



Linking Policy to Programming

Situational analysis on young key populations' sexual and reproductive health and rights in Zimbabwe

This brief presents the findings of a situational analysis of the sexual and reproductive health and rights (SRHR) of young key populations (YKPs)¹ in Zimbabwe, undertaken by HEARD, University of KwaZulu-Natal. The analysis was part of a larger, multi-country project (2017-2020) which seeks to strengthen the legal and policy environments for YKPs and improve their SRHR in Southern Africa². The analysis brought together existing and new data in order to capture the political, legislative, socio-economic and socio-cultural issues that affect the SRHR of YKPs. Data collection included qualitative and quantitative data from published and grey literature and existing data sets, as well as primary data obtained through key informant interviews with actors from government, international organizations or NGOs working with young people on issues of SRHR.

Key Findings

The Socio-Economic and Legal Context

Together with long standing political challenges, the economy of Zimbabwe has been in decline for nearly two decades, with deepening contexts of poverty for households. Levels of poverty are worse in rural areas of the country and are where 67% of the population are located. Ninety-four percent of employed Zimbabweans work in the informal sector and almost all (98%) consist of youth 15-24 years [1]. Over half (54%) of the population are under the age of 20 years and fertility rates are high [2].

There are no clear legal frameworks or legal protections for young key populations in Zimbabwe. Although there has been recent policy attention to including (young) key populations in health planning [3, 4], the legislative framework for key populations, in general, remains punitive. There are also some inconsistencies and gaps in the age of consent laws in Zimbabwe which make these laws difficult to interpret and apply. Vague laws are reportedly used as reason to deny health and related services by some health care providers. While no specific law or policy restrict access to health services to key populations in Zimbabwe, the lack of enabling legislation and policy was reported during key informant interviews to be used instrumentally against key populations and pose barriers to access to SRH services. However, there is also evidence of effort to bridge these gaps in practice through various policy and guideline documents [3, 4].

The following section provides a brief overview of the specific legislative, policy and age of consent laws affecting young key populations:

All people under 18 years are considered 'minors' in Zimbabwe (Children's Act, General Law Amendment Act). Age of consent for sexual activity differs between married minors and unmarried minors. For unmarried minors, age of consent is 16 years for males and females; sex with a child under 12 years is classed as statutory rape and a criminal offence. It is less clear regarding provisions for sexual activity between individuals aged 13-15 years; sex with a person aged 13 and 14 years is regarded as rape unless there is evidence that the participating minor consented and was capable of consenting. No provision exists for sex with a person aged 15 years although it is prohibited under the provisions of Section 70 in The Criminal Law Act [5]. For married people, age of consent for sex is 12 years although there are reportedly plans raise the age to 16 years [5]. Sexual

activity between young persons who are both younger than 16 years but older than 12 years is only an offence if a probation officer makes the recommendation for the couple to be charged. Same sex marriages are prohibited and sex between men is criminalised, but not between women (Section 73 of the Zimbabwean Penal Code). Consensual sex between male adolescents above 16 years is classed as an 'indecent act'. However, only men over 14 years can be charged with the offence [5].

Solicitation for the purposes of prostitution is considered a criminal offence in Zimbabwe (Criminal Law (Codification and Reform) Act (Chapter 09:23) 2005). The 'loitering for the purpose of prostitution' provision in the Criminal Law Act has historically been frequently invoked if a non-conforming individual or woman is seen walking alone or in a group. However, in 2015 the Zimbabwe Lawyers for Human Rights were instrumental in having the conviction of nine women who were arrested for solicitation overturned resulting in reported positive changes in police practice and fewer arbitrary arrests of female sex workers [6]. It is not known if the situation has changed for gay sex workers.

There are particular protections for youth related to selling sex. It is considered an offence "if the owner of a place knowingly induces or allows a young person to enter or be in the place for the purposes of engaging in unlawful sexual conduct with another person or with other persons generally, the owner shall be guilty of permitting a young person to resort to a place for the purpose of engaging in unlawful sexual conduct" (s86). According to section 87, allowing a child (under 18 years of age) to "associate with or to be employed by any prostitute as a prostitute or to reside in a brothel" is also considered an offence. This raises questions around the living arrangements of children of sex workers and the extent that this legislation is enforced.

