual health”, page 10.

275 A review of sexuality and HIV education initiatives, found that CSE programmes which “addressed gender or power were five times as likely to be effective as those that did not; fully 80% of them were associated with a significantly lower rate of sexually transmitted infections or unintended pregnancy.” See further N. Haberland, *The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies. International Perspectives on Sexual and Reproductive Health*, 2015, 41(1):31–42, www.guttmacher.org/journals/ipsrh/2015/03/case-addressing-gender-and-power-sexuality-and-hiv-education-comprehensive; See also UNFPA Operational Guidance for Comprehensive Sexuality Education 2014.

276 The CESCR Committee has clarified that “the right to sexual and reproductive health, combined with the right to education (articles 13 and 14) and the right to non-discrimination and equality between men and women (articles 2.2 and 3), entail a right to education on sexuality and reproduction that is comprehensive, non-discriminatory, evidence-based, scientifically accurate and age appropriate.” CESCR Committee General Comment No. 22 para 9; para 68; CRC Committee General Comment 4 para 26; CRC Committee General Comment 20, para 61.

277 The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people, <http://en.unesco.org/news/comprehensive-sexuality-education-millions-young-people-eastern-and-southern-africa>; <http://youngpeopletoday.net/>

278 The Eastern and Southern African Ministerial Commitment includes targets by 2015 to: ensure “A good quality comprehensive sexuality education (CSE) curriculum framework is in place and being implemented; Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented; decrease by 50% the number of adolescents and young people who do not have access to youth-friendly SRH services, including HIV, that are equitable, accessible, acceptable, appropriate and effective; push towards eliminating all new HIV infections among adolescents and young people aged 10-24; Increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels; Reduce early and unintended pregnancies among young people by 75%; Eliminate gender-based violence; Eliminate child marriage.” UNESCO Progress review of ESA Commitment pages 13-14.

All of the adolescents who participated in Amnesty International's research reported that they had received "some" elements of sexual and/or reproductive health education at school, mainly included in biology and science subjects, but hardly enough to make informed decisions, including how to prevent pregnancy and HIV in the context of their sexual relationships. With the exception of two adolescent girls (who felt the information may encourage children to have sex),²⁷⁹ all adolescent participants reported that they would like more information at school on reproduction and relationships. Girls reported to Amnesty International that they had not received any form of information or education at school that could equip them to negotiate safer sexual relationships.²⁸⁰

Amnesty International's interviews with adolescents who had experienced pregnancy illustrate that a lack of access to quality and adequate CSE has profound consequences. Two interviewees noted they did not understand how they became pregnant.²⁸¹ One girl who was pregnant aged 17 explained: "[There are] no people giving education to young people...at school they talk about HIV, they say not to share razor blades or needles but [I was not] told about condoms." She said she sought advice from friends.²⁸²

As noted above, Zimbabwe's demographic health data reveals that nearly 40% of girls and 24% of boys are sexually active before they reach the age of 18.²⁸³ Findings from ZDHS 2015 also highlight that "less than half of young people aged 15-24 with primary school level education and of those living in rural areas have comprehensive knowledge of HIV prevention methods." This marks a downward trend since 2010/11.²⁸⁴

A number of evaluations indicate that Zimbabwe's failures to provide CSE in schools is undermining adolescents' sexual and reproductive health initiatives.²⁸⁵ A 2012 UNESCO and UNFPA review of school curricula in East and Southern Africa found that Zimbabwe's provision of CSE lacked content on sexuality and sexual behaviour, focused on negative portrayal of relationships, failed to mention condoms, and was weak and inconsistent in relation to gender.²⁸⁶ The review also found sexual education at schools failed to take a human rights based approach and was "too dependent on religious framing of acceptable/ unacceptable behaviours."²⁸⁷ Similarly, a 2015 evaluation of Zimbabwe's first ASRH Strategy found that "[t]here is little evidence that the school-based programs undertaken in Zimbabwe are effective in changing sexual practices and behaviours of adolescents. To be effective, the Ministries of Health and Education will need to agree that school-based sex education must include more than abstinence-only education."²⁸⁸

In their 2016 concluding observations to Zimbabwe, the CRC Committee recommended that Zimbabwe "[e]nsure that sexual and reproductive health education is part of the mandatory school curriculum and that it targets adolescent girls and boys, with special attention to improving the knowledge of and the availability of reproductive health-care services with a view to reducing teenage pregnancies and preventing HIV/AIDS and other sexually-transmitted infections."²⁸⁹ Guidance from the CRC and CEDAW Committees have stressed that CSE development and implementation should "empower girls" and "aim to transform cultural views against adolescents' access to contraception and other taboos regarding adolescent sexuality."²⁹⁰

Zimbabwe's Ministry of Primary and Secondary Education (MoPSE) has recently introduced a new educational curriculum.²⁹¹ It includes components of sexual and reproductive health and rights, to be provided in stand-alone subject, Guidance and Counselling. When discussing the new curriculum with Amnesty International, teachers, adolescents and NGO partners praised the requirement that Guidance and Counselling is now a compulsory and examinable subject. A male Head Teacher and female teacher who participated in a community dialogue facilitated by Amnesty International felt strongly that more information was required at school.²⁹² The teacher commented, "young people don't understand enough at the moment...the fact that so many young girls are falling pregnant is indicative that they don't understand."²⁹³

279 Participant in Amnesty International focus group discussion in Epworth 28 March 2017; Participant in Amnesty International focus group discussion in Hopley 1 April 2017.

280 Amnesty International focus group discussions with adolescent girls in Epworth 28 March 2017, Hopley 1 April 2017, Caledonia 7 April 2017 and individual interviews with adolescents on 27 May 2017.

281 Amnesty International interview 27 May 2017.

282 Amnesty International interview 27 May 2017.

283 Zimbabwe Demographic and Health Survey 2015, page 63-34 and Table 4.5.

284 UNFPA Adolescent Sexual and Reproductive Health Zimbabwe Demographic and Health Survey 2015 Key Findings; <http://zimbabwe.unfpa.org/sites/default/files/pub-pdf/ASRH%20Factsheet%20FINAL%20%281%29.pdf>

285 Ngwenya S. Communication of reproductive health information to the rural girl child in Filabusi, Zimbabwe. *Afri Health Sci* 2016;16(2): 451-461. <http://dx.doi.org/10.4314/ahs.v16i2.13>;

286 UNESCO and UNFPA Sexuality Education: A ten-country review of school curricula in East and Southern Africa 2012, page 7.

287 UNESCO and UNFPA Sexuality Education: A ten-country review of school curricula in East and Southern Africa 2012, page 7.

288 Johns Hopkins Bloomberg School of Public Health Review of ASRH Strategy I 2015.

289 CRC Committee Concluding observations on the second periodic report of Zimbabwe 2016, para 61 (b).

290 CRC Committee General Comment 4 para 26; See also CEDAW Committee, Concluding Observations on Portugal, UN Docs. CEDAW/C/PRT/CO/8-9, para. 33; CEDAW Committee, Concluding Observations on Timor-Leste, UN Doc. CEDAW/C/TLS/CO/2-3, para. 27(d), in which the Committee has expressed concern about sexuality education that only focuses on health and prevention of pregnancy and diseases and has called on States parties to make sure that sexuality education integrates a strong gender perspective and addresses socialized gender roles and stereotypes, patriarchal attitudes, and unequal power dynamics.

291 The Republic of Zimbabwe Ministry of Primary and Secondary Education Curriculum Framework for Primary and Secondary Education 2015-2022.

292 Amnesty International focus group discussion in Mutare, 4 April 2017.

293 Teacher (female) participating in focus group discussion in Mutare on 4 April.

However, many stakeholders questioned the MoPSE's commitment to implementing substantive CSE,²⁹⁴ the provision of which remains a subject of political and public controversy.²⁹⁵ Notably, the MoPSE has previously been reported as creating implementation barriers, including "a prohibition on all but abstinence education."²⁹⁶

Amnesty International's findings highlight that the failure to tackle systematic implementation challenges and the prevailing emphasis on abstinence may undermine the objectives of the new curriculum to provide CSE in schools. A key concern is that, instead of including age-appropriate material on responsible and consensual sexual activity and relationships within the curriculum the conceptualization of adolescent sexuality and sexual behaviour is predominantly negative and removed from the realities of many adolescents' lived experiences.²⁹⁷

Implementation of the new curriculum also continues to rest upon individual decisions by teachers. Teachers retain wide discretion over choosing relevant content, potentially allowing them to avoid or drop lifesaving information due to personal discomfort or religious convictions.²⁹⁸ Amnesty International interviewed one teacher with more than 20 years' experience, including as the Head of the Guidance and Counselling Department in two government secondary schools. She said she was "loving the new curriculum" but noted there was sometimes a "backlash" from "religious parents."²⁹⁹ She was also anxious that in some schools teachers were reluctant to deliver the lessons. She explained that:

"In some schools they don't teach Guidance and Counselling. You find out that in many schools it is on the timetable but some teachers are not willing and they rather teach their own major... Some headmasters are conservative so they control the information you can give to kids. I've heard that, the Head Master calls himself a Christian and everyone had to teach [his way] so no info about condoms or contraceptives."³⁰⁰

