

A BASELINE SURVEY ON THE PREVAILING SITUATION ON SEXUAL REPRODUCTIVE HEALTH RIGHTS (SRHR) FOR WOMEN HUMAN RIGHTS DEFENDERS AND POLITICAL ACTIVISTS IN ZIMBABWE.



Table of Contents

Executive Summary	1
Introduction	1
Methodology	2
Presentation of findings	3
Recommendations	13
Conclusion	14

1.0.EXECUTIVE SUMMARY

This research is a baseline survey on the prevailing situation of women human rights defenders (WHRDs) and political activists with regards to their Sexual and Reproductive Health Rights (SRHR). The survey reached out to 500 women in Midlands, Bulawayo, Matabeleland South, Masvingo, Manicaland and Harare provinces. Participants were purposively selected for their work in human rights, leadership and activism. Key findings show that there is unmet need and shortage of services and supplies which address SRHR needs due to the ongoing economic crisis. There is also challenges on a constrained policy and cultural environment which impact negatively on women satisfying their SRHR needs. Key recommendations are for policy interventions at different levels, attitudinal changes and educational and information programmes targeting communities. Awareness raising and trainings on SRHR must be offered within institutions and political parties.

2.0. INTRODUCTION

Women's Academy for Leadership and Political Excellence (WALPE) undertook this baseline survey on the prevailing situation of women human rights defenders (WHRDs) and political activists with regards to their Sexual and Reproductive Health Rights (SRHR). This was after realizing that Women Human Rights Defenders (WHRDs) and political activists lack adequate awareness on their sexual and reproductive health rights (SRHR) and are often vulnerable within their work space and where they operate. This lack of awareness and vulnerability places WHRDs and political activists at risk and also adversely affects their work and rights. More critically, the SRHR gaps directly affect the ability of women to freely and fully participate in leadership and democratic processes.

The survey was also used to evaluate if the country is in course to attain the United Nations Sustainable Development Goal number 3 (SDG 3) which speaks of ensuring healthy lives and promote wellbeing for all at all ages. Specifically, the survey looked at subsection 3.7 which aims to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030. This is more important because according to the Guttmacher

Institute¹, 38% of young Zimbabwean women have had sex by age 18 and this age keeps dropping, while a quarter of young women between 15-19 years have started childbearing with a third of these births being unplanned.

While contraceptive use increased between 2009 and 2013, the current rising costs of the product and its unavailability in some health centers is a cause for concern and has a direct impact on the SRHR situation of women in Zimbabwe.

The overall aim of the research was to establish the prevailing SRHR situation on the status of WHRDs and political activists and present recommendations on how to address these. This was done by assessing the existing levels of knowledge on the subject, existing perceptions and attitudes and proposed interventions which can be undertaken.

Therefore, this report presents a snapshot of the prevailing SRHR situation for WHRDs and political activists in Zimbabwe. It draws focus on the prevailing situation using the existing information from the Zimbabwe Demographic Health Survey (2015) and also the data from the participants in the survey.

3.0. METHODOLOGY

The research was a qualitative study which used semi-structured interviews with a purposively selected sample size which was drawn from well-known WHRDs and activists in communities where WALPE is working. Focus group discussions (FDGs) were also done with the target population and the snowballing technique was used to identify participants for these discussions. Key informant interviews were also conducted with experts in the SRHR field and also with government officials. International documents which address the issue were also consulted through desktop reviews.

4.0. PRESENTATION OF FINDINGS

4.1. Demographics

The research reached out to a total of 500 women across six provinces of Midlands, Bulawayo, Matabeleland South, Masvingo, Manicaland and Harare. The following

¹ Guttmacher Institute 2014 Series, No.3 <https://www.guttmacher.org/sites/default/files/pdfs/pubs/IB-Zimbabwe.pdf>

table shows the distribution of the numbers per province and other key informant interviews.

Table 1: *Distribution of respondents by province*

Province	Number
Harare	96
Bulawayo	96
Masvingo	96
Matebeleland South	96
Manicaland	96
TOTAL	480

20 key informants were interviewed and the following table summarizes their different areas of expertise.

