



May 31, 2011

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary Information on Zambia Scheduled for Review During the 49th Session of the CEDAW Committee

Dear Committee Members:

This letter is intended to supplement the 5th and 6th periodic reports of the government of Zambia, scheduled for review by this Committee during its 49th session. The Center for Reproductive Rights (the Center), an independent non-governmental organization based in New York, with a regional office in Nairobi, Kenya, uses the law to advance reproductive freedom as a fundamental human right. With this submission, the Center hopes to further the work of the Committee by providing information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW or “the Convention”).

This letter highlights several areas of concern related to the status of reproductive and sexual health and rights of women and girls in Zambia. Reproductive and sexual rights are fundamental to women’s health and social equality and an explicit part of the Committee’s mandate under CEDAW. The commitment of States parties to respect, protect, and fulfill these rights deserves serious attention.

We wish to bring to the Committee’s attention the following areas of special concern: the continuing high rates of maternal mortality and morbidity, particularly due to deaths and disabilities resulting from unsafe abortion that occur in spite of Zambia’s comparatively liberal abortion law; the lack of access for women and girls to reproductive healthcare and information, including contraception and HIV/AIDS treatment; the high rate of adolescent pregnancy; and the prevalence of gender-based violence and discrimination affecting women and girls, including early marriage. These problems reflect deficiencies in the Zambian government’s implementation of CEDAW and directly affect the health and lives of women and girls in Zambia.

Of particular concern are recent developments in Zambia’s constitutional review process that could severely restrict women’s reproductive rights in Zambia, rather than maximize this important opportunity to promote and protect women’s rights. This threat comes in the form of language in the most recent draft constitution, which states that life begins at conception. As explained below (*see infra* pp. 5-6), such constitutional language has been used in other countries to restrict access to emergency contraception, assisted reproductive technologies, and safe and legal abortion services – restrictions which have a clear, detrimental impact on women’s health and rights. Although the proposed Constitution of Zambia Bill of 2010

failed to pass in Parliament in March 2011, it may be revived again later this year, and there is no indication that this language will be removed in future proposed bills. We strongly urge the Committee to raise this issue in its questions and recommendations to the Zambian government.

I. RIGHT TO REPRODUCTIVE HEALTHCARE AND INFORMATION (ARTICLES 10, 12, 14(2)(B), AND 16(1)(E))

Ratification of the Convention commits States parties to ensure access “to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning” [Article 10(h)]; “to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning [and to] ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period” [Article 12]; to ensure to rural women “access to adequate health care facilities, including information, counseling and services in family planning” [Article 14(2)(b)]; and to ensure to women the “rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” [Article 16(1)(e)].

A. MATERNAL MORTALITY AND MORBIDITY

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of the pregnancy, irrespective of its duration, from any cause related to or aggravated by the pregnancy or its management.¹ Maternal mortality levels and trends serve as indicators of the health status of women and may point to violations of women’s human rights. The Committee has recognized that high maternal mortality and morbidity rates “provide an important indication . . . of possible breaches of [States parties’] duties to ensure women’s access to health care.”² The Committee has observed that “[m]any women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include ante-natal, maternity and post-natal services” and has further noted that “it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services.”³

State of Maternal Health in Zambia

Improvement of maternal health, which includes a reduction in maternal mortality rates, is also one of the eight Millennium Development Goals (MDGs) agreed to by Zambia.⁴ Under the MDGs, Zambia is expected to attain a reduction of the maternal mortality rate to 162 deaths per 100,000 live births.⁵ As Zambia acknowledges in its recent report to the Committee, however, the country’s maternal mortality rate “remain[s] high” and increased between 1996 and 2002 from 649 to 729 deaths per 100,000 live births.⁶ In its 2002 Concluding Observations, the Committee expressed serious concern over Zambia’s high rate of maternal mortality and recommended that Zambia formulate appropriate policies and allocate sufficient resources to combat this particular problem.⁷

Yet, according to the 2007 Zambia Demographic and Health Survey (2007 ZDHS), the maternal mortality rate remains unacceptably high at 591 deaths per 100,000 live births.⁸ In its recent progress report on reaching the MDG goal of reducing maternal mortality, the World Health Organization (WHO) reported a somewhat lower maternal mortality rate than

the 2007 ZDHS but noted that Zambia had made “no progress” in meeting the MDG for maternal mortality.⁹

In its fifth and sixth periodic reports, the Zambian government attributes its high maternal mortality rate to a “high percentage of unskilled home deliveries, limited access to facilities . . . , lack of transport and poor quality of care” as well as pregnancy and delivery hardships such as “[o]bstructed labor, ruptured uterus, postpartum deaths from haemorrhages, infections and post abortion complications.”¹⁰ In its National Strategic Health Plan 2006-2010, the Zambian Ministry of Health “estimated that approximately 50% of maternal mortality is directly attributed to postpartum hemorrhage, sepsis, obstructed labour, post-abortion complications and eclampsia” and cited “[o]ther contributing factors [to] include delays in accessing healthcare at community and health center levels.”¹¹ In the 2007 ZDHS, 73.5% of Zambian women surveyed likewise reported at least one serious problem in accessing healthcare, including: a lack of drugs, transportation difficulties, the distance to a healthcare facility, and a lack of money for treatment.¹² As the survey further noted, these barriers can also have an impact on a woman’s ability to seek healthcare during pregnancy and assistance during delivery.¹³

In addition, according to the 2007 ZDHS, only 46.5% of live births are assisted by a skilled health worker (described in the survey as a doctor, clinical officer, nurse, or midwife).¹⁴ Further, the disparity in access to skilled healthcare services for urban and rural women is pronounced: 83% of live births in urban areas are assisted by a skilled health worker versus only 31.3% of live births in rural areas.¹⁵ In the absence of a skilled health worker, a relative (25.2%) or traditional birth attendant (23.3%) usually assists during childbirth.¹⁶ Furthermore, according to the survey, over half of the women giving birth in Zambia (50.5%) do not receive any postnatal care.¹⁷ As already acknowledged by the Zambian government itself, lack of access to equipped health facilities and skilled birth attendants contributes to Zambia’s high maternal mortality rate.¹⁸

Adolescent Maternal Health

The high rates of adolescent pregnancy in Zambia also have a significant impact on the health of adolescent mothers. Adolescent mothers suffer from higher rates of maternal mortality and morbidity and are particularly vulnerable to pregnancy-related conditions such as anemia, obstetric fistula, and post-childbirth septic infections due to physical immaturity at time of childbirth, lack of access to antenatal and obstetric care, lower social and economic status, and low levels of education.¹⁹ According to the 2007 ZDHS, the high rate of adolescent pregnancy in Zambia is “a major health concern because of its association with higher morbidity and mortality for both the mother and child” and because it often exacts negative consequences on “female educational attainment.”²⁰

Currently, the rate of adolescent pregnancy in Zambia stands at nearly 28% for girls aged 15-19.²¹ Among 19-year-old women, 54.6% have already begun childbearing.²² Zambian girls with no education (54.3%) are more than twice as likely to start childbearing early as those with a secondary education (20.8%); similarly, adolescents in the lowest wealth quintile (37.2%) are more than twice as likely to start childbearing early as those in the highest wealth quintile (14%).²³ The Zambian government has acknowledged that adolescent mothers are more likely to suffer from higher rates of maternal morbidity and mortality²⁴ and that adolescent pregnancy is one of the country’s “major demographic and public health challenges.”²⁵

Although the Zambian government has recognized maternal health and the reduction of the maternal mortality rate as a national health priority, it has yet to address effectively barriers women face in accessing quality maternal healthcare – and has acknowledged as much in its report. These barriers include a significant shortfall in the availability of qualified medical personnel, the lack of sufficient facilities offering quality maternal healthcare, the lack of necessary medical supplies, and financial barriers to accessing services.²⁶ In June 2010, the government officially launched its Campaign for Accelerated Reduction of Maternal Mortality in Zambia, but the country’s maternal mortality rate remains unacceptably high.²⁷

B. UNSAFE ABORTION AND POST-ABORTION CARE

Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. When death does not result from unsafe abortion, women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain, or infertility. Although national statistics on the prevalence of unsafe abortion in Zambia are not available, according to hospital-based records, unsafe abortions are estimated in Zambia to be the cause of approximately 30% of maternal deaths and one of the top five causes of maternal mortality in Zambia.²⁸ Additional research suggests that up to 80% of all women in Zambia who seek treatment for complications from unsafe abortions are under the age of 19.²⁹

Denying access to a medical procedure that only women need exposes women to health risks not experienced by men, as only women incur the direct physical and emotional consequences of an unwanted or dangerous pregnancy. Such laws also discriminate against young and low-income women in Zambia who are less likely to have the resources to access safe abortion.³⁰ The Committee’s General Recommendation 24 states that “barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”³¹ In its 2002 Concluding Observations, the Committee expressed serious concern about the high level of unsafe abortions in Zambia and recommended that the government implement appropriate reproductive health programs to address this.³²

