SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS REGRESSION AND MOVEMENT BUILDING IN ZAMBIA

AN ANALYSIS OF CLAWBACKS AND EFFORTS

FINDINGS AND RECOMMENDATIONS

In partnership with Canada

CENTER for REPRODUCTIVE RIGHTS

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Contents

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HRH	human Resources for Health
ICPD	International Conference on Population and Development
IUCDs	Intra Uterine Contraceptive Devices
LARC	Long-Acting Reversible Contraception
LMNs	Local Medicines Transparency Alliance Networks
LSHE	Life Skills and Health Education
MedRAP	Medicines Research and Access Platform
MMR	Maternal Mortality Rate
MoH	Ministry of Health
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UNESCO	United Nations Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

1.0 THE STUDY BACKGROUND

1.1 The Study Background

Access to sexual and reproductive health and rights (SRHR) is essential for the well-being of all people, especially women and adolescent girls. However, significant barriers exist that still prevent people from accessing and benefiting from lifesaving services, treatments, medications, and information, which negatively impact their health, well-being, and ability to thrive and provide for those in their care. The WHO defines sexual and reproductive health (SRH) and rights (SRHR) as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system and its functions and processes. This includes the ability to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. It also encompasses the right to make informed choices about one's sexual and reproductive health, free from discrimination, coercion, and violence.

Notwithstanding all efforts made by governments and civil society organizations (CSOs) on a global basis, nearly 800 women a day die due to complications related to pregnancy and childbirth, and annually an estimated 5 million children do not reach the age of five, with half of these deaths occurring in sub-Saharan Africa (WHO, 2023). In sub-Saharan Africa, the maternal mortality rate (MMR) is estimated at 545 maternal deaths per 100,000 live births, 136 times higher than the MMR in Australia and New Zealand (4 maternal deaths per 100,000 live births) (WHO, 2023). Research has estimated that the lives of four million women, newborns, and children in sub-Saharan Africa could be saved per year if coverage of interventions such as emergency obstetric care, breastfeeding counseling, and treatment for infections such as diarrhea and pneumonia increased to 90% of families (Friberg et al., 2010). In 2020 alone, an estimated 374 million new cases of STIs occurred (WHO, 2021). For some of these STIs, such as syphilis, sub-Saharan Africa again suffers the highest burden globally. Access to essential commodities and services for sexual and reproductive health (SRH) can prevent a significant proportion of these deaths and disabilities. However, about 4.3 billion people will not have access to at least one essential reproductive health intervention over the course of their lives (WHO, 2022).

Sexual and reproductive health is increasingly under attack by both traditional and religious fundamentalist groups that work with some authoritarian government leaders and economic interest groups to reverse progress achieved in the last few decades. At the United Nations, governments such as Russia, the Holy See, and the United States are leading efforts to oppose resolutions in support of universal access to SRHR.

1.2 Purpose of the Study

Zambia has been a regional leader in advancing sexual and reproductive health and rights (SRHR), with legal frameworks that have supported bodily autonomy and improved access to essential services. Legislative milestones, such as the Termination of Pregnancy Act of 1972, have provided for safe abortion under specific conditions, while national policies have promoted comprehensive reproductive health care and, to an extent, comprehensive sexuality education (CSE) (UNFPA, 2021). These measures have contributed to declining maternal mortality rates and enhanced access to family planning, reflecting a broader commitment to SRHR in the country.

However, recent socio-political shifts in Zambia signal a troubling regression in these gains. Conservative influences and political debates are increasingly challenging the progressive aspects of the existing legal and policy frameworks. Notably, there is growing **opposition to CSE**, with critics arguing that it undermines traditional values and promotes behaviors they consider inappropriate for youth (UNESCO, 2019). Parents, teachers and religious leaders argue that CSE may encourage early sexual debut. This resistance poses a significant threat to the implementation of age-appropriate, evidence-based sexuality education in schools—a key pillar in empowering young people to make informed decisions about their sexual and reproductive health.

Similarly, despite legal provisions for safe abortion, access to these services is being eroded by **restrictive interpretations of the law**, reduced funding, and societal stigma. In a nation that prides itself on its Christian heritage, religious leaders wield considerable influence over public policy and opinion. Their vocal opposition to certain laws and practices, particularly those related to safe abortion and sexual and reproductive health rights (SRHR), can significantly impact the development and implementation of legislation. This influence extends to the executive, legislative, and judicial branches of government, shaping the country's stance on these critical issues. Politicians often seek to capitalize on controversial topics, including safe abortion laws and SRHR practices, to garner support and advance their careers. By doing so, they can inadvertently or deliberately contribute to the erosion of progress made in these areas. Their rhetoric and actions can create societal anxiety, making it challenging for individuals to access essential services and commodities. Traditional leaders and conservatives frequently espouse harmful narratives that undermine efforts to promote SRHR. One such narrative posits that a body capable of pregnancy is biologically prepared for sex, regardless of age or consent. This line of reasoning has led some leaders to downplay the severity of issues like early

marriage, defilement, and rape. For instance, a chief was once quoted as saying that he saw no issue with a man having intercourse with a girl who menstruates, regardless of her age. This perspective is rooted in a flawed understanding of adulthood, which is often tied to the onset of menstruation rather than emotional, psychological, or legal maturity. The influence of these leaders and politicians can have far-reaching consequences for SRHR in the country. By shaping public opinion and policy, they can limit access to essential services, perpetuate harmful practices, and undermine efforts to promote healthy and respectful attitudes toward sexuality and reproduction. It is crucial to recognize the impact of these narratives and work towards creating a more informed and supportive environment for SRHR. Health facilities often struggle with limited resources and an environment of uncertainty regarding service provision, which further undermines women's ability to exercise their reproductive rights (Human Rights Watch, 2022). The cumulative impact of these challenges not only reverse decades of progress but also deepens inequalities in access to quality SRHR services, particularly for marginalized and vulnerable populations.

