Investing in Sexual and Reproductive Health and Rights
Policy Brief
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Foreword

The new 2030 development agenda of the Sustainable Development Goals calls on all of us to step up our efforts in our areas of work to meet targets set. Indeed meeting these targets and achieving positive outcomes in the area of Sexual Reproductive Health requires huge investment and collaboration by all key stakeholders. In Zimbabwe the new development agenda presents opportunities for achieving these positive outcomes.

We know that many women and girls are dying from complications of child birth. At estimated 8 women and girls die every day due to pregnancy complications. Many other women and girls suffer serious birth injuries such as fistula. It is well known that every maternal death is associated with 20 to 50 cases of severe maternal morbidity or injuries. Until 2 years ago, women living with fistula could not receive treatment. We are now reaching women with life changing surgery but we still need to reach much more.

Cervical cancer is affecting the health and well-being of women in Zimbabwe. Over 4.3 million women at reproductive age in Zimbabwe are at the risk of developing cervical cancer, which is associated with the high HIV prevalence. Current estimates indicate that every year 2,270 women are diagnosed with cervical cancer and 1,451 die from the disease. To date at least 105 screening sites and more than 425,066 women have been screened but we still need to expand these services and reach many more women.

The adolescent fertility rate in Zimbabwe is estimated at 110 births per 1,000 women aged 15-19 years (ZDHS 2015), implying that 1 in 10 adolescent girls give birth every year. Therefore is a need to increase access to family planning for young people, unmarried sexually active women and strengthen the promotion and uptake of long acting reversible family planning methods to widen women’s choices as the method mix is skewed towards short term methods orals contraceptives (56%).

Gender Based Violence remains a huge impediment to the development of women and girls. Key findings from the Zimbabwe Demographic and Health Survey for 2015 confirms that violence against women and girls remain a huge problem in Zimbabwe. At least 1 in every 3 women have experienced physical violence since the age of 15. There is need to advocate for, and develop policies that advance gender equality and social protection, including the elimination of all forms of gender based violence and discrimination against young women and girls. In addition many young girls are forced into child marriages greatly endangering their lives and limiting their potential. There are opportunities highlighted in this booklet through the recently adopted Southern African Development Community Model Law on Marriage to address this challenge.

This booklet highlights in greater detail some of the areas requiring our attention as various stakeholders and investment and support for improved outcomes on maternal health, particularly the prevention and treatment of cervical cancer and fistula, access to family planning, young people’s development and prevention and response to Gender Based Violence.

Dr Esther Muia
UNFPA Zimbabwe
Country Representative
Family Planning
Family Planning (FP) allows individuals and couples to plan for and attain their desired number of children, the spacing and timing of the children’s births. This is attained through use of contraceptive methods and the treatment of involuntary infertility. The practice of family planning has a direct bearing on the outcome of each pregnancy a woman has as well as her health and well-being.

Key Facts

- Globally, an estimated 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception.¹
- Although Zimbabwe’s modern contraceptive prevalence rate is relatively high (67%), over 10% of sexually active women would like to stop having children or delay pregnancy but are not doing so (have unmet need for family planning)²
- Unmet Need for FP is considerably higher (12.6%) among young women aged 15-19 years than the national average (10.4%²)
- Although the maternal mortality ratio has shown early signs of decline, it still remains very high.
- Optimal use of family planning could prevent 32% of maternal deaths.³ Thus by preventing unintended pregnancy, family planning/contraception prevents deaths of mothers and children.
- Family planning reduces the need for abortion, especially unsafe abortion, which has negative outcomes such as infertility, maternal deaths etc.
- The practice of FP reinforces people’s rights to determine the number and spacing of their children as desired.

