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Joint Stakeholder Report

Joint stakeholder report by:

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Zoe-Janice Health Foundation is a national organization of young people in the field of health, research and advocacy aimed at empowering adolescents and young people to advocate for a more equitable and inclusive health system that effectively addresses our key and diverse needs through evidence based advocacy, research and youth-led community monitoring.
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SRHR Africa Trust - Zambia
SRHR Africa Trust (SAT) is an innovative organisation with a regional footprint contributing to improved systems for Sexual and Reproductive Health and Rights (SRHR) of girls, adolescents, and women in East and Southern Africa (ESA). Through its UN- ECOSOC consultative status, SAT connects community voices and experiences to national, regional, and international networks while bringing global best practices in adolescent and youth SRHR to communities through strategic partnerships, innovation, and advocacy.
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The PACT
A Vibrant Coalition of 152+ youth Organizations working collaboratively and strategically in the global HIV response. Since 2013, we have been building solidarity across youth organizations to ensure the health, well-being and human rights of all young people.
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Sexual Rights Initiative
The Sexual Rights Initiative is a coalition of national and regional organizations based in Canada, Poland, India, Argentina, and Southern Africa that work together to advance human rights related to sexuality at the United Nations.
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Key Words

Adolescents, young people, child marriage, HIV, sexual and reproductive health and rights, gender based violence.

Executive Summary

1. In May 2022, youth-led, and youth and child-focused organisations representing various aspects of sexual reproductive health and rights in Zambia convened to develop a report for the Universal Periodic Review (UPR) focusing on health, specifically SRHR, HIV and GBV, concerning adolescents and young people in various settings, taking into account their evolving capacities.

2. This joint submission assesses the Zambian Government's human rights record since the third cycle of UPR in 2017, and highlights some of the emerging or increasing challenges, especially in the wake of the COVID-19 pandemic. It specifically assesses Government's fulfilment of adolescent and young people's sexual reproductive health and rights, providing follow-up recommendations on key areas of concern Government should prioritise in the coming cycle.

3. It further analyses Zambia's implementation of recommendations from the previous UPR process, highlighting successes and gaps for continued implementation. Three key areas in adolescent health requiring attention were identified:

    a. Increased new HIV infections among adolescents and young people

    b. Adolescent and young people's access to health services

    c. Adolescent sexuality and pregnancy and access to sexual reproductive health (SRH) education

Background: Increased New HIV infections Among Adolescents and Young People

4. Previous Related UPR Recommendations

- 102.49. Carry on with ensuring the reduction of HIV prevalence in Zambia (Egypt);

  (Accepted)

- 102.53. Step up efforts in prevention and treatment of HIV/AIDS infections (Belarus),

  (Accepted)

- 102.54. Continue its programmes and interventions to reduce the HIV/AIDS infections among its people with the support of the World Health Organisation (WHO) and other international organisations (Singapore); (Accepted)

5. The Zambian health system is comparatively centralised, with the Ministry of Health (MOH) responsible for formulating national health policies and providing oversight of the general health sector in the country.

6. In 1999, the Zambian Government announced that HIV/AIDS was a major health, economic, and social concern. Since then, the country has formulated and implemented various policy changes. Following the formulation of the National AIDS Strategic Framework (NASF) 2017-2021 and the Adolescent Health Strategy (2017-2021) the

Zambian Government embarked on a programme aimed at attaining universal health coverage (UHC). One of the aims of this programme is to end HIV/AIDS by the year 2030. Zambia also pitched epidemic control of HIV/AIDS as a must-attain target.

7. Around 12,000 HIV infections were estimated to have been averted in 2020 compared to 1,200 in 2004. According to UNAIDS, annual HIV infections (for all ages) in Zambia declined from 60,000 in 2010 to 51,000 in 2019 and annual AIDS-related deaths have also declined significantly from 24,000 in 2010 to 19,000 in 2019, a decline of about 30 per cent.