In Zambia, the legal and policy landscape on abortion is highly complex and does not facilitate access to safe and legal abortion. Recent developments in the constitutional review process threaten to further complicate the situation and impede women’s access. The Termination of Pregnancy Act of 1972 (TOP Act) permits abortion in Zambia when the pregnancy is terminated by a registered medical practitioner if continuation of the pregnancy (1) would involve risk to the life of the woman, risk of injury to the physical or mental health of the woman, or risk of injury to the physical or mental health of any of the woman’s existing children, that is greater than if the pregnancy were terminated, or (2) would result in the birth of a child with “such physical or mental abnormalities as to be seriously handicapped.”³³ The law permits providers to take the woman’s “actual or reasonably foreseeable environment or . . . her age” into account when determining whether continuation of the pregnancy would involve any of the enumerated risks.³⁴ The Zambian Penal Code, however, still criminalizes unlawful abortion, authorizing sentences of up to fourteen years in prison for women who unlawfully procure an abortion and up to seven years for the person providing the abortion.³⁵

Yet, despite the exceptions provided for under Zambia’s abortion law, access to safe and legal abortion in Zambia remains limited. Though the Penal Code provides an exception for

termination of pregnancy for a female child in cases of rape or defilement,³⁶ the TOP Act itself does not explicitly provide for abortion in cases of rape or incest and further contains procedural barriers that severely restrict access to safe and legal abortion services for many women in Zambia. Notably, except under emergency circumstances, an abortion must be obtained in a hospital and be approved in advance by the abortion provider as well as two other registered medical practitioners, one of whom has specialized in “the branch of medicine in which the patient is specifically required to be examined.”³⁷

The procedural requirement that an abortion must be performed by a “registered medical practitioner” is arbitrary and unnecessary as key studies by the WHO and others have demonstrated that first-trimester abortions, for instance, can be safely and capably performed by mid-level healthcare providers, such as nurses and clinical officers.³⁸ The “registered medical practitioner” requirements are particularly burdensome in light of the scarcity of this cadre of medical professionals in Zambia. A 2009 Guttmacher Institute report noted that, as of 2004, there were only 1.3 physicians for every 10,000 Zambians.³⁹ The requirement that an abortion take place in a hospital is equally arbitrary and burdensome by failing to take into account the fact that many women, particularly in rural areas, may not have access to a hospital and that certain procedures, particularly first-trimester abortions which typically involve either medical abortions or vacuum aspiration, may safely take place at lower level health facilities rather than hospitals.⁴⁰

The Zambian government, however, has recognized that legal and practical barriers exist under the country’s abortion law. In May 2009, the Zambian Ministry of Health published a series of standards and guidelines for administering comprehensive abortion care, including post-abortion care services for abortion complications. The standards and guidelines provide clarification for medical providers on the abortion provisions under Zambian law, including a broader interpretation of the law, for instance, to cover abortion in cases of rape or defilement for both women and girls; how to implement the legal provisions; and how to provide safe abortion services and manage abortion complications.⁴¹ In particular, the standards and guidelines acknowledge that abortion is a safe procedure when performed by a trained service provider under hygienic conditions, without categorically requiring that abortions be performed only in hospitals by trained doctors.⁴²

Specifically, the standards and guidelines recognize that skilled health providers other than doctors may perform abortions with proper training, stating that the Zambian Ministry of Health “shall make provision for all trained and skilled health providers to administer drugs [and manual vacuum aspiration procedures] for termination of pregnancy in accordance with” Zambian law and that “[w]ith appropriate training, health care providers who are not doctors (mid level providers) can provide first trimester manual vacuum aspiration abortions as safely as doctors can.”⁴³ Furthermore, the standards and guidelines state that “[t]ermination of pregnancy is a safe procedure when performed under hygienic conditions with the right equipment by trained providers,” recognizing that the different stages at and conditions under which a pregnancy is terminated will determine the type of facility and health system level at which the patient is treated.⁴⁴

It remains unclear, however, whether healthcare providers are aware of the provisions permitting abortion under Zambian law or the guidelines, and some healthcare providers stigmatize women seeking abortions and, accordingly, give these women lower quality care.⁴⁵ A 2010 news report cited one example of a woman who sought an abortion from a clinic, where the healthcare provider asked her if the reason she wanted to terminate the

pregnancy was that she had committed adultery since the healthcare worker saw no justifiable health reason for wanting to terminate the pregnancy. The healthcare worker demanded that the woman go through couples counseling with her husband before undergoing the abortion. Eventually, the woman resorted to an herbal remedy from a traditional healer, which caused such terrible hemorrhaging that she had to have a hysterectomy in a hospital.⁴⁶

Recent constitutional developments threaten to undermine any progress the government has made in addressing the scourge of unsafe abortion. Zambia is one of only four countries in Africa, and a handful of countries worldwide, specifically to address abortion in the text of its Constitution.⁴⁷ The Zambian Constitution currently states that no person shall “deprive an unborn child of life by termination of pregnancy” except where authorized by an Act of Parliament.⁴⁸ Zambia is currently undergoing a constitutional review process, which presents an opportunity to affirm individual rights and freedoms, including women’s rights, and to remove any unnecessary language concerning termination of pregnancy. Zambia, however, retained in the Constitution of Zambia Bill of 2010, the same provision regarding termination of pregnancy and added highly problematic language stating that “[e]very person has . . . the right to life, which begins at conception.”⁴⁹ Although this bill failed to pass in Parliament in March 2011, it may be revived after six months.⁵⁰

Language in the draft Constitution stating that life begins at conception may have serious, harmful repercussions for women’s health and rights and directly contravenes international human rights law, which does not recognize the right to life prior to birth.⁵¹ In other countries where such language has been constitutionally adopted, the primary objective has been to restrict further a country’s existing abortion law and to ensure both that any future liberalization of the law is rendered more difficult and that an expansive interpretation of the existing law in the courts is precluded.⁵² Proponents of such language argue that it guarantees a fetal right to life and seek to limit access to safe and legal abortion on this basis – violating women’s human rights and, in Zambia, potentially leading to even higher maternal mortality and morbidity rates from unsafe abortion than currently exist.

Further, this type of language can be – and has been – used to restrict women’s access to emergency contraception and fertility treatments, where courts, legislators or health regulators choose to define conception as beginning at the moment of fertilization and to offer rights protections to the fertilized egg. For example, constitutional courts in Ecuador, Chile, and Peru have issued decisions, based on inaccurate scientific arguments, limiting access to emergency contraception on the grounds that their constitutions protect the right to life from conception⁵³; similarly, in 2000, the Costa Rican Constitutional Chamber banned in vitro fertilization (IVF), on the basis that some fertilized eggs or embryos might perish in the IVF process, violating the frozen embryos’ right to life from conception.⁵⁴

Experience clearly shows that this language may pose a serious threat to women’s human rights. Should it be used to restrict access to abortion, contraception and fertility treatments, it may also contravene Zambia’s obligations as a signatory of CEDAW to protect, promote and respect women’s fundamental human rights. As such, the statement that life begins at conception should not be included in the Zambian Constitution, and we strongly urge the Committee to raise this issue with the government of Zambia during its review.

C. ACCESS TO COMPREHENSIVE FAMILY PLANNING SERVICES AND INFORMATION

Access to family planning services and information is central to protecting the rights of women and girls to life and health. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe illegal abortions that can result in complications or death. Moreover, lack of contraceptive access affects a woman's right to control her fertility, her right to decide whether to have children and the number and spacing of children, and her right to self-protection against sexually transmissible infections (STIs), including HIV/AIDS.