Family Planning 2020 (FP 2020)

Zimbabwe is among countries in the FP2020 initiative, which is a global partnership that began in 2012, to support the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP 2020 works with governments, civil society, multilateral organizations, donors, the private sector, and the research and development community to facilitate adoption of FP/contraceptive methods by 120 million new users by 2020. This is achieved through implementation of the following:

- Increased political commitment and accountability for delivery of family planning services
- Substantially increasing access to family planning information, services, and supplies
- Creating a healthy and sustainable market for family planning/contraceptive commodities
- Adaptation and development of new and innovative contraceptive methods

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¹ WHO 2015 Family Planning/Contraception
² ZDHS 2015
Zimbabwe’s Commitments to FP 2020

The 2012 London FP Summit which gave birth to FP2020, saw Zimbabwe making the following commitments:

- Increase the Contraceptive Prevalence Rate (CPR) from 59% to 68% by the year 2020.
- Reduce the unmet need for family planning from 13% to 6.5% by 2020.
- Double FP budget, (including the procurement of contraceptive commodities), from 1.7% to 3% of the national health budget. Budget support includes support for improved access for women and girls from the poorest wealth quintiles
- Remove user fees for family planning services by 2013.
- Improve the method mix with the emphasis on long term and reversible methods, and strengthen the integration of family planning with reproductive health, HIV and maternal health services
- Develop innovative service delivery models to meet the needs and rights of adolescent girls; and reduce their unmet need from 16.9% to 8.5% by 2020
- Strengthen public-private partnerships, including civil society organizations in the provision of community-based and outreach services

Zimbabwe’s Commitments to FP 2020 were updated in 2017 at the London Summit. The following commitments were reinforced in 2017

- Improve availability and access to quality integrated Family Planning and Contraceptive Services with the aim of reaching all women irrespective of age, marital or socioeconomic status and/or geographical location by the year 2020
- Improve access and uptake of voluntary contraceptive services among adolescent girls through reducing unmet need for modern methods of family planning for adolescents from 12.6% to 8.5% by 2020
- Expand contraceptive choice by promoting a comprehensive package of contraceptive services, with 30% of married women using long acting reversible contraceptives by 2020
- Strengthen supply chain management system for FP commodities as part of the national integrated Medical Procurement and Supply Management System and maintaining stock outs below 5%
- Adopt innovative financing approaches to mobilise domestic resources for contraceptives, including engagement with the private sector developed, piloted and adopted at national level by 2020.

Achievements

Contraceptive Prevalence Rate

The country’s modern family planning methods prevalence rate (mCPR) for married women of 69% (FPET 2018) is one of the highest in the Sub Saharan Africa Region and the country has reached its national goal of 68% by the year 2020. This is a great achievement for the country. The graph below shows the country goal and the current growth rate. The multi-stakeholder efforts have contributed to a significant growth of the mCPR.
Unmet Need for Family Planning

- The concept of unmet need of FP points to the gap between women’s reproductive intentions and what is currently happening.

- Unmet need for family planning has been decreasing since 2012 as shown by the graph on page 7. The 2015 ZDHS findings show that the unmet need for FP is at 10.4%, which is higher than the country’s target of 6.5%. With the prevailing rate of progress, the following graph shows that the country is unlikely to reach the target of 6.5% by the year 2020.
• Unmet need for FP among young women remains higher (12.6%) than the national average (10.4%). Unmet need is twice as high among sexually active unmarried women (20.5%). It is also higher among urban sexually active women than their rural counterparts (22.5% versus 17.9%).

• More effort is needed to reach marginalized women and girls who are not accessing Family Planning services.
Impact of FP Utilisation in ZIMBABWE

As a result of the FP2020 global partnership and the country’s efforts to fulfil its commitments, the following impact was realised since June 2012.

2,203,000
Women are using modern method of contraception in Zimbabwe

As a result of contraceptive use in 2018:

785,000
Unintended pregnancies will be prevented

173,000
Unsafe abortions will be averted

2,600
Maternal deaths will be averted
Method Mix and Use of Long Acting Reversible Contraceptives (LARCs)

- The family FP method mix is dominated by short acting methods such as the pill.
- Long acting reversible contraceptive methods (LARCs) such as the implants and Intra-uterine Contraceptive Devices (IUCDs) are the most effective available reversible contraceptive methods; and once inserted, last for several years; eliminating the need for daily contraceptive action.
- Although the utilisation of implants more than doubled in the past 5 years as a result of national efforts to promote LARCs, greater efforts are required to increase their uptake, especially the IUCD

Budget Allocation to FP Services and Commodities

Due to the economic crisis, government faces challenges in fulfilling the FP2020 financial commitment of increasing the national budget allocation of family planning from 1.7% to 3%. Government provides a grant towards salaries of FP employees for the Zimbabwe National Family Planning Council. However, all family planning funding for programming and commodities are still wholly provided by development partners, which is not sustainable. The budget allocation to FP services by the government remain low as compared to the available needs for the country.