The same teacher commented that teachers often need support and training to deliver quality CSE.³⁰¹ While some teachers may be specialized in Guidance and Counselling, others will be required to deliver the lessons with limited experience of how to discuss sensitive topics, or the skills necessary to ensure participation and the critical thinking required for changing attitudes and group norms. A recent UNFPA country review of Zimbabwe has highlighted that: "[s]trengthening skills among both pre-service and in service teachers has been identified as among the highest priorities". It notes that teachers often also lack skills in participatory methodologies of teaching, and that "many teachers and teacher-trainers are uncomfortable with topics of sexuality and sexual abuse."³⁰² Zimbabwe is credited by UNESCO for improving pre-service teacher training, with requirements to include CSE from 2015, and also strengthening in-service training for over 10,000 teachers.³⁰³ According to a 2013 report from Zimbabwe's Statistics agency, there were 65 547 primary school and 41,759 secondary school teachers working in Zimbabwe in 2012.³⁰⁴

It is also significant that the new curriculum provides for teachers to seek skilled resource support from external sexual and reproductive health educators – for example health care professionals or NGO counsellors - to visit schools. However, teachers, NGO and IGO officials highlighted that in practice, organizing such visits requires following a "disproportionally cumbersome process" that "puts most people off".³⁰⁵ Teachers explained that the external delegate is required to secure a clearance for the visit from both the Police and MoPSE at the national and district levels. In effect, these obstacles maintain the status quo of teachers being the sole providers of sex education in schools.³⁰⁶

In reviewing Zimbabwe's progress towards targets of the Eastern and Southern Africa Ministerial Commitment on CSE and sexual and reproductive health services for adolescents and young people, UNESCO found that the failure to ensure a "multi-sectoral strategy/framework" was a key weakness.³⁰⁷ Amnesty International was informed that MoPSE and MoHCC are developing a Schools

294 Amnesty International Interviews with NGOs and public health researchers in Harare, March and April 2017.

295 Guttmacher Institute, 2014, citing Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, Zimbabwe Demographic and Health Survey, 2010–2011, Calverton, MD, USA: ZIMSTAT and ICF International, 2012, noting that "the majority of adults—63% of women and 52% of men—do not believe that 12–14-year-olds should be taught about how condoms can prevent HIV infection."

296 Johns Hopkins Bloomberg School of Public Health Review of ASRH Strategy I 2015.

297 UNESCO and UNFPA Sexuality Education: A ten-country review of school curricula in East and Southern Africa 2012, which critiques curriculums where the universal ethics informing moral behaviour are based on religion rather than human rights.

298 The Republic of Zimbabwe Ministry of Primary and Secondary Education Guidance and Counselling: Strengthening Life Skills, Sexuality, HIV and AIDS Education Teacher's Manual, Secondary Edition; "The teacher is expected to use his/her discretion in using any information from the bibliography and to lookout for more information to enhance the delivery of Guidance and Counselling." At page 25.

299 Amnesty International interview with Teacher 27 May 2017.

300 Amnesty International interview with Teacher 27 May 2017.

301 Amnesty International interview with Teacher 27 May 2017.

302 UNFPA Operational Guidance for Comprehensive Sexuality Education 2014 highlights that "[s]trengthening skills among both pre-service and in service teachers has been identified as among the highest priorities" and notes that teachers often also lack skills in participatory methodologies of teaching, and that "many teachers and teacher-trainers are uncomfortable with topics of sexuality and sexual abuse." page 35.

303 UNESCO Progress review of ESA Commitment, Country Report Zimbabwe Including training 3,693 primary school teachers and 7,720 secondary. <http://youngpeopletoday.net/wp-content/uploads/2016/07/ESA-Commitment-Report-Digital.pdf> at page 94.

304 Zimbabwe National Statistics Agency, Education Report 2013, Table 4.9: Primary School Teachers by Training and Province, 2012 p.22 and Table 5.8: Secondary School Teachers by Province, 2009 – 2012 page 32, www.zimstat.co.zw/sites/default/files/img/publications/Education/Education_Report.pdf

305 Amnesty International Interview with Teacher 27 May 2017.

306 See further Johns Hopkins Bloomberg School of Public Health Review of ASRH Strategy I 2015, which found this requirement undermined the implementation of ASRH initiatives; IPPF highlight the supportive role that NGOs and civil society can play in delivering CSE, including for reaching marginalized adolescents and young people, see further IPPF Fulfill! Guidance document for the implementation of young people's sexual rights 2016 page 22.

307 UNESCO Progress review of ESA Commitment.

Health Policy (SHP) and were able to review a draft (as of April 2017).³⁰⁸ It is significant that as part of mainstreaming health topics into the curriculum, the draft SHP clearly references the implementation of age-appropriate sexual and reproductive health and life skills education, including CSE, and provides for referral for sexual and reproductive health services. However, the SHP draft lacks clarity as to the specific sexual and reproductive health services that may be provided, either at school or under referral.

Amnesty International's findings indicate the need for Zimbabwe's health and education systems to urgently improve the implementation of CSE policies to ensure that the new curriculum succeeds in empowering adolescents to exercise their sexual and reproductive health and rights.

³⁰⁸ Amnesty International sought further information from both the MoPSE and MoHCC by letter on 7 June 2017, we had not received a reply by the time of publication.

5.1.3 COST BARRIERS: “FREE SERVICES MEAN NO SERVICES”

As discussed in earlier sections,³⁰⁹ barriers to sexual and reproductive health services, information and education undermine girls’ rights, including their right to make informed decisions regarding their health and lives. Appropriate and timely antenatal care plays an important role in improving maternal and child health and preventing maternal deaths.³¹⁰ It aims to detect and treat existing health problems and to screen for complications that may develop in the pregnancy. The WHO recommends a minimum of four antenatal care visits, starting in the first 12 weeks of pregnancy.³¹¹ Antenatal care connects women and girls with the health system and is an opportunity to provide vital health information. Zimbabwe’s health data confirms that antenatal care attendance is linked to an increased likelihood of delivery with a skilled birth attendant; only 21% of live births to women who received no antenatal care took place in a health facility, compared to 86% of live births who received four or more visits.³¹²

Early attendance at antenatal clinics is particularly important for pregnant women and girls living with HIV.³¹³ HIV testing and treatment during pregnancy has “important implications for the goal of eliminating new paediatric HIV”³¹⁴ and reducing risks of maternal mortality and morbidity. In Zimbabwe, studies have indicated that “adolescents were 66% less likely to know their HIV status before [antenatal care].”³¹⁵ Overall, ZDHS data indicates high rates of antenatal care in Zimbabwe, with 93.3% of women receiving antenatal care from a skilled provider. However, only 45% receive care during the first four months of pregnancy.³¹⁶

Zimbabwe’s human rights obligations require that access to reproductive and maternal health services are prioritized within the health system.³¹⁷ In guidance aimed at strengthening State parties’ efforts to reduce maternal mortality and morbidity in line with human rights standards, the Office of the UN High Commissioner for Human Rights has emphasized the obligation to devote all available resources to sexual and reproductive health services, and to “ensure [o]ut-of-pocket costs cannot impede accessibility of care, irrespective of whether services are provided by public or private facilities.”³¹⁸ It further provided that governments’ must also pay “particular attention to vulnerable or marginalised groups, including adolescents.”³¹⁹

“Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include ante-natal, maternity and post-natal services. The [CEDAW] Committee notes that it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.”

CEDAW Committee, General Recommendation 24 on women and health³²⁰

In 2011 the government of Zimbabwe issued policy guidance that maternal health services should be provided free of charge, and received international assistance to establish a Health Transition Fund to provide free maternal and child health services at all public health facilities.³²¹ These measures have contributed to the decline in Zimbabwe’s maternal mortality ratio since 2010.³²² Despite this progress, Amnesty International continues to document antenatal fees and transport costs as barriers to accessing maternal and newborn care for women in Zimbabwe.³²³ Amnesty International’s current research further confirms that the 2011 policy is not fully implemented and fees for maternal health services continue to be charged in public health facilities run by local authorities and municipalities.³²⁴

309 From page 17.

310 For example, antenatal care is an opportunity to provide nutritional supplements that treat anaemia and malnutrition, reducing the risk of haemorrhage. RC Pattinson, Basic Antenatal Care Facility Manager Notes 2005.

311 WHO, Standards for Maternal and Neonatal Care, 2004.

312 Zimbabwe Demographic and Health Survey 2015 page 145, noting that 77% of women give birth with skilled assistance at delivery (up from 66% in 2010/11).

313 Amnesty International, Struggle for Maternal Health: Barriers to Antenatal Care in South Africa, Index number: AFR 53/006/2014, citing Black et al. Effect of Human Immunodeficiency Virus Treatment on Maternal Mortality at a Tertiary Center in South Africa. A 5-Year Audit *Journal of Obstetrics and Gyn.* Vol. 114, No. 2, Part 1, August 2009.

314 R Musarandega et al. PMTCT Service Uptake Among Adolescents and Adult Women Attending Antenatal Care in Selected Health Facilities in Zimbabwe *Journal of Acquired Immune Deficiency Syndromes* 2017 Jun 1; 75(2): 148–155. Published online 2017 Feb 20. doi: 10.1097/QAI.000000000000132

www.ncbi.nlm.nih.gov/pmc/articles/PMC5427987/ (hereafter R Musarandega et al. PMTCT Service Uptake Among Adolescents and Adult Women Attending Antenatal Care in Selected Health Facilities in Zimbabwe).