8. However, despite the milestones attained so far, the HIV burden remains high and it disproportionately affects women and girls. In 2019, it was estimated that there were 26,000 new HIV infections among women 15+ years old, compared to 19,000 among their male counterparts.[1]

[1] See UNICEF Zambia HIV/AIDS page: HIV/AIDS | UNICEF Zambia

9. Less than half of adolescents aged 15-19 years have comprehensive knowledge of HIV, only an estimated four in 10 do. Comprehensive knowledge is defined as knowing that condom use and limiting sexual intercourse to one uninfected partner are HIV prevention methods, and knowing that a healthy-looking person can have HIV. Further, not enough

adolescents have accessed HIV testing. Only 6 in 10 adolescent girls and 5 in 10 adolescent boys aged 15-19 years have ever been tested for HIV and know their HIV status. Additionally there remains a commodity gap with regards to access to condoms and other protective barriers.

10. The spread of HIV among adolescents and young people is exacerbated by several important factors:

    a. Harmful cultural practices such as child marriage, “sexual cleansing”, and sexual initiation rituals, justified in the name of cultural values and traditions

b. Accessibility of sexual and reproductive health commodities such as condoms

remains a challenge, compounded by regular stock-outs

c. Shortages of HIV test kits in local health facilities

Legal and Policy Context: Experiences of Adolescents and Young Adults

11. With regard to the policy environment shaping the delivery of HIV-related services for adolescents, adolescents have highlighted various impediments to the quality of services. The slow implementation and decentralisation of adolescent-friendly services were acknowledged as areas that require further attention:

"My recommendation is about policy. At the moment, adolescents are being sidelined. Adults are able to talk for themselves and children are also represented but no one represents the adolescents". (**Focus group discussion, health care provider, Lusaka)**

12. In Zambia, centralisation of adolescent health services hinders access to SRH services by adolescents and young people in rural communities. Health facilities in rural settings are not well stocked, and lack youth-friendly services, thereby limiting quality, availability, appropriateness, affordability and accessibility of such services to adolescents and young people. Slow implementation of these services was, in part, caused by only a few healthcare workers having been trained to deliver Adolescent Friendly Health Services

(AFHS) particularly, in rural areas as a result of resource constraints. AFHS are a combination of high-quality services that are relevant, accessible, attractive, affordable, appropriate and acceptable to adolescents and young people. The services are provided in line with the minimum healthcare package and aim to increase acceptability and utilisation of health services by young people in the National Standards and Guidelines for Youth Friendly Health Services developed by the Ministry of Community Development Mother and Child.

13. Multisectoral interventions involving Government and Non-Governmental Organisations, and other stakeholders, provide care and support the experiences of adolescents in their diversity. This includes nutritional, psychosocial and adherence support delivered through home visits, as well as through general outreach activities designed to increase the reach of youth-friendly services in the community:

    "Sometimes they give us food here [at Twafwane], when they also receive [it] and we feel good because they help us. When you are taking these [antiretroviral] drugs, you need to have food [and] eat so that you have strength". **(Interview, 19-year-old female, Kitwe)**

14. It is imperative that Zambia increase the roll-out of youth-friendly services. Youth-friendly services, youth clubs, youth centres and youth corners in HIV clinics provide an environment where adolescents can speak privately with peers, community members and healthcare providers, and begin to develop a better understanding of their own needs and challenges with the help of those allies. The variety, complementarity, organisation and reach of community-based and outreach services seemed to be transformative, providing a conducive setting where small but incremental changes in attitudes about HIV were starting to take place:

    "Here at the centre we have workshops and they teach us a lot of things such as the 'adventure of life'. They teach us that life does not end just because you are HIV-positive. There are still a lot of things that we can do and achieve in life. I enjoy such things because they encourage us". **(Interview, 15-year-old female, Lusaka)**

Adolescent and Young People's access to health services - Adolescent sexuality, pregnancy and access to Sexual Reproductive health education