What Needs to be Done?

- Advocate for an increase in the FP budget allocation to reach the 3% as in FP2020 Zimbabwe Commitment
- Remove user fees for Family Planning (FP) as they present a major barrier to accessing FP services
- Improve method mix and strengthen the uptake of long acting reversible contraceptive methods
- Conduct research to understand the determinants of unmet need for FP
- Increase access to FP services to young people and unmarried sexually active young women

Planned and well managed family sizes allow for increased investment per child in health, nutrition and education

Planned and well managed family sizes allow for increased investment per child in health, nutrition and education
What is the demographic dividend?

A demographic dividend is a boost in economic growth that occurs when there is a larger number of people in the working age than those below or above working age. The demographic dividend can speed up the attainment of many Sustainable Development Goals, including Goal 1: ending poverty in all its forms everywhere and SDG 3: Good health and well-being for all.

The key to harnessing the demographic dividend is enabling young people – and adolescent girls in particular – to enjoy their human rights to achieve their potential. Creating and realizing the dividend depends on the empowerment, education, employment and health of young people, together with higher saving and investment in productive resources. During their window periods for the demographic dividend, countries such as South Korea, Singapore, Thailand, Malaysia, and later China, experienced sustained high economic growth. In line with the African Union vision 2063, Zimbabwe stands at the threshold of entering the demographic dividend that can be harnessed in the coming 15 to 30 years. This is attributed to post-independence health policies, programmes and investments in maternal and child health and family planning as well as education policies and programmes which have seen the country achieving the highest literacy rate in Africa. However, there are challenges that need to be overcome.

What are the challenges to reaping the Demographic Dividend?

- High rates of early marriage. At least 31% of girls married before the age of 18
- High rates of teenage pregnancy especially among girls residing in the rural areas (Nearly 1 in 10 girls age 15-19 years gives birth every year)
- High maternal deaths especially among young girls who accounted for 34% of all maternal deaths in 2012.
- Increase in drop-outs at secondary school level (25%)
- Lack of employment opportunities especially among the urban youths. Highest proportion of unpaid family workers are in the 15-19 year age group – 40%. In 2012, unemployment rate among adolescents (20-24 years) living in urban areas was 36%.
- Gender Based Violence remains a huge problem affecting young women and girls. At least 1 in 3 women have experienced physical violence since the age of 15, according to the 2015 Zimbabwe Demographic and Health Survey.

How can Zimbabwe reap the Demographic Dividend and what are the efforts underway?

A huge investment is required if Zimbabwe is to start reaping the demographic dividend. Here are some ways:
Investing in young people, especially in girls is key to reaping the demographic dividend. A young adolescent girl can be an asset for a country if she is not married off during her childhood; not forced to leave school or exposed to unintended and early pregnancy that put her at high risk of illness, maternal injuries as well as death. UNFPA Zimbabwe, with support of its development partners, has been implementing a number of programmes such as the Sista2Sista to empower girls. Through this programme, vulnerable adolescent girls (10-19 years) are recruited into girls only clubs and mentored in order to enable them to make informed sexual and reproductive health decisions. This program has reached over 23 000 girls and recorded a pregnancy rate of less than 1% among the recruited girls.