Contraceptive Access in Zambia

Access to contraception in Zambia is undermined by a number of factors, notably shortfalls in contraceptive delivery systems and in providing comprehensive family planning information, including information about emergency contraception (EC). According to a recent Guttmacher Institute report, 41% of births in Zambia are unplanned,⁵⁵ and the Zambian Ministry of Health has acknowledged that “[u]nplanned pregnancy is prevalent and common in Zambia” with women in Zambia having an average of one more child than desired.⁵⁶ According to the 2007 ZDHS, 27% of all married Zambian women and 18% of all Zambian women (married and unmarried) have an unmet need for family planning, meaning that these women want to limit the number of children or delay childbirth but are not using contraception.⁵⁷ Women in rural areas have a higher rate of unmet need (28.2%) than women in urban areas (23.2%).⁵⁸ Currently married women with no or only a primary education (28% for each group) are more than twice as likely to have an unmet need for family planning as compared with women with more than a secondary education (13%).⁵⁹ While unmet need for family planning decreases with higher education and economic status, nearly one out of five women (19%) in the highest wealth quintile have an unmet need.⁶⁰ Further, according to the survey, few Zambian women (only 8.6%) start using contraception before they begin childbearing.⁶¹ Approximately one out of three women (29.4%) already have one child when they first begin using contraception, suggesting that some women may not have access to sufficiently comprehensive family planning information in order to make informed decisions about childbearing and the number and spacing of children.⁶²

Past studies on family planning and EC completed by the WHO and Population Council demonstrate that the principal barriers to obtaining contraception in Zambia include the following: (1) cultural and provider biases, which marginalize unmarried women, women who do not obtain consent from their male partners, and adolescents; (2) poorly trained service delivery personnel and inefficient delivery systems; and (3) a narrow range of available contraceptives.⁶³

Cultural and provider biases represent significant barriers to accessing EC. Past studies have confirmed that unmarried women and adolescents prefer to obtain EC in pharmacies or non-clinic based settings where they encounter more friendly providers.⁶⁴ This creates additional financial burdens for women. The 2007 ZDHS reported that approximately only 10% of women pay for contraception in the public sector while 70% of women pay in the private sector, suggesting that users who feel marginalized in public clinic-based settings may face financial barriers to accessing contraception, including EC, if obliged to purchase them in the private sector.⁶⁵ In addition, the 2007 ZDHS reported that only 9.3% of women and 11.4%

of men have knowledge of EC and that only 0.5% of women have actually used EC, indicating also a deficiency in access to and information about EC.⁶⁶

Adolescent Access to Contraception

As already noted in the WHO and Population Council studies, the contraceptive gap is particularly worrying among Zambian adolescents, where many young adults choose to purchase contraception from chemists and pharmacies because traditional clinics lack youth-friendly family planning services, thus creating financial barriers to access because they feel obliged to pay for contraception in the private sector rather than obtain it for free in public clinics.⁶⁷ The 2005 Zambia HIV/AIDS Service Provision Assessment Survey similarly reported that only approximately one out of three public and private health facilities providing services for voluntary HIV/AIDS testing and counseling and prevention of mother-to-child transmission also offered youth-friendly services.⁶⁸

The Committee has asked States parties to pay particular attention to “the health education of adolescents, including information and counseling on all methods of family planning”⁶⁹ and to ensure “the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality.”⁷⁰ The Committee has also specifically recommended that States parties develop preventive programs to address the problem of high rates of adolescent pregnancy and unsafe abortion.⁷¹ Research demonstrates that adolescents who initiate sex at an earlier age are typically at higher risk of becoming pregnant, which carries adverse health and education consequences for adolescent mothers, or of contracting STIs than those who delay first sexual intercourse and thus have a shorter duration of exposure to these risks.⁷² In Zambia, more than half of young women (58.5%) and men (51.1%) age 18-24 have reported first having sexual intercourse before age 18.⁷³ Consequently, it is critical for Zambia to make available to young men and women in a youth-friendly setting the family planning services and reproductive health information that they need to make informed choices and thus protect themselves against early pregnancy and STIs.

II. VIOLENCE AND DISCRIMINATION AGAINST WOMEN AND GIRLS (ARTICLES 1, 2, 12, 14, AND 16)

States parties are obligated under CEDAW to take steps to eliminate sex-based discrimination by both public and private actors.⁷⁴ This requirement of non-discrimination permeates all of Zambia’s duties under CEDAW, including the obligation “to eliminate discrimination against women in all matters relating to marriage and family relations” [Article 16(1)].⁷⁵ In addition, the Committee has determined that States parties have an obligation under the CEDAW “to eliminate all forms of violence against women,” as discrimination against women includes gender-based violence.⁷⁶

In its 2002 Concluding Observations, the Committee asked for the repeal of Article 23(4) of the Zambian Constitution, which permits discriminatory laws to exist in the areas of personal and customary law that most adversely affect women, namely marriage, divorce, property, inheritance, and family relations.⁷⁷ The existing Constitution is inherently contradictory as Article 11 recognizes the equality of men and women before the law and subsections (1) and (3) of Article 23 forbid discrimination on the basis of sex, yet Article 23(4) permits discrimination to continue in areas of marriage, family, and customary law.⁷⁸ In the recent debate over a new Zambian Constitution, the Special Rapporteur on Violence Against

Women expressed concern to Zambian officials at the conclusion of her visit in December 2010 that the 2010 draft Zambian Constitution retained provisions related to Article 23(4) despite the Committee's earlier call for its repeal.⁷⁹ Although the Zambian Parliament failed to pass legislation for a new Constitution in March of this year, the bill may be reconsidered after six months, and it is unclear whether government officials have any intention of removing this provision.⁸⁰

A. SEXUAL AND PHYSICAL VIOLENCE

Gender-based violence (GBV), including sexual and physical violence, continues to be a serious problem in Zambia affecting the health and human rights of women and girls. In its 2002 Concluding Observations, the Committee expressed its serious concern "at the high level of violence against women and girls, including domestic violence and marital rape."⁸¹ It "urge[d] [Zambia] to assign the issue of violence against women high priority and to recognize that such violence" is a violation of CEDAW.⁸² It also requested that Zambia enact legislation addressing domestic violence and implement a zero tolerance policy towards GBV.⁸³

In 2008, the Zambian Gender in Development Division (GIDD) released a multi-year national action plan on GBV, likewise noting that violence against women and girls is common in Zambia, that adequate legal and social service protections do not exist for women and changes to Zambian laws and policies must be enacted, and that a coordinated multi-sector response by government and civil society actors is necessary.⁸⁴ The GIDD national action plan specifically called for the passage of the pending anti-GBV bill as well as enactment of laws addressing domestic violence, common definitions of GBV offenses, harmonization of customary and statutory law where customary law does not adequately respond to GBV cases, and policies to support coordinated health, psychosocial, and legal responses to GBV and to raise awareness about GBV among government officials.⁸⁵ For example, while a recent Population Council study in the Copperbelt province determined that Victim Support Units (VSUs), which commenced operation in 1994 in police stations to assist survivors of violence and are now operating countrywide,⁸⁶ are effective providers of EC to survivors of sexual violence (likewise concluding that the EC project could be scaled up nationally),⁸⁷ the VSUs still lack resources, proper data collection techniques, and consistent training on how to handle and address GBV cases.⁸⁸

While sexual and gender-based violence is generally under-reported in Zambia and difficult to quantify,⁸⁹ the 2007 ZDHS indicates that 51.9% of all Zambian women have experienced either physical or sexual violence.⁹⁰ Data also showed that nearly half of all Zambian women (46.8%) have experienced physical violence since they were 15 years old and that approximately one out of three women experienced physical violence in the 12 months preceding the survey.⁹¹ 70.3% of ever-married women age 15-49 reported that the abuse was perpetrated by their current husband or partner,⁹² and 39.6% of ever-married women aged 15-49 experienced some form of physical violence by their husband or partner in the 12 months preceding the survey.⁹³

One in five Zambian women (20.2%) has experienced sexual violence,⁹⁴ and 42% of all women with experience of sexual violence reported that their current husband or partner committed the abuse.⁹⁵ The 2007 ZDHS also showed that 16% of ever-married women age 15-49 had experienced some form of sexual violence by their husband or partner in the 12 months preceding the survey.⁹⁶ Data showed that 15% of women who have experienced

sexual violence were age 14 or younger and that 20.1% were between ages 15-19 when they were first sexually assaulted, meaning that one out of three Zambian women in this group was first sexually assaulted as an adolescent.⁹⁷ The 2004 Zambia Global School Health Survey also reported that approximately one out of three female students surveyed had been physically forced to have non-consensual sex.⁹⁸ While specific statistics concerning sexual violence against girls in schools are not readily available, reports document sexual abuse of girls in schools.⁹⁹ Of particular note is the case of a 13-year-old girl who was raped by her teacher at a Lusaka school for which she received a judgment for compensatory damages in 2008 from the High Court of Zambia.¹⁰⁰ The judge in the case further called upon the Zambian Ministry of Education to enact regulations to address the issue of sexual violence in schools.¹⁰¹ It is unclear what steps the Ministry of Education has taken in this regard since the 2008 decision was issued.