15. In the last review, Zambia received and accepted the following relevant recommendations:
    a. 102.48. Continue to implement measures which allow all people to have access to healthcare services (Cuba); (Accepted)
    b. 102.57. Allocate specific funding within the health budget for child, maternal and reproductive health (New Zealand); (Accepted)
    c. 102.61. Strengthen efforts to reduce maternal mortality rates (New Zealand); (Accepted)
16. While the Ministry of Health in Zambia has placed adolescent health high on the agenda, adolescents and young people still experience challenges in accessing health services. The provision of adolescent health services in Zambia in the last 5 years was guided by a strategy that was implemented from 2017-2021 in response to the gaps in access to health services. This strategy has since expired and, at the time of writing this report, a new Adolescent Health Strategy was under development. The immediate past Adolescent Health Strategy 2017-2021, was largely financed by development partners.

17. Not all Zambian adolescents have access to adolescent responsive health services, especially in regard to sexual and reproductive health (SRH). These disparities are partly due to limited protection and enablement, limited access, inequitable distribution of adequately trained health professionals, cost and poor Youth Friendly Health Services delivery, and are particularly problematic in rural areas.

18. Our review of the Zambian sexual and reproductive health services shows service obstacles that adolescents face, such as judgmental attitudes of providers, a lack of confidentiality, limited contraceptive options, and the lack of policies and guidelines for protecting adolescents' rights to information and services.

19. The National Standards and Guidelines for Youth Friendly Health Services describes the 'basic essential' clinical health services to be provided to the young people, and a 'comprehensive health package'. The basic package is focused on HIV and SRH services, and includes the provision of Information/Social Behaviour Change Communication (SBCC) and counselling on issues and services concerning Family planning (FP), antenatal care (ANC), post-natal and nutrition; and now HIV testing and counselling.

20. Facilitating Adolescents' Access to Modern Contraceptives is a more sustainable investment that the Government of the Republic of Zambia can make to improve the health and future of adolescents by averting, for instance, new HIV infections and unintended pregnancies. Some of the efforts undertaken by the government of Zambia to demonstrate commitment to improving access to health services by adolescents and young people include the formulation of the Adolescent Health Strategy delivered under the Health Promotion Department of the Ministry of Health with dedicated staff to deliver Adolescent health from national to district levels.

21. At national level, there is an Adolescent Health Unit, in which the department of Public Health at the Ministry of Health leads implementation of the Adolescent Health Strategy. Various stakeholders are involved in the implementation of the Adolescent Health (ADH) work in Zambia through Technical Working Groups (TWG) established at all levels (national, provincial and district), with membership constituting all key stakeholders in adolescent health. The Government allocated 8.1% of the 2021 budget to health, and 8% in the 2022 budget.

22. Zambian adolescents (10-19 years) and youth (20-24 years) are sexually active with an estimated 12.7% of females having had at least one sexual experience by the age of 15, as opposed to 16.3% among males. Among unmarried adolescents, 50.3% of adolescent girls report ever having sex and 19.1% are currently sexually active. Among adolescent boys, 45.3% report ever having sex, while 15.3% are currently sexually active.

23. Due to inadequate comprehensive sexuality education, prevailing conservative social values with regards to sexuality, and a lack of access to sexual and reproductive health information and services, adolescents are ill-equipped to navigate sexuality and relationships in healthy and positive ways. This lack of access to education, information, and services increases the risks of unintended pregnancies, unsafe abortion, maternal mortality, sexual violence, sexually transmitted infections (STIs), HIV. The risks are compounded by social determinants of health such as exposure to violence, poverty, illiteracy, discrimination on the basis of gender and early marriages.

24. Due to religious beliefs, patriarchal social norms and harmful cultural practices, girls are married off at a younger age than their male counterparts, this makes girls more susceptible to child marriage and HIV. Women in rural areas are more likely to be married off at a younger age, and thus they are more likely to begin having sexual intercourse earlier than women in urban areas (16.2 years versus 17.3 years). Although there are provincial differences, trends indicate that the age at onset of sexual activity remains low in many settings. Some sexual activity occurs in the context of human rights violations such as rape, coerced sex, sexual abuse or child marriage.