Table 2: *Key informants by their area of expertise*

Key informant(s)	Areas of expertise
4	SRHR experts
5	Experienced women human rights defenders
6	Women parliamentarians
5	Legal practitioners who specialize in women rights
20	

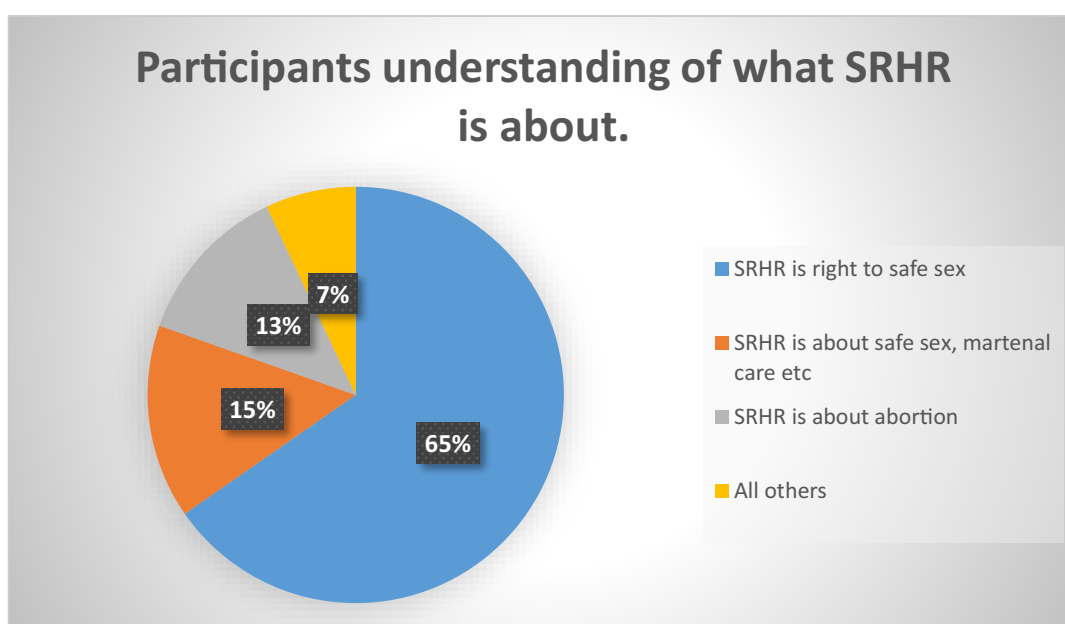
This then brought the grand total number of participants in the research to 500.

4.2. Levels of knowledge

4.2.1 Understanding of SRHR

The majority of the participants (65%) understood SRHR to just mean the right to safer sex and family planning. While this is a vital aspect of the SRHR, it

does not speak to other important aspects which are critical to the enjoyment of this right such as access to medical treatment after exposure, safe abortion, accessing quality maternal health care, menstruation health among others. This level of understanding shows that much advocacy has been done around sexual education and the need for safe sex for both married and unmarried couples.² The following pie chart summarizes the understanding of the participants on SRHR issues.



4.2.2 Sexual Transmitted Infections (STIs) and HIV

All the participants knew one form of STI or another and were also aware of HIV. This shows that there has been comprehensive work on awareness around these issues. This is affirmed by one of the participants who said *“STIs and HIV information is everywhere, even in the bus or kombi you can get it.”*