315 R Musarandega et al. PMTCT Service Uptake Among Adolescents and Adult Women Attending Antenatal Care in Selected Health Facilities in Zimbabwe.

316 Zimbabwe Demographic and Health Survey 2015 pages 150-151 tables 9.1 and 9.2.

317 CESCR Committee General Comment 14, para 44.

318 OHCHR Technical Guidance para. 46, citing Report of the Working Group on Arbitrary Detention 1999 ref: E/CN.4/2000/4, para. 12; WHO, World Health Report 2010: Health Systems Financing: the Path to Universal Coverage (Geneva, 2010).

319 OHCHR Technical Guidance para 15, citing CESCR Committee General Comment No. 14 para. 43.

320 CEDAW Committee, General Recommendation 24, para 27.

321 UNICEF www.unicef.org/infobycountry/zimbabwe_61823.html; CARMMA Updates *Maternal Death Rates Fall in Zimbabwe by 36 Percent* 12 February 2015, <http://carmma.org/update/maternal-death-rates-fall-zimbabwe-36-percent>

322 CARMMA; National Health Strategy For Zimbabwe 2016-2020 noting that between 2009 and 2012 external funding significantly increased from \$167 million in 2009 to \$428 million by 2012, and has been used to particularly retention of health workers and procurement and distribution of essential health commodities, amongst other things. At page 10.

323 Amnesty International, No Chance to Live, Newborn Deaths at Hopley Settlement, Zimbabwe 2010 AF46/018/2010.

324 Amnesty International interviews and focus group discussions, meetings with health officials and NGO partners. See also the MoHCC NHS 2016-2020 notes that “Currently all urban facilities are under administration of the local government and usually underfunded to support basic primary health services”, page 48.

The continued lack of regulation means that fees varied between facilities, dependent on the facilities' funding needs. Fees for contraceptive services were reported to range from US\$1-15.³²⁵ Fees were also reported as ranging from US\$10-30 for antenatal care, with costs for giving birth rising dramatically when complications arise. A senior obstetrician at a major hospital in Harare estimated that costs for a birth by caesarean section may start at US\$100 and could rise to US\$300 if a blood transfusion was required.³²⁶ In addition, pregnant women and girls are required to pay for ambulances (US\$15+) and to bring necessary items with them when they give birth, including gloves, blankets, maternity pads, painkillers and surgical antiseptic.³²⁷ Referred to as "the preparation" (or "bebe lait") the list also includes items for the baby, including nappies, clothing and blankets. The total cost of such items was estimated at US\$60.

Despite Zimbabwe's obligation to prioritize reproductive, maternal and child health care,³²⁸ it was reported that many health facilities rely on money raised from maternal health services as a necessary source of income in a context of gross underfunding.³²⁹ As a representative from an NGO working on right to health issues in Zimbabwe explained; "free services mean no services."³³⁰

The impact of these "out of pocket" costs disproportionately disadvantages adolescents who were already marginalized, including as a result of their pregnancies. As noted above, nearly all of the girls who had experienced pregnancy interviewed by Amnesty International reported that they had been abandoned by their male partners. As the following cases illustrate, the burden of fees resulted in delayed access to maternal health services or not receiving care at all.



MAIDEI'S EXPERIENCE

"Maidei" is 17 and is seven months pregnant. Maidei has not been able to receive antenatal care, as she cannot afford the US\$25 registration fee. She lives with her mother and two siblings, in a settlement on the outskirts of Harare. Maidei had to leave school aged 15 as she could not afford the school fees.

Maidei was 12 when she first had sexual intercourse. She has since relied on the advice of friends and women working at markets on how to prevent pregnancy and HIV infection. Maidei's first visit to a clinic was only in December 2016, when she went for her pregnancy test.

When Maidei discovered she was pregnant, her boyfriend ended the relationship and denied paternity. Despite this, her mother sent her to live with his family, where she was beaten and abused, made to sleep outside, and called names. She went to the police to report them, but was persuaded to drop the charges.

Her mother eventually allowed her to return home. Maidei is now working part-time laundry jobs to earn the money for the clinic fees to give birth. She wants to know the condition of her baby, and whether there are any complications or problems. She is anxious about giving birth, as she cannot afford the preparation, and worries that if she cannot pay the necessary fees, she will not be allowed to leave the hospital. She told Amnesty International "you can go and give birth but you won't come out unless you pay."³³¹

When "Sarah" discovered she was pregnant aged 17 she had no support from her stepmother or her male partner who denied paternity. Sarah had no money to pay the US\$25 registration fee for antenatal care. She found piecemeal work doing laundry. She was eight months' pregnant by the time she had saved enough. Sarah lives nearly 5kms from the local clinic, and when she went into labour she walked there with help from her stepmother's friend. It was not safe to walk, but Sarah had no choice because there was no money for transport. "I was worried. I thought the baby would come out."³³²

A clinic counsellor who supports adolescents living with HIV expressed concern that many adolescents were planning to give birth at home because they were unable to pay fees. She explained, "Even if you are in labour – if you didn't register, [the clinic] won't take you

325 Condoms were 50 cents, contraceptive pills cost \$1 for a six month supply, but additional fees were reported for a clinic card each time (so \$3/ six months).

Contraceptive injections were reported as costing \$4 for 6 months (so \$5 in total with the clinic card).

326 Amnesty International interview 27 May 2017.

327 Amnesty International reviewed a copy of a list from a clinic outside of Harare, July 2017.

328 CESCR General Comment No. 14 para 44.

329 Citizen Health Watch Patient's Forum reports 2016; CWGH Input into the 2017 National Health budget 2017. The CWGH raise concern that "user fees collected by the major Central Hospitals are still not reflected in the MoHCC's budget", citing a report from the Parliament Portfolio Committee on Health, 2015.

330 Meeting with NGO in Harare April 2017.

331 Another girl, who is currently 6 months pregnant explained that the \$25 registration fee for antenatal care was too expensive so she was travelling about one hour to a free clinic and hoped to transfer back to the paid clinic before the birth if she had saved the fee by then – otherwise she would plan to give birth at the free clinic, Amnesty international focus group discussion in Hopley 1 April 2017.

332 Interview with Amnesty International 27 May 2017.

– they send you back until you come with the money.”³³³ NGOs and girls who participated in focus group discussions and interviews told Amnesty International they had heard reports that women who had given birth in health facilities had not been able to leave until fees were paid.³³⁴ One participant alleged that she had been held for two days after she gave birth, until her sister was able to borrow the US\$25 fee.³³⁵

These experiences correlate with data from the ZDHS 2015 which documents “obtaining money to pay for treatment” as the most commonly cited problem for adolescents needing access to health care (34.2%).³³⁶ In 2013, the UN reported concern regarding continued demands for user fees, noting that “Zimbabwe has no law that compels government clinics and hospitals to provide primary care to women, children or other vulnerable groups for free, although there are state subsidies,” and advocating for the “abolishment of user fees for maternity services supported by the Health Services Fund.”³³⁷

As noted above,³³⁸ Zimbabwe’s health budget declined in real terms in 2017. Analysis from the Community Working Group on Health (CWGH), a network of health advocacy organisations in Zimbabwe notes this decline reflects persistently low allocations of the total government expenditure to Health since 2010.³³⁹ The MoHCC has highlighted the budget allocation as insufficient in a context where the health system is deeply reliant on international assistance.³⁴⁰ Zimbabwe receives significant international funding for programmes aimed at reproductive, maternal, new-born and child health, including through the Health Development Fund and Results Based Financing.³⁴¹ The report of the Auditor General on the 2016 financial year, noted concern, however, that “the Health Assistance Programme’s financial records revealed that the [MoHCC] had outstanding bills from various health service providers amounting to \$7 128 128 for services rendered to the vulnerable and indigent people,” which was acknowledged to have resulted in “members of the public who benefited from this facility being turned away by the referral hospitals.”³⁴² The Auditor General further noted a failure of the MoHCC to implement audit recommendations, and highlighted a crisis in service delivery, reporting shortages of essential medicines, and “Inadequate funding for the procurement of new equipment and medicines”, use of “[o]bsolete hospital equipment” unavailability of water, and unavailability of specialised personnel.³⁴³ On visiting health facilities, the Auditor General found cases of negligence and non-attendance, including “two cases of non-attendance to patients by doctors and nurses which led to death of a pregnant woman at Chiredzi District Hospital.”³⁴⁴

Amnesty International’s findings also indicate government failures to utilize existing budget allocations – including from international assistance – in a manner that ensures adolescents’ access to sexual and reproductive health services and information. The CWGH has highlighted that the Ministry of Finance’s budget allocation to Health in 2017 has, “tried to align...with actual expenditures” in order to address the MoHCC’s weak budget execution.³⁴⁵ The CWGH suggest that in 2016, the MoHCC had spent only 62% of the allocated budget by 30 September.³⁴⁶ However, both the CWGH and MoHCC suggest that the failure rests, in large part, with the Ministry of Finance’s delayed release of the allocated funds. The MoHCC cite, for example, Harare Central Hospital, which in 2015 “had only received \$560,000 out of a budget application of \$17,500,000” by September of that year. This pattern appears to have continued in 2017. The Government of Zimbabwe’s Consolidated Statement of Financial Performance for January and March 2017 indicate major

333 Interview with Amnesty International 7 April 2015.

334 The 19-year-old was a participant in an Amnesty International focus group discussion in Caledonia 7 April 2017. The participant has a child aged 13 months. She explained she didn’t attend antenatal care because of the costs and although she received good care at the clinic when she gave birth, she claimed she was unable to leave for two days until the money came for the fees. Her sister raised the \$25 through borrowing it and she spent two months looking for work to pay it back; see also Patients Forum Monitoring Reports compiled by Citizen Health Watch have raised concern regarding charging fees for maternal health services at Epworth Clinic, including allegations of detention of women for non-payment. According to their reports, compiled based on visits to the clinic in April and November 2016, the Sister in Charge at the clinic claimed that the detentions were ‘council policy’ and that the clinic was “instructed [by the council] to detain women who fail to pay for up to five days before they release them.” Further reports of detention of women after child birth came from meetings with NGOs and a Doctor in Harare held in April 2017.