Cultural and societal views perpetuate violence against women, with more than three out of five Zambian women (61.9%) believing that physical violence by a husband against his wife is justified in at least one circumstance¹⁰² and nearly half of Zambian men (48.2%) believing that physical violence under similar circumstances is likewise justified.¹⁰³ With regard to a wife's justification for refusing sexual relations, only 39% of Zambian women believed that a wife was justified in all three suggested circumstances – namely, where the husband knows he has an STI, the husband sleeps with other women, and when she is tired or not in the mood.¹⁰⁴ Views that legitimize spousal abuse were recently highlighted when, in September 2010, two Zambian political leaders were criticized in news reports when they severely beat their wives during domestic disputes and when one of the leaders reportedly remarked that “he beat his wife because he loved her.”¹⁰⁵

In its report to the Committee, the Zambian government recognized that gender-based violence is “an area of concern that requires immediate attention.”¹⁰⁶ The government of Zambia also noted an increase of nearly 400% between 2000-2005 in reported cases of defilement (from 306 cases in 2000 to 1,511 cases in 2005); the government reported that cases of rape increased from 129 in 2001¹⁰⁷ to 308 in 2003 and then decreased to 216 by 2005.¹⁰⁸ Even when victims do report rape and defilement, the rates of conviction by Zambian authorities are low: between 2000-2004, for example, only 19.4% of rape cases and 18.7% of defilement cases resulted in convictions.¹⁰⁹

Despite these high rates of physical and sexual violence, The Anti-Gender-Based Violence Bill 2010, and the accompanying amendments to the Penal Code, have only recently passed through Parliament and have not yet been signed into law.¹¹⁰ While the country's Penal Code was revised in 2005 to provide stiffer penalties for certain sexual offenses,¹¹¹ it does not contain any provisions defining marital rape, and the 2010 Penal Code amendments, which have not yet been signed into law, made no such changes in this regard either.¹¹²

B. HEALTHCARE FOR AND TREATMENT OF HIV-POSITIVE WOMEN

The Committee has noted that “issues of HIV/AIDS and other sexually transmitted [infections] are central to the rights of women and adolescent girls to sexual health,” and has urged States parties to ensure “without prejudice and discrimination, the right to sexual health information, education and services for all women and girls.”¹¹³ Furthermore, in its 2002 Concluding Observations, the Committee “urge[d] [Zambia] to ensure that women and girls... with HIV/AIDS are not discriminated against and are given appropriate assistance.”¹¹⁴ Zambia, however, has failed to prevent discrimination against women and

girls on the basis of HIV status and to provide adequate health services and access to preventive measures, including family planning and information, in order to empower women to protect themselves against HIV/AIDS and other STIs.

Zambia still faces a generalized HIV epidemic. The 2007 ZDHS showed an overall HIV prevalence rate of 14.3% among men age 15-59 and women age 15-49, and women still faced a higher overall rate (16.1%) than men (12.3%).¹¹⁵ Adolescent women in Zambia also remain at particular risk of HIV transmission. Young women age 15-24 were particularly vulnerable with an overall HIV prevalence rate that is twice that of young men in the same age group (8.5% for women versus 4.3% for men), and HIV prevalence among young women age 15-19 years (5.7%) is likewise greater than that of young men in the same age group (3.6%).¹¹⁶ This disproportionate risk to women is rooted in social and cultural factors that lead to women beginning sexual activity at younger ages, often due to early marriage, as well as the prevalence of coerced sex and age disparities between young girls who have sex with older men.¹¹⁷

A 2007 Human Rights Watch report documented significant gender-based abuses impeding the ability of women to seek HIV-related treatment and serious shortfalls in the Zambian government's response to these abuses.¹¹⁸ Women surveyed for the report described physical, sexual, and psychological abuse at the hands of their partners when they attempted to discuss their HIV status or treatment with them and its profound adverse impact on their ability to seek out and continue appropriate anti-retroviral treatment.¹¹⁹ Women interviewed also identified unequal property rights and the feared loss of property as a result of divorce, abandonment, or a husband's death – due, for instance, to mistreatment by the husband or husband's family following disclosure of the woman's HIV status – as obstacles hindering their access to and continuation of treatment.¹²⁰

The report identified significant inadequacies in the Zambian government's response to these problems. While the government had incorporated gender considerations into its national HIV/AIDS and development policies, healthcare facilities in Zambia administering HIV treatment did not address GBV because existing health protocols and training guidelines did not cover it and because healthcare workers and HIV counselors were not equipped to identify and handle it.¹²¹ In addition, the report noted that other major hindrances in the Zambian health system were the shortage of personnel and inadequate infrastructure and number of healthcare facilities.¹²² The report also noted shortcomings in the Zambian legal system concerning domestic violence and inadequate legal protections of women's property rights¹²³ as well as lack of resources for and training of law enforcement and lack of legal and social support services.¹²⁴

Research by the Southern Africa Litigation Centre (SALC) on the reproductive health concerns of HIV-positive women in Zambia concluded that women living with HIV do not have safe spaces in which to discuss their health concerns.¹²⁵ Women surveyed noted that they had difficulty accessing contraception, for instance, due to unavailability or lack of information; that alternative forms of contraception, other than condoms, were generally not promoted for HIV-positive women; and that these alternative forms of contraception were not always available in public clinics, so the women were then obliged to purchase their contraception in the private sector.¹²⁶ They also had difficulty negotiating safe sex practices with their male partners as a result of economic dependency, poverty, and violence.¹²⁷

In addition, the women reported pressures from healthcare providers to be sterilized,¹²⁸ a coercive practice that the Committee has stated must be prevented by governments¹²⁹ and that violates, among other fundamental rights, a woman's right to information, right to physical and mental integrity, and right to reproductive autonomy.¹³⁰ Forced and coercive sterilization also causes lasting adverse consequences to a woman's physical and mental health, such as robbing a woman of her reproductive capabilities and risking her alienation from her partner and family.¹³¹ Women interviewed in the SALC study also recognized that unsafe abortions could lead to heavy bleeding and death, and several interviewees had either known of HIV-positive women who died or witnessed HIV-positive women die as a result of unsafe abortions.¹³² They felt that the Ministry of Health should be responsible for assuring that free, safe abortion services are available to women.¹³³

C. EARLY MARRIAGE

The Committee has identified 18 as the appropriate legal age of marriage for both men and women and has rejected arguments in support of an earlier marriage age for girls because of the associated risks to their health and education.¹³⁴ Married girls often receive little or no schooling, have limited autonomy and decision-making power within the couple, particularly where they are married to much older spouses, are vulnerable to increased rates of maternal mortality and morbidity, and are at greater risk for HIV infection.¹³⁵

Despite these facts and the Committee's recommendation, the minimum legal age for marriage in Zambia is 16, and parental consent is required if either party marries below the age of 21.¹³⁶ In practice, however, as the statistics also bear out, the cultural preference for early marriage is widespread, particularly since girls are viewed as a source of income and wealth for payment of their dowries upon marriage.¹³⁷ The Zambian government's report states that early marriage is still practiced and that the payment of *lobola*, or bride price, remains a factor in the traditional marriage process, and where *lobola* is paid, "the husband has absolute rights over children and the reproductive rights of the wife."¹³⁸ In its 2002 Concluding Observations, the Committee expressed concern over the competing duality of Zambian statutory and customary law, which often discriminates against women, in the arena of marriage and family relations.¹³⁹

The statistics for Zambia over the past several years indicate that early marriage for girls is prevalent. For instance, a 2009 Population Council and UNFPA report on adolescents in Zambia observed that nearly one in five girls between 15-19 were then married or already divorced, separated, or widowed and that the total number of girls age 15-24 either in unions or divorced, separated, or widowed reached an astonishing 93.2%.¹⁴⁰ In 2005, UNICEF similarly reported that 42.1% of girls between 20-24 were married by the age of 18.¹⁴¹ Of this group, nearly half did not know how to prevent HIV infection, and nearly one-third had never used any form of contraception, making girls in such circumstances highly vulnerable to risks related to HIV infection and pregnancy.¹⁴²

The Zambian government has also recognized that, in addition to early marriage, early pregnancy and the withdrawal of girls from school still occur and present challenges for attaining gender parity in education.¹⁴³ In its 2002 Concluding Observations, the Committee likewise expressed its concern at "the high dropout rate of girls [from school] due to pregnancies" and urged Zambia "to strengthen its efforts . . . to prevent girls dropping out of school."¹⁴⁴ While the Zambian Ministry of Education formally instituted a re-entry policy for pregnant school girls in 1997, reports suggest that the policy still faces some resistance

from society, educators, and parents, though much less so than when the policy was first instituted.¹⁴⁵ In addition, reports suggest that return rates are still low and that girls who return to school may also be socially stigmatized or singled out by peers.¹⁴⁶

We hope that the Committee will consider addressing the following questions to the government of Zambia:

1. In view of Zambia's elevated maternal mortality rate, how is the government implementing its Campaign for Accelerated Reduction of Maternal Mortality (CARMM) in Zambia and what resources is the government applying to ensure CARMM's success? What other concrete measures does the government propose to take to reduce the number of deaths due to pregnancy and childbirth-related complications? What steps are being taken to ensure that healthcare facilities are adequately equipped and personnel adequately trained to provide quality, hygienic maternal healthcare? Since CARMM's inauguration in June 2010, can the government point to any specific results reached towards the goal of reducing the maternal mortality rate?
2. Data indicate that approximately 30% of all maternal deaths are caused by unsafe abortions and that it is one of the top five causes of maternal mortality, due at least in part to lack of information and understanding among health providers about Zambia's abortion law. How does the government propose to educate the public, including doctors, about the country's abortion law and to ensure access to equipped healthcare facilities and availability of trained personnel in order to reduce the high rate of maternal death and disability associated with unsafe abortions? How are the *Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia* that were issued in 2009 being implemented? What steps are being taken to ensure that safe, legal abortions can be obtained in public hospitals in accordance with the existing abortion law and guidelines?
3. In view of the ambiguities created by the proposed provision in the draft Constitution stating that life begins at conception and its potential harmful repercussions on the reproductive rights and health of Zambian women, how does the government propose to ensure that this provision is not adopted as part of the draft Constitution?
4. Can the government otherwise update the Committee on the status of the constitutional review process in Zambia? What efforts are being made to repeal contradictory provisions of Article 23 of the Zambian Constitution, in accordance with the Committee's 2002 request, which prohibit sex discrimination but make exceptions in particular matters of family and inheritance as well as customary law, where women are most adversely affected?
5. How does the government propose to improve access to family planning services and information to address the unmet need for contraception in Zambia? How does the government propose to reach youth in terms of education about family planning options, particularly as it relates to reduction of adolescent pregnancy rates and prevalence of HIV/AIDS among adolescents?

