

STATUS OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN ZAMBIA

Violence Against Women and HIV/AIDS Prevention and Treatment

This brief is Part 3 of a three-part series entitled “Status of Sexual and Reproductive Health and Rights in Zambia,” reporting on progress, gaps, and existing challenges in SRH&R.

In 1994, the International Conference on Population and Development (ICPD) affirmed that Sexual and Reproductive Health and rights (SRH&R) are human rights. Pursuant to this, several international instruments contributed to global consensus on how reproductive health rights are intrinsically linked to other fundamental human rights. The Government of the Republic of Zambia (GRZ) has fully committed to fulfilling the SRH&R of all people by ratifying 11 international instruments of law (seven global and four regional treaties) (see Table 1).

In addition to ratifying global and regional treaties, Zambia has also committed to achieving Sustainable Development Goals (SDGs). Some SDGs directly relate to SRH&R. These are: ensuring healthy lives and promoting well-being for all at all ages (Goal 3); ensuring quality education for all (4); achieving gender equality and empowering all women and girls (5); reduced inequalities (10); and enhancing partnerships to achieve SDGs (17). Other SDGs have an indirect effect on SRH&R. These include decent work (8), and peace, justice, and strong institutions (16). Government is therefore obligated to ensure that it respects, protects, and fulfils every person’s rights.

Using a human-rights-based approach, the Government of Zambia under the leadership of the Human Rights Commission, and in collaboration with the United Nations Population Fund, Office of the High Commissioner for Human Rights, Women and Law in Southern Africa, and with technical facilitation by the Population Council, conducted an assessment of the status of SRH&R in the country guided by a global assessment framework (see Table 2). The aim was to assess Zambia’s commitment to fulfilling government obligations on seven SRH&R–related themes. The themes, selected through a consensus-building approach, are:



(1) access to contraceptive information and services; (2) access to safe abortion and postabortion-care services; (3) maternal health care; (4) prevention and treatment of HIV; (5) comprehensive sexuality education; (6) violence against women and girls; and (7) rights of marginalised populations, particularly adolescents and sex workers. The working questions were:

- a) Do national SRH indicators show that Zambia is meeting the sexual and reproductive rights of all of its people?
- b) Are the country's existing laws, policies, financing mechanisms, budgetary allocations, implementation measures, monitoring and evaluation, and remedial and redress mechanisms respecting, protecting, and upholding SRH&R in Zambia?

KEY FINDINGS

Overall, under each theme, based on the assessment framework and informed by desk reviews and consultative processes, Zambia is making steady progress in fulfilling SRH&R, although challenges still remain.

Violence Against Women

Human Rights Considerations and Government Obligations

Violence against women is an abuse of human rights. Perpetrated mainly by men against women, sexual and gender-based violence (SGBV) is a form of discrimination. It degrades women and deprives them of opportunities to enjoy the same human rights as men. International law prohibits all forms of gender-based violence (GBV). Article 3(4) and Article 4 of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, and Article 11 of the SADC Protocol on Gender and Development, direct governments to prohibit and punish GBV. The Convention on the Elimination of All forms of Discrimination Against Women also directs government to adopt and implement appropriate measures to ensure the protection of women's rights, including protection from all forms of violence and abuse. GRZ therefore has an obligation to protect all people, especially women and girls, from all forms of GBV.

Legal and Policy Environment

Zambia has taken steps to protect women from SGBV.

These steps include:

- Anti-GBV Act of 2011. This law prohibits GBV. It comprehensively defines various aspects of GBV including but not limited to harassment; intimidation; physical, mental, social, or economic abuse; emotional, verbal, or psychological abuse; stalking; forced marriage; child marriage; and sexual cleansing. The law empowers any citizen to report GBV.
- Penal Code Act, Chapter 87, Sections 132 and 138 prohibit the rape of a woman above the age of 16 years and defilement of a child below 16 years of age. Section 247 prohibits common assault, Section 248 prohibits assault occasioning actual bodily harm, and Section 248A prohibits battery including battery of children.
- Zambia Police (Amendment) Act No. 14 of 1999, Section 53, establishes the Victim Support Unit (VSU). Section 53(2) states that the functions of the VSU shall be to provide professional counselling to victims of crime and to offenders, and to protect citizens from various forms of abuse.

Besides the enactment of these laws, the government has also introduced fast-track courts to administer justice to survivors of GBV expeditiously, and introduced provision of post-exposure prophylaxis (PEP) to prevent HIV and emergency contraception (EC) to prevent pregnancy among survivors of sexual violence. GRZ is also rolling out an innovative program that will ensure that PEP and EC are provided at the police station, because police are the first contact point for survivors of sexual violence.