335 Participant of Amnesty International focus group discussion with adolescent girls in Caledonia 7 April 2017.

336 Other challenges include distance to health facilities (31.1%) and “getting permission to go” (6.8%), Zimbabwe Demographic and Health Survey 2015.

337 www.aljazeera.com/indepth/features/2014/02/zimbabwe-maternal-mortality-crisis-20142561739198301.html citing United Nations in Zimbabwe Periodic Publication, Issue Paper Series, Paper 1 2013, which notes, the “requirement to pay user fees to access health services further drives a wedge between women from poor and the rich households.” www.zw.one.un.org/sites/default/files/UN-ZW_IssuePaperSeries-1_MMR_June2013.pdf; See also the Organisation for Public Health Interventions and Development Trust (OPHID) 2014 review of access to maternal health services among people of apostolic faith, commissioned by MOHCC, which cites a member of the Johanne Masowe community, that ‘clinics will not allow the mothers to leave the clinic without any payment they arrest them because the people have nothing and cannot pay’ Exploring the Forgotten Variable OPHID OR Series 2014: Report 2 Engaging, Listening and Learning from Apostolic Birth Attendants (hereafter OPHID Apostolic Birth Attendants 2014).

338 See page 14.

339 CWGH Position Paper on the Budget for Health – 2018 and Beyond, noting Health Allocation (% of Total Government Expenditure) was 2010: 7.7%; 2011: 7.9%; 2012: 8.6%; 2013: 6.6%; 2014: 8.2%; 2015: 7.3%; 2016: 8.3%; 2017:6.9%, at page 4.

340 National Health Strategy for Zimbabwe 2016-2020.

341 According to the CWGH Zimbabwe received \$48,500,000 under the Health Development Fund, (previously the Health Transition Fun) which is funded by the European Union, UK, Sweden, Ireland and Global Alliance for Vaccines (GAVI), for Maternal and Child Health Care in 2017, see further, CWGH Input into the 2017 National Health budget; Results Based Financing is funded by the World Bank. See further Policy Brief, CWGH, Save the Children and Action Aid, Assessing Government Financing for RMNCH Services in Zimbabwe, 2016.

342 Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page 27.

343 Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, pages 277-279.

344 Report of the Auditor-General for the Financial Year Ended December 31, 2016 on Appropriation Accounts Finance and Revenue Statements and Fund Accounts June 14 2017, page 280.

345 CWGH Input into the 2017 National Health budget.

346 CWGH Input into the 2017 National Health budget, Post Budget Analysis – Health Sector Allocations 2017, Table 1 and Figure 2.

underspend on goods and services related to medical and education supplies.³⁴⁷ In March 2017, \$95,000,000 was allocated for medical goods and services, but only \$2,500,000 spent.³⁴⁸ The MoHCC has emphasised the impact of such disbursement delays on patients; “This means that hospitals are primarily operating at very poor cash flow positions funded by charging patients for services and overstressing creditors thereby increasing debts”³⁴⁹ Responding to the Auditor General’s report, the MoHCC noted that “we would like to highlight that the hospitals have been reeling under financial problems. We had not received any Government of Zimbabwe (GOZ) support by the time of audit.”³⁵⁰

At Zimbabwe’s Universal Periodic Review review before the Human Rights Council in 2017, a number of States parties to the ICCPR called on Zimbabwe to improve access to health services, including for children and pregnant women.³⁵¹ Kenya recommended that Zimbabwe “Upgrade primary and secondary health-care infrastructure and increase budgetary allocations to the Ministry of Health and Child Care in line with regional and international obligations.”³⁵² Ghana advised Zimbabwe should “[s]trengthen efforts to increase women’s access to health-care facilities and medical assistance in order to address the prevailing high maternal mortality rate.”³⁵³ The CRC Committee has raised similar concerns. In its Concluding Observations to Zimbabwe in 2016,³⁵⁴ the CRC Committee recommended that Zimbabwe; “[f]acilitate access to free maternal and child health services.”³⁵⁵ The Committee further recommended Zimbabwe increase resource allocation to primary health care and improve strategies for “retaining qualified health personnel and accelerate the training of health workers”.³⁵⁶

The MoHCC’s National Health Strategy 2016-2020 identifies the objective to “reduce the maternal mortality ratio from 614 to 300 by 2020”, including through early and continuous utilization of [quality] ANC services and strengthening Adolescent Sexual Reproductive Health.³⁵⁷ Although these measures include plans to introduce a “payment exemption policy”³⁵⁸ and to develop a health financing policy,³⁵⁹ there is no detail as to how priority would be given to those most marginalized. The National Gender Policy 2013-2017 includes an objective to “improve gender sensitivity in health service delivery” and commits to “[a]dvocate for increased budget allocation for financing gender responsive policies and programmes in the health sector and in national HIV and AIDS policies and strategies.”³⁶⁰ Indicators of success under the objective of Gender and Health include “the proportion of [the] population by gender accessing health services” and Zimbabwe’s maternal mortality ratio.³⁶¹ The Ministry of Women Affairs, Gender and Community Development, committed to producing an end of term review of the policy in 2017.³⁶²

Zimbabwe’s current economic downturn has impacted severely on the determinants of health and has exacerbated disadvantages for marginalized adolescents.³⁶³ Cost barriers to sexual and reproductive health services undermine the right to health and put the lives of pregnant girls at unnecessary risk.

7 June 2017, Amnesty International wrote to the MoHCC to request information on the measures taken to ensure that necessary health services are economically accessible to young people, including the monitoring and review of user fees. No reply had been received at the time of publication.

347 Government of Zimbabwe Consolidated Statement of Financial Performance of the Consolidated Revenue Fund for the period ended January 2017; Government of Zimbabwe Consolidated Statement of Financial Performance of the Consolidated Revenue Fund for the period ended March 31 2017.

348 Government of Zimbabwe Consolidated Statement of Financial Performance of the Consolidated Revenue Fund for the period ended January 2017; Government of Zimbabwe Consolidated Statement of Financial Performance of the Consolidated Revenue Fund for the period ended March 31 2017.

349 National Health Strategy for Zimbabwe 2016-2020 page 49.

350 Government of Zimbabwe Consolidated Statement of Financial Performance of the Consolidated Revenue Fund for the period ended January 2017; Government of Zimbabwe Consolidated Statement of Financial Performance of the Consolidated Revenue Fund for the period ended March 31 2017.

351 UPR Info, Zimbabwe, Second Review Session 26 Review in the Working Group: 2 November 2016 Adoption in the Plenary: 16 March 2017 www.upr-info.org, citing: Zimbabwe accepted recommendations, including: A - 131.101 Bangladesh; A - 131.102 Uganda; A - 131.115 Algeria; A - 131.118 Ghana; A - 131.120 Kenya; A - 131.119 Myanmar; A - 131.124 Morocco.

352 A - 131.120 Kenya as reported in Second Review Session 26 Review in the Working Group: 2 November 2016 Adoption in the Plenary: 16 March 2017.

353 A - 131.118 Ghana as reported in Second Review Session 26 Review in the Working Group: 2 November 2016 Adoption in the Plenary: 16 March 2017.

354 CRC Concluding Observations Zimbabwe 2016, noting: the “Committee is concerned about the insufficient allocation of financial resources to ensure the implementation of the State party’s [health] programmes...” noting “(a) The persistent high maternal, child and infant mortality and morbidity rates; (b) The limited access to health-care services for children living in poverty and in remote and rural areas and user fees imposed for HIV, maternal and child health services;...” at para 58.

355 CRC Concluding Observations Zimbabwe 2016 at para 59.

356 CRC Concluding Observations Zimbabwe 2016 at para 59. The Committee further recommended Zimbabwe “Implement the reports of OHCHR on technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce...preventable maternal morbidity and mortality (A/HRC/21/22).”

357 National Health Strategy for Zimbabwe 2016-2020 page 42.

358 National Health Strategy for Zimbabwe 2016-2020 page 42.

359 National Health Strategy for Zimbabwe 2016-2020 page 53.

360 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 page 17.

361 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 Page 23.

362 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 Page 24.