6. What steps are being taken to make access to EC and HIV post-exposure prophylaxis a reality for survivors of sexual violence? In view of the reported success in establishing VSUs in police stations countrywide, and also the provision of EC via trained VSU officers, how does the government propose to continue supporting expansion and training of VSUs and making EC available to all survivors of sexual violence, either via VSUs or healthcare facilities?
7. In 2008, the High Court of Zambia awarded compensatory damages to the family of a 13-year-old girl who had been raped by her teacher, and called upon the Ministry of Education to enact regulations to address sexual violence in schools. How does the government propose to address sexual violence against girls in schools? What steps are being taken by the Zambian government to enact the regulations called for by the High Court?
8. In view of the high HIV prevalence rates in Zambia, and in particular, the higher rate of HIV prevalence among women and girls, what steps are being taken to address the reproductive health and family planning needs of HIV-positive women and girls? What steps are being taken to incorporate training and awareness of GBV by HIV counselors and healthcare providers at HIV treatment centers? What steps are being taken to educate healthcare providers on the reproductive health concerns and rights of HIV-positive women, in particular, with regard to contraception and forced sterilization?
9. What steps are being taken to address the elevated rates of early marriage for girls in Zambia? How does the government propose to address harmonizing customary and statutory regimes for marriage and family relations with Zambia's obligations under CEDAW, particularly where those regimes discriminate against women and girls?
10. Can the government update the Committee on the legislative status of The Anti-Gender-Based Violence Bill and related amendments to the Penal Code recently passed by Parliament? How does the government plan to implement the bill's provisions? How does the government plan to address marital rape, which is still not defined, even in the most recent amendments to the Penal Code?

We hope that the Committee will consider making the following recommendations to the government of Zambia:

1. The government should demonstrate its commitment to reducing maternal mortality and morbidity by increasing the number of healthcare facilities that are fully equipped to provide comprehensive maternal healthcare and by increasing the number of skilled health providers available to offer quality antenatal and postnatal care as well as assistance during childbirth.
2. The government should demonstrate its commitment to reducing the high maternal mortality rate due to unsafe abortions by educating the public and doctors about Zambia's existing law, by ensuring that doctors and other healthcare personnel receive the training necessary to provide safe and legal abortions and quality post-abortion care, and by providing healthcare facilities with appropriate equipment and personnel to provide safe abortions and proper post-abortion care.

3. The government should ensure that, as the constitutional review process continues, future constitutional drafts contain no language stating that life begins at conception or referring to when life begins and make no reference to abortion, a medical procedure better addressed through legislation or regulations and not in the framework of a constitution. The current TOP Act should also be amended to allow abortion explicitly in cases of rape and incest. The government should harmonize the TOP Act with the existing standards and guidelines, such that the administrative requirements of the existing law are modified by allowing mid-level providers to perform abortions, by allowing women to obtain safe, legal abortions in healthcare facilities other than hospitals, which are not often within easy reach of women, particularly in rural areas, and by eliminating the requirement that three doctors give advance approval of a request for an abortion.
4. The government should make concerted efforts to ensure an adequate and consistent supply of contraceptives, including EC, and initiate campaigns to ensure that women and youth have proper, non-judgmental access to family planning information, paying special attention to the prevention of adolescent pregnancy and the control of STIs. The government should also allocate additional resources and training to VSUs to enable greater multi-sector collaboration for survivors of gender-based violence and to ensure that VSU officers are dispensing EC.
5. The government should demonstrate its commitment to improving access to services and treatment for HIV-positive women by incorporating GBV concerns into healthcare protocols and by training healthcare providers and HIV counselors to identify and respond to gender-based abuse of HIV-positive women.
6. Per the Committee's earlier request, the government should repeal Article 23(4) of the existing 1996 Constitution, which permits discrimination against women in matters of family and marriage and under customary law. Likewise, in accordance with the Committee's recommendations, the government should amend Zambian law to set the minimum legal age for marriage at 18.
7. The government should amend the Zambian Penal Code to include marital rape as a punishable offense and to remove any provisions criminalizing abortion.
8. The government should demonstrate its support for passage of The Anti-Gender-Based Violence Bill and related Penal Code amendments by allocating sufficient resources to implement the bill's provisions, particularly as they relate to filing of complaints with police, issuing orders of protection by courts, establishing shelters for survivors of violence, and funding the Anti-Gender-Based Violence Committee and Fund. The government should also enact regulations to address sexual violence against girls in schools.
9. The government should continue to raise awareness among students, educators, and parents about its school re-entry policy allowing pregnant girls and adolescent mothers to stay in or return to school, and it should enforce penalties where schools fail to comply.

We hope that this information is useful as the Committee prepares to review the Zambian government's compliance with CEDAW. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

Elisa Slattery
Regional Director
Africa Program
Center for Reproductive Rights

¹ WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2008, 4 (2010), available at <http://www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html> [hereinafter TRENDS IN MATERNAL MORTALITY].

² Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Women and health*, (20th Sess., 1999) para. 17, U.N. Doc. A/54/38 (1999) [hereinafter CEDAW Committee, *General Recommendation No. 24*].

³ *Id.* para. 27.

⁴ UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 30-31 (2010), available at <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20low%20res%2020100615%20-.pdf>; TRENDS IN MATERNAL MORTALITY, *supra* note 1, at 3.

⁵ MINISTRY OF HEALTH, GOVERNMENT OF THE REPUBLIC OF ZAMBIA, NATIONAL HEALTH STRATEGIC PLAN 2006-2010 15, tbl. 6 (2005), available at http://www.moh.gov.zm/files/shared/alth_Strategic_Plan_Revised_July_20__2006_1_.pdf [hereinafter ZNHSP 2006-2010].

⁶ Government of Zambia, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: Combined 5th and 6th periodic reports of States parties: Zambia*, paras. 19, 131, U.N. Doc. CEDAW/C/ZMB/5-6 (2010) [hereinafter Zambia Government Report (2010)].

⁷ CEDAW Committee, *Concluding Observations: Zambia*, paras. 242-43, U.N. Doc. A/57/38 (Part II) (2002) [hereinafter *Concluding Observations: Zambia* (2002)].

⁸ CENTRAL STATISTICAL OFFICE [ZAMBIA] ET AL., ZAMBIA DEMOGRAPHIC AND HEALTH SURVEY 2007, 253, tbl. 15.4 (2009), available at <http://www.measuredhs.com/pubs/pdf/FR211/FR211%5BRevised-05-12-2009%5D.pdf> [hereinafter 2007 ZDHS].

⁹ TRENDS IN MATERNAL MORTALITY, *supra* note 1, annex 3, at 32 (reporting a rate of 390 deaths per 100,000 live births in 1990, which peaked at 600 in 2000 and dropped to 470 in 2008).

¹⁰ Zambia Government Report (2010), *supra* note 6, para. 131.

¹¹ ZNHSP 2006-2010, *supra* note 5, at 32; see also Brenda Zulu, *Women and Maternal Mortality*, TIMES OF ZAMBIA, Mar. 9, 2011 (discussing challenges to maternal health in Zambia to include lack of skilled birth attendants, equipped medical facilities, and access to emergency obstetric care), available at <http://allafrica.com/stories/201103100012.html>.

¹² 2007 ZDHS, *supra* note 8, at 136-37, tbl. 9.10.

¹³ *Id.*

¹⁴ *Id.* at 131-32, tbl. 9.6.

¹⁵ *Id.* at 132, tbl. 9.6.