4.2.3 Access to contraceptives

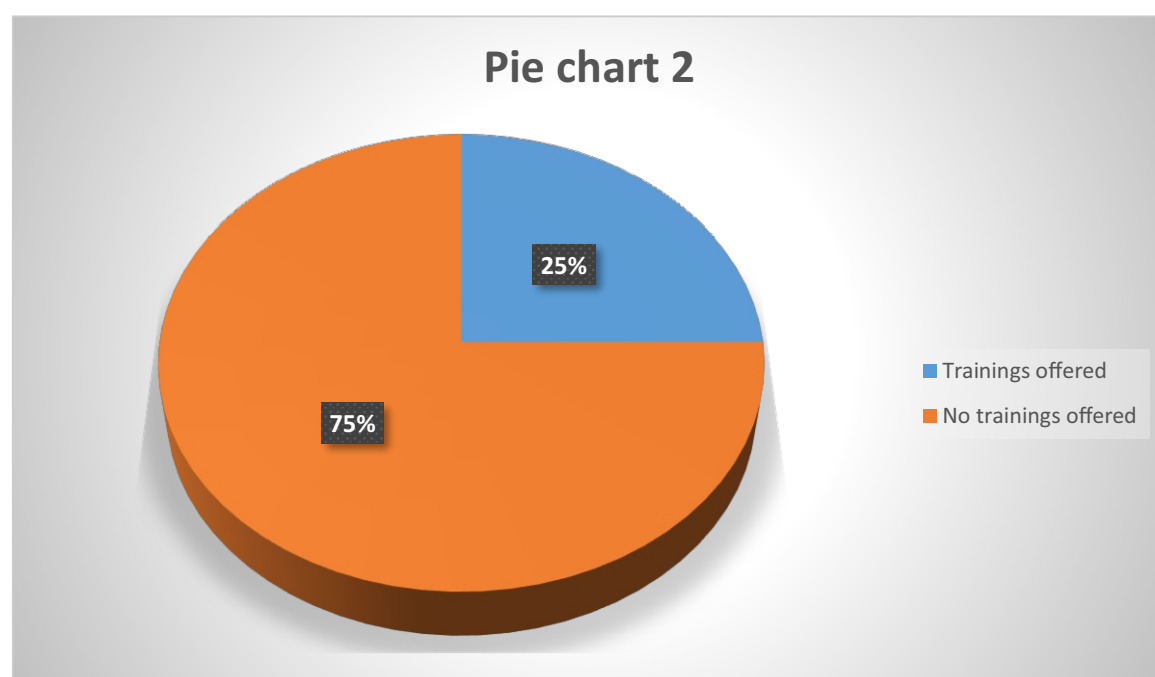
The majority of participants (55%) indicated that their local clinics and health centers offered SRHR services such as treatment, family planning services and contraceptives. The other 45% indicated that the services were not being offered

at their local centers mainly because of lack of medicines and requisite equipment. One participant noted that *“condoms were last offered at our health center last year (2018) around March. Since then there are not there.”* This is a major concern as the condom is one of the widely used contraceptive in Zimbabwe.³

4.2.4 Availability of SRHR trainings at local health centers

On trainings, 75% of the participants said that their local health center or clinic did not offer any SRHR trainings but just advise. 25% said their centers offered training if one was a peer educator or home based care worker. The following chart shows the distribution of this data:

Pie chart 2: *Availability of SRHR trainings at local health centers*



An SRHR expert noted that *“our health centers generally lack such facilities except for home based care volunteers. Now with resource constraints, there is very little if any training going on in communities.”*

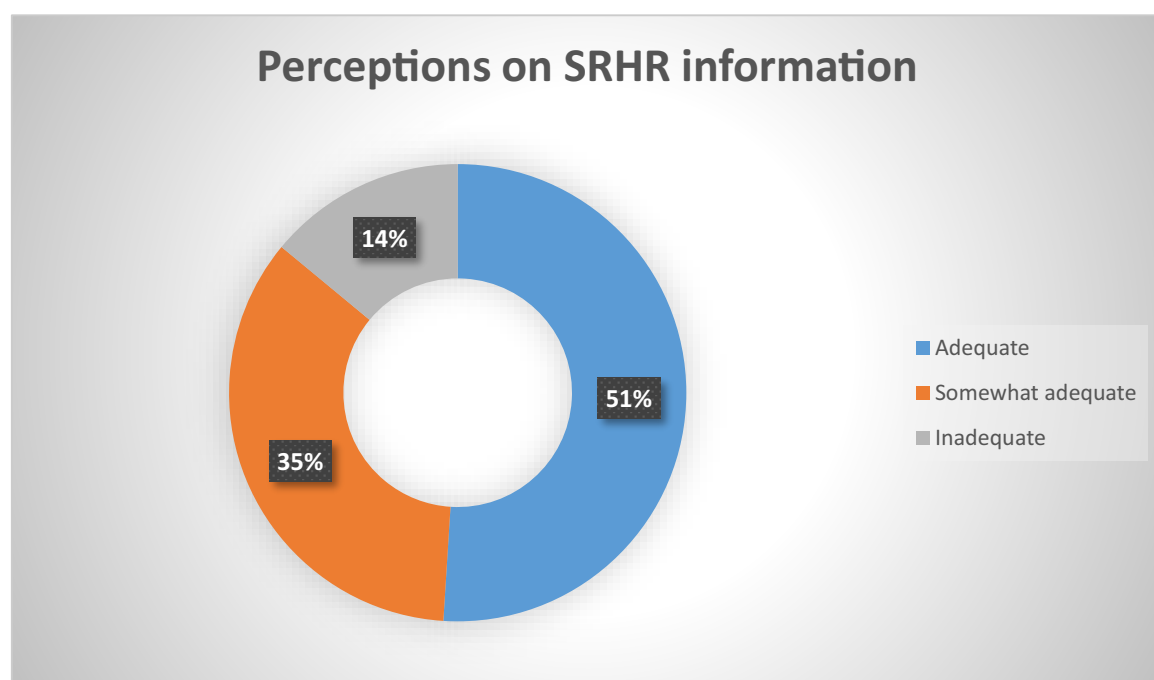
³ Zimbabwe National Statistics Agency (ZimStat) and ICF International: Zimbabwe Demographic and Health Survey, 2012.