363 See background section above.

5.2 LEGAL FRAMEWORK

INTERNATIONAL AND REGIONAL HUMAN RIGHTS OBLIGATIONS

Human rights treaty bodies have recognized that adolescent girls worldwide are the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth.³⁶⁴ Preventable maternal morbidity and mortality are a violation of the right to health and life.³⁶⁵ Such outcomes represent a failure of governments to respect, protect and fulfil the rights of women and girls to health, equality and non-discrimination.³⁶⁶ A human rights approach to maternal health and sexual and reproductive rights requires states to go beyond public health practices, but must also ensure that women and girls are empowered to claim their rights.³⁶⁷

Zimbabwe has ratified or acceded to several international and regional human rights treaties, which require the State parties to ensure that all adolescents have access to the full range of their sexual and reproductive rights, including sexual and reproductive health services and information, and comprehensive sexuality education, free from barriers and discrimination.³⁶⁸

COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH POLICIES FOR ADOLESCENTS

The African Commission on Human and Peoples' Rights (ACHPRs) has emphasized the obligation on States parties, under article 14 of the Maputo Protocol, to “develop a national public health plan with comprehensive sexual and reproductive health services, protocols, guidelines and standards that are consistent with current evidence-based standards established by WHO and the committees responsible for ensuring compliance, by States, with the relevant United Nations conventions”.³⁶⁹

The CRC Committee has emphasized that states should “review or introduce legislation recognizing the right of adolescents to take increasing responsibility for decisions affecting their lives.”³⁷⁰ This includes the need to balance the “right to protection, the best interests principle and respect for the evolving capacities of adolescents.” In this regard, the Committee specifically urges that any minimum “age limits should recognize the right to make decisions in respect of health services or treatment.” The Committee has further urged states to adopt comprehensive gender and sexuality-sensitive sexual and reproductive health policies for adolescents and has emphasized that unequal access by adolescents to sexual and reproductive health information, commodities and services amounts to discrimination.³⁷¹

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND INFORMATION

The CRC Committee has urged states to ensure that all adolescents can access free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education, available both online and in person. This should include information on family planning; contraception, including emergency contraception, and condom use; prevention, care and treatment of sexually transmitted infections; counselling; pre-conception care; maternal health services; and menstrual hygiene.³⁷² The Committee has found that both short- and long-term contraceptives should be made readily available to adolescents.³⁷³ The Committee also urged states to remove all barriers to such services, commodities and information, including the requirements for third-party consent or authorization, stigma and fear, and intersecting forms of discrimination.³⁷⁴

The ACHPRs has also urged State parties to ensure comprehensive, integrated, rights-based, women-centred and youth-friendly sexual and reproductive health services that are free of coercion, discrimination and violence;³⁷⁵ to take action to remove legal and policy barriers that hinder women's access to sexual and reproductive health services,³⁷⁶ and obstacles such as those arising from marital status, age, disability as well as economic and geographic barriers faced by women who want access to family planning / contraception and safe abortion services, especially young women.³⁷⁷

364 CRC Committee General Comment 20 para. 59.

365 UN OHCHR Technical Assistance.

366 UN OHCHR Technical Assistance.

367 UN OHCHR Technical Assistance, para. 8; The CESCR Committee has urged States to prevent and eliminate discrimination, stigmatization and negative stereotyping that hinders access to sexual and reproductive health, particularly for the groups most at risk of discrimination, CESCR General Comment 22 para. 31.

368 These include the Convention on the Rights of the Child (CRC), International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) and African Charter on the Rights and Welfare of the Child (ACRWC).

369 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 30.

370 CRC Committee General Comment 20 para. 39; see also CRC Committee General Comment 4 para 35.

371 CRC Committee General Comment 20 para. 59, citing CESCR Committee General Comment 20 (2009) on non-discrimination in economic, social and cultural rights, para. 29;

372 CRC Committee General Comment 20 para. 59 and 63.

373 CRC Committee, General Comment 15 para. 30.

374 CRC Committee General Comment 20 para. 60.

375 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 29,

376 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 35.

377 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 61.

The UN Special Rapporteur on the right to health has stated that: “All adolescents must be guaranteed access to confidential, adolescent-responsive and non-discriminatory sexual and reproductive health information, services and goods, including family planning, modern forms of contraception, counselling, pre-conception care, maternal care, sexually transmitted infections, diagnosis and treatment, and safe abortion.”³⁷⁸

The CESCR Committee has noted that states are obliged to ensure that adolescents have full access to appropriate information on sexual and reproductive health, including family planning and contraceptives, the dangers of early pregnancy and the prevention and treatment of sexually transmitted diseases, including HIV/AIDS, regardless of their marital status and whether their parents or guardians consent, with respect for their privacy and confidentiality.³⁷⁹ The Committee also stated that states must also take affirmative measures to eradicate social barriers in terms of norms or beliefs that inhibit individuals of different ages and genders, women, girls and adolescents from autonomously exercising their right to sexual and reproductive health.³⁸⁰

ADOLESCENTS' ACCESS TO SAFE ABORTION

Human rights treaty bodies have repeatedly highlighted the link between maternal mortality and high rates of clandestine and unsafe abortions.³⁸¹ The CEDAW and CRC Committees and the ACHPRs have recommended that States decriminalize abortion.³⁸² The CEDAW Committee has categorized the “criminalization of abortion, denial or delay of safe abortion and post-abortion care” as “forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.”³⁸³ Both the CRC Committee and the ACHPRs have also called on states to ensure that adolescents have access to safe abortion and post-abortion services, regardless of the legal status of abortion.³⁸⁴ The CRC Committee has further tasked states to review legislation with a view to guaranteeing the best interests of pregnant adolescents, to ensure that their views are always heard and respected in abortion-related decisions,³⁸⁵ and consider allowing access to safe abortion for adolescents without the need for parental consent.³⁸⁶

COMPREHENSIVE SEXUALITY EDUCATION (CSE)

Under the rights to health, education and non-discrimination, states have an obligation to ensure that adolescents have access to comprehensive sexuality education (CSE), both in and outside formal education systems, and without parental consent.³⁸⁷ In particular, the CESCR Committee has noted that access to comprehensive education and information on sexual and reproductive health that takes into account the evolving capacities of children and adolescents is a non-derogable obligation.³⁸⁸

The CRC Committee has required states to guarantee age-appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards and developed with adolescents as part of the mandatory school curriculum, and also available for out-of-school adolescents.³⁸⁹ The Special Rapporteur on the right to health has also noted that: “Age-appropriate, comprehensive and inclusive sexuality education, based on scientific evidence and human rights, should be part of the mandatory school curriculum”.³⁹⁰ States should also develop public education campaigns to raise awareness about sexual and reproductive health issues, such as risks of early pregnancy and prevention of sexually transmitted infections, through medical and other alternative forums.³⁹¹

The ACHPRs has also urged State parties to guarantee information and education on sex, sexuality, HIV, and sexual and reproductive rights. The content must be evidence-based, facts-based, rights-based, non-judgemental and understandable in content and language.³⁹² The content must take into account the level of maturity of adolescent girls and youth.³⁹³ The Commission has also urged State parties to ensure that educational institutions (primary and secondary schools) include human rights issues in their curricula including sexual and reproductive health and women's rights.³⁹⁴

378 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 90; Report of the Special Rapporteur on the right to health, 2016, para. 90.

379 CESCR Committee General Comment 22 para. 44.

380 CESCR Committee General Comment 22 para. 48.

381 CRC Committee General Comment 20 para 13; CRC Committee Concluding Observations to Zimbabwe 2016 para. 61 (c);

382 ACHPRs Press Release: Launch Of The Campaign For The Decriminalization Of Abortion In Africa: Women And Girls In Africa Are Counting On Us To Save Their Lives! 18 January 2016 www.achpr.org/press/2016/01/d287/; Report of the UN Special Rapporteur on the right to health, 2016 para. 92; CEDAW Committee general recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19 14 July 2017 ref: CEDAW/C/GC/35 (hereafter CEDAW General Recommendation 35); UN Docs. CRC/C/ARE/CO/2, para. 58(d); CRC/C/BRA/CO/2-4, para. 60; CRC/C/CHL/CO/4-5, para. 61.

383 CEDAW Committee General Recommendation 35 at para. 18.

384 CRC Committee General Comment 15 para. 70.

385 ACHPRs General Comment 2 on article 14 of Maputo Protocol; CRC General Comment 20 para. 60; See also: UN Doc. CRC/C/MAR/CO/3-4 (2014), para. 57 (b); UN Doc. CRC/C/KWT/CO/2 (2013), para. 60; See also UN Doc. CRC/C/SLE/CO/3-5 (2016), para.s. 32 (c); UN Doc. CRC/C/GBR/CO/5, para. 65 (c); UN Doc. E/C.12/KEN/CO/1 (2008), para. 33; (UNMIK), UN Doc. E/C.12/UNK/CO/1 (2008), para. 30; UN Doc. CRC/C/IRL/CO/3-4 (2016), para. 58 (a).

386 CRC Committee General Comment 15 para. 31.

387 CRC Committee General Comment 15 para.s 31, 59; CRC, CRC Committee General Comment 4 para.s 7, 26, 28, 39(b); CRC Committee General Comment 20 para. 60, 61; CEDAW, General Recommendation 24 (1999) on Women and Health (Article 12), para. 18.

388 CESCR Committee General Comment 22 para. 49.

389 CRC Committee General Comment 20 para. 61.

390 Report of the UN Special Rapporteur on the right to health, 2016, para. 91.

391 CRC Committee General Comment 15 para. 28; CRC Committee General Comment 4 para. 28.

392 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 26.

393 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 51.