In terms of the legislative and policy environment related to accessing SRH services, according to the Constitution of Zimbabwe, all citizens and permanent residents have the right to access basic healthcare services, including reproductive health services. However, age of consent requirements hamper access to SRH services and commodities for YKPs. Donor rules and regulations are also cited as barriers to providing assistance to female sex workers [7].

The Zimbabwe penal code restricts all forms of abortion except when the life of the women or foetus is at risk. In addition to strong social disapproval of childbirth outside marriage, many young girls may resort to clandestine and unsafe abortion.

There is no legislation that specifies age of minor where parental consent is required for medical treatment [5]. In practice, parental consent to receive medical treatment is required for persons under 16 years and pharmacies require parents/guardians to be present before they will dispense medication to a child under 16 years [5].

Minors over 16 years can access hormonal contraceptives without parental consent and these are reportedly made available without need for a prescription or parental consent through a public sector initiative for minors between 16 and 18 years of age (5). Minors under 16 years cannot access hormonal contraceptives without parental consent. However, condoms and other barrier contraceptive methods are available without parental consent. Emergency contraception is viewed as a medical treatment and subject to the Medicines and Allied Substances Control Regulations, 1991.

Transmission of sexual infection or deliberate transmission of HIV is criminalised under The Criminal Law Code Act Chapter 9:23. The Zimbabwe National Guidelines on HIV Testing and Counselling (2014) and the Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe (2016) create an enabling environment for access to HIV testing and receipt of antiretroviral treatment. No parental consent is required for HIV testing if a minor is 16 years and above, or married, pregnant or a parent. Parental consent is required if the individuals is below 16 years excepting if they are a mature minor "who can demonstrate that he or she is mature enough to make a decision on their own. The 'best interests of the child' principle is endorsed by these guidelines which provides room for medical providers to act in the interest of the child without parental consent.

The increased attention to key populations in Zimbabwe is reflected in a number of recent national documents. Zimbabwe's extended National HIV and AIDS Strategic Plan 2015-2020 (ZNASP III) now identifies four main key population groups; "gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs" [4]. Prisoners and people living with disabilities are also recognised as being vulnerable to HIV and in lacking access to services. Further, the country's new Adolescent Sexual and Reproductive Health Strategy (2016-2020) [3] targets specific vulnerable groups, including adolescents and young girls engaged in sex work as well as adolescent inmates, amongst others. However, the Strategy has come under criticism for being based on culturally acceptable and politically correct sexual and reproductive health practices since it remains silent on the addressing the SRH issues specific to YKP as well as issues of sexual orientation and choice. There are no laws or policies that provide for hormonal treatment for transgender people and no provision in the Births and Death Registration Act to change gender markers. The diagnosis and treatment of anal STIs is not included in the National Guidelines on STIs.

Key issues per young key population group

Young women who sell sex

While HIV prevalence amongst adult female sex workers (FSWs) is not nationally representative, estimates suggest HIV prevalence is high (around 58%) [8]. There is relatively good age disaggregated data for FSW in Zimbabwe. This dataⁱⁱ suggests that HIV prevalence rises exponentially in the older the sex worker group, pointing to greater prevention efforts needed in the

younger population of sex workersⁱⁱⁱ. Young sex workers (age 18-24) are 4.2 times more likely to be living with HIV than young women (20-24) who do not sell sex (36% compared to 8.5%) [8]. In a 2013 survey in a border town, Beitbridge, HIV prevalence among young female sex workers age 18-20 was found to be 33.3%, rising to 43.5% among those age 21-25 [9]. In another study, 27-32% of female sex workers reported recent experience of genital sores, ulcers or unusual genital discharge, with about 66% seeking treatment and care for their symptoms [10]. Young female sex workers report the highest numbers of unprotected sex acts with clients [10]. Key informants reported high rates of clandestine abortion amongst YWSS.

While HIV prevalence data amongst FSW is available, there exists no data on male sex workers (MSW) or transgender sex workers in Zimbabwe. Further, there are no population size estimates for sex workers of any sex or gender. The limited epidemiological data, globally, suggest a generally high HIV prevalence amongst MSWs with a higher burden of HIV than men having sex with men (MSM) [11] and a higher STI prevalence than FSWs.