4.3. Perceptions and attitudes

4.3.1 Information on SRHR from local health centre

This question sought to establish the prevailing perception on the information on SRHR available at local health centres. The participants' views were categorized into the 3 variables; adequate, partly adequate and inadequate. A slight majority of participants 51% felt that the information from their local health centre was adequate, 35% felt it was partly adequate and some 14% indicated that it was inadequate. This shows that a significant number of women in communities are not satisfied with the information from local health centres.

Pie chart 3: *Perceptions on SRHR information from local health centres*

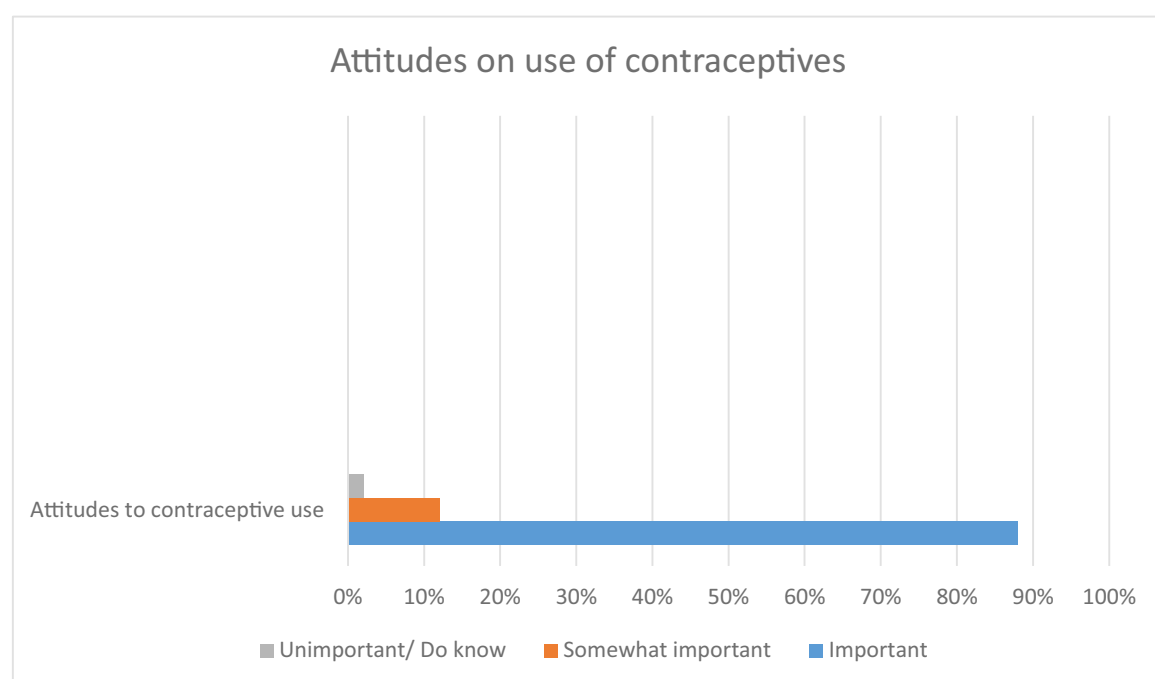


4.3.2 Views on the use of contraceptives

The views of the participants were categorized into 3 variables, important, partly important and unimportant/ do not know. 86% of the participants said they felt that using contraceptives was important, 12% felt that using contraceptives was partly important as it sometimes infringed with their

religious beliefs and 2% either said it was unimportant or did not know. This shows that an overwhelming majority of women support the use of contraceptives as shown in the following table:

Chart: *Attitudes on the use of contraceptives*



4.3.3 Satisfaction with available method of contraception at local health centre.

The question sought to measure participants' attitudes on the satisfaction they get from the available contraception methods at local health centres. Responses from the participants were grouped into three variables; adequate, partly adequate and inadequate. Majority of participants expressed lack of satisfaction on the methods of contraceptives largely available at local health centres (38% partly adequate and 25% inadequate). This is an indictment on the health system as it shows that there is massive shortages of basics required to deliver on SRHR needs for women. The following table provides a summary of the responses:

Table 3: Levels of satisfaction with available contraceptive methods

<i>Variable</i>	<i>Percentage (100%</i>
<i>Adequate</i>	37%
<i>Partly adequate</i>	38%
<i>Inadequate</i>	25%

One young unmarried participant noted that *“when I need a Jadelle they tell me they have only condoms, now even the condoms are not there and this puts me at risk of getting pregnant or worse still an STI or HIV.”*

4.3.4 Availability of SRHR policies in political parties/community based organizations (CBOs) and churches.

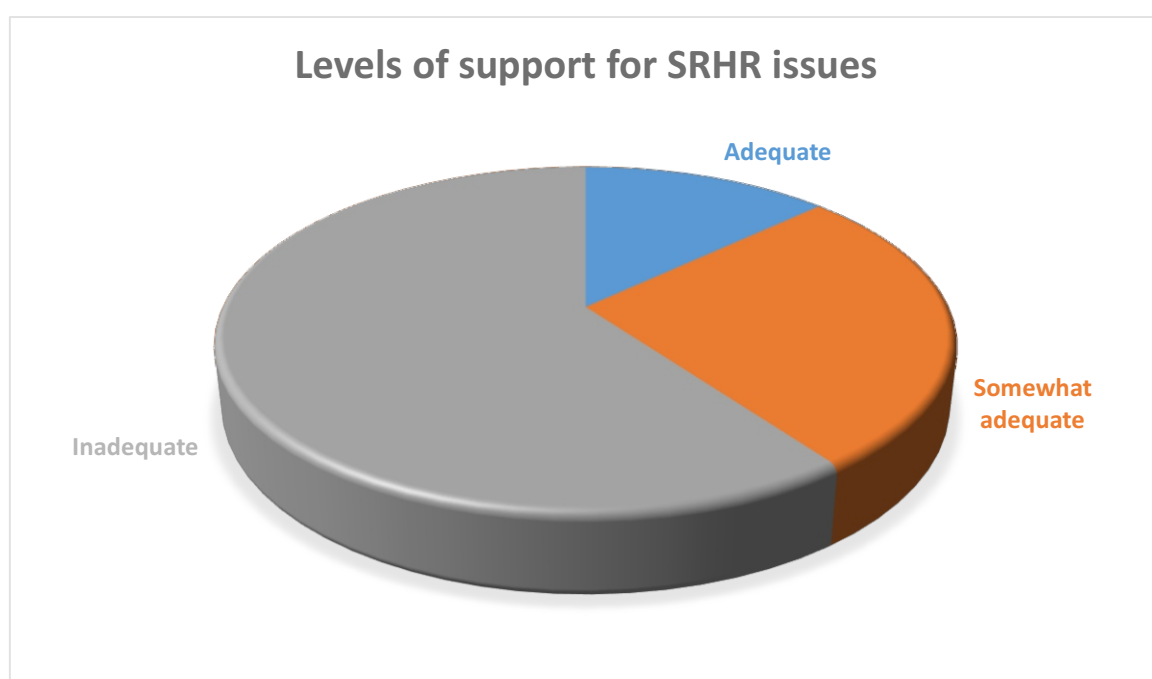
The question sort to establish the extent to which participants felt on the need for internal policies which deal with SRHR issues. The majority of the participants (88%) indicated that they indeed felt it was important that the political party, church or community organization they are part of should have SRHR policies. This shows that women believe that the presence of policies can go a long way in addressing their SRHR needs within the organizations they are part of. Two participants (a lawyer and an SRHR expert) gave interesting insights with one stating that *“SRHR policies are very important especially in political parties and churches because women’s rights are being infringed without any recourse. Such policies will make it possible to hold those responsible to account.”* The other opined that *“policies are very important as they set the ground for changing culture and regulations in communities and organizations. They will basically set the norms and values of interaction.”*