¹⁶ *Id.* at 131-32, tbl. 9.6; MINISTRY OF HEALTH, GOVERNMENT OF THE REPUBLIC OF ZAMBIA, ANNUAL HEALTH STATISTICAL BULLETIN 2008 60 (2009), available at <http://www.moh.gov.zm/?q=content/2008-annual-health-statistical-bulletin> [hereinafter ANNUAL HEALTH STATISTICAL BULLETIN].

¹⁷ 2007 ZDHS, *supra* note 8, at 134, & tbl. 9.8.

¹⁸ See Zambia Government Report (2010), *supra* note 6, para. 131; see also Zulu, *supra* note 11.

¹⁹ WHO & UNFPA, PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 10-11, 13-15 (2006), available at http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.

²⁰ 2007 ZDHS, *supra* note 8, at 64.

²¹ *Id.* at 64, tbl. 4.9.

²² *Id.*; Gilbert Kaimana, *MSI Zambia out to promote family planning*, TIMES OF ZAMBIA, June 18, 2009 (on file at the Center for Reproductive Rights); News Release, Marie Stopes International, MSI Zambia launch generates frank support from government (June 16, 2009), *available at* http://www.mariestopes.org/News/International/MSI_Zambia_launch_generates_frank_support_from_governm ent.aspx [hereinafter News Release, MSI Zambia].

²³ 2007 ZDHS, *supra* note 8, at 64, tbl. 4.9.

²⁴ Zambia Government Report (2010), *supra* note 6, para. 132.

²⁵ MINISTRY OF HEALTH, GOVERNMENT OF THE REPUBLIC OF ZAMBIA, STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION MORBIDITY AND MORTALITY IN ZAMBIA vi (2009) [hereinafter STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION].

²⁶ ZNHSP 2006-2010, *supra* note 5, at 24-25, 51-52, 57-59; *see also* ANNUAL HEALTH STATISTICAL BULLETIN, *supra* note 16, at 36-38, tbls. 4.2a, 4.2b & 44-46, tbls. 5.1, 5.2.

²⁷ Florence Bupe, *MoH reviewing law on abortion*, THE POST NEWSPAPERS ZAMBIA, June 11, 2010, *available at* http://www.postzambia.com/post-read_article.php?articleId=10248; Zulu, *supra* note 11.

²⁸ *Stigma and Bureaucracy Drive Maternal Deaths*, IRIN HUMANITARIAN NEWS & ANALYSIS, Mar. 11, 2010, *available at* <http://allafrica.com/stories/201003110859.html>; Rebecca Stewart, *Legal, but they don't know it*, THE GUARDIAN, July 23, 2009, *available at* <http://www.guardian.co.uk/journalismcompetition/legal-dont-know-it>; Brenda Zulu, *Health Ministry on Track to Reduce Deaths From Unsafe Abortions*, TIMES OF ZAMBIA, June 8, 2009, *available at* <http://allafrica.com/stories/200906080697.html>; *State Acts to Reduce Unsafe Abortion*, TIMES OF ZAMBIA, June 6, 2009, *available at* <http://allafrica.com/stories/200906080784.html>; Rose Hoban, *Zambia: Abortion* (PRI's The World radio broadcast, Apr. 23, 2009), *available at* <http://www.theworld.org/2009/04/zambia-abortion/>; *Zambia: call for safe abortion*, ZAMBIA SUNDAY MAIL, Sept. 21, 2008, *available at* <http://www.ippf.org/NR/exeres/EA05DD15-4980-442B-A4C8-08B75C6A5122.htm>; *see also* STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION, *supra* note 25, at iv.

²⁹ News Release, MSI Zambia, *supra* note 22; *see also Stigma and Bureaucracy Drive Maternal Deaths*, *supra* note 28; Stewart, *supra* note 28.

³⁰ *See* R.N. Likwa et al., *In Brief: Unsafe Abortion in Zambia*, at 2 (Guttmacher Inst., Nov. 2009) [hereinafter *Unsafe Abortion in Zambia*] (noting the low cost of seeking out an unsafe and illegal abortion with traditional healers in Zambia as opposed to the much higher cost of paying for a legal abortion at public and private health facilities).

³¹ CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, para. 14.

³² *Concluding Observations: Zambia* (2002), *supra* note 7, paras. 242-43.

³³ Termination of Pregnancy Act of 1972, sec. 3(1)(a-b) (Zam.) [hereinafter TOP Act].

³⁴ *Id.* sec. 3(2).

³⁵ Penal Code Act No. 15 (2005), Cap. 87, 7 Laws of Rep. of Zambia (1995), sec. 152 [hereinafter Penal Code (2005) (Zam.)]. Notably, when the Penal Code was amended in 2005, it raised the term of imprisonment from seven to fourteen years for women who self-abort or attempt to self-abort and wholly added the penalty provisions authorizing community service or counseling for girls who do the same, where the earlier Penal Code had contained no such provision. *Compare to* Penal Code Act of 1995, Cap. 87, 7 Laws of Rep. of Zambia, sec. 152.

³⁶ Penal Code (2005) (Zam.), *supra* note 35, sec. 152(2).

³⁷ TOP Act, *supra* note 33, secs. 3(1), (3), (4).

³⁸ *See* WHO, *Mid-level health-care providers are a safe alternative to doctors for first-trimester abortions in developing countries* [WHO/RHR/HRP/08.15], Dec. 31, 2008, *available at* http://www.who.int/reproductivehealth/publications/unsafe_abortion/rhr_hrp_08_15/en/index.html.

³⁹ *Unsafe Abortion in Zambia*, *supra* note 30, at 2-3.

⁴⁰ *See* WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 59-61 (2003), *available at* <http://whqlibdoc.who.int/publications/2003/9241590343.pdf>.

⁴¹ *See* STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION, *supra* note 25, at 5-30.

⁴² *Id.* at 11-12.

⁴³ *Id.* at 11.

⁴⁴ *Id.* at 11-12.

⁴⁵ *Unsafe Abortion in Zambia*, *supra* note 30, at 1; *see also Stigma and Bureaucracy Drive Maternal Deaths*, *supra* note 28.

⁴⁶ *Stigma and Bureaucracy Drive Maternal Deaths*, *supra* note 28.

⁴⁷ *See* CONSTITUTION, art. 26(4) (2010) (Kenya), *available at* <http://www.kenyalaw.org/Downloads/The%20Constitution%20of%20Kenya.pdf>; CONSTITUTION ACT, art. 15(5)

(2005) (Swaz.); CONSTITUTION, art. 22(2) (1995) (Uganda); CONST. OF ZAMBIA of 1991 (as amended by Act No. 18 of 1996) art. 12(2) [hereinafter ZAMBIA CONST. (1996)].

⁴⁸ ZAMBIA CONST. (1996), *supra* note 47, art. 12(2).

⁴⁹ The Constitution of Zambia Bill, 2010, art. 40(1).

⁵⁰ The Zambian Parliament, 5th Sess., 10th Assemb., Mar. 29, 2011, *available at*

http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=1416&Itemid=86 [hereinafter The Zambian Parliament, 10th Assemb.]; *Govt. Has Lost Chance on Constitution Making*, TIMES OF ZAMBIA, Apr. 1, 2011, *available at* <http://allafrica.com/stories/201104010391.html>; *There's no crisis over Constitution – Banda*, TIMES OF ZAMBIA, Mar. 31, 2011, *available at* <http://www.times.co.zm/news/viewnews.cgi?category=all&id=1301556571>; *Constitution flop temporal setback, RB*, LUSAKA TIMES, Mar. 30, 2011, *available at* <http://www.lusakatimes.com/2011/03/30/constitution-flop-temporal-setback-rb/>.

⁵¹ See Rhonda Copelon et al., *Human Rights Begin at Birth: International Law and the Claim of Fetal Rights*, 13(26) REPRODUCTIVE HEALTH MATTERS 120-29 (2005).

⁵² See, e.g., CONSTITUTION OF THE DOMINICAN REPUBLIC (2010) art. 37 (recognizing right to life from moment of conception); ZAMBIA CONST. (1996), *supra* note 47, art. 26(1)-(2) (2010) (Kenya) (stating that the life of a person begins at conception).

⁵³ Resolución [S.] No. 0014-2005-RA, 26 de mayo de 2006, Tribunal Constitucional del Ecuador [Constitutional Court]; Sentencia [S.] Rol. 740-07-CDS, 18 de abril de 2008, Tribunal Constitucional de Chile [Constitutional Court]; Sentencia [S.] Exp. 02005-2009-PA/TC, 16 de octubre de 2009, Tribunal Constitucional del Perú [Constitutional Court].

⁵⁴ Sala Constitucional de la Corte Suprema de Justicia [Constitutional Court], Expediente No. 95-001734-0007-CO, Voto No. 2306-00, 15 de marzo de 2000 (Costa Rica).

⁵⁵ *Unsafe Abortion in Zambia*, *supra* note 30, at 3.