394 ACHPRs General Comment 2 on article 14 of Maputo Protocol para. 27.

The CRC Committee has further advised that sexuality education should aim to transform cultural views against adolescents' access to contraception, as well as other taboos regarding adolescent sexuality.³⁹⁵ Attention should be given to gender equality, sexual diversity, sexual and reproductive health rights, responsible parenthood and sexual behaviour and violence prevention, as well as to preventing early pregnancy and sexually transmitted infections. Information should be available in alternative formats to ensure accessibility to all adolescents, especially those with disabilities.³⁹⁶ The UN Special Rapporteur on the right to education has noted that states must ensure that curriculum materials do not perpetuate harmful or discriminatory stereotypes, and should pay special attention to diversity and gender issues, including ensuring that there is no gender role stereotyping, such as portraying the primary role of women as being mothers.³⁹⁷

Furthermore, all sexuality education programmes, both in and out of school, should not censor or withhold information or disseminate biased or factually incorrect information, such as regarding contraceptives or abortion.³⁹⁸ The content should also not be discriminatory, including on grounds of gender and sexual orientation, both in content and in teaching methodologies.³⁹⁹

ADDRESSING GENDER STEREOTYPES

The Human Rights Committee has long acknowledged the critical role that tradition, history, culture and other social structures such as gender have played in women's full enjoyment of the rights under the International Covenant on Civil and Political Rights (ICCPR).⁴⁰⁰

Treaty monitoring bodies have repeatedly condemned laws that prohibit health services needed only by women. The CEDAW Committee has also required States parties to recognize the interconnection between women's right to health, gender equality and addressing harmful gender stereotypes. Under right to health and article 12 of the CEDAW, the Committee has noted that State parties are required to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights.⁴⁰¹

The CEDAW and CESCR Committees have made the connection between denial of access to contraception and violations of a number of women's rights related to gender equality, noting that patriarchal attitudes, cultural stigma, gender stereotypes, prejudices about sexual and reproductive health services, and taboos about sexuality outside of marriage all contribute to the lack of access to contraception.⁴⁰² The CEDAW and CESCR Committees have called on states to conduct public awareness campaigns to tackle these gender inequalities as a means of improving access to contraceptives for women.⁴⁰³

The CRC Committee, CEDAW Committee, CESCR Committee and the Human Rights Committee have urged states to address both de jure and de facto discrimination in private and public spheres, adopt measures to eliminate gender stereotypes about women in family and society, and address practices that disproportionately impact women.⁴⁰⁴ This requires that states take positive measures to create an enabling environment that ameliorates those social conditions, such as poverty and unemployment, which impact women's right to equality in health care.⁴⁰⁵

NATIONAL LEGAL FRAMEWORK GUARANTEEING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND INFORMATION

CONSTITUTION OF ZIMBABWE (2013)

Zimbabwe enacted a new Constitution in 2013. It includes a "Declaration of Rights", enshrining a number of fundamental human rights and freedoms.⁴⁰⁶ The Constitution obligates the state, as well as every institution and agency of the government at every level, to respect, protect, promote and fulfil these rights and freedoms.⁴⁰⁷

395 CRC Committee General Comment 4 para. 26.

396 CRC Committee General Comment 4 para. 61.

397 Report of the UN Special Rapporteur on the right to education, paras. 21-23, 87 (d).

398 CRC Committee, General Comment 3 (2003) para. 16; CESCR Committee General Comment 14 para. 34; Report of the UN Special Rapporteur on the right to education, para. 39, (2010).

399 Report of the UN Special Rapporteur on the right to education, para. 63, (2010). The UN Special Rapporteur on the right to education has noted that States should take steps to ensure that programs are free from harmful sex or gender based or heteronormative stereotypes of those based on mental or physical ability, at para. 63.

400 Human Rights Committee, General Comment No. 28: Equality of rights between men and women (article 3), U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), para 5.

401 CEDAW, General Recommendation 24 (1999) on Women and Health (Article 12), para. 28.

402 CEDAW Committee, Concluding Observations: Iraq, paras. 42-43, U.N. Doc. CEDAW/IRQ/CO/4-6 (2014); Hungary, paras. 30 & 31(a), U.N. Doc CEDAW/C/ HUN/CO/7-8 (2013); Georgia, paras. 30-31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014); Solomon Islands, para. 36(b), U.N. Doc. CEDAW/C/SLB/CO/1-3 (2014); CESCR Committee, Concluding Observations: Ecuador, para. 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).

403 CEDAW Committee, Concluding Observations: Iraq, paras. 42-43, U.N. Doc. CEDAW/IRQ/CO/4-6 (2014); CESCR Committee, Concluding Observations: Ecuador, para. 28, U.N. Doc. E/C.12/ECU/CO/3 (2012).

404 Human Rights Committee, Concluding Observations: Cape Verde, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012); Jordan, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010); Canada, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999); CEDAW Committee, General Recommendation 25 (2004) on temporary special measures (Article 4), para. 10; CRC General Comment 15 para. 10.

405 Human Rights Committee, Concluding Observations: Kyrgyzstan, para. 401, U.N. Doc. A/55/40 (2000); CEDAW Committee, General Recommendation 25 (2004) on temporary special measures (Article 4), para. 81; CRC General Comment 15 (, para. 10.

406 Constitution of Zimbabwe Chapter 4.

407 Constitution of Zimbabwe Section 44.

Section 76 of the Constitution provides the right to access health services and specifically includes reproductive health-care services.⁴⁰⁸ The Constitution also protects a number of related rights, including equality⁴⁰⁹ and privacy⁴¹⁰ which are necessary to support the full realization of adolescents' sexual and reproductive health and rights.⁴¹¹ The Constitution recognizes gender equality as a guiding value⁴¹² and prohibits discrimination on grounds including an individual's sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock.⁴¹³ Children's rights are further strengthened through specific provisions.⁴¹⁴ A "child" is defined as a boy or girl under the age of 18,⁴¹⁵ and the Constitution provides that a "child's best interests are paramount in every matter concerning the child."⁴¹⁶ The section reiterates the right of children to education, health care services, nutrition and shelter.⁴¹⁷

The Constitution provides that interpretation of the Declaration of Rights "must take into account international law and all treaties and conventions to which Zimbabwe is a party."⁴¹⁸ The clause has been interpreted by Zimbabwe's Constitutional Court to support a purposive interpretation of Zimbabwe's Constitution and legislation to ensure alignment with the country's commitments under international human rights law.⁴¹⁹ In the 2016 case of *Loveness Mudzuru and Another v. Minister of Justice and Others*⁴²⁰ the Court relied on Zimbabwe's obligations under both the CRC and the African Charter on the Rights and Welfare of the Child (ACRWC) when finding that child marriage violated the Constitution.⁴²¹

Zimbabwe has committed to undertake a review of national laws to ensure alignment with the rights protected under the Constitution and international human rights treaties.⁴²² This review has been welcomed by the CRC Committee and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC).⁴²³ However, human rights treaty bodies have raised concerns that the process to harmonize domestic laws with the new constitutional provisions has been exceedingly slow.⁴²⁴ The ACERWC has also called on Zimbabwe to "harmonize the definition of the child in all laws in line with article 2 of the African Children's Charter."⁴²⁵ Most recently, at Zimbabwe's Universal Periodic Review before the Human Rights Council in March 2017, the Zimbabwe Government responded to calls by other State parties to complete this process, and confirmed it was "cognisant of the need to speed up the alignment of laws with the Constitution in order to implement some of the recommendations that have been supported".⁴²⁶

It is a key objective of Zimbabwe's National Gender Policy 2013-2017, to "ensure that the constitutional and legislative provisions on gender justice are implemented and gender equality targets set in the national and international and regional protocols, to which Zimbabwe is party, are achieved."⁴²⁷ The Policy includes commitments to "Conduct a gender audit of all existing relevant laws, identify gaps in line with the new constitutional provisions, and recommend areas for review or enactment of new instruments; Advocate for the

408 Constitution of Zimbabwe Section 76.

409 Constitution of Zimbabwe Section 56.

410 Constitution of Zimbabwe Section 57, the Right to Privacy, includes at S57 (e) the right not to have their health condition disclosed.

411 The CESCR Committee has confirmed that "the right to sexual and reproductive health is...indivisible from and interdependent with other human rights." Noting in particular, "civil and political rights underpinning the physical and mental integrity of individuals and their autonomy, such as the right to life; liberty and security of person; freedom from torture and other cruel, inhuman or degrading treatment; privacy and respect for family life; and non-discrimination and equality." CESCR Committee General Comment 22 at para. 10.

412 Constitution of Zimbabwe Section 3 (g) and see also Section 56 (2) 'Women and men have the right to equal treatment including to the right to equal opportunities in political, economic, cultural and social spheres.'

413 Constitution of Zimbabwe Section 56 (3) states that "Every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their nationality, race, colour, tribe, place of birth, ethnic or social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock."

414 Constitution of Zimbabwe Section 81 Rights of children.

415 Constitution of Zimbabwe Section 81 (1).

416 Constitution of Zimbabwe Section 81 (2) A child's best interests are paramount in every matter concerning the child.

417 Constitution of Zimbabwe Section 81 (1) (f).

418 Constitution of Zimbabwe Section 46 1 (c), which provides: "When interpreting this Chapter, a court, tribunal, forum or body must take into account international law and all treaties and conventions to which Zimbabwe is a party."