Indicators of Progress

Violence against women and girls is high in Zambia. Although there was a slight decrease in the number of women reporting physical violence from 47% in 2007 to 43% in 2014, SGBV is still significantly high. In 2014, 43% of women aged 15–49 had experienced physical violence since age 15, and 17% of women had ever experienced sexual violence, of which 10% experienced it in the past 12 months (2013-14 Zambia Demographic and Health Survey). Domestic violence is high. Women who have ever married experience intimate partner violence more

than those who have never been married, with violence largely attributed to husbands or partners. More than half (57%) of women who are divorced, separated, or widowed, and 48% of currently married women have experienced physical violence, as compared with 27% of never married women (2013-14 ZDHS).

Although adolescent girls age 15–19 are the least likely when compared with other age groups to have experienced physical and sexual violence, gender-based violence is high among adolescent girls and young women with 29 percent ever experiencing physical violence and 8.2% ever experiencing sexual violence.

There is an increase in the reporting of GBV to the police. Reports indicate that 10,217 GBV cases in 2013 and 15,124 GBV cases in 2014 were reported to the police's VSU, and 1,003 children in 2011 and 1,431 in 2012 were defiled. Violence against women and girls is therefore a significant human-rights concern that needs to be addressed.

Indicators of Progress

Patriarchy Perpetuates GBV

Zambia has a dual legal system—both customary and statutory law. Article 7(d) of the 2016 amended Constitution permits the practice of customary law that is consistent with the Constitution. However, allowing customary law practices without a law that codifies what is good customary law that is consistent with the Constitution and what is bad customary law is problematic for women's rights. Traditionally, and according to cultural norms in Zambia, society is very patriarchal, with women viewed as inferior to men. This gender power imbalance has perpetuated the social tolerance of men mistreating women and reinforces the control of women by men. Customary law also permits discrimination against women in family affairs—polygamy (men can marry two women, while women cannot marry two men), bride price (paying to marry a woman, which subordinates the woman), and in some cases sexual cleansing, which puts women at risk of HIV infection and deprives them of the right to choose. As a result of these power imbalances, women have been socialized to believe that it is acceptable to be beaten by a man. The 2013-14 ZDHS reports that 47 percent of women aged 15–49 thought it was acceptable to be beaten.

Withdrawal of GBV Cases

Although laws and policies have been developed, there are still a number of procedural and evidence-presentation challenges in the courts of law that have continued to have a negative impact on justice for women and girls. Section 8 of the Criminal Procedure Code Act (CPC) stipulates that subordinate courts may promote reconciliation for assault and other offences not amounting to a felony. This provision of the law prompts complainants in GBV cases to withdraw those cases. Women, in particular, given their lack of economic and social power, tend to withdraw their cases because a breadwinner may be imprisoned, which could lead to poverty at the household level. In 2012, for example, of the 1,500 GBV cases that were in court, 233 (15.5%) were withdrawn from court hearings (UNDP 2013). The other complication is that although under Section 17 the CPC provides for medical examination of the accused person at any time during the trial by order of the court, there is no way of compelling an accused person to provide specimens during investigations. Clearly, this may lead to loss of evidence, especially in sexual-assault cases, which leads to fewer convictions of perpetrators and a miscarriage of justice for survivors of sexual violence.

Lack of Justice for Survivors of GBV in Rural Areas

In most rural areas, there are no police officers and no formal court systems; the nearest police stations are a long distance away from some villages. This means that cases of GBV are not reported to the police and if reported may be reported late, which negatively impacts the quality of evidence, resulting in low conviction rates or miscarriage of justice. Lack of transportation by the police also

Violence Against Women in Zambia Is Too High

Among women aged 15–49, 17% have experienced sexual violence:

- **17% in urban areas; 18% in rural areas**
- **20% among those with no education or primary education; 15% among those with tertiary education**
- **14% among the richest; 18% among the poorest**

Among women aged 15–49, 43% have experienced physical violence.



compromises investigations in rural areas. Police fail to follow up cases to collect evidence, interview witnesses, and carry out other necessary aspects of investigations. In situations where GBV cases are reported to the police and commenced in court, due to the distance, most survivors withdraw the cases or simply fail to attend court because it is too expensive to repeatedly travel there (Mwimbu et al. 2013). To seek justice, survivors of GBV in rural areas rely on traditional courts. The traditional courts, which are not recognised by the law, are adjudicated upon by traditional leaders including chiefs, headmen, and women who have limited or no knowledge of the law and human-rights approaches and rely on customary and traditional interpretations of GBV circumstances (Shezongo-McMillan 2013). Relying on customary law and practice may work against women, because customs seem to favor men. Traditional leaders should be trained in human rights and basic laws on GBV in order to understand that GBV is a human-rights issue.