⁵⁶ STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION, *supra* note 25, at vi.

⁵⁷ 2007 ZDHS, *supra* note 8, at 106, 108.

⁵⁸ *Id.* at 107-08, tbl. 7.3.1.

⁵⁹ *Id.* at 108, tbl. 7.3.1.

⁶⁰ *Id.*

⁶¹ *Id.* at 79-80, tbl. 5.11.

⁶² *Id.*

⁶³ WHO ET AL., AN ASSESSMENT OF THE NEED FOR CONTRACEPTIVE INTRODUCTION IN ZAMBIA 9-11, 30-33, 35-38, 55-67 (1995), *available at*

http://www.who.int/reproductivehealth/publications/family_planning/HRP_ITT_95_4/en/index.html; *see also* POPULATION COUNCIL, EMERGENCY CONTRACEPTION IN ZAMBIA: SETTING A NEW AGENDA FOR RESEARCH AND ACTION 2 (1998), *available at* <http://www.ecafrique.org/pubdetail.php?subcat=23> [hereinafter EMERGENCY CONTRACEPTION IN ZAMBIA]; POPULATION COUNCIL ET AL., TESTING ALTERNATIVE CHANNELS FOR PROVIDING EMERGENCY CONTRACEPTION TO YOUNG WOMEN 1-2 (2001) (also citing to same WHO study), *available at* <http://www.ecafrique.org/pubdetail.php?subcat=23> [hereinafter TESTING ALTERNATIVE CHANNELS].

⁶⁴ EMERGENCY CONTRACEPTION IN ZAMBIA, *supra* note 63, at 9-11; TESTING ALTERNATIVE CHANNELS, *supra* note 63, at 14-17.

⁶⁵ 2007 ZDHS, *supra* note 8, at 81-82, tbl. 5.14.

⁶⁶ *Id.* at 68, tbl. 5.1 & 70, tbl. 5.3.1.

⁶⁷ See WHO ET AL., *supra* note 63, at 10, 31-33, 37; EMERGENCY CONTRACEPTION IN ZAMBIA, *supra* note 63, at 9-11; TESTING ALTERNATIVE CHANNELS, *supra* note 63, at 14-17; *see also* Brenda Zulu, *Family Planning Helps Prevent Unplanned Pregnancies*, TIMES OF ZAMBIA, Mar. 9, 2011, *available at* <http://allafrica.com/stories/201103100163.html>.

⁶⁸ ZAMBIA MINISTRY OF HEALTH ET AL., ZAMBIA HIV/AIDS SERVICE PROVISION ASSESSMENT SURVEY 2005 45 (2006), *available at* http://www.measuredhs.com/pubs/pub_details.cfm?ID=611&ctry_id=47&SrchTp=ctry.

⁶⁹ CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, para. 23.

⁷⁰ *Id.* para. 18.

⁷¹ See, e.g., CEDAW Committee, *Concluding Observations: Barbados*, para. 250, U.N. Doc. A/57/38 (2002); *Ecuador*, para. 318, U.N. Doc. A/58/38 (2003); *Estonia*, para. 100, U.N. Doc. A/57/38 (2002); *Mozambique*, para. 37, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); *Uganda*, para. 148, U.N. Doc. A/57/38 (2002).

⁷² 2007 ZDHS, *supra* note 8, at 214; *see also* STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION, *supra* note 25, at vi.

⁷³ 2007 ZDHS, *supra* note 8, at 214, tbl. 13.16.

⁷⁴ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, art. 2(d)-(e), G.A. Res. 34/189, UN GAOR, 34th Sess., U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into*

force Sept. 3, 1981). (“States Parties . . . undertake . . . [t]o refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation [and to] take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.”).

⁷⁵ *Id.* art. 16(1).

⁷⁶ CEDAW Committee, *General Recommendation No. 19: Violence against women*, (11th Sess., 1992) paras. 4, 6, U.N. Doc. A/47/38 (1993) [hereinafter CEDAW Committee, *General Recommendation No. 19*].

⁷⁷ *Concluding Observations: Zambia* (2002), *supra* note 7, paras. 230-31.

⁷⁸ ZAMBIA CONST. (1996), *supra* note 47, arts. 11 & 23.

⁷⁹ Fédération Internationale des Ligues des Droits de l’Homme (FIDH), *UN Special Rapporteur on Violence Against Women Statement on Conclusion of Visit to Zambia*, Dec. 14, 2010, available at <http://www.africa4womensrights.org/post/2010/12/14/Zambia-UN-Special-Rapporteur-on-Violence-Against-Women-Statement-on-Conclusion-of-Visit-to-Zambia>. It should be noted that the anti-discrimination provisions under Article 23 of the existing Constitution of Zambia (1996) are found under Article 48 of the draft Constitution of Zambia Bill (2010).

⁸⁰ See The Zambian Parliament, 10th Assemb., *supra* note 50; *Govt. Has Lost Chance on Constitution Making*, *supra* note 50; *There’s no crisis over Constitution – Banda*, *supra* note 50; *Constitution flop temporal setback*, *RB*, *supra* note 50.

⁸¹ *Concluding Observations: Zambia* (2002), *supra* note 7, para. 238.

⁸² *Id.* para. 239.

⁸³ *Id.*

⁸⁴ REPUBLIC OF ZAMBIA, GENDER IN DEVELOPMENT DIVISION, NATIONAL ACTION PLAN ON GENDER-BASED VIOLENCE: 2008-2013 14-19 (2008), available at http://www.undp.org.zm/joomla/attachments/033_GBV-NAP_2008-2013_FINAL_%28%291.pdf?8e2474a80d13c9785641fc2923161380=2f8b877c624e33ebbe92ab614ffe31e5 [hereinafter NATIONAL ACTION PLAN ON GBV].

⁸⁵ *Id.* at 12, 15.

⁸⁶ *Id.* at 12; HUMAN RIGHTS WATCH, HIDDEN IN THE MEALIE MEAL: GENDER-BASED ABUSES AND WOMEN’S HIV TREATMENT IN ZAMBIA 58 (2007), available at <http://www.hrw.org/en/reports/2007/12/18/hidden-mealie-meal> [hereinafter HIDDEN IN THE MEALIE MEAL].

⁸⁷ POPULATION COUNCIL, THE COPPERBELT MODEL OF INTEGRATED CARE FOR SURVIVORS OF RAPE AND DEFILEMENT: TESTING THE FEASIBILITY OF POLICE PROVISION OF EMERGENCY CONTRACEPTIVE PILLS (2009), available at http://www.popcouncil.org/pdfs/2009RH_ZambiaCopperbeltModelIntCare.pdf.

⁸⁸ NATIONAL ACTION PLAN ON GBV, *supra* note 84, at 12; HIDDEN IN THE MEALIE MEAL, *supra* note 86, at 58-60.

⁸⁹ See News Release, Human Rights Watch, Zambia: Enact Law to Curb Sexual Violence (Dec. 10, 2008), available at <http://www.hrw.org/en/news/2008/12/10/zambia-enact-law-curb-sexual-violence> [hereinafter HRW, Zambia News Release].

⁹⁰ 2007 ZDHS, *supra* note 8, at 281, tbl. 17.6.

⁹¹ *Id.* at 275-277, tbl. 17.1.

⁹² *Id.* at 278, tbl. 17.2.

⁹³ *Id.* at 285, tbl. 17.9.

⁹⁴ *Id.* at 278-279, tbl. 17.3.

⁹⁵ *Id.* at 280, tbl. 17.5.

⁹⁶ *Id.* at 285, tbl. 17.9.

⁹⁷ *Id.* at 280, tbl. 17.4.

⁹⁸ WHO ET AL., ZAMBIA GLOBAL SCHOOL HEALTH SURVEY 10, tbl. 4 (2004), available at <http://www.cdc.gov/gshs/countries/africa/zambia.htm>.

⁹⁹ See, e.g., Lilian Museka, *Zambia: child sexual abuse on the rise*, AFRONLINE, Nov. 12, 2010, available at <http://www.afronline.org/?p=10301>; see also Children In Need Network, *Child Abuse in Zambian Schools Rampant*, <http://www.chin.org.zm/articles.php?newsid=7> (last visited May 26, 2011).

¹⁰⁰ Museka, *supra* note 99; EqualityNow.org, Equality Now Adolescent Girls’ Legal Defense Fund, http://www.equalitynow.org/english/campaigns/agldf/agldf_en.html (last visited Apr. 22, 2011) (discussing status of same case and judgment for 13-year-old Zambian girl for sexual abuse by teacher and efforts by Equality Now to raise awareness of sexual violence against girls in schools in Zambia).

¹⁰¹ EqualityNow.org, *supra* note 100.