419 Judgment No. CCZ 12/2015 Const. Application No. 79/14 *Loveness Mudzuru and Another v Minister of Justice, Legal & Parliamentary Affairs and Others*, with the court noting, for example, "The meaning of s 78(1) of the Constitution is not ascertainable without regard being had to the context of the obligations undertaken by Zimbabwe under the international treaties and conventions on matters of marriage and family relations at the time it was enacted on 22 May 2013."

420 *Loveness Mudzuru and Another v Minister of Justice, Legal & Parliamentary Affairs and Others*.

421 *Loveness Mudzuru and Another v Minister of Justice, Legal & Parliamentary Affairs and Others*, Malaba DCJ finding that; "By signing these documents Zimbabwe expressed its commitment to take all appropriate measures, including legislative, to protect and enforce the rights of the child as enshrined in the relevant conventions to ensure that they are enjoyed in practice" page 27.

422 Human Rights Council, Report of the Working Group on the Universal Periodic Review – Zimbabwe, 19 December 2011, A/HRC/19/14, recommendation 93.4 (South Africa); Human Rights Council, Report of the Working Group on the Universal Periodic Review – Zimbabwe 2016 A - 131.6 Islamic Republic of Iran, A - 131.7 Germany; A - 131.8 Congo; A - 131.9 Philippines; A - 131.10 Uganda; A - 131.11 Egypt; A - 131.13 Togo; A - 131.15 Czechia; A - 131.20 Tunisia; as cited in UPR Info's briefing 2RP: Responses to Recommendations & Voluntary Pledges Second Review Session 26 Review in the Working Group: 2 November 2016 Adoption in the Plenary: 16 March 2017; Committee on the Rights of the Child, List of issues in relation to the second periodic report of Zimbabwe, Addendum Replies of Zimbabwe to the list of issues* CRC/C/ZWE/Q/2/Add.1 notes: "The Ministry of Justice, Legal and Parliamentary Affairs formed an Inter-ministerial Taskforce on the alignment of laws, in order to fast track the alignment of laws to the new Constitution"; Report of the Human Rights Council on its thirty-fourth session, May 21 2017 at para 589 (UN Doc: A/HRC/34/2).

423 CRC Concluding Observations Zimbabwe 2016; Concluding Observations and Recommendations by the African Committee of Experts on the Rights and Welfare of the Child on the republic of Zimbabwe's Implementation of the African Charter on the Rights and Welfare of the Child 2015.

424 Human Rights Council, Report of the Working Group on the Universal Periodic Review – Zimbabwe, 19 December 2011, A/HRC/19/14, recommendation 93.4 (South Africa); Human Rights Council, Report of the Working Group on the Universal Periodic Review – Zimbabwe 2016 A - 131.6 Islamic Republic of Iran, A - 131.7 Germany; A - 131.8 Congo; A - 131.9 Philippines; A - 131.10 Uganda; A - 131.11 Egypt; A - 131.13 Togo; A - 131.15 Czechia; A - 131.20 Tunisia; as cited in UPR Info's briefing 2RP: Responses to Recommendations & Voluntary Pledges Second Review Session 26 Review in the Working Group: 2 November 2016 Adoption in the Plenary: 16 March 2017.

425 Concluding Observations and Recommendations by the African Committee of Experts on the Rights and Welfare of the Child on the republic of Zimbabwe's Implementation of the African Charter on the Rights and Welfare of the Child 2015.

426 Report of the Human Rights Council on its thirty-fourth session, May 21 2017 para 589.

427 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 page 11.

enactment of new laws, and/or support any efforts towards enactment of laws needed to deliver the gender equality provisions as provided in the new constitution; and Identify harmful laws, cultures and traditional practices that infringe on women's and girls' rights and that impede the gender equality objectives and lobby for their elimination".⁴²⁸ Zimbabwe's Ministry of Women Affairs, Gender and Community Development was due to report on progress made under these objectives in 2017.⁴²⁹

Zimbabwe has a number of laws relating – directly or indirectly - to the provision of sexual or reproductive health services and information for adolescents. These include the Public Health Act (1924) which recognises children aged 16 and above as capable to consenting to medical treatment.⁴³⁰ Amnesty International was informed by NGO partners in Harare, that the Act has undergone a consultative review process since 2010, to develop the Public Health Bill.⁴³¹ The Bill is understood to include recognition of the right to health, including reproductive health care, but does not clarify ages of consent to such services.⁴³²

The Sexual Offences Act (2001) sets the age of consent to sex as 16.⁴³³ However, the Criminal Law Codification Act 2004 creates an offence of extra-marital sexual intercourse with a minor and provides a defense to a charge of statutory rape of a child aged between 12 and 16, if there was "consent".⁴³⁴ The legislation has been criticized for creating confusion within Zimbabwe as to the age of consent for sex and limiting access to justice for child rape survivors.⁴³⁵

The Termination of Pregnancy Act (No. 29 of 1977) (as amended 2001), allows abortion when it is necessary to save the life of the woman, to preserve her physical health, when there is foetal impairment and when the conception is the result of rape or incest.⁴³⁶ Abortion outside of those exceptions is criminalised.⁴³⁷ In 2016, the CRC Committee emphasized Zimbabwe's "restrictive abortion law and the lengthy procedures for authorizing abortions, which result in illegal and unsafe abortions" and recommended Zimbabwe "ensure children's access to safe abortion and post-abortion care services, in law and in practice."⁴³⁸

In 2016, the Constitutional Court ruled that Section 22(1) of the Marriage Act and The Customary Marriages Act [Chapter 5:07] were unconstitutional for allowing marriage under the age of 18.⁴³⁹ The Court set the legal age for marriage as 18 for both girls and boys from the date of the judgment.⁴⁴⁰ The government has yet to amend the Marriage Act or enact related legislation to comply with the court's judgment to prevent or prosecute subsequent cases of child marriage.

428 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 page 13.

429 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 page 24.

430 Public Health Act of Zimbabwe (Act 19 Of 1924), Interpretation section (1).

431 Amnesty International meetings with NGO partners in Harare in April 2017 and subsequent follow up information.

432 On 7 June 2017 Amnesty International wrote to the MoHCC to request further information regarding the progress made in amending the Act, we had not received a reply by the date of publication.

433 Sexual Offences Act 8/2001 section 3.

434 Sexual Offences Act 8/2001 section 70 (4) (1).

435 Herald 'Concern as Zimbabwe sets age of consent at 12' 9 June 2015 <http://www.herald.co.zw/concern-as-courts-set-age-of-consent-at-12/>; National Adolescent Fertility Study 2016.

436 Termination of Pregnancy Act, Acts 29/1977, 6/2000, 8/2001, 22/2001.

437 Termination of Pregnancy Act (No. 29 of 1977) Section 3 (2): "Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level ten or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment."

438 CRC Concluding Observations Zimbabwe 2016 para.s 60 (c) 61 (c).

439 *Loveness Mudzuru and Another v Minister of Justice and Others* 2016.

440 *Loveness Mudzuru and Another v Minister of Justice and Others* 2016.

6. CONCLUSION

The government of Zimbabwe has taken welcome steps in recent years towards respecting, protecting and fulfilling the sexual and reproductive rights of adolescent girls. These include setting important targets to reduce Zimbabwe's maternal mortality ratio from 614 to 320 deaths per 100,000 live births by 2020.⁴⁴¹ And political commitments under the UN Agenda 2030⁴⁴² and the African Union's Agenda 2063,⁴⁴³ which include targets related to health, education, inequality and the empowerment of women and girls.⁴⁴⁴ However, the discrepancy between the slow rates of decline in the maternal mortality ratio among adolescents compared to older women, signals a need for urgent action.

The publication of the National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision, 2016 and National Adolescent Sexual and Reproductive Health Strategy II 2016-2020 and the development of the School Health Policy and new Guidance and Counselling curriculum mark significant opportunities for reducing adolescent pregnancy and related health and social risks. However, critical gaps remain, including the lack of information on sexual and reproductive rights, stigma of adolescent sexual development and the cost of health services.

Amnesty International's research reveals how the lack of information on sexual and reproductive rights, as well as on entitlements to the services, goods and programmes which the government has made available, continue to hamper girls' ability to exercise these rights.

The absence of a clear legal framework has resulted in a disturbing ambiguity surrounding the rights of adolescents to access the health services and information that are vital for their well-being and futures. The government must address this vacuum of information through removing requirements regarding age and third party consent for health services.

To reduce the stigma of adolescent sexual development, the government should also undertake awareness-raising programmes aimed at communities, schools, health professionals and state officials. Such programmes should aim to challenge and change the underlying social and cultural attitudes which perpetuate harmful practices, gender stereotypes and discrimination, and to empower women and girls to exercise their rights.

The Ministry of Primary and Secondary Education has a critical role to play in implementing the new Guidance and Counselling curriculum to ensure that the content equates to evidence-based comprehensive sexuality education and that teachers are supported to deliver the content. Strengthening coordination between government departments is long overdue, and can be assisted through implementing the School Health Policy and finalizing the National Action Plan to End Child Marriage.

Adolescent girls living in contexts of poverty and marginalization need to be prioritized to ensure they can realize their rights to education and health. The government should remove financial and structural barriers which impede women's and girls' ability to access maternal health and contraceptive services, including emergency contraception, distance from health facilities, lack of transport, and out of pocket costs of health services. The government should increase domestic financing for sexual and reproductive health services and ensure the timely disbursements of budget funds from the Ministry of Finance. It should seek any necessary international assistance and co-operation.

