"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.

Many laws and policies shape the provision of adolescent HIV and sexual and reproductive health care (AHIV/SRH). These relate to ages of consent to medical treatment and sex, sexual behaviour, specific SRH services, and education around HIV/SRH concerns. There is little information about the inconsistencies in those national law and policy frameworks that regulate AHIV/SRH in Southern Africa, and the potential of ensuing conflicting duties of service providers. It is unclear if the current frameworks facilitate or obstruct comprehensive AHIV/SRH service provision (or both), what the legal duties of healthcare and other service providers are, or how the current law and policy frameworks influence the decisions that providers make when providing AHIV/SRH advice and care.

This research brief, 1 in a series of 5, presents findings from a mixed-methods study that the Gender, Health and Justice Research Unit conducted in Malawi, Mozambique, Namibia, Zambia and Zimbabwe. The study explored what service providers in adolescent, SRH and HIV NGOs know about the laws and policies on adolescent HIV and SRH services, and analyses the impact of conflicting laws and policies on adolescents' knowledge and the use of services.

Zimbabwean data were collected through an online survey (n=21) and in-depth interviews (n=13) with representatives of organisations working on adolescent HIV and SRH and policy makers.

Cite as: Müller, A., Spencer, S., Malunga, S. & Daskilewicz, K. (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.

Zimbabwean adolescent HIV/SHR indicators highlight that adolescents between 12 and 18 have numerous HIV/SRH concerns.

For example, researchers estimate that up to 30% of adolescents aged 15-19 are living with HIV (Khan, 2003). However, access to HIV testing for adolescents is limited as guardian support is required (Ferrand et al., 2010). Girls under the age of 15 are the most vulnerable to sexual violence, most often by male relatives, neighbours and school teachers (Njovana & Watts, 1996). In a study of orphaned adolescent women (aged 16-19) who were out of school, 14% reported having experienced sexual violence or rape (Dunbar et al., 2010). This has important implications for the prevalence of teenage pregnancy: it appears that gender based violence (GBV) is both a cause and consequence of teen pregnancy (Hof & Richters, 1999). Additionally, GBV increases teenagers risk for HIV: 30% of pregnant girls aged 15 to 19 years were HIV-positive (Blum et al., 2004).

While research evidence is limited, studies also suggest that both teenage pregnancies and teenage abortions are significantly underreported, due to the criminalisation of abortions under the existing law (Mashamba & Robson, 2002). Young people aged 15-24 are also at the highest risk for STIs, with key factors being "early sexual experimentation; limited access to reproductive health services, including treatment for STIs, information about sexual health, and advice on responsible behaviour; harmful cultural practices; social and urban changes in values; loss of traditional support systems; and economic insecurity" (Stally, 2003). As a result of limited access to knowledge and services, adolescents report using traditional herbs believed to prevent and treat STIs, identify perceived "safe" times to have sex, and use plastic wrap in place of condoms (Stally, 2003). Such limited access to knowledge and services is more severe in rural than in urban areas. The large majority of adolescents, however, would like free and adequate information and services for contraception and STI prevention (Khan, 2003). According to a report by UNESCO and UNFPA (2012), some of this information is provided in age-specific life skills education in schools. However, the report found that in this HIV/AIDS-focused curriculum, sex was mostly conceptualised as dangerous and negative, and the universal ethics informing moral behaviour were based on religion rather than human rights.

Additionally, information about the law and policy framework, and adolescents' rights, was absent. Crucial curriculum gaps on information on contraception and non-normative sexuality and gender identities mean that adolescents need to seek such information elsewhere, such as at non-governmental youth and SRH organisations. Our research brief presents findings on the law and policy knowledge of providers at those organisations.

CONSENSUAL SEX

The majority of participants correctly identified 16 years as the minimum age of consent to sex. Participants were less sure about the provisions for consensual sex between adolescents aged 12 to 16: 1 thought it was decriminalised, 4 were certain it was criminalised, and 7 said it depended on the age gap. Our interviews with service providers and policy makers confirmed that most knew about the minimum age of consent to sex, but fewer were clear about the provisions affecting 12-16 year olds.