**Investing in Family Planning**

Access to voluntary family planning services for women, couples, and adolescents, supports the health and well-being of individuals and can have positive economic, environmental, and social benefits for families and communities. When women and couples have access to the information and means that allow them to choose the timing of pregnancy, the intervals between births lengthen, average family size shrinks, and teen births become less frequent. Whilst this ensures that women and couples have their desired number of children that they are able to care for, it also improves maternal and child survival. When families are well planned and managed, breadwinners of the household can invest more of their resources in each child. Households also save more money. Family sizes allow for increased investment per child in health, nutrition and education. UNFPA supports the Government of Zimbabwe to ensure women and girls have access to family planning to plan child birth. For Young People particularly UNFPA Youth friendly health services were supported through the public sector to encourage uptake of integrated SRH and HIV services including family planning. This included training of specific service providers as well as sensitization of all staff. In 2015, at least 98 000 young women aged 16-24 years were reached with family planning services.

**Education**

It is key to invest in young people’s empowerment, including through education. There is need to promote equal access of boys and girls to universal primary and secondary education to provide equal opportunities of job security and lifelong learning to adults. In addition, age appropriate Comprehensive Sexuality Education helps to empower young women and men through information on Sexual Reproductive Health and Rights. UNFPA in collaboration with other UN agencies has supported both in and out of school Comprehensive Sexuality Education. This included supporting policy and strategy development, technical support to development of syllabi, teacher and learner materials. In 2015 at least 105 332 learners were reached with sessions on life skills education in schools. On 7 December 2013 Zimbabwe affirmed Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African, popularly referred to as the ESA Commitment. There is need for the collaborative action of the Ministry of Primary and Secondary Education and the Ministry of Health and Child Care to be strengthened.

**Employment and entrepreneurship**

Access to meaningful skills leading to meaningful employment is very important. There is need to implement the reviewed education curriculum to increase quality and relevance of education to the labour market and national developmental needs. There is need to also promote strategies for youth employment through engagement of young people in policymaking processes. Develop strategies for encouraging full, decent employment – as opposed to informal employment – through youth engagement in policy development.
What are the prospects for harnessing the demographic dividend?

UNFPA supported a study in 2017 to assess Zimbabwe’s opportunities for harnessing the demographic dividend as well as to explore priority policy and programme options that the country could adopt for optimum demographic dividend benefits. The study findings provided guidance on key areas of investment that the country should adopt to optimise the dividend. Zimbabwe is currently in its demographic dividend window which will last until 2060. An average individual in Zimbabwe begins to generate a surplus by earning more from their labour than they consume at the age of 30 years. This period of surplus lasts for only 24 years, that is, until about age 53 years. This means that Zimbabwe’s dependant population is much larger than the theoretically defined dependant population of under 15 years and of 65 years and above. High levels of unemployment and limited opportunities for decent wages in the labour force has contributed to the inability of younger adults in their twenties and early thirties to fully finance their consumption through their labour income. Reaping the dividend requires sectors to work together, be it governance, education, health, protection or economic empowerment.

What Needs to be Done

1. Regularly update the results of the Zimbabwe demographic dividend study with new data from surveys and censuses.
2. Advocate for the best investments during different national processes such as debate on the national budget.
3. Sponsor bills that are necessary to ensure that the policy environment is conducive to reaping the demographic dividend.

Prevention of Gender Based Violence and Response

There is need to advocate and develop policies that advance gender equality and social protection, including the elimination of all forms of gender based violence and discrimination for young women and girls. UNFPA, together with partners, has been involved in both prevention and response to GBV through supporting the Government of Zimbabwe to set up One Stop Centres in Gwanda, Gweru, Harare and Rusape to help women and girl survivors of violence to receive comprehensive health, psycho-social, police and legal services in one place. Communities also need to be fully engaged to ensure prevention messages are disseminated and harmful social norms which promote GBV including child marriages are addressed.