441 MoHCC National Health Strategy 2016-2020, Objective 10 page Xi.

442 UN Agenda 2030 (also referred to as the Sustainable Development Goals) <https://sustainabledevelopment.un.org/>

443 African Union Agenda 2063, 'The Africa We Want' https://au.int/sites/default/files/pages/3657-file-agenda2063_popular_version_en.pdf

444 All of the UN Agenda 2030 Goals are cross cutting, but see specifically, Goal 3 Ensure healthy lives and promote well-being for all at all ages, Goal 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, Goal 5 Achieve gender equality and empower all women and girls, Goal 10 Reduce inequality within and among countries ; AU Agenda 2063, Aspiration 1 A prosperous Africa based on inclusive growth and sustainable development and Aspiration 6, An Africa whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children.

7. RECOMMENDATIONS

TO THE GOVERNMENT OF ZIMBABWE:

- Review and revise all laws related to adolescents' sexual and reproductive health and rights in Zimbabwe to ensure that there are no inconsistencies related to the age at which adolescents' can access sexual and reproductive health information, education, and services. This includes: the Public Health Act (1924); the Children's Act [Chapter 5:06] [as amended by Section 2 of Act 23 of 2001, with effect from 18th January, 2002]; the Sexual Offences Act (2001) and the Criminal Law Codification Act (2004) and the Termination of Pregnancy Act (1977)
- Provide clarification in all policies relating to sexual and reproductive health services, education and information,⁴⁴⁵ to ensure:
 - Adolescents have the right to access to sexual and reproductive health information, education and services, irrespective of their age, without parental consent, based on their evolving capacities, and
 - The age of consent to sexual activity and the minimum age of marriage should not be a barrier to the age at which adolescents can access sexual and reproductive health information, education and services.
- Develop and urgently disseminate clear instructions for health care providers on adolescents' right to sexual and reproductive health services and information without parental consent and according to the adolescent's evolving capacities.
- Amend the Termination of Pregnancy Act (1977) and the Criminal Law Act (2007), to decriminalize abortion in all circumstances as recommended by the African Commission on Human and People's Rights and UN treaty bodies.⁴⁴⁶
- In line with the recommendations of the Committee on the Rights of the Child, take urgent measures to prevent maternal deaths and injuries of adolescents resulting from unsafe abortion, including by ensuring that girls can access safe, timely and quality abortion and post-abortion care in law and in practice. Ensure that the views of pregnant adolescent girls are always heard and respected in abortion decisions, and that their best interest is guaranteed.
- Develop and disseminate guidelines for health care providers on the delivery of youth-friendly health services. These should clearly advise how to assess adolescents' ability and maturity to understand medical information and take health-related decisions. The guidelines must ensure health services and information are provided in a youth-friendly and age appropriate manner, which respects adolescents' rights to informed consent, privacy and confidentiality.
- Provide specific and on-going training to all health workers to enable them to:
 - Implement the guidelines for the delivery of youth-friendly services;
 - Understand and support adolescents' sexual and reproductive rights more broadly, including their right to access sexual and reproductive health services and information without parental consent and according to the adolescent's evolving capacities.
- Undertake public information and education campaigns, including within media, communities and in schools to:
 - Transform cultural views against adolescents' access to contraception and other taboos regarding adolescent sexuality, including harmful gender stereotypes, and promote gender equality, sexual diversity; and

⁴⁴⁵ Including the: National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision, 2016; Zimbabwe National Guidelines on HIV Testing and Counselling 2014; School Health Policy; and the National Adolescent Sexual and Reproductive Health Strategy II 2016-2020.

⁴⁴⁶ African Commission on Human and People's Rights 18 January 2016, Press Release: Launch Of The Campaign For The Decriminalization Of Abortion In Africa: Women And Girls In Africa Are Counting On Us To Save Their Lives! www.achpr.org/press/2016/01/d287/

- Raise awareness among different stakeholders about adolescents' sexual and reproductive rights. These include the right to access sexual and reproductive health information and services, such as all modern contraceptive methods, including emergency contraception, without parental consent and in line with their evolving capacities; and
- To include accurate, evidence-based and comprehensive information about modern contraceptive methods and how they work, including emergency contraception, with a view to correcting commonly-held misconceptions.
- Ensure that all young people can access youth-friendly sexual and reproductive health information and services, at government health facilities – including under school health programmes - while fully respecting their right to informed consent, privacy and confidentiality in public health facilities.
- Ensure that women and girls can access safe, effective, affordable and acceptable methods of family planning, including the full range of modern contraceptive methods and services, and that all forms of contraception, including emergency contraception, can be independently and confidentially accessed.
- Ensure that sexual and reproductive health services are affordable, especially to adolescents, including by strictly implementing the Ministry of Health and Child Care policies which provide for free maternal health services including antenatal care and skilled birth assistance, and free sexual and reproductive health services, including contraception.
- Ensure the prioritization of the most marginalized sections of the population and the equitable distribution of health facilities, health professionals, goods and services throughout the country, including choices on where to build new facilities.
- Finalize and implement the School Health Policy by the middle of 2018 to ensure that all young people, both in and out of school, have access to quality, age-appropriate, and evidence-based comprehensive sexuality education, and are empowered to take informed decisions about their sexuality and health, including through provision of information on:
 - family planning and contraceptives, the prevention of HIV and the prevention and treatment of sexually transmitted infections;
 - the full range of sexual and reproductive rights, including the rights to be free from discrimination and violence, to information, to health, and to remedy when rights are violated;
 - gender equality, sexual diversity, and provide tools to challenge harmful gender stereotypes, and social norms and attitudes underlying gender based violence.
- Develop and implement programmes for capacity-building and ongoing support for teachers to deliver the comprehensive sexuality education curriculum and syllabus, including through participatory approaches, and ensure that all students have access to quality comprehensive sexuality education and are empowered to know and claim their human rights including sexual and reproductive rights. Progress should be regularly monitored, including reports of progress made, to be submitted to human rights treaty bodies and under the Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people.
- Ensure that all women and girls have access to child care benefits or other necessary support. Girls should be able to return to school and continue their education if they wish to do so.
- Ensure that all health facilities prominently display the Patients' Charter and that all patients have access to grievance redress and remedy, both within health facilities and through the judiciary, in case of human rights violations.
- Ensure that the Ministry of Finance and Economic Development disburse the budget allocations to the Ministry of Health and Child Care in a timely manner, and support the Ministry of Health and Child Care in seeking innovative funding strategies to overcome cost barriers to sexual and reproductive health services and funding shortfall for the family planning budget.
- Ensure that the Ministry of Women Affairs, Gender and Community publish their end of term review of Zimbabwe's National Gender Policy 2013-2017,⁴⁴⁷ by the end of the first quarter of 2018, including their findings as to:
 - Reviewing Zimbabwe's laws, cultures and traditional practices that infringe on women's and girls' rights and that impede the gender equality objectives and progress in lobbying for their elimination; and
 - Their oversight of the implementation of constitutional and legislative provisions on gender justice and gender equality targets – including the proportion of population by gender accessing health services - under national and international and regional protocols, to which Zimbabwe is party.

447 Ministry of Women Affairs, Gender and Community Development, National Gender Policy 2013-2017 Page 24.

TO INTERNATIONAL PARTNERS:

- Take steps, individually and through international assistance and cooperation, to ensure the full realization of women's and girls' sexual and reproductive rights in Zimbabwe.
- Take steps to ensure the coordination of resource allocations from international partners to assist in improving transparency accountability.
- Ensure funding to prioritize adolescent girls living in contexts of poverty and marginalization, which is ring fenced and aligned with strong accountability mechanisms to ensure the resources go where they are most needed.
- Ensure that all international assistance and cooperation to the government of Zimbabwe is directed and distributed in a non-discriminatory manner, promotes human rights and gender equality, and prioritizes disadvantaged and marginalized groups.

**AMNESTY INTERNATIONAL
IS A GLOBAL MOVEMENT
FOR HUMAN RIGHTS.
WHEN INJUSTICE HAPPENS
TO ONE PERSON, IT
MATTERS TO US ALL.**

“LOST WITHOUT KNOWLEDGE”

BARRIERS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION FOR ADOLESCENTS IN ZIMBABWE

Despite the recent development of policies aimed at improving the sexual and reproductive health of young people, adolescent girls in Zimbabwe experience high rates of unintended pregnancy and are at disproportionate risk of maternal mortality, morbidity and HIV infection. Many girls are forced into marriages by families hoping to avoid the stigma associated with pre-marital sex, or the cost of raising a child.

The findings in this report illustrate that, in Zimbabwe, adolescent girls face a disturbing context of isolation from sexual and reproductive health services, information and education. Barriers include confusion and inconsistent interpretations of laws and policies relating to the age at which girls are able to access sexual and reproductive health services without parental consent. This situation is compounded by intense stigma around the sexual activity of adolescents and a lack of comprehensive sexuality education. Fees charged for antenatal care and delivery in many public health facilities have resulted in adolescents delaying access to maternal health services or not receiving care at all.

Zimbabwe has an obligation to respect, protect and fulfil human rights – including the right to health. This report calls on the Zimbabwean authorities to act to remove these barriers.