Slow implementation of the GBV Act

Operationalisation of the GBV Act has been slow, rendering it almost unenforceable in its current state. Specific difficulties regarding enforcement include the need to establish shelters for survivors. By 2013, only two shelters had been established by the government, rules of court as provided in Section 40 of the Act (to provide for the procedures and form of commencement of actions under the Act) had not been developed yet, and the Anti-GBV Fund as provided for in Section 32(1) had not been established yet. The fund is meant to provide economic empowerment to survivors of GBV, because women who are victims of GBV are usually economically

dependent on the perpetrators who, in most cases, are their husbands or guardians.

Recommendations

- Government, jointly with statutory law entities, needs to clarify the relationship and boundaries between customary laws and institution and the civil and criminal justice system. Creative ways must be found to codify a victim's rights to be treated in accordance with human rights and gender equality standards. All customary law that is discriminatory should be abolished.
- Article 231 of the 2016 amended constitution has established the Gender Equity and Equality Commission. In 2015, Gender Equality and Equity Act No. 22 of 2015 was enacted. However, it has not been operationalised yet. Becoming operational is dependent on the issuing of a statutory instrument by the Minister, appointing the date of the Act's commencement. It is recommended that the Minister responsible for Gender immediately issue a statutory instrument to operationalise the Act.
- Create the Anti-GBV fund as provided for under the Anti-GBV Act and ensure that the Act is fully implemented.
- Legislative efforts must be continuously pursued along with widespread endeavors to educate and change the mindsets of men, women, and children through all available means, including schools, the media, and traditional and religious leaders (Rashid Manjoo, UN Special rapporteur on GBV, Para. 107).

Prevention and Treatment of HIV and AIDS

Human Rights Considerations and Government Obligations

As part of their right to education, health, dignity, nondiscrimination, and quality of life, people should be provided with accurate and unbiased information on how to protect themselves from HIV infection and its impact on their lives. People living with HIV have the right to be free from all forms of stigma and discrimination and, just like anyone else in society, have the right to access all forms of health and HIV and AIDS services, including treatment.

Legal and Policy Environment

Zambia has developed a multisectoral response to HIV and AIDS coordinated by the National AIDS Council (NAC), which was created by the National AIDS/STI/TB Council Act. No. 10 of 2002. In 2005, an HIV policy was put in place that was the basis for the development of five four-year National HIV/AIDS Strategic Frameworks (NASF). The most recent NASF is for the period 2014–16 (a revised version of the 2011–15 NASF) during which several HIV prevention, treatment, care, and support programs were implemented and led to positive results.

Indicators of Progress

HIV prevalence reduced from 16% in 2001 to 13% in 2014 among adults 15–49 years of age (see Figure 1) (CSO, MOH, and ICF International 2014). The number of health facilities providing HIV treatment had increased from 564 in 2012 to 592 in 2014. By 2014, 91.7% (671,066) of the 731,546 adults and children living with HIV were on lifesaving drugs. To prevent mother-to-child transmission of HIV, Option B+, a policy whereby a pregnant woman who tests positive regardless of her CD4 count is immediately begun on HIV treatment, has been implemented in Zambia, where all public-health-sector HIV services are free.

Gaps and Challenges

In spite of these successes, Zambia is among the ten countries in the world with the highest HIV prevalence. There is a need, therefore, to continue focusing on HIV prevention and access to treatment.

The Prevention of Mother-to-Child Transmission (PMTCT) program has focused mainly on prong 3 of the Elimination of Mother-to-Child Transmission (EMTCT) program, which involves administration of ART (antiretrovirals); there is a need to enhance prong 1 which is about primary prevention of HIV among child bearing women and prong 2, which addresses unplanned pregnancies among HIV-positive women.

A review of HIV program financing reveals that the majority of HIV funds come from external donors. To sustain HIV prevention and treatment programs, Zambia should establish an HIV fund, which is provided for under the

NAC Act. GRZ and its cooperating partners should further strengthen the NAC for effective coordination of various organizations implementing HIV activities (civil, private, faith-based), to ensure the success of national programs.