Child marriage in Zimbabwe

In Zimbabwe, child marriage is a formal or informal union before age 18 years. Zimbabwe has one of the highest child marriage prevalence rates, ranking number 41 in the world of countries with highest child marriage prevalence rates. On average, one out of three girls will be married before their 18th birthday. In 2017, 21.6% of women aged 20-24 years were married or in union before the age 18 years (ICDS 2017).
SADC Model Law on Eradication of Child Marriage and Protecting Children Already in Marriage
The SADC Model law on Eradicating Child Marriage was adopted by the SADC Parliamentary Forum (SADC PF) on 3 June 2016. A model law is a draft law adopted by an international organisation or other intergovernmental body as a model or good example of how the member states can legislate for a particular issue. It typically contains clauses that are seen as best practices for tackling various issues related to the subject matter. The SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, is not the first model law to be adopted by an intergovernmental body that Zimbabwe is a member of. The SADC model law on HIV & AIDs in Southern Africa adopted in 2008 by SADC PF is a good example. Another example is the Model Law on International Commercial Arbitration adopted by the United Nations Commission on International Trade Law (UNCITRL) which was incorporated into Zimbabwean law as the Arbitration Act [Chapter 7:15].

How the SADC Model Law was Developed

The SADC Model law was developed over a 2 year period through a process of intense consultation and collaboration among the SADC PF members, legal experts from the SADC States, Parliamentary counsel and legislative drafters as well as stakeholders from the civil society.

Role of the United Nations in the Development and Adoption of the Model Law

The Unites Nations is a champion of the human rights of women and children, as evidenced by the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Elimination of all Forms of
Discrimination against Women (CEDAW). Further, in June 2015, the UN Human Rights Council passed a resolution to end child, early and forced marriage. Child marriage is therefore a violation of human rights and calls for strengthened efforts to prevent and eliminate this harmful practice, as well as support married girls. The United Nations Population Fund (UNFPA) and the United Nations Children’s Fund (UNICEF) worked in close collaboration with SADC PF, contributing financial resources and technical expertise to bring the Model law to fruition.

Is the Model Law an International Treaty and to What Extent is it Binding?

The model law is not an international treaty or agreement. Its provisions are not binding on any State. It is more of a recommendation by the SADC PF, of legislative measures to address various aspects of policy related to eradicating Child Marriages. The recommendation however has very strong persuasive value due to the high level of consensus about its desirability among representatives of states, experts and other respected stakeholders. The Model Law can be described as “soft law” due to its high persuasive nature, though not binding in character.

Provisions of the SADC PF Child Marriage Model Law – A Summary

In summary, the Model Law consists of 8 parts:

- **Part 1** makes a general call upon member states of the SADC to adopt measures to eradicate child marriages, prevent its occurrence and protect children already in marriage or affected by child marriages.

- **Part 2** contains some provisions restating rights relevant to the topic of Child Marriage. These rights are not new as they are already part of the international human rights treaties that Zimbabwe is party to. They are also well articulated in the Constitution.

- **Part 3** contains provisions that outlaw child marriage.

- **Parts 4 and 5** set out standards to prevent and to mitigate the effects of Child Marriage. These measures include education and vocational training for girls and assistance to child victims of Child Marriage.

- **Part 6** encourages SADC member states to keep track of information and data concerning child marriage in their own territories in acknowledgement of the fact that they will only be able to understand and deal with the problem comprehensively if they have a clear picture of the problems on the ground.

- **Parts 7 and 8** incorporate provisions envisaging implementation of the law including proposals for criminal measures against perpetrators and a monitoring mechanism under the SADC.

Are Zimbabwean Laws and Policies Aligned to the Model Law?

Zimbabwean laws and policies are in full alignment with the model law. In tandem with the Model Law, section 78 of the Constitution outlaws child marriages. Further it affirms the fundamental rights of children protected under section 81 of the Constitution. It also affirms the commitments that Zimbabwe has under key human rights instruments particularly, the UN Convention on the Rights of the Child (CRC), the UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the African Union Convention on the Rights and Welfare of the African Child (AUCRWAC).
Purpose of the Model Law

The Model Law is a useful resource in the ongoing national efforts to develop and implement effective and sustainable solutions not only to end Child Marriage in Zimbabwe but also to build a society in which the rights of children, particularly girls are protected. While it is not a binding instrument, the model law provides a sound base of reference or a template of detailed rules or measures regarding eradication of Child Marriage. It serves as the basis for adoption of legislation and policies to address Child Marriage. It is also useful in influencing positive changes and addressing harmful practices affecting the rights of children.