25. In tandem with the high rates of child marriage, and the age of sexual debut - childbearing begins early in Zambia, likely as a result of a lack of access to CSE, and lack of sexual health commodities such as modern contraceptives and condoms. More than one-third of women give birth by age 18 and more than half give birth by age 20. 29% of adolescent girls and women aged 15-19 years are already mothers or pregnant with their first child, of

which the vast majority of births- 111.1 per 1,000 girls, occur within the context of marriage. Thus, adolescent births, like early marriages, are high in Zambia.

26. Too many girls are dropping out of school because of unplanned pregnancies with at least 15 000 dropouts in 2019, a number which is still unacceptably high. Less than half of the number of those who drop out of school return to school through the Re-entry Policy of the Ministry of Education. Further, few girls who fall pregnant can stay in school during their pregnancy and return after childbirth, creating poverty traps for families. One of the reasons that these girls fail to return to school after pregnancy is lack of caregivers for their babies. In addition, they experience stigma on returning to school because they are considered to be mothers and not children. At policy level, the School Re-entry Policy is not well monitored and funded. It is clear that Zambia must do more to ensure that pregnant girls are not forced to disrupt their education when they are pregnant, and that schools put in place adequate support for pregnant people and those who give birth to stay in school.

27. There are varied reasons why girls and young women opt to marry early; some adolescent girls marry earlier than they might have planned because of an unplanned pregnancy. Through the influence of social norms and cultural practices, for instance, young women and girls aspire to get married due to peer pressure and as a way of acquiring some independence, and a respectable social and economic status in the community. The percentage of women aged 15-19 who have begun childbearing increases with age, from 6% among those aged 15 to 53% among those aged 19.

28. Adolescent pregnancy undermines girls' human rights and compromises their opportunity to fully realise their socioeconomic development potential. In Zambia, low comprehensive sexuality knowledge and limited access to modern contraceptives, among other things, exposes adolescents and young people to the risk of pregnancy and childbearing.

29. The most effective way for sexually active Zambian girls and women to prevent pregnancy is to use a modern contraceptive method. In Zambia 30.1% of sexually active adolescent women aged 15-19 are currently using at least one method of modern contraception whilst sixty three percent of women aged 15–19, need contraceptives. There are a number of factors that limit utilisation of modern contraceptives by adolescents and young people including, poor availability and inaccessibility of SRHR services. In addition, there are poor health provider attitudes to adolescents seeking services which are compounded by negative social norms towards modern contraceptives. Legal and policy barriers such as age of consent to medical services and to sex, also inhibit access to modern contraceptives by young people.

30. According to mothers aged below 20 years reporting births, 50.6% of births or current pregnancies were mistimed (that is, wanted at a later date), 47.7% were wanted, and 1.7% of births or current pregnancies were not wanted at all.

31. Four out of ten adolescents have comprehensive knowledge about HIV. One of the major platforms for Sexual Reproductive Health education of adolescents and young people has been Comprehensive Sexuality Education in schools and out of school. The Government, through the Ministry of Education, developed the Comprehensive Sexuality Education (CSE) framework in 2013 to enhance the provision of Reproductive Health and Sexuality Education (RHSE) in schools as part of the school curriculum. In September 2020, Zambia witnessed a systematic campaign against the implementation of CSE in Zambian Schools. Part of the reason CSE faced opposition from sections of religious leaders was due to misunderstandings and misconceptions about what CSE is. It was perceived as promoting sexual immorality and being a foreign agenda to advance LGBTQI rights.

32. In addition, challenges in the implementation of CSE in Zambia were underpinned by limited capacity due to fewer trained teachers to roll out CSE in schools. In October 2020, the Government mandated that in-school CSE continue to be implemented while the curriculum content undergoes review through wider stakeholder consultations including

parents, young people, CSOs and the general public. Additionally, the implementation of CSE has been characterised by under financing resulting in delivery limitations.

33. Funding to support contraceptives and family planning commodities continues to be driven by external funding from cooperating partners, and the Government does not adequately allocate funds towards contraceptives from domestic financing. For instance, the Government budget allocation from domestic resources for contraceptives as a percentage of the total funding needed was 6.15%. In addition, the Government did not highly prioritise contraceptives, and its budget allocation for contraception as a percentage of the total Government budget allocation for health was 0.16%. There was no actual Government disbursement towards contraceptives.