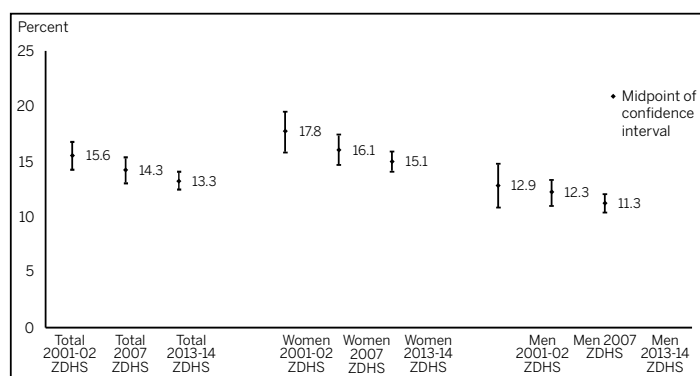
Recommendations

- Establish the HIV/AIDS fund. To complement donor funding for sustainability of HIV programs, GRZ should begin the process of establishing the national HIV and AIDS Fund in order to raise internal resources for the national response.
- Repeal discriminatory laws. Ensure that laws that criminalise individuals (men who have sex with men, transgender individuals, sex workers) are repealed in order to facilitate these individuals access to HIV prevention, treatment, and care services.
- Strengthen the National AIDS Council's capacity. Currently the NAC is not an independent authority and is viewed as a department under the Ministry of Health. As a result it has no authority to effectively coordinate other government ministries' HIV programs, which has led to fragmented ministerial HIV responses. NAC should be turned into an authority that will effectively coordinate all government HIV programs including ministries to harmonise various budgets and programs in each ministry and to accelerate a multisectoral response to HIV.

Conclusion

In general, progress has been made in meeting government obligations to respect, protect, and fulfil the SRH&R of all people in Zambia. In most thematic areas assessed, statistics show improvements. For example, maternal deaths and HIV prevalence have significantly reduced;

Figure 1: Trends in HIV prevalence among adults aged 15–49



knowledge and use of FP services has improved, and postabortion-care services are available. Comprehensive Sexuality Education has been introduced in schools and progress is being made to ensure that CSE reaches out-of-school adolescents. National policies have been developed, and progressive laws have been enacted. There are bills (Marriage Bill and Child Code Bill) pending enactment into law that will contribute to improvements in meeting people's SRH&R needs in Zambia. In spite of these achievements, progress is very uneven across geographic locations and population segments. Women and girls in rural areas are disadvantaged—especially those who have limited education. Progress is too slow among rural populations and uneducated women and girls with regard to such issues as use of modern contraceptive methods and access to information on SRH, including FP, maternal health, and gender stereotyping. While urban areas enjoy relatively easy access to health and justice, this is not the case in rural areas where distances to health facilities and judicial services hinder people, particularly women and girls, from seeking services and redress in cases of abuse and rights violations.

Zambia must do much more to guarantee the rights of vulnerable populations. This report has established that data are limited regarding the numbers and needs of all vulnerable population groups present in the country. Data collection, and research into the SRH&R of these vulnerable groups, will be an essential step toward improving SRH&R. The involvement of vulnerable groups, through participation and enhanced accountability, can also play a role in improving SRH&R. Adolescents are a subset of vulnerable population groups that need attention. High teenage pregnancy, HIV prevalence, and child marriage are all issues that require immediate attention to ensure those adolescents' SRH&R needs are met.

Examining barriers through the human-rights-based approach helps identify actions that need to be taken to improve SRH&R in Zambia. There is therefore a need to strengthen the accountability framework that will utilise human-rights-based approaches and hold GRZ accountable for fulfilling its human-rights obligations. This framework would monitor and ensure that the government is

complying with international and national commitments while also using various national institutions, and government and nongovernment actors, to ensure implementation of the recommendations identified in the assessment, and ultimately achieve progressive attainment of SRH&R for all individuals in Zambia.

Table 1: Global and regional treaties ratified by Zambia

Global treaties		
	Treaty	Date of ratification
1.	International Convention on the Elimination of All forms of Racial Discrimination	4 Feb 1972
2.	International Covenant on Economic, Social, and Cultural Rights	10 Apr 1984
3.	International Covenant on Civil and Political Rights	10 Apr 1984
4.	Convention on the Elimination of All Forms of Discrimination Against Women	21 Jun 1985
5.	Convention on the Rights of the Child	6 Dec 1991
6.	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	7 Oct 1998
7.	Convention on the Rights of Persons with Disabilities	1 Feb 2010
African regional treaties		
8.	African Charter on Human and People's Rights	1 Oct 1984
9.	Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa	2 May 2006
10.	African Youth Charter	16 Sep 2009
11.	SADC Protocol on Gender and Development	26 Nov 2012

Table 2: Assessment Framework

Themes assessed	Indicators of progress	Local laws guaranteeing SRH&R	Gaps and challenges in progressive realisation of rights
Access to contraceptive information and services Access to safe abortion and postabortion-care services Maternal health care Prevention and treatment of HIV Comprehensive sexuality education Violence against women and girls Rights of vulnerable populations	On each of these themes: Are indicators showing improvements toward upholding the rights of all people in Zambia?	On each of these themes: Are there laws and policies respecting and protecting the SRH&R of all people? Are these laws and policies being fully enforced and implemented?	On each of these themes: What are the legal and human rights gaps and challenges that should be addressed?

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