¹⁰² 2007 ZDHS, *supra* note 8, at 264, tbl. 16.6.1 (percentage of women agreeing that wife abuse was justified for burning the food, arguing with her husband, leaving the house without telling her husband, neglecting the children, or refusing to have sexual intercourse with her husband).

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- ¹⁰³ *Id.* at 265, tbl. 16.6.2.
- ¹⁰⁴ *Id.* at 267, tbl. 16.7.1.
- ¹⁰⁵ See, e.g., Valentine Chanda, *Lawmakers Excuse Gender Violence*, GENDER LINKS, Nov. 25, 2010, available at <http://allafrica.com/stories/201011260678.html>.
- ¹⁰⁶ Zambia Government Report (2010), *supra* note 6, para. 8.
- ¹⁰⁷ It should be noted that, in paragraph 8 of its report to the CEDAW Committee, the Zambian government reports 198 cases of rape in 2001 but that, in the accompanying Table 1.1, the Zambian government reports 129 cases of rape in 2001 and 198 cases of rape in 2002. The Center has used the statistics provided by the government in Table 1.1.
- ¹⁰⁸ Zambia Government Report (2010), *supra* note 6, para. 8, tbl. 1.1.
- ¹⁰⁹ *Id.* para. 9, tbl. 1.2.
- ¹¹⁰ In November 2010, the Minister of Gender and Women in Development and the Minister of Justice presented the draft anti-GBV bill and proposed Penal Code amendments to Parliament. See The Zambian Parliament, 5th Sess., 10th Assemb., Nov. 25, 2010, available at http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=1338&Itemid=86. Having passed the second reading in late February 2011 and the third reading in early March 2011, the Anti-Gender-Based Violence Bill and the Penal Code amendments have reportedly not yet been signed into law. See The Zambian Parliament, 5th Sess., 10th Assemb., Feb. 24, 2011, available at http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=1366&Itemid=86; The Zambian Parliament, 5th Sess., 10th Assemb., Mar. 4, 2011, available at http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=1393&Itemid=86; *Anti-Gender Bill Passes Second Reading*, TIMES OF ZAMBIA, Feb. 25, 2011, available at <http://allafrica.com/stories/201102250453.html>; Sututu Katundu, *GIDD urges enactment of gender-based [bill]*, THE POST NEWSPAPERS ZAMBIA, Jan. 20, 2011, available at http://www.postzambia.com/post-read_article.php?articleId=17468.
- ¹¹¹ Zambia Government Report (2010), *supra* note 6, para. 24; Penal Code (2005) (Zam.), *supra* note 35.
- ¹¹² The Penal Code (Amendment) Bill, 2010 (Sept. 22, 2010); *Marital Rape not clearly spelt out in the current Rape Act*, LUSAKA TIMES, July 28, 2010, available at <http://www.lusakatimes.com/2010/07/28/marital-rape-spelt-current-rape-act/>; Nada Ali, *Zambia: Curbing Sexual and Gender-Based Violence*, HUMAN RIGHTS WATCH: ON THE ISSUES, Dec. 16, 2008, available at <http://www.hrw.org/en/news/2008/12/16/zambia-curbing-sexual-and-gender-based-violence>; HRW, *Zambia News Release*, *supra* note 89; HIDDEN IN THE MEALIE MEAL, *supra* note 86, at 54-55.
- ¹¹³ CEDAW Committee, *General Recommendation No. 24*, *supra* note 2, para. 18.
- ¹¹⁴ *Concluding Observations: Zambia* (2002), *supra* note 7, para. 245.
- ¹¹⁵ 2007 ZDHS, *supra* note 8, at 228, tbl. 14.3.
- ¹¹⁶ *Id.* at 235, tbl. 14.8.
- ¹¹⁷ *Id.* at 214, 221; STANDARDS AND GUIDELINES FOR REDUCING UNSAFE ABORTION, *supra* note 25, at vi.
- ¹¹⁸ HIDDEN IN THE MEALIE MEAL, *supra* note 86.
- ¹¹⁹ *Id.* at 21-31.
- ¹²⁰ *Id.* at 31-38.
- ¹²¹ *Id.* at 41-47.
- ¹²² *Id.* at 47-50.
- ¹²³ *Id.* at 53-58.
- ¹²⁴ *Id.* at 58-62.
- ¹²⁵ SOUTHERN AFRICA LITIGATION CENTRE, BRIEF SUMMARY OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS CONCERNS OF WOMEN LIVING WITH HIV IN ZAMBIA, at 6 (undated) (on file at Center for Reproductive Rights) [hereinafter SALC STUDY].
- ¹²⁶ *Id.* at 2-3.
- ¹²⁷ *Id.* at 3.
- ¹²⁸ *Id.* at 4-5.
- ¹²⁹ CEDAW Committee, *General Recommendation No. 19*, *supra* note 76, paras. 22, 24(m).
- ¹³⁰ See, e.g., CENTER FOR REPRODUCTIVE RIGHTS, DIGNITY DENIED: VIOLATIONS OF THE RIGHTS OF HIV-POSITIVE WOMEN IN CHILEAN HEALTH FACILITIES 26-29 (2010), available at <http://reproductiverights.org/en/document/dignity-denied-download-report> [hereinafter DIGNITY DENIED]; see also CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 36-37 (2007) (discussing importance of information and informed consent for women in making reproductive health decisions), available at <http://reproductiverights.org/en/document/failure-to-deliver-violations-of-womens-human-rights-in-kenyan-health-facilities>.
- ¹³¹ DIGNITY DENIED, *supra* note 130, at 28.

¹³² SALC STUDY, *supra* note 125, at 5.

¹³³ *Id.* at 6.

¹³⁴ CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations* (13th Sess., 1994) para. 36, U.N. Doc. HRI/GEN/1/Rev.1 (1994).

¹³⁵ UNICEF, EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE 1-2 (2005), available at http://www.unicef.org/publications/index_26024.html [hereinafter UNICEF, EARLY MARRIAGE]; Population Council, *Child Marriage Briefing: Zambia*, Aug. 2004, available at <http://www.popcouncil.org/pdfs/briefingsheets/ZAMBIA.pdf>; see also Brenda Zulu, *Poverty Perpetuating Child Marriages*, TIMES OF ZAMBIA, Mar. 9, 2011 (discussing adverse health, educational, and economic consequences for married girls), available at <http://allafrica.com/stories/201103100164.html>; *Marrying Off Young Girls is a Tradition Here*, IRIN HUMANITARIAN NEWS & ANALYSIS, Dec. 20, 2010 (same), available at <http://allafrica.com/stories/201012210896.html> [hereinafter *Marrying Off Young Girls*].

¹³⁶ See Marriage Act, Cap. 50, LAWS OF REP. OF ZAMBIA, secs. 10(1)(ii), (17), 33(1); OECD Development Centre, *Gender Equality and Social Institutions in Zambia*, at 1 (undated), available at <http://genderindex.org/country/zambia>; see also Zambia Government Report (2010), *supra* note 6, para. 182.

¹³⁷ Zulu, *supra* note 135; *Marrying Off Young Girls*, *supra* note 135.

¹³⁸ Zambia Government Report (2010), *supra* note 6, paras. 14, 115(b), 181, 196(a)(ii).

¹³⁹ *Concluding Observations: Zambia* (2002), *supra* note 7, para. 250.

¹⁴⁰ POPULATION COUNCIL & UNFPA, THE ADOLESCENT EXPERIENCE IN DEPTH: USING DATA TO IDENTIFY AND REACH THE MOST VULNERABLE YOUNG PEOPLE (ZAMBIA 2007) 22 (2009), available at http://www.popcouncil.org/pdfs/PGY_AdolDataGuides/Zambia2007.pdf.

¹⁴¹ UNICEF, EARLY MARRIAGE, *supra* note 135, at 32-33, tbl. 2.

¹⁴² *Id.*

¹⁴³ Zambia Government Report (2010), *supra* note 6, para. 115(b).

¹⁴⁴ *Concluding Observations: Zambia* (2002), *supra* note 7, paras. 246-47.

¹⁴⁵ FORUM FOR AFRICAN WOMEN EDUCATIONALISTS ZAMBIA (FAWEZA), FAWE BEST PRACTICES: RE-ENTRY FOR ADOLESCENT SCHOOL-GIRL MOTHERS 4, 10-11 (2004), available at

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http://www.widnet.org.zm/empowerment_reentry.php [hereinafter WIDNET, *The Re-Entry Policy*].

¹⁴⁶ WIDNET, *The Re-Entry Policy*, *supra* note 145; Chinemu Phiri, *ZAMBIA: A successful case for re-entry policy*, AFRICANEWS, Apr. 4, 2011, available at

http://www.africanews.com/site/ZAMBIA_A_successful_case_for_reentry_policy/list_messages/38029; see also FAWEZA, *Zambia: 15,000 school girls fall pregnant every year*, Mar. 26, 2011, available at

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