34. Stock out of commodities was 38% in 2020, whereas the acceptable WHO stockout standard is at 10%. This means that the government has a lot of work to do to address the stockouts, one of which include addressing gaps within the commodity supply chain.

Gender-Based Violence (GBV)

35. During the last cycle Zambia received a number of recommendations on gender based violence that it accepted, including:

    - 102.24. Adopt and implement appropriate measures to address the sexual abuse and exploitation of children as well as child labor (Slovakia);
    - 102.33. Address the continued high prevalence of violence against women and girls, including by strengthening training for the judiciary and law enforcement personnel to enhance their capacity to respond effectively to cases of violence against women and girls

36. Gender-Based Violence (GBV) is defined by the United Nations as any act of violence that results in physical, sexual, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. In Zambia, 43% of women aged 15-49 have experienced physical violence at least once. In 2018, 20.9% of adolescents aged 15-19 and 34.2% of young women aged 20-24 experienced physical violence as well as other forms of violence since the age of 15.

37. Even though there is a Police Victim Support Unit Report very few victims of gender- based violence feel confident to report cases or seek help. 58.3% Adolescent girls aged 15-19 never sought help or told anyone against 26.7% who sought help to stop the violence. Among 20-24 year-old women, only 30.1% sought help. In addition, 56.5% did not seek help or tell anyone. Boys and men rarely report abuse due to deeply entrenched social values perpetrated by a patriarchal society that implies that it is shameful for men and boys to be victims of abuse.

38. For girls, sexual gender-based violence manifests itself in child marriages, defilement[2] and rape among others. Although the country has made strides on reducing child marriage from 42% in 2013 to 29 % in 2018, the statistics are still high given the aspirations of the Sustainable Development Goals to end the practice, and national commitments made in the Ending Child Marriage Strategy 2016-21 to achieve a 30% reduction in child marriage by 2021.

39. Socio-cultural beliefs and practices contribute negatively to the prevalence of SGBV. Among some of the harmful practices experienced by girls is child marriage which is a form

[2] This is any sexual intercourse with a child under the age of 18 years old, whether or not the child consents.

of SGBV. Other gender-related harmful practices that negatively affect girls and women include sexual cleansing rituals and initiation ceremonies. Patriarchy remains one of the drivers of gender inequality in Zambia; the socialisation of boys and girls at home and in school favours boys to have power over girls. Women largely have economic dependence on men because they have limited access to productive assets and good livelihood prospects.

40. Inadequate laws on SGBV and domestic violence, and poor implementation of the policy framework on SGBV limits the administration of justice to address gender-based violence. The Anti Gender-Based Violence Act of 2011 and the Juveniles Act including other acts of violence against children are weak pieces of legislation and cannot be used to enforce prosecution of Child Marriage perpetrators. According to the Penal Code, the Juveniles Act, Chapter 53 of the Laws of Zambia and Anti Gender-Based Violence Act, there is a gap in the legislation or sentencing guidelines in place that addresses children under 18 years of age engaging in a child marriage.

41. The strategy to end child marriages in Zambia expired in 2021; it is therefore expected that before coming up with the next National Ending Child Marriage Plan, there will be an evaluation conducted to assess the extent to which the immediate past strategy achieved its objectives. To ensure the attainment of gender equality in the development processes by redressing the existing gender imbalances, the Government revised the Gender Policy in 2014. There is, however, no Gender Strategy to support its implementation.

42. In addition, there is no specific law that classifies sex in child marriage as abuse with no exceptions, except some pieces of legislation that prohibit sexual intercourse with a person below the age of 16 and classifies it as an offence called “defilement” (Penal Code, Chapter 87 of the Laws of Zambia). Furthermore, there is no law that can directly prosecute child marriage. The only law that can prosecute child marriages is the Education Act if the child in question was at school.