Furthermore, the recent **cuts to USAID funding** as directed by the US's department of government efficiency for some of the Sexual and Reproductive Health and Rights (SRHR) activities in Zambia are likely to have devastating consequences for the country's most vulnerable populations, particularly women and adolescents. With USAID being a significant contributor to Zambia's SRHR programs, the funding cuts will lead to a reduction in essential services such as family planning, maternal healthcare, malaria prevention and treatment and HIV/AIDS prevention. This exacerbates existing challenges, including high rates of teenage pregnancy, maternal mortality, and HIV/AIDS prevalence. The cuts will undermine Zambia's progress towards achieving the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality). These developments have further dealt a significant blow to the progress made in integrating Sexual and Reproductive Health Rights (SRHR) services into HIV/AIDS clinics. Programs that had been working to incorporate SRHR services into these relatively established clinics, which were nearing stability and maturity, have been abruptly halted. This reversal not only undermines the advancements made over the years but also jeopardizes the health and well-being of individuals relying on these services. The situation has been further exacerbated by a recent announcement from the United States Ambassador to Zambia. On May 8, 2025, the Ambassador declared a **US$50 million funding withdrawal** aimed at supporting the procurement of essential medicines. The decision was attributed to the Zambian government's perceived inaction in addressing the widespread

theft of American-donated medications and medical supplies (US Embassy Website, Zambia, 2025). This withdrawal of funding not only worsens an already dire situation but also raises concerns about the potential for other supporting governments to follow suit. The loss of funding and the halting of SRHR service integration programs can have far-reaching consequences, including reduced access to essential healthcare services, increased vulnerability to health crises and potential long-term damage to the healthcare system. The implications of these developments underscore the need for urgent action to address the underlying issues and ensure the continued provision of critical healthcare services.

In this context, analyzing Zambia's current SRHR landscape reveals a complex interplay between historical achievements and emerging threats, especially those targeting safe abortion, that jeopardize both individual autonomy and public health outcomes.

Therefore, the **main objective** of the study was to review Sexual and Reproductive Health and Rights regression and movement building and analyze clawbacks and efforts made by Zambia to address some of the critical issues affecting especially women and adolescent girls' wellbeing and health.

1.3 The Study Methodology

This study employed a desk review design, focusing on the analysis of existing literature and policy documents related to Sexual and Reproductive Health and Rights (SRHR) in Zambia. The review was conducted between January and May 2025, employing the following approach:

1. Review of national policies and laws on SRHR to identify barriers to accessing SRHR services.
2. Analyzed literature on SRHR policy regression, movement building, and the needs of vulnerable populations.
3. Collect in-depth contextual information on policy synergies, challenges, and contradictions influencing the implementation of the Comprehensive Sexuality Education Framework.

To achieve this, varied sources of data were scouted. These included;

1. National policies and laws: Review of existing national policies and laws related to SRHR in Zambia.
2. Literature review: Analysis of academic literature, reports, and articles on SRHR policy regression, movement building, and the needs of vulnerable populations.
3. Grey literature: Review of grey literature, including reports, guidelines, briefs, and fact sheets from organizations working on SRHR in Zambia.

2.0 LITERATURE REVIEW (EFFORTS)

In Zambia, Sexual and Reproductive Health and Rights (SRHR) are defined in some Acts of Parliament and other policy documents. Although a few are satisfactorily covered and described, many are often diluted by policy gaps and challenges in implementation. While the Zambian government has made commitments to SRHR through international treaties and the Sustainable Development Goals (SDGs), there are significant disparities in access to services, particularly for marginalized groups like adolescents that need comprehensive legislation and policy. The country struggles with **unmet needs for family planning**, high rates of **teenage pregnancy**, and **low access** to SRHR services. Additionally, there are ongoing challenges related to gender norms and the need to engage men in SRHR.

In 1994, the International Conference on Population and Development (ICPD) affirmed that Sexual and Reproductive Health and Rights (SRHR) 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 SRHR of all people by ratifying several international instruments of law. These include

i. International Convention on the Elimination of All Forms of Racial Discrimination.
ii. International Convention on Economic, Social and Cultural Rights.
iii. International Covenant on Civil and Political Rights.
iv. Convention on the Elimination of All Forms of Discrimination against Women.
v. Convention on the Rights of the Child.
vi. Convention Against Torture and Other Cruel Inhuman or Degrading Treatment and Punishment
vii. Convention on the Rights of people with Disabilities.
viii. African Charter on Human and People's Rights

ix. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol).
x. Africa Youth Charter
xi. SADC Protocol on Gender and Development.
xii. The Abuja Declaration
xiii. Sustainable Development Goals
xiv. The Maputo Plan of Action

In addition to ratifying global and regional treaties, Zambia has also committed to achieving Sustainable Development Goals (SDGs). Some SDGs directly relating to SRHR 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 SRHR. These include decent work (8), and peace, justice, and strong institutions (16). Government is therefore obligated to ensure that it respects, protects, and fulfills every person's rights.

The Constitution of Zambia as amended in 2016 provided for non-discrimination (article 23). In other words, discrimination is prohibited. In Article 23(1) the constitution prohibits formulation of laws that are discriminatory. It states that "…a law shall not make any provision that is discriminatory either of itself or in its effect" and in article 23(2) it prohibits discrimination by institutional behavior stating "…a person shall not be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority." Other laws that promote equality and non -discrimination include the Education Act of 2011, persons with disabilities Act 2012, the Anti-Human Trafficking Act of 2008, the Gender Equity and Equality Act of 2015 and the Amended Constitution No. 2 of 2016. The Industrial and Labor relations Act, Chapter 269 of the laws of Zambia; Section 108 prohibits discrimination in places of work on the grounds of sex, status, race, culture, and religious practices. The Persons with disabilities Act, prohibits discrimination on grounds of a person being a person living with a disability.

Further, in article 11 it provides that every person in Zambia is entitled to the fundamental rights and freedoms of the individual regardless of "his race, place of origin, political opinions, color, creed, sex or marital status." Article 266 (amended) constitution defines a child as a person who has not attained the age of 18 years and below. Medicines Research and Access Platform (MedRAP) is in support of the upholding of this age definition in the currently contested Bill 7, as evidenced by press releases and the advocacy conducted thus far (Times of Zambia, 2025)

The Zambia marriage Act sets the minimum age of marriage at 21 years. However, a child can marry from the age of 16 years by consent of a legal guardian (who mainly are male). The

Education Act No. 23 of 2011 in Section 18 provides that subject to the constitution and any other written law, a learner who is a child shall not contract any form of marriage. Section 2 (a) and section 2(b) outlaws marrying off children in school. Section 2(a) states “a person shall not marry or marry off a learner who is a child” while section 2 (b) states “a person shall not prevent or stop a learner who is a child from attending school for the purposes of marrying or marrying off the learner who is a child.” Section 3 criminalizes the act of marrying a child who is a learner. It states, “a person who contravenes this section commits an offence and is liable, upon conviction, to imprisonment for a period of not less than fifteen years and may be liable to imprisonment for life.”

The Zambian Constitution in Article 11(a) protects the right to life. The constitution states; “It is recognized and declared that every person in Zambia has been and shall continue to be entitled to the fundamental rights and freedoms of the individual, that is to say, the right to life, liberty and security of the person and the protection of the law.”