Many providers felt that the age of consent to sex should be the same as the age of consent to marriage, to ensure that sex only take place between married couples. This shows the strong impact of personal religious beliefs on the interpretation of legal provisions:

> 👉 *Most participants knew about the minimum age of consent to sex, but fewer were clear about the provisions affecting 12-16 year olds*

"The law is trying to create that society that you know, delays sexual debut. The law actually even prefers a situation whereby adolescents can only indulge in sex when they get married. We are a generally Christian country and the religious moral will say no sex before marriage. Sex is only something which can be enjoyed after marriage. So there's no way the law can provide for minors having sex with minors."

MARRIAGE

All providers knew about the recent constitutional court judgment setting the legal age for marriage at 18. However, many felt uncertain about the implications for the legal age of consent to sex:

"… we are celebrating the recent judgment on the legal age of marriage. But it also doesn't speak to the legal age of sexual activity. So as we celebrate it, we are also realising that there are also some gaps around that."

> 👉 *All providers knew about the recent constitutional court judgment setting the legal age for marriage at 18. However, many felt uncertain about the implications*

Many remarked that there was now a need to 'align' the age of consent to marriage to the age of consent to sex, by raising the age of consent to sex to 18. This likely stems out of two concerns: first, as mentioned above, linked to religious values that prohibit sex outside married couples; and second, linked to customary practices that allow for underage girls to be married if they become pregnant. In the latter case, providers may see raising the age of consent for sex as a way of protecting girls from underage marriage. However, despite the overall awareness about the constitutional judgement on the age of consent to marriage, some providers misinterpreted the implications for adolescents:

"[T]here's a recent policy or law, whatever that was elected. It says that you impregnate someone below the age of 18 years, it's now a crime. This is a recent one. But you can see there is no harmony between these two policies. Which means you are allowed to sleep with a child, a person who is above 16 years; at 16 years you can sleep with that girl, you can do sex, whatever. But what they don't want is just to impregnate that one, below the age of 18 it's a crime."

Issue	Law name	Law description	Policy Name	Policy description
Consensual sex	Sexual Offences Act 8 of 2001	• Sets the age of consent to sex at 16 for boys and girls • Does not make mention of sex between individuals of the same sex • Extra-marital sex with a young person aged 12-16 is a criminal offence, but the sentence can be reduced if the perpetrator is under the age of 16 him- or herself • Children under the age of 12 are deemed incapable to consent.	N/A	No policy documents establishing an age to consent to marriage were found in the desktop and literature review
	Criminal Law Act (2004)	• Section 73 classifies consensual sex between two male adolescents aged 12-16 as "indecent act with a young person", and consensual sex between male adolescents above the age of 16 as sodomy • No provisions exist for consensual sex between two female adolescents		
Marriage	Constitution of Zimbabwe (2013)	• Sets the age of consent to marriage at 18 • Defines marriage as to a person of the opposite sex • Article 2.18 (b) of the Constitution mentions that "children are not pledged into marriage"	N/A	No policy documents establishing an age to consent to marriage were found in the desktop and literature review
	Marriage Act (2004)	• Article 22(1) specifies diverging ages of consent to marriage with the age of 18 for boys and the age of 16 for girls • This Act has been found unconstitutional by a 2016 Constitutional Court judgment		
Access to medical services, including AHIV/ SRH services	Legal Age of Majority Act (1982)	• The age of majority is 18	National Adolescent Sexual and Reproductive Health Strategy 2010 – 2015 (Ministry of Health and Child Welfare)	Aims to create access for young people to family planning and HIV services, does not stipulate ages of consent for these services but references the "16 years and above age restriction for voluntary counselling and testing for HIV"
	Children's Protection and Adoption Act (1994)	• Section 2 defines anybody under the age of 16 as a child, and hence not capable of consent	Zimbabwe National Guidelines on HIV Testing and Counselling (2005) (Ministry of Health and Child Welfare)	Sets the age of consent for HIV testing at 16, but entitles "mature minors" who are under age 16 but pregnant, married or who are parents to access HIV testing