Little is known about transgender sex workers in Zimbabwe but global evidence suggests that they are a particularly vulnerable sub group, with a significantly higher HIV prevalence than all the other groups of sex workers and in transgender women not engaging in sex work [12]. Given the complexities around sexual identity, many transgender sex workers may self-identify as “gay” or “MSM” and be classified as “male” sex workers [13], with the result that their specific needs remain invisible. Because of their specific needs, some scholars have argued that transgender women engaged in sex work should be considered as an entirely separate group from MSW [11]. While the literature is scant, the evidence suggests heightened human rights violations towards transgender sex workers, with homophobia compounding the illegal status of sex work-related violence [14]. Key informant interviews pointed to added difficulties for male transgender people compared to female transgender people in availability and accessibility of SRH services due to the complexities of explaining their STIs. Uptake of SRH services are low and HIV testing behaviours and treatment outcomes are reported to be poor amongst young female sex workers^{iv}. A survey among 2722 sex workers in 14 sites in the country found young women who sell sex had significantly lower levels of HIV testing and engagement with care [15]. Treatment cascades for sex workers in Zimbabwe reveal gaps that are particularly pronounced for young sex workers (18-24 years). These young sex workers are less likely to know their HIV status, be on treatment and be virally suppressed compared to adult sex workers [16].

Young lesbian, gay, bisexual, transgender and intersex individuals (LGBTI)

There is a lack of data regarding the LGBTI population in Zimbabwe. Only a small number of non representative research studies have been conducted on LGBTI populations and the full diversity of these populations and their specific needs is not known. Size estimations or bio-behavioural surveillance of LGBTI populations have not yet been carried out in Zimbabwe.

There are no age disaggregated SRH data for LGBTI people in Zimbabwe. Most of the available data is related to HIV prevalence, and where data does exist there are reliability issues (i.e. unpublished, sampling issues, not peer reviewed). In an unpublished study in 2013 by Biomedical Research and Training Institute, HIV prevalence among MSM was found to be 23.5% [10]. In another study, 5.8% of WSW in Zimbabwe self-reported being HIV positive [17]. The mean age of WSW in the study was below 30, but based on the judgments of the community-based organizations involved, younger women were likely overrepresented in the study, creating a skewed picture. In a very small non-peer reviewed survey (n=32), 25% of transgender people in Zimbabwe self-reported being HIV positive [18].

There is a small transgender movement in Zimbabwe. Few individuals are openly transgender, with the criminal laws impacting on visibility of transgender persons who are harassed and intimidated on the basis of gender expression [19]. Even less is known about intersex persons in Zimbabwe with reports of ‘corrective’ surgery being performed on infants in Bulawayo [19]. With the exception of sex workers, it is not known to what extent other KPs access ART.

Young people who inject drugs

Research on people who inject/use drugs in Zimbabwe is very limited. Preliminary results from a Zimbabwe Civil Liberties and Drug Network study indicate that over 80% of drug users in Zimbabwe are reluctant to seek medical attention and are afraid of the stigma associated with the local primary health care delivery services [20].

Young prisoners

HIV prevalence in prisons in Zimbabwe is high (estimated at 28% in 2015 ; 26.8% among male detainees and 39% among female detainees) but the evidence suggests that prisoners have access to antiretroviral treatment [21]. The population size estimate of prisoners in 2011 was 14,700. Data from a 2011 survey among prisoners in Zimbabwe (most recent age disaggregated data) reveal that about 10% of the adult prison population is below the age of 24 [22]. In the survey sample, 1% (161/14,976) were juveniles age 13-17 years.

Stigma and Discrimination

Stigma and discrimination is a powerful marginalizing force for key population members and has strong influence over their health and wellbeing. Key informants reported widespread social rejection at the family and community level for LGBTBI and sex workers. This has resulted in an expressed “I don’t care” attitude in terms of personal risk in acquiring HIV³. While there is currently significant activity on the ground in terms of representation by KP-led and focussed organisations, high levels of stigma will likely continue to persist for some time. KP representatives shared fears of backlash from the community should they disclose their gender or sexual preferences. According to informants, being verbally insulted by family and community is common and KP-related meetings or activities are generally discouraged by the greater community through public ridicule, reporting to law authorities, and threats of violence. Sex work is similarly stigmatised and sex workers face discrimination based on social, religious and cultural grounds.