The Eighth National Development Plan 2022-2026 prioritizes improving Sexual and Reproductive Health (SRH), expanding access to Family Planning (FP), and significantly reducing Maternal Mortality as core components of its human capital development agenda. It explicitly aims to decrease the Maternal Mortality Ratio (MMR), increase the contraceptive prevalence rate (CPR), and reduce unmet need for FP, particularly among adolescents and rural populations. Strategies include strengthening integrated SRH services within primary healthcare, enhancing the availability and distribution of contraceptives, promoting male involvement in FP, scaling up adolescent-friendly SRH services, and ensuring skilled birth attendance through improved access to emergency obstetric care and trained health workers. The plan recognizes these interventions as critical not only for improving health outcomes but also for empowering women and girls, reducing poverty, and contributing to broader socio-economic development by enabling informed choices about childbearing and health.

National Youth Policy (2024) themed "Accelerating Youth Participation and Empowerment in Zambia," aims to address the multifaceted challenges and opportunities faced by young people, recognizing them as key agents of national development. It focuses on holistic empowerment,

encompassing social, political, and economic aspects to equip youth with necessary skills, health, and resources for full participation. The policy seeks to improve access to education, health, and employment, ensuring inclusivity and creating an environment where youth can thrive and contribute to societal progress. It also recognizes the rights of youths to access comprehensive SRHR services and information. The policy aims to create an enabling environment that promotes the rights and responsibilities of youth and fosters their participation in national development, with SRHR being a key component.

Zambia's 2022-2026 Adolescent Health Strategic Plan focuses on strengthening health systems to achieve universal health coverage through a primary health care approach, aligning with the National Health Strategic Plan 2022-2026 and the Vision 2030. The strategy aims to improve adolescent health outcomes, particularly addressing HIV/AIDS, STIs, and gender-based violence, and it incorporates key strategies from the Integrated Reproductive SRH policy.

The Termination of Pregnancy Act (1972) outlines the conditions under which a pregnancy can be terminated, including when it poses a risk to the pregnant woman's life or health or if the child would suffer from severe abnormalities. It governs the legality of abortion in Zambia thus;

- If the pregnancy endangers the woman's life or physical/mental health.
- If there is a substantial risk that the child would have severe physical or mental abnormalities.
- In cases of rape, incest, or defilement.

Requires certification by three registered medical practitioners (except in emergencies where only one registered practitioner can make the decision). To support the legality further, the 2018 Amendment to Zambia's Health Services Act aimed to strengthen access to safe abortion within Zambia's existing legal framework (where abortion is permitted on broad therapeutic grounds since 1972). This is in addition to the National Standards and Guidelines on Safe Abortion in Zambia whereby in 2009, Zambia developed comprehensive standards and guidelines on safe abortion. The purpose of "this standards and guidelines document is to ensure that women prevent unwanted pregnancies and those with unwanted/unintended/risky pregnancies get appropriate services to prevent the occurrence of unsafe abortion and associated morbidity and mortality." (MOH, 2009)

National Gender Policy (2023) - This policy aims to address gender inequalities and create a just and equitable society where women and girls have equal opportunities.

National Health Strategic Plan (2022-2026) - This is a policy document that focuses on improving health outcomes towards the achievement of Universal Health Coverage (UHC).

The National HIV/AIDS Strategic Framework 2023 – 2027 demonstrates a clear effort to integrate HIV and SRH services and address critical issues like gender inequality and the needs of GYW and PLHIV, representing positive steps for SRHR.

The Penal Code Chapter 87- Section 132 and section 138 prohibits rape and defilement. A person committing the offence of rape is liable to imprisonment for life. The law also prohibits attempts of rape (section 134), and abduction of women for purposes of marriage (sec 135).

The offence of defilement which is defined as having unlawful carnal knowledge with a child is created under section 138 of the penal code. This protects both boys and girls from sexual abuse. The offender cannot plead in defense that he had reasonable cause to believe and he indeed believed that the child was above the age of 16. This defense is no longer acceptable at law. Consent of the child to sex is immaterial and cannot be used as defense.

The penal code also outlaws assault. Section 247 prohibits common assault; section 248 prohibits assault occasioning actual bodily harm while section 248A prohibits battery including battery of children. In a society where physical abuse to women, girls and children are used as weapons of punishment, this restriction protects victims against abuse and SRHR crimes.

The Penal Code Amended in 2005 under Section 165 prohibits fraudulent pretense of marriage. Any person who willfully and by fraud causes any woman who is not lawfully married to him to believe that she is lawfully married to him and to cohabit or have sexual intercourse with him in that belief, is guilty of a felony and is liable to imprisonment for ten years." Section 166 prohibits polygamy creating an offence called bigamy. Therefore, under statute law, polygamy is not allowed, but it is allowed under customary law.

National Policies on marriage and age for marriage have been put in place including program to end child marriages. Anti-Child marriage campaign was launched to educate the communities on the law seeking to end child marriages. Its vision is "a Zambia free from child marriage by 2030." The campaign against child marriage has engaged traditional leaders to be champions against child marriage. Since the campaign began, there is anecdotal evidence that traditional leadership is changing customary law on child marriage.

The establishment of the National Strategy on Ending Child Marriage 2016-2021 provided a framework to encourage concerted efforts in the prevention of child marriages. The framework sought to strengthen Multisectoral responses in reducing children's vulnerability to marriage, facilitate the development and review of policies and legislation. Additionally, it aims at facilitating positive change in attitudes, behaviors, health beliefs and practices and provision of child-sensitive services.

The National Reproductive Health Policy 2008 sets to "discourage early marriages and institute measures to reduce the rate of pregnancies among girls below 18 years of age." (MOH, 2008) It also guarantees free contraceptives in public health facilities.

The Zambia National Guidelines and Protocols 2006 were developed to act as guides for health-care workers on best practices in provision of quality FP services.

The Zambia's National Population Policy (2007) calls for everyone to have access to appropriate and accurate information on population and development issues for all the Zambian population, regardless of their location, gender, age, race, social, economic, cultural and political status.

The Zambia Roadmap for Accelerating the Reduction of Maternal, New born And Child Mortality 2011-2016 - is a comprehensive plan proposing an integrated approach to Reproductive Health and Maternal and Child Health services through the prioritization of basic packages of interventions delivered to communities. This is a means through which maternal, neonatal and child mortality can be reduced. It strategically looks at funding, supply and delivery of essential

medicines and Family planning commodities as well as training health workers who will distribute them in health facilities and communities.

The implementation of the Integrated Family Planning Scale up Plan 2013-2020 has particular stipulations for increasing the demand of Family planning services through country wide dissemination of accurate FP information.

The Zambia Police (amendment) Act No.14 of 1999 - establishes in section 53 the Victim Support Unit. Section 53(2) provides that the functions of a Victim Support Unit shall be-

a) To provide professional counselling to victims of crime and to offenders; and to
b) Protect citizens from various forms of abuse.