What Needs to be Done

The SADC model law calls on the protection of the rights of Children in SADC member states by ending child marriage and other harmful practices that violate the rights of children.

In order to ensure this is done, Zimbabwe can adopt the Model Law in its entirety, (subject to necessary adjustments in keeping with Zimbabwean drafting styles and traditions) through the legislative process to transform it into an Act of Parliament. This is the process undertaken with the Arbitration Act which was passed by Parliament to incorporate the UNCITRAL Model law on Commercial Arbitration into Zimbabwean law.

Progress made towards the adoption of the SADC model law

A marriages bill has been developed that will outlaw marriage of children 18 years and below. The bill is yet to be presented to parliament for adoption into law. Consultations with the public are ongoing.
Cervical Cancer

4

2010
2 Pilot screening Sites

2015
83 screening sites in rural and urban areas

2030
Screening sites available at all central, provincial and districts hospitals
Cervical Cancer in Zimbabwe

Background

Cervical cancer is the second most common cancer among women and is a major cause of death worldwide, accounting for approximately half a million new cases per year. In Zimbabwe, cervical cancer is the most common cancer among women, accounting for a third (33.4%) of all cancers among black women. The disease burden for cervical cancer has been greatly influenced by the HIV epidemic. Current estimates indicate that every year 2,270 women are diagnosed with cervical cancer and 1,451 die from the disease.

What is a cervix?

The cervix is the opening to the womb from the vagina. Sometimes it is called mouth of the womb.

What is cervical cancer?

It is cancer that occurs at the mouth of the womb caused by a virus called Human Papillomavirus (HPV) which is usually sexually transmitted. The majority of women (80%) will acquire this virus in their lifetime but will not have any symptoms or signs. However, it can take between 10 to 20 years before one develops cancer or even less, if the woman has HIV infection.
What are the risk factors for cervical cancer?

Every woman is at risk of developing cervical cancer.

The following further increase that risk but there are many other unknown factors:

• Early age of first sexual intercourse
• Multiple sexual partners
• Partner who has multiple sexual partners
• HIV infection
• Sexually Transmitted Infections (STIs)
• Smoking

NB Cervical Cancer is not genetically or hereditarily determined

How can you prevent cervical cancer?

• Delaying age of first sexual intercourse
• One faithful sexual partner
• Correct and consistent use of condoms
• Vaccination against HPV

How can Cervical Cancer be Detected?

Early detection is important to enable treatment before the cancer spreads. There are simple screening tests that can be carried out. These include screening using Visual Inspection with Acetic Acid and Cervicography (VIAC) or Pap Smear. VIAC is the commonly used test in most of the government health facilities.

What is VIAC?

VIAC is a method of cervical cancer screening that is based on visual inspection of the mouth of the womb (cervix) after application of acetic acid to detect pre-cancerous lesions. They are called pre-cancerous, meaning that they might turn into cancer if not found and treated early. Cervicography involves taking a digital picture of the cervix. The picture can be viewed on a TV or computer screen for interpretation by a trained health worker. If the result is abnormal or positive, it does not mean that one has cervical cancer, but that further tests or treatment for abnormal cells is required.

Why VIAC?

VIAC is a “see and treat” method. It’s simple, painless and results are available immediately. Treatment can be offered at the same visit. Any woman 18 years and above should be screened for cervical cancer. VIAC can be done anytime even during menstruation or after a miscarriage but if pregnant, it should be postponed until 6 weeks after delivery.

How often should one get screened?

A woman should be screened every 2 years if HIV negative and every year if HIV positive.

Cervical cancer and HIV

The immune system of HIV infected women are sometimes not as strong as they used to be, even if they take their ART medications. When the immune system is weak, cancers can sometimes grow in the body and cervical cancer is one of the cancers HIV infected women have a high chance of getting. All women, especially those who have HIV, need to be screened early for cervical cancer so that if pre-cancerous cells are detected one can be treated before they develop into cancer.