4.2.5 Level of support for SRHR issues in political parties/ CBOs/ churches.

This question sought to have an in depth understanding into how participants viewed their organizations’ prioritization of SRHR issues. Responses were grouped into 3 variables adequate, somewhat adequate and inadequate. Majority of the participants (60%) felt that the support towards SRHR in their

political party/community/organization/church is inadequate while 27% felt it was somewhat adequate and 13% felt that they were adequate information on SRHR. From this data, it is apparent that there is need to increase awareness on SRHR issues within community based organizations, political parties and churches so as to change attitudes and perceptions towards supporting SRHR needs.

Pie chart: *Levels of support for SRHR issues*



4.3.5 Attitudes on “pregnant women are fit to hold public office”

All the participants felt that pregnant women should be allowed to hold public elected office as it has no impact on their ability to deliver on their mandate. This is an important finding because it shows that women human rights defenders, activists and politicians recognize the importance of allowing women to freely participate regardless of whether they are pregnant or not. A Masvingo participant stated that “*we have to stand with each other as women regardless of whether one is pregnant or not because it has no effect on their ability to lead.*”

4.3.6 Local support for pregnant women to hold office in community based organizations/ political parties/churches.

The question sought to establish prevalent community attitudes on the ability for pregnant women to take up leadership as interpreted by the women themselves. Participants' responses were separated into 3 variables; adequate support, somewhat adequate and no support. Majority of the participants (88%) indicated that there was no support for pregnant women to take up elected leadership positions as communities felt they should be confined to the home. The following table summarizes this.

Table 4: Support for pregnant women in local community

<i>Variable</i>	<i>Percentage (100)</i>
<i>Adequate</i>	10%
<i>Somewhat adequate</i>	2%
<i>Inadequate</i>	88%

A women's rights activist summed this situation up saying *"women are generally looked down upon by society especially when they are pregnant."*

4.3.7 Reporting sexual harassment in political parties/CBOs/church.

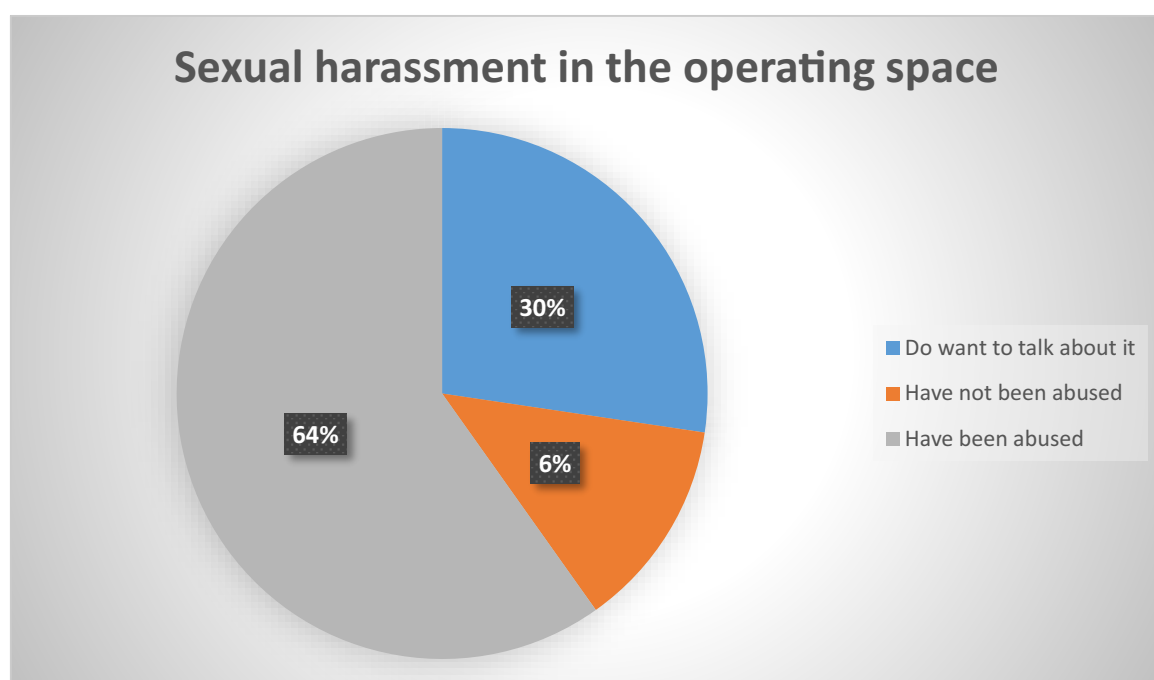
This question sought to establish if there exist mechanisms which women who have been abused can use to get help within their institutions. Majority of the participants (76%) indicated that they were not aware of channels to report within their organization, political parties or churches. This means that there are lack of laid down channels which can protect women from abuse which need to be addressed.