The Health Policy of 2012 compliments the National Health in All Policies Strategic Framework 2017-2021. These are comprehensive and overarching national policies to provide for an appropriate and evidence-based policy framework to guide the health sector toward attainment of national, regional and global health objectives. The overall purpose of the Health Policy is "to reduce the burden of disease, maternal and infant mortality and increase life expectancy through provision of a continuum of quality effective health care services as close to the family as possible in a competent clean and caring manner." With regard to the state obligation of ensuring that, reproductive health services are available, accessible, and acceptable and are of good quality. However, the policy limits adolescents' access to SRH services except with legal consent of parents and guardian.

The Public Health Act Chapter 295 of the Laws of Zambia does not directly deal with availability of reproductive health services. It however provides for the protection of the right to health by regulating various public health issues that include sanitation and housing; how to deal with epidemics, suppression of infectious diseases and infection control. In Part III it focuses on sexually transmitted infections. Sections 58(1) and 58(2) criminalize willful infection of another person with a venereal disease. Venereal disease is defined in section to mean syphilis, gonorrhea,

gonorrheal ophthalmia, soft chancre, venereal warts and venereal granuloma. It does not include HIV. Willful transmission of HIV is therefore not criminalized in Zambia.

In health facilities, sex workers are often afraid to disclose their reproductive health circumstances. This may lead to a health care worker to fail to conduct appropriate sexual history interviews and physical examinations, which may lead to misdiagnosis and ineffective or even harmful treatment. (Malala M et al, 2015) There is silence of adolescents who are sex workers and how such category benefits from the SRH services. There is a need to think of ways to protect the human and sexual and reproductive health rights of sex workers in Zambia, including adolescents.

The Health Professionals Act, which in section 3 establishes the Health Professions Council of Zambia that regulates conduct of health practitioners through the propagation of a Code of Ethics, protects life of all including that of pregnant women. In section 60 of the Health Professionals Act, a health professional commits professional misconduct if the health practitioner breaches the code of ethics or encourages another health practitioner to break or disregard the principles of the code of ethics (Sec 61(f)).

Learner pregnancy retention and re-entry law and policy - In 1997, Zambia adopted the Learner Re-entry policy whose objective is to provide opportunities to girls, who drop out of school as a result of pregnancy, to be able to go back to school after delivery and continue access to education unlike in the past when they were expelled from school. This enables girls not only to acquire further education, but also to have access to comprehensive sexuality education that may contribute to preventing further teenage or early pregnancy and child marriages.

The Education Act No.23 of 2011 - empowers the Minister to issue a statutory instrument to make regulations for changing the curriculum. In section 108(1)(i), the Education Act states "the Minister may, by statutory instrument, make regulations "…. providing for the development and adoption of guidelines to promote education on sexuality, reproductive health, HIV and AIDS and personal relationships in any educational institution."

The Juvenile Act Sec 75 and 76 – provides for the right to education and information for juveniles that come into conflict with the law.

The Persons with Disabilities Act No.6 of 2012 protects the right to education of persons living with a disability. Under section 4(b) is the principle of non-discrimination while in sections 22 to 26, the Act directs that persons with disability must attend school and acquire an education like anyone else.

Zambia has made policies to promote CSE through -

a) School curricula include comprehensive, evidence-based, and non-discriminatory sexuality education including safe sex practices and contraception.
b) Ensure accurate public education and awareness campaigns on the prevention of HIV transmission, child marriage, sexual and reproductive health and gender-based violence.

In 2014, the Ministry of Education began conducting in-service training for teachers to ensure that teachers are equipped with skills on how to deliver CSE curriculum. In order to ensure that all teachers are competent in CSE, the diploma teachers training curriculum has also been revised. In 2014 the Zambia Primary Teachers' Diploma Syllabus was revised to include CSE."

The Anti-GBV Act No. 1 of 2011: Is aimed at domesticating the Convention on the Elimination of all forms of discrimination against women. The adopted Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Maputo Protocol further protect women again discrimination. They are both international human rights instruments that aim to promote gender equality and protect women's rights, but they differ in their scope and focus. CEDAW is a global treaty, while the Maputo Protocol is a regional treaty specific to the African continent. The Anti-GBV Act comprehensively defines various types of GBV. These include 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 Act also establishes the Anti-Gender Based Violence Committee whose role among others is to monitor the activities of all the relevant institutions on matters connected with gender-based violence and make recommendations for a national plan of action against GBV. In addition, the Act provides for the

establishment of shelters where victims of GBV can go to seek protection from the perpetrators of violence. To ensure the popularization of the GBV Act, government has translated the simplified version of the Act into seven local languages.

The National Referral Mechanism on Gender Based Violence and Violence against Children – Practical Handbook - Published in 2014, the handbook provides clear explanations of what GBV is and how the community can deal with it. It simplifies the Anti-GBV Act and provides interpretations for the general public and practitioners to understand the Anti-GBV Act.
It then provides a list of various service providers of GBV services and their contact details for referrals.

The Zambia Family Planning 2030 commitments - Zambia's FP2030 commitments are viewed as critical enablers for achieving the country's Costed Implementation Plan (CIP) goals, focusing on accelerating progress toward universal health coverage and sustainable development goals by expanding access to contraception.

Human resources for health and their role in SRHR - The World Health Organization (WHO) defines human resources for health (HRH), as all people whose main activities are aimed at promoting, protecting and improving health. Human resources for health or health workforce include people who provide health services such as medical doctors, nurses, midwives, clinical officers, pharmacists and laboratory technicians. These health workers may work in facilities and institutions run by the public and private sectors or by nongovernmental and faith-based organizations.

The links between the availability and accessibility of HRH and subsequent service coverage and health outcomes for SRH are well established. Without HRH, prevention and treatment of diseases, rehabilitation and advances in health including SRH cannot reach those in need. Thus, a competent, enabled and efficiently deployed health workforce is crucial to the achievement of the health-related sustainable development goals (SDGs).
SRH commodities - Availability of essential commodities and supplies for SRH related services is critical for the improvement of SRH. The government of Zambia is implementing strategies to ensure that medicines and supplies are affordable and available.

One of the strategies is the implementation of the National Health Sector Supply Chain and Implementation Plan to strengthen forecasting and quantification, procurement, coordination, and distribution of medicines and medical supplies in the country. In addition, the government has issued some supportive policies including sectoral health policies and integrated frameworks that address SRH commodities specifically and ensure medicine pricing and procurement strategies are in place to ensure medicines are affordable and available.