43. Zambia has a dual legal system that has a bearing on the consent for marriage- and these are not harmonised. Statutory laws recognize legal marriage at 21 while under customary law, a child can be married off as long as there is consent by two families and dowry paid, and if that girl has attained puberty. The Education Act of 2011 requires that no girl in school should be taken into marriage. This is also supported by the Gender Equality and Equity Act of 2015. In arranged marriages under customary law underpinned by cultural practices in many parts of rural Zambia, perpetrators ensure that a girl stops school before they get married.

44. In other instances, the inadequate enforcement of laws against perpetrators of defilement and child marriage continues to threaten the dignity of adolescent girls and young women. The gaps in the law on how to deal with perpetrators of child marriage makes enforcement difficult.

45. Despite being a signatory to the UN Paris principles on the establishment and mandate of National Human Rights Institutions (NHRIs), the Human Rights Commission (Zambia) does not operate under any particular policy directive in response to human rights violations, including child marriage. The human rights commission has no legal framework mandating it to prosecute violations of human rights including Child Marriages. The weak regulatory policy framework in its current form therefore requires strengthening for it to function optimally.

46. Since the Human Rights Commission has a unit called the “Children’s Office” that deals with children’s issues, including child marriage, this structure should be supported

adequately by changing legislation through strengthening its mandate and repealing Amendment Act No. 2 of 2016:

a. To ensure that the Human Rights Commission has the power to prosecute human rights violations
b. It should be independent and have the power to call the Government to account on human rights issues
c. It must be adequately funded

47. The Government has also strengthened the House of Chiefs and used this institution to help address child marriage. GBV One Stop Centres at provincial level have been established and Chiefs engaged in their operationalization. In some chiefdoms, by-laws have been enacted and these are supported by the Child Protection Committees, a structure under the department of Child Development.

48. The Police Victim Support Unit has also been strengthened through capacity building and increased budget allocation to optimise its functionality and help in addressing SGBV for all age groups.

49. To address Child Marriages as a result of low economic status among vulnerable families, in 2021 the Government made education for all children compulsory through the Free Education Policy, making education more accessible to many young people who were unable to go to school previously on account of school fees. Juvenile Justice Courts were established across the country and deployment of resident Magistrates instituted. Child Courts have judges that are helping in expediting the dispensing of child-related cases.

50. All these measures, however, require strengthening and scaling up. The Adolescent Health Strategy 2022-2026 and Integrated Reproductive SRH policy 2022-2026 have both incorporated key strategies aimed at addressing SGBV including Child Marriage.

Recommendations

51. Increase access to HIV testing, treatment and care for adolescents and young people that is systematically disaggregated.

52. Legislate budgets, plan and deliver an improved system for sexual and reproductive health and HIV commodities, and report annually to parliament on commodity access in Zambia.

53. Develop budgets aimed at increasing access by adolescents and young people to modern contraceptives and to report regularly on access, adolescent fertility and teen pregnancies.

54. Introduce training on adolescent health and sexual reproductive health into health professionals' pre-service training and in-service training to continue professional development.

55. Build resourced strategies to cater to increased demand for sexual and reproductive health services and commodities- including condoms and contraception.

56. Take practical and policy steps to break barriers between education and health, to utilise school health programmes to reach underserved adolescents and young people.

57. Expedite the CSE review process and ensure it incorporates sexual and reproductive health education and life skills in the in-school and out of school curricula.

58. Strengthen policy frameworks and ensure delivery of comprehensive gender-based violence health services at all levels.

59. Expedite harmonisation of customary law and statutory law on consent for marriage.

60. Strengthen and empower the Human Rights Commission's Children's Department through amending of the Human Rights Commission Act to ensure effective reporting, monitoring and implementing of child protection policies.

61. Enhance capacity of health workers, teachers, the Police Victim Support Unit, community members and parents in the delivery of gender-based violence services, accompanied by a budget and reported to parliament annually.

62. Develop budgets that support community awareness and responsive actions that address bottlenecks to access to comprehensive GBV preventative and curative services, and report on these annually.