A participant summarized this stating that *"the system is difficult to navigate you are never sure if anyone you are telling will sympathize with you or instead attack you."*

4.3.8 Sexual harassment in the operating space.

This was a tough question for the majority of participants as it was rather sensitive and personal. It was asked to ascertain if women are confident to speak out if they have been abused. A majority of participants (64%) said they have been abused but would not likely openly talk about this subject while 30% indicated that they have been abused and are willing to talk about it. This also reflects that the issue of reporting sexual harassment is still a sensitive area which is not openly talked about even by the victims. The pie chart breakdown these findings.

Pie chart: *Sexual harassment in the operating space*



A women rights lawyer noted that *“most women would rather not talk about their abuse as it leads to labelling and stereotyping.”*

4.4.Interventions:

4.4.1 Actions to improve SRHR situation in CBOs/churches/political parties

Participants indicated a number of interventions they would like to see implemented to improve responses to SRHR needs and WALPW chose the top five proposed interventions. The following table summarizes these responses:

Table 4: *Proposals to improve SRHR issues*

Proposed interventions
Trainings in SRHR
Awareness campaigns
Providing psycho-social support
SRHR products
Legal support

5.0. Recommendations:

5.1.1 Developing and implementing SRHR policies

SRHR needs for women are subject to complex set of cultural, social, economic and political influences. There a lot of barriers which prevent women from taking preventive actions and some of these can be solved by the developing and implementation of SRHR policies within political parties, CBOs, churches and also at Government level.

5.1.2 Attitudinal change

It is very important to change attitudes of communities towards women's SRHR needs this can be done by awareness raising programmes targeting women as key constituency, men and boys and also the broader community which must change its attitude. There is also need to build community responses which guarantee anonymity

and confidentiality in the provision of SRHR needs for women in communities so that women can confidently seek these services without fear of stigma.

5.1.3 Educational and information programmes

There is need to undertake educational and information programmes targeting communities through campaigns conceived in local languages and resonating to the local contexts. Given that traditional means of communicating SRHR rights issued in communities are changing there is need to also increase the material available to women including using social media to reach them in their safe spaces. The need for awareness raising and trainings on SRHR within political parties, churches and CBOs cannot be overemphasized.

5.1.4 Availing services and infrastructure

The current economic crisis the country is going through has meant a loss in the number of qualified and experienced health professionals in the country, incessant shortages of basic medical supplies and deteriorating medical infrastructure. This has seen a decline in the levels of contraceptive use among women and a gap in unmet needs due to shortages. There is that need to ensure that services are provided especially for women human rights defenders and political activists who are usually busy with their institutions' work and mostly miss out on community initiatives on SRHR. Further, there is need for policy makers at all levels to advance the issue of building and repairing medical infrastructure so as to increase accessibility and improve quality of service.

6.0. Conclusion

The findings from the research show that the prevailing SRHR situation for women human rights defenders and political activists is characterized by deteriorating service and unmet need as well as lack of guiding policies for organizations and structures they are working with. There is need to make interventions which will put Zimbabwe on the path to attaining SDG 3 especially on meeting the SRHR needs of women and girls' activists.