The 2024 Zambia Demographic and Health Survey (ZDHS) revealed key findings regarding Sexual and Reproductive Health and Rights (SRHR). In urban areas, a higher percentage of women (51.0%) than men (50.0%) were knowledgeable about HIV prevention methods. Conversely, in rural areas, more men (38.0%) than women (33.0%) knew about HIV prevention. Data on adolescent sexual activity and contraceptive use revealed a significant percentage of sexually active adolescents, with a low percentage using modern contraceptives, highlighting the need for targeted SRHR programs for this age group. A significant reduction in maternal deaths was observed, indicating advancements in maternal health services and care. 3.0

3.0 FINDINGS AND ANALYSIS OF KEY RESULTS (CLAWBACKS)

The 2016 amendment to the constitution to introduce the **meaning of a child** has **not been aligned** with other enabling legislations and continue to create confusion in the policy and legal framework in the country. There are different pieces of legislation and policies that define a child in a different way depending on that specific law or policy perspective. For instance, the **Gender Policy (2015)**, the **National Child Policy (2006)**; **Anti-Human trafficking Act (2008)**, **The Wills and Administration of Estates Act**, all define a child as a person below the **age of 18**. On the other hand, the **Penal Code Chapter 37**, the **Anti-GBV Act of 2011** and the **Juvenile Act Chapter 53** defines a child as a person below the **age of 16.** Further the **Employment of Young Persons and Children's Act** defines a child as a person below the **age of 14**. For purposes of adopting a child, the **Adoption Act** in section 2(1) defines infant as a person who has not attained the age of twenty-one years, but does not include a person who is or has been married.

Due to a cultural and religious disposition of most local communities, Zambia practices a dual legal system that recognizes both statutory and **customary law**. The constitution in article 23 (4)

(d), recognizes the value of customary law. Although there is no single definition of what customary law is in the constitution neither is there a place where there is a clear codification of what constitutes customary law, people have a right to practice their customs as defined by their culture. Customary law is based on what the community has practiced over time and that which has been passed on from generation to generation. Customary law is therefore contextual and localized to particular groups of people in Zambia.

In rural areas, some of the customary law **practices** have contributed to maternal mortality. Customs that restrict eating **nutritional food** during pregnancy and those that focus on the sexuality of a pregnant woman have contributed to morbidity and mortality of mothers. There is need to harmonize customary and statute laws in order to increase protection of sexual and reproductive health rights vis-à-vis cultural and traditional practices

In its application, customary law is often **discriminatory**, particularly against women, "in such areas as bride price (lobola), guardianship, inheritance, appointment to traditional offices, exercise of traditional authority and age of maturity. It tends to see women as adjuncts to the group to which they belong such as a clan or tribe, rather than equals." (M Ndulo, 2011) Customary law also discriminates when it comes to allowing the practice of polygamy. Women are not allowed to marry more than one man while men are allowed to marry more than one woman. The courts in Zambia have dealt with the issue of discrimination based on traditional customary practices.

The recognition of customary law in the constitution has compounded the problem of **early marriages**. Under customary law, definition of a child is not by the number of years the child has, but by biological and sociological circumstances. Hence, a child who has come of age (started menstruating for example) is considered to be an adult. This completely ignores the emotional, psychological or legal maturity of the girl.

The constitution allows **customary marriages**. Under customary law, consent of the parents is more important than consent of the parties intending to marry (L Mushota, 2005). In the case of *Sibande V the People,* the court held that "in Zambia it is not generally unlawful for a man to have carnal knowledge of a girl under the prescribed age if he is lawfully married to her, lawfully here means that both the parents or guardians of the girl have consented to the marriage, but

unfortunately, consent of the girl alone cannot be raised as a defense to a charge."(Sibande Vs The People, 1979). A child can therefore be married as long as the parents have agreed and she has reached puberty according to that child's culture.

National Youth Policy and Plan of Action (2015) and Adolescent Health Strategy (2017 – 2021) The gaps associated with this policy including challenges in effective implementation has been a major hindrance to the realization of policy objectives; hence, bridging this gap is crucial for the policy's success. In addition, the policy aims to enhance access to quality services, but there's room for improvement in extending coverage and increasing the quality of services, particularly for marginalized groups. The policy needs to be reviewed in order to accommodate quality services that extend the scope, particularly for marginalized groups. Furthermore, while the policy recognizes the importance of investing in young people, more needs to be done to address youth employment and empowerment, particularly in the context of Vision 2030 and SDGs.

For example, the youth **friendly corner program** has not been rolled out across the country, which means adolescents are left to access services in the mainstream service provision, which are not always youth friendly. As much as the policy seeks to promote provision of comprehensive sexuality education (CSE), unfortunately **sexual and reproductive health services cannot be provided in schools**. The 2015 Youth policy requires a review to include curricula that will appropriately introduce SRH services in schools to enable adolescents utilize contraception methods that will prevent teenage pregnancy. Notably, the policy of the **Ministry of Education** does not allow such services to take place in schools but to establish referrals to **Ministry of Health** facilities for such purposes. This is a missed opportunity to increase access to adolescent friendly sexual and reproductive health services. This extends to some **health facilities under religious leadership** where contraceptive and some family health services are not offered

Termination of Pregnancy Act (1972)— Some observable Issues that the policy has failed to address are **restrictive grounds for abortion**. The Act permits abortion only in cases where the pregnancy poses a risk to the life or health of the pregnant woman or if the child would suffer from severe physical or mental abnormalities. This limited scope can lead to unsafe abortions. Secondly,

even when abortion is permitted, punitive measures may be dispensed by the court of law if procedure is not adhered to the letter. An example is a case of **Violet Zulu,** a 24-year-old woman from Lusaka's Ngombe compound, who was handed a **seven-year prison sentence** for terminating a 7-month pregnancy. The verdict was delivered by Lusaka Magistrate Mutinta Mwenya after Zulu admitted to the act, revealing that she used local herbs, commonly known as Muleza, for the abortion. Violet Zulu confessed to taking matters into her own hands due to the alleged denial of responsibility by the man involved in the pregnancy. The court heard that she administered the local herbs to abort the 7-month-old pregnancy, a move that led to her legal predicament. The court's decision reflects the legal stance on abortion in Zambia, where the termination of pregnancies is generally prohibited except when the life of the mother is in danger. The case also highlights the complexities surrounding issues of reproductive health, personal choices, and the legal framework governing such matters in the country. It also underscores the challenges faced by individuals, especially young women, when navigating the social and legal implications of unwanted pregnancies.

The conditions under which abortion is legal are too restrictive. In a country where the patient to doctor ratio is 12,000, it becomes highly inconvenient and unlikely that safe and adequate access to abortions is possible. However, some pro-abortion organizations and suppliers of commodities for safe abortion have argued that the policy in its crude form is adequate, except the need for having three (3) registered medical practitioners to authorize.