	Children's Act (2002)	• Section 76 empowers a magistrate to give consent to medical treatment where the parents of a child cannot be found or when they are unreasonably refusing consent • The inference is therefore that a child cannot give consent without parental assistance	Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe (2013) (NMTPAC and Ministry of Health and Child Care)	• Does not comment on ages of consent for accessing HIV testing • States "education about sexual and reproductive health should be part of the counselling and treatment of HIV-positive adolescents. Education and information should be tailored according to the patient's own knowledge and maturity. This clearly varies across the age group and should be assessed during counselling"
	Constitution of Zimbabwe (2013)	• Section 4.33(1) provides that every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive healthcare services		
Teenage pregnancy	Termination of Pregnancy Act (1977)	• Allows legal abortions in order 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 • Termination of pregnancy on request is not legal	National Gender Policy 2013 (Ministry of Women Affairs, Gender and Community Development)	• Directs the education and training sectors to "provide facilities and a policy framework to enable girls who fall pregnant to continue with their education" • A related policy circular by the Ministry of Education, Sports and Culture stresses that pregnant girls should be assisted in staying in school as long as possible
	Criminal Law Act (2007)	• Section 60 states that anyone who terminates a pregnancy will be criminally liable		
Same-sex activity	Criminal Law Act (2007)	• Article 73 criminalises any sexual acts between two men • The law does not mention sexual acts between women	Zimbabwe National HIV and AIDS Strategic Plan	Lists men who have sex with men (MSM) as one of the key populations who should be targeted to reduce HIV transmission
Confidentiality in provision of AHIV/SRH services	Criminal Law Act (2007)	• Does not require reporting of same-sex activity, abortion or consensual sex between adolescents	National Adolescent Sexual and Reproductive Health Strategy (2010-2015)	Suggests that as a minimum condition, adolescents be assured by service providers of privacy and confidentiality

ACCESS TO MEDICAL SERVICES

Participants had varied opinions from what age adolescents could access HIV and other SRH services: some thought it was 16 (as per the HIV testing and counselling guidelines), others thought 18 (as per the age of majority). Providers who thought the age of consent to services was 16 inferred this knowledge from the National HIV Testing and Counselling Guidelines and assumed it applied to all SRH services. While most providers knew about the 'mature minor' regulation that provides access to adolescents who are pregnant or parents, many providers admitted that they were unsure, and others cited the law, even if what they said was not in the law:

Many providers admitted that they were unsure, and others cited the law, even if what they said was not in the law

"Sometimes [...] nurses won't offer contraception to young people, adolescents who are below 16, because they say it's law but legally there's nowhere where it's written. It's just a practice. So sometimes people will say it's policy. It's a law when in actual fact there is no law on that one."

Others still, simply used their own discretion based in their own moral framework, rather than a legal one. This lack of clarity likely stems from the inconsistencies and variety of age groups referred to in HIV and SRH policies, which range from 10 to 24 in the definition of adolescent.

TEENAGE PREGNANCY

Teenage pregnancy: All providers were aware of the Termination of Pregnancy Act and could list the conditions under which women could have a legal abortion. Some providers were unclear about their legal obligation to report knowledge of an illegal abortion, even though no such obligation exists:

All providers were aware of the Termination of Pregnancy Act and could list the conditions under which women could have a legal abortion

"Anyone who comes into contact with someone who has committed a crime, they are obliged to report, you know, to say [s] so doctors are really legally also obliged to actually report. So I think I supposed it's an ethical dilemma to say as a doctor do I then report?"

SAME-SEX ACTIVITY

All providers knew that same-sex activity between male adolescents was criminalised. However, not many were aware that this did not apply to female adolescents. Participants had differing opinions on how the legal framework impacted on access to services for LGBTI adolescents, with some stating that the law "only existed on paper", while others, who were specifically working with LGBTI individuals, provided detailed accounts on state-sanctioned discrimination and persecution under the legal framework. Furthermore, some participants were under the erroneous impression that they had a duty to report knowledge of same-sex activity:

Some participants were under the erroneous impression that they had a duty to report knowledge of same-sex activity

"It's just like the child sexual abuse, you are forced to report."