Stigma, overlaid by youth, is a fundamental barrier to YKPs accessing SRH information and services in the health sector. Government clinics and hospitals in Zimbabwe were reported to be largely hostile to lesbian, gay and transgender people and to sex workers of all genders and to lack understanding of the range of their specific SRH needs. While accessing HIV and AIDS care did not seem to pose problems given that treatment was not predicated on sexual orientation, accessing STI services for anal warts, for example, was cited as very challenging. Many sex workers choose not to disclose their work to health professionals, misrepresent their health problem, pay bribes to be treated or avoid care entirely [13, 14]. Some clinics refuse to treat sex workers for an STI unless they bring their partner along or restrict the number of condoms issued [14]. If they are young, they are reportedly remonstrated for not being in school. Injecting drug users and bisexual females similarly cite stigma as barrier to health services [20].

Conclusion

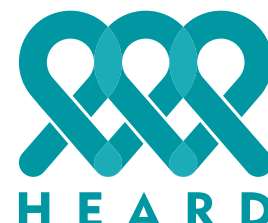
There are a number of intersections between the different key population categories. Sex workers of all genders can also be substance users, homosexual or bisexual and/or have spent time in prison. Sexual orientation can be at odds with sexual practices and gender roles in a context of sexual exchange driven by economic need. Male sex workers include gay, bisexual, transgender, and possibly heterosexual, SWs. Frequently, MSW are grouped as ‘MSM’ which masks the diversity and complexity of the population that makes up young men who sell sex in Zimbabwe. Where tailored health services exist, they are generally orientated towards female sex workers (18 years and over) and MSM. Little is known about the SRH situation of young women who sell sex <18 years. Some male sex workers or young men who sell sex resist being labelled as sex workers which makes it difficult to identify and reach those most at risk. For young males and females who sell sex, sexual orientation (and safe sex) is very much shaped by economic need with unprotected sex the norm. Hegemonic masculinities and submissive femininities characteristic of the traditional ‘spousal’ roles have strongly shaped expectations of conduct in not only heterosexual, but also homosexual, relationships. Further, the way in which gender is invoked and the gendered relationships both within and outside of the LGBTBI community are shaped in very particular ways by the constrained economic context. The social determinants of health conceptual model provides a useful framework to analyse these intersections and the impact of the politico-socioeconomic context and extent of access to services amongst members of these groups with a view to understanding how these determinants shape vulnerability to poor SRH outcomes.

- 1 Groups of young people considered ‘key populations’ in the HIV response include sex workers, lesbians, gays, bisexuals, transgender and intersex people, people who inject drugs and prisoners
 - 2 HEARD collaborates in this project with the United Nations Development Programme (UNDP) and African Men for Sexual Health and Rights (AMSHeR).
 - 3 MSW Key Informant 2, Bulawayo
- i Section 56 of the Constitution of Zimbabwe states that “all persons are equal before the law and have the right to equal protection and benefit of the law” and that “every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their... sex, gender...or social status” and this is reportedly often cited by advocates of KP rights, in the absence of other protections (Moyo et al 2016).
 - ii In Cowen et al. (2013), 28% (234/836) of sex workers surveyed were below the age of 25. The median age of entry into the National Sex Worker Program (Sisters with a Voice) is 27 years, but program and survey data suggest that 25-40% of sex workers are less than 23 years old (PEPFAR, 2016b, p.31).
 - iii In the Sisters Antiretroviral therapy Programme for Prevention of HIV – an Integrated Response (SAPPH-Ire) trial in Zimbabwe, 785 of 2722 sex workers surveyed across 14 sites were between the ages of 18 and 24 (26.8% of the sample) (Cowen et al., 2014). HIV prevalence was found to be 36% among sex workers age 18-24, rising to 55% among those 25-29, 69% among those 30-39, and 77% among those older than 40 (Cowen et al., 2014, p.14).
 - iv While 69% of HIV positive sex workers age 25 or older know their status, just 39% of sex workers below the age of 25 do. Further, while 48% of older HIV-positive sex workers (≥25 years) are on treatment and 37% are virally suppressed, just 21% of younger sex workers (<25 years) are on treatment and just 13% are virally suppressed. In Cowen et al. (2013), 28% (234/836) of sex workers surveyed were below the age of 25.

Further information:

Further details on this multi-country research project can be found on <https://www.heard.org.za/research-post/linking-policy-to-programming-2/> and on <https://www.africa.undp.org/content/rba/en/home/about-us/projects/linking-policy-to-programming.html>

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