The Constitution of Zambia in article 12(2) - states, "a person shall not deprive an unborn child of life by termination of pregnancy except in accordance with the conditions laid down by an Act of Parliament for that purpose."

In as much as **The 2018 Amendment to Zambia's Health Services Act** sought to strengthen implementation of the 1972 Act, with amendments such as the reduction in judicial barriers resulting in eliminating requirements for court orders or police reports for rape/incest survivors, streamlining access for vulnerable groups and clarity that abortions are legal under specific conditions (rape, incest, fetal impairment, mental/physical health risks), reducing ambiguity for providers and patients, it still has gaps. Some of the gaps include; It permits providers to refuse services but lacks mechanisms to ensure timely referrals, potentially denying care entirely

(especially in rural areas with few providers). Furthermore, it fails to address societal stigma or educate communities about legal rights, resulting in low service uptake and continued reliance on unsafe methods.

The National HIV/AIDS Strategic Framework 2023 – 2027 contains significant regressive elements or omissions, particularly regarding the **rights** of Key Populations, the lack of commitment to Comprehensive Sexuality Education, and the complete silence on safe abortion access. The framework's effectiveness in advancing SRHR will depend heavily on how ambiguities are interpreted and implemented, and whether the critical gaps (especially regarding KPs and abortion) are addressed through complementary policies and programs.

Penal Code (Chapter 87 of the Laws of Zambia) – Though it aligns with the Termination of Pregnancy Act for legal exceptions, the penal code criminalizes illegal abortions. Article 151 states "any person who, with intent to procure miscarriage of a woman, whether she is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years."

The Penal Code, Section 165, criminalizes fraudulent pretenses of marriage; however, the provision predominantly focuses on protecting women from deception. To ensure gender neutrality and equitable protection under the law, it is recommended that the section be reviewed to explicitly include men as potential victims of such fraudulent activities.

The Zambia law is silent on how to deal with consensual sexual activity when both parties are below the age of 16 years. In such cases, both male and female below age of 16 should be prosecuted. However, the study finds that such prosecutions are very rare.

The Zambia Penal Code (Amendment) Act No. 23 of 2022, which was signed into law on December 23, 2022, abolished the death penalty. This Act removed provisions from the Penal Code that allowed for capital punishment. Zambia also acceded to the Second Optional Protocol to the ICCPR on December 19, 2024, a treaty aimed at abolishing the death penalty.

The penal code in Sections 155 – 158 deals with "Unnatural Offences," which are applicable to **homosexuality**. Sections 155 and 156 of the penal code criminalize what are termed as **"carnal knowledge against the order of nature"**. It attracts a penalty of not less than fifteen years with the possibility of imprisonment for life. Section 158 speaks directly to **"indecent practices"** between people of the same sex whether they be male or female as well as whether it's done in public or private. Open public advocacy on homosexuality illicit emotional reactions and stringent moral judgements from the public attract risk of prosecution by the courts of law.

In 2013, Paul Kasonkoma was arrested and prosecuted after appearing on a local TV show. He was calling on government to decriminalize most at risk populations (sex workers, men who have sex with men) to more effectively target its responses to HIV. He was charged under section 178(g) of the Penal Code with the idle and disorderly offence of soliciting in a public place for immoral purposes. The subordinate court found him not guilty. Government appealed the judgement of the subordinate court to the high court. The High Court also acquitted him. (Global Freedom of Expression, 2015). This example highlights the risks faced by individuals and organizations who stand to speak on behalf of special groups. In itself, advocacy for targeted groups is not a crime, as it falls under free speech, but cases are several where such campaigns or messaging has led to prosecution. Organizations (CSOs) working on or defending the rights of sexual minorities also suffer harassment, violence and ridicule.

In 2014, two men Philip Mubiana and James Mwape were prosecuted on accusation of being homosexuals. This was because a neighbor suspected that the two lived as if they are husband and wife. On the day the two men had a domestic dispute; they were picked by the public and taken to the police where they were both charged with homosexual offences. The court acquitted both of them for lack of evidence. (Case 1B/01/2013 (unreported) – Subordinate Courts Kapiri Mposhi).

Zambia has not set in motion any implementation framework on sexual minorities arising from **Resolution 275** of the African Commission on Human and People's Rights, to protect Human Rights violations against persons on the basis of their real imputed sexual orientation or gender identity. Zambia has criminalized same sex relationships. The same sex relationship is frowned

upon by the society. The environment is very hostile for any program intervention protecting the rights of LGBTQ. The **Zambia Human Rights Commission** instead works on promoting the rights of key population, promoted as human rights. There is no work undertaken by the Commission focusing on any of the known measures to promote the principles and obligations of sexual minorities. It is challenging to get any adolescents declaring openly to being sexual minorities for fear of being discriminated and rejected by society and subjected to violence, harassment and ridicule among other human rights violations.

In Zambia, people living with HIV can be represented through laws in the Penal Code or **Anti-Gender Based Violence Act**, 2010 as well as the **Public Health Act**. Section 183 of the Penal Code makes it illegal and unlawful or negligently do any act, which the person knows or believes is likely to spread a disease that is dangerous.

Although the law does not directly prohibit sex work, it is illegal in Zambia to live on the proceeds of sex work. The Penal Code Chapter 304 of the Laws of Zambia in Section 146 (1) (a) says "A person who- (a) knowingly lives wholly or in part on the earnings of **prostitution**; or (b) in any public place, persistently **solicits** or importunes for immoral purposes, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding fifteen years." Section 149 – prohibits brothels and their ownership. Criminalization of sex work contributes to increased stigma and discrimination against sex workers in Zambia. In the stigma index conducted by Network of Zambian People Living with HIV, it was established that female sex workers are among the populations that are discriminated against both in health service provision as well as in society in general (NZP+, 2009).

The National Reproductive Health Policy - There is no policy directive on the provision of safe and legal abortion services as one of the policy measures to reverse recourse to unsafe abortion.

The Health Policy of 2012 - is regressive to adolescents' access to SRH services except with legal consent of parents and guardian due to the defined age restrictions.

Anti-Gender Based Violence Act 2010 – section 3(1) in defining sexual abuse includes sexual contact by a person aware of being infected with HIV or any other sexually transmitted infection with another person without that other person being given prior information of the infection. This categorization poses negative impact to PLWHA. There is need for movement building by like-minded CSOs to protect the dignity and sexual rights of everyone.

The Public Health Act Chapter 295 of the Laws of Zambia does not directly deal with availability of reproductive health services. Sections 58(1) and 58(2) criminalize willful infection of another person with a venereal disease. In this case, venereal disease is defined to mean syphilis, gonorrhea, gonorrheal ophthalmia, soft chancre, venereal warts and venereal granuloma. It does not include HIV. Willful transmission of HIV is therefore not criminalized in Zambia.