Conclusion

The laws and policies governing adolescents' access to HIV and SRH are relatively clear about specifying ages of consent, and provide a 'mature minor' clause to allow access for certain adolescents below the minimum age.

However, providers have inconsistent knowledge of the laws and policies, especially around the ages of consent to access to HIV and SRH services. Providers knew the laws that had received public attention in the recent past (related to age of consent to marriage, abortion and same-sex activity), but this did not necessarily mean that they were familiar with their obligations under these laws. It is concerning that some were under the erroneous impression that they needed to report individuals who had abortions, or engaged in same-sex activity.

Such misinformation can have detrimental consequences for adolescents accessing services related to abortion or same-sex activity. Providers' knowledge also has important implications for adolescents' access to information around HIV and SRH –if professionals working with, and in support of, adolescents do not possess the knowledge, it is unlikely that adolescents themselves will be informed. Further, adolescents that are aware of their rights under the law might at times have to work against providers' lack of knowledge and misinformation.

REFERENCES

Blum, R. W., & Nelson-Mmari, K. (2004). The health of young people in a global context. *Journal of Adolescent Health*, 35(5), 402-418.

Mashamba, A., & Robson, E. (2002). Youth reproductive health services in Bulawayo, Zimbabwe. *Health & place*, 8(4), 273-283.

Stally, A (2003). STI Risks High Among Zimbabwe's Youth. *Population Reference Bureau*

Khan, N. (2003). State of Denial: Adolescent Reproductive Rights in Zimbabwe.

Ferrand, R. A., Munaiwa, L., Matsekete, J., Bandason, T., Nathoo, K., Ndhlovu, C. E., ... &

Corbett, E. L. (2010). Undiagnosed HIV infection among adolescents seeking primary health care in Zimbabwe. *Clinical Infectious Diseases*, 51(7), 844-851.

Njovana E, Watts C. Gender violence in Zimbabwe: a need for collaborative action. *Reprod Health Matters*, 1996; (7):46-52.

Dunbar, M. S., Maternowska, M. C., Kang, M. S. J., Laver, S. M., Mudekunye-Mahaka, I., &

Padian, N. S. (2010). Findings from SHAZ!: a feasibility study of a microcredit and life-skills HIV prevention intervention to reduce risk among adolescent female orphans in *Zimbabwe. Journal of Prevention & Intervention in the Community*, 38(2), 147-161.

Hof, C., & Richters, A. (1999). Exploring intersections between teenage pregnancy and gender violence: Lessons from Zimbabwe. *African Journal of Reproductive Health*, 3(1), 51-65.

UNESCO & UNFPA (2012). Sexuality Education: A ten-country review of school curricula in East and Southern Africa. Paris: UNESCO.

RECOMMENDATION FOR SERVICE PROVIDERS AND POLICY MAKERS

* Policy documents should be specific and consistent about ages to access HIV and SRH services. This specificity should embrace a rights-based approach and be inclusive to enable service providers at NGOs and in health facilities to serve clients of all ages.

* The 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.

* NGO healthcare service providers working with adolescents need to increase their knowledge of the legal and policy framework governing adolescent HIV and SRH, in order to offer inclusive SRH services, and educate adolescents about their rights, enabling them to make their own informed decisions about sexual activity, HIV and SRH.

* Cultural norms about adolescent sexuality play an important role in adolescent access to services. Priority should be given to assisting NGO and healthcare service providers to understand their role in adolescent sexual and reproductive healthcare through pre-service and in-service training and values clarification.

* Providers need to know their obligations under the existing legal and policy framework with regards to mandatory reporting. Trainings on this should emphasise a rights-based approach to avoid reporting of adolescents in cases where it is not legally mandated.

FORDFOUNDATION

The research for this brief was funded by the Ford Foundation.