In health facilities, sex workers are often afraid to disclose their reproductive health circumstances. This may lead to a health care worker to fail to conduct appropriate sexual history interviews and physical examinations, which may lead to misdiagnosis and ineffective or even harmful treatment (Malala M et al, 2015). There is silence of adolescents who are sex workers and how such category benefits from the SRH services. There is a need to think of ways to protect the human and sexual and reproductive health rights of sex workers in Zambia, including adolescents.

Marriage Act Chapter 50 of the laws of Zambia - In Section 17, the law provides that a person can only marry if they are 21 years old. If they have to marry below that age, consent must come from the father not the mother unless the father "be dead, or of unsound mind or absent from Zambia…" the act completely disregards the opinion of the mother in consenting to marriage of her child.

Learner pregnancy retention and re-entry law and policy - In 1997, Zambia adopted the Learner Re-entry policy whose objective is to provide opportunities to girls, who drop out of school as a result of pregnancy, to be able to go back to school after delivery and continue access to education unlike in the past when they were expelled from school. This enables girls not only to acquire further education, but also to have access to comprehensive sexuality education that may contribute to preventing further teenage or early pregnancy and child marriages. Over the years,

the implementation of this policy has faced numerous challenges. Schools have not embraced the policy and data on girls dropping out and making the re-entry is not readily available. The policy puts much emphasis on guiding and counseling as opposed to providing right information and education on CSE and issues of prevention and access to SRH services.

All schools in Zambia are required to grant girls maternity leave for a specified period. The letter of maternity -template reviewed assumes that a girl who becomes a mother automatically gets to be separated from the child to resume school. The policy fails to address the socio-economic barriers that such girls face, i.e. not able to get a caregiver to take care of the child when they resume school. Some faith-based schools prefer the girls to transfer to other schools. This actually applies to even teachers who fall pregnant but are not married. The girls too, face a lot of stigma and would prefer not to resume learning at the same school but go to alternative one. While the policy is good, structural measures have not been put in place towards its successful implementation. The policy has no implementation and monitoring framework for its success.

The government needs to come to the realization that girls who fall pregnant and drop out of school require more support in accessing SRH information and services and continuous counseling to address the barriers in their lives including poverty, harmful cultural practices and lack of community support mechanisms to mentor them and childcare support services.

CSE - Although significant progress has been made in developing and rolling out an in-school comprehensive education curriculum, this is not the case with out of school youth. Currently there is no curriculum that targets them and there is no mechanism of how the in-school youth CSE can be used at community level to reach out to out of school youth. In 2014, Zambia developed and rolled out a comprehensive in-school sexuality education curriculum that is consistent with the UNESCO guidelines on comprehensive sexuality education. The curriculum targets children 10 to 24 years old and caters for grades 5 to 12. However, it was renamed to Life Skills and Health Education (LSHE). This change came about following concerns and opposition from religious leaders and other stakeholders regarding the original CSE curriculum. The Ministry of Education addressed these concerns by revising the curriculum framework and renaming it to LSHE, which

is seen as a more palatable term that focuses on overall health, well-being, and life skills rather than solely on sexuality. Some components of CSE have been integrated in other subjects such as science, biology and civic education. Teachers are therefore expected to teach various CSE in these different subjects.

The Education Act provides for education for all. The CSE program by policy should be for in and out of school youth. However, looking at the limitation of what is approved in the taught curriculum; it limits knowledge and avoids to provide age-appropriate comprehensive sexuality education. The issue of the age of accessing health services including family planning services remains unclear.

Studies undertaken by UNFPA in Zambia on SRHR show that majority of girls who become pregnant while in school (86%) are in primary school (10–14 years) (UNFPA, 2022). This suggests that CSE and SRH services are not reaching that large section of adolescents—a problem requiring immediate remedial action.

The Zambia Education Policy has one of the specific objectives to ensure that education "foster healthy living, physical coordination and growth. The policy is silent on CSE provisions.

The National Youth Policy of 2015 aims to ensure reproductive health education for youths. In policy directive number 4.3, it is the objective of the policy "to increase access to comprehensive, youth-friendly, gender-sensitive sexuality (family life) education." The policy commits to "Promote the provision of Comprehensive Sexuality Education (CSE) and Sexual Reproductive Health (SRH) services that meet the specific needs of youth."

There is no specific law that compels government to ensure public education and communication strategies on HIV, child marriage and GBV. However, several policies have included public sensitization and communication as a central strategy to promote public awareness on these issues. Over the years several campaigns on HIV, sexual and reproductive health, GBV have been launched and implemented nationally. Programs such as "Health Matters", "One Love Kwasila

campaign", Child Health Week, and so on, have been instrumental in raising awareness on various sexual and reproductive and rights matters.

The challenge has been that most of these campaigns are sponsored by CSOs with direct donor funding. This has resulted in significant regression in the face of the current **dwindling donor support** to continue these campaigns. There is need for movement building to encourage government take up such campaigns to ensure continuity of the programs.

There is currently no legislation on **Gestational surrogacy** in Zambia.

Human resources for health and their role in Sexual Reproductive health - Although the WHO recommends a ratio of 2.5 health workers per 1,000 populations to provide the minimum public health and clinical interventions, the corresponding ratio for Zambia is 0.98 health workers per 1,000 populations. Yet, the inclusion of the health workforce as a key strategy to achieve SRH is key in every country, especially for the vulnerable populations.

In Zambia, there is a critical challenge of HRH. Despite the recent strategies to improve HRH, the country has less than half the required WHO recommended HRH workforce in all categories (Mutale W et al, 2013). A high staff turnover at public health facilities, especially in rural areas where there is a net negative migration, is a challenge. At health facility level, disparities in the skills and expertise available at the health facilities. Most of the health cadres do not have necessary skills to provide SRH services (MOH, 2017).

SRH commodities - Despite some policies and national commitments, challenges to accessing the lifesaving commodities remain, especially in rural areas. Main challenges include commodity stock outs and low availability, as well as limited knowledge among clinical and community-based staff on how to prescribe and use them.

At MoH's family planning annual review, the following were found to be challenges regressing SRHR

1. High attrition of trained health care providers in LARC
2. Inadequate equipment in health facilities for the provision of LARC services – especially for IUCDs

3. Low uptake of LARC methods – IUCDs
4. Low male involvement in FP services
5. Stock out of family planning commodities including condoms mainly due to:

   Global strain on full supply of Implants –Implanon and Jadelle hence erratic supply
6. Distribution to the last mile-Lack of adequate transport for distribution to SDPs and community level.
7. Stock out of administrative supplies – e.g. family planning cards and registers
8. Delayed launching of the CIP and the FP2030 Zambia Commitments
9. High numbers of removal of implants 62,631 and 5,035 IUCDs
10. Gaps in Data capturing

The results of a similar study conducted by HAI/MedRAP in 2022 on Availability of Sexual and Reproductive Health Commodities indicate that nine of the 14 family planning commodities in the public sector had an **availability of less than 60%.** The results also show that the public sector had higher availabilities of most of the family planning methods compared to the other sectors. This implies that public sector is the dominant source of family planning commodities in Zambia. However, the levels of availability found in this study fall far **below the WHO target of 80%,** implying that access to quality health services is still limited. This suggests that women, and adolescent girls in particular, face increased health risks, ranging from teenage pregnancies, unplanned pregnancies, to increased risk of HIV and STI infections. For example, the emergency contraceptive pill (levonorgestrel 1.5mg), used to prevent pregnancy when women and girls have unprotected sex or the condom breaks, had an availability of 56% in the public sector, 52% in the private sector, and 14% in the faith-based sector.

Cultural and religious practices - Policy regression and conservative forces have contributed to a decrease in contraceptive access in the public sector, potentially increasing unintended pregnancies, unsafe abortions, and maternal mortality (Final Report, 2020). This highlights the ongoing challenges in maintaining and expanding SRHR services. Movement building and civil society engagement are crucial for advancing SRHR. Supporting civil society organizations and media to influence accountability can help strengthen alliances between providers, clients, and different actors (T. Makama et al, 2024). Social accountability mechanisms have the potential to

make services more responsive to the needs of marginalized groups, though representation of the poorest remains a challenge. Vulnerable populations face significant barriers to SRHR who experience rights violations during asylum processing, even in countries that have international obligations to protect them. Poorer women are more likely to experience earlier sexual debut, have multiple sexual partners, and engage in transactional sex. Education plays a critical role in improving SRHR outcomes. Keeping children in school increases their chances of financial security, reduces exposure to intimate partner violence, lowers HIV infection risk, and provides access to comprehensive sexuality education. Domestic resource mobilization for SRHR remains challenging. Few governments have met the Abuja Declaration target of allocating 15% of their annual budget to health. Alternative financing methods, such as voucher systems, may need to be explored.

These findings underscore the complex interplay between policy, social factors, and economic realities in shaping SRHR outcomes for vulnerable populations. They highlight the need for multifaceted approaches that address both structural barriers and immediate service delivery challenges.

The Zambia Family Planning 2030 commitments - Zambia's Family Planning Program is highly donor dependent. In order to sustain national ownership, the Country needs to increase domestic resource mobilization for Family Planning commodities, service delivery and demand creation. To attain the demographic dividend, there is need to prioritize strategic investments in human capital (health and education) as well as implement sound economic and governance policies.

4: DISCUSSIONS AND RECOMMENDATIONS

This study aimed to review the regression of Sexual and Reproductive Health Rights (SRHR) and analyze efforts made by the Zambian government to address critical issues affecting women and adolescent girls. The review revealed significant challenges, including child marriage, adolescent pregnancy, gender-based violence, regressive policies, beliefs and practices, non-adherence and compliance to policy directives and limited access to SRHR services.

Adolescent girls in Zambia face numerous challenges, including high prevalence of adolescent childbearing. In 2020, 16,419 pregnant girls were reported in primary and secondary schools, with only 7,954 readmitted back. Another challenge is limited access to WASH facilities. This lack of access to sanitation facilities contributes to absenteeism and school dropout. Deep-rooted socio-cultural and gender norms also pose critical barriers to adopting healthy behaviors and demanding quality services. The decision to change Comprehensive Sexuality Education (CSE) to Life Skills Education constitutes a significant level of regression. MedRAP will lead movement-building efforts to advocate for CSE to be taught as an examinable discrete curriculum entity from early childhood education to secondary school level.

The following recommendations are made

1. Harmonize the definition of a child: Support the proposed Constitution of Zambia (Amendment) Bill No. 7 of 2025, which seeks to define a child as a person under the age of 18 for all purposes and intents.

2. Review restrictive policies and legal frameworks: Ensure services and commodities for ASRHR are prioritized at all levels of interventions.

3. Increase public and private sector investment: Enhance and promote wider investment in quality and affordable health services, especially in rural areas.

4. Improve availability of SRHR commodities: Increase allocations towards family planning commodities and ensure a well-functioning supply chain.

5. Conduct regular monitoring and evaluation: Government officials should conduct regular visits to health facilities and schools to monitor adherence to minimum standards in SRHR service provision.

5.0 CONCLUSION

MedRAP's strategic approach to movement-building harnesses the power of Local Medicines Transparency Alliance Networks (LMNs) to catalyze systemic transformation in Sexual and Reproductive Health and Rights (SRHR). Anchored in four interdependent pillars, this framework establishes a robust infrastructure for coordinated, community-driven action.

1. Amplifying Grassroots Advocacy

MedRAP activates LMNs as dynamic advocacy engines operating at both national and district levels. Network members are equipped with the tools and knowledge necessary to engage in Comprehensive Sexuality Education (CSE) policy analysis and to interface effectively with local authorities. This grassroots mobilization fosters informed participation and strengthens community voices in SRHR discourse.

2. Strengthening Multi-Sectoral Coalitions

Through the facilitation of inclusive dialogue platforms, MedRAP brings together diverse stakeholders to bridge ideological divides. These engagements aim to reconcile national policies, legislative frameworks, and CSE guidelines with prevailing cultural and religious values, drawing upon Zambia's own data to ground discussions in local realities.

3. Catalyzing Youth-Led Movements

Youth Accountability Hubs serve as incubators for adolescent leadership, where young advocates are trained to document rights violations and spearhead community campaigns. By humanizing statistical data and elevating lived experiences, these youth-led initiatives render SRHR advocacy more relatable and impactful.

4. Shifting Strategic Narratives

In collaboration with media practitioners, MedRAP co-develops communication tools that reframe SRHR education as a cornerstone of sustainable development and economic resilience. These efforts also spotlight success stories—such as the reintegration of adolescent mothers into educational systems—to inspire public support and policy responsiveness.

To operationalize this strategy, MedRAP convenes stakeholder meetings that foster collaboration among government agencies, civil society organizations, and international partners. These forums serve as critical spaces for presenting research findings, engaging policymakers and duty bearers, and advocating for the effective implementation of existing SRHR policies.

By embracing this multi-dimensional approach, MedRAP aims to expand access to SRHR services—particularly for adolescents and young people—while promoting policy reform, reinstating CSE, and cultivating a culture of transparency and accountability in SRHR governance. Ultimately, this strategy empowers local communities to drive enduring change and contributes to

improved health outcomes and expanded opportunities for women and adolescent girls across Zambia.

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