What are the efforts under way to prevent and treat cervical cancer?

In 2010 and 2011, UNFPA supported the Ministry of
Health and Child Care (MoHCC) to set up pilot cervical cancer screening sites using Visual Inspection with Acetic Acid and Cervicography (VIAC) at United Bulawayo Hospitals (UBH) and Masvingo District Hospital. The programme aims to increase the population coverage of cervical cancer screening in the public health sector. Using lessons learned and experience from the two pilot sites the programme has since expanded and to over 105 screening sites and more than 425,066 women have been screened for cervical cancer.

UNFPA advocates for an expanded national cervical cancer programme so that as many women as possible are reached with life-saving screening and treatment services. The VIAC programme is potentially sustainable due to the low operational costs once set up. It serves as an entry point to other SRH services such as HIV counselling and testing, STI treatment and family planning making; it a worthy investment. While the increase in cervical cancer screening sites has been highly commendable, there is still a much more that needs to be done to increase coverage of cervical cancer screening and treatment services in Zimbabwe.
5 | Obstetric Fistula
The situation

Complications during pregnancy and childbirth are leading causes of death and disability among women of reproductive age. In Zimbabwe, it is estimated that for every woman who dies due to pregnancy related causes another 20 - 50 suffer severe complications such as fistula. Obstetric Fistula is a neglected crisis that affects over 2 million of women and girls worldwide.

Obstetric fistula (or vaginal fistula) is a medical condition in which a fistula (hole) develops either between the rectum and vagina, or the bladder and vagina resulting from prolonged obstructed labour without timely access to emergency obstetric care, notably a caesarean section. The existence of fistula reflects chronic health inequities and health-care system constraints, as well as wider challenges, such as gender and socioeconomic inequality, child marriage and early child bearing. All of these factors can undermine the lives of women and girls and interfere with their enjoyment of their basic human rights. Since 2003 UNFPA has led and coordinated the Campaign to End Fistula globally.

Causes of Obstetric Fistula and How it Presents?

Direct causes of obstetric fistula

- Prolonged labour when a caesarean section cannot be timely performed. Obstructed and prolonged labour causes the foetal’s (baby) head to put too much pressure on the mother and damages the bladder, urethra or rectum.
- Pelvic fracture, cancer, or radiation therapy of the pelvic area,
- Sexual abuse, rape, and surgical trauma.

The affected tissues die and a fistula forms between the nearby organs. The following may occur:

- Fistula between vagina and bladder leading to continuous leakage of urine
- Fistula between rectum and vagina leading to leakage of faeces through the vagina
- Fistula between bladder, rectum and vagina leading to leakage of urine and faeces into the uterus first then vagina
**Indirect causes**

Social, political, and economic causes that indirectly lead to the development of obstetric fistula include:

- **Poverty:** Obstetric fistula occurs mostly among women and girls living in extreme poverty.
- **Malnutrition:** Lack of access to proper nutrition contributes to stunted growth leading to underdeveloped pelvis not suitable for childbirth.
- **Lack of education:** Lack of knowledge on pregnancy complications leads to women presenting at health facilities without antenatal care resulting in delayed interventions for complications.
- **Early marriage and childbirth:** Obstetric fistula afflicts girls who become pregnant while still physically immature.
- **The role and status of women in society:** Husbands and other family members have control in determining the healthcare that the women receive.
- **Harmful traditional practices** especially those that encourage child marriages.
- **Lack of good quality or access to maternal health care.** This could be due to shortage of skilled personnel at delivery.

**Effects of Obstetric Fistula on the Woman**

A woman with obstetric fistula goes through humiliating experiences such as continuous leakage of urine and faeces. The leakage irritates the skin around the genital area and also gives off offensive odour. Other serious problems are infection of the urinary system, and sexual dysfunction. Psychosocially, the woman may be abandoned by her husband and significant others as she loses her dignity. Stigma and depression are serious consequences leading to isolation.

**How to prevent Obstetric Fistula?**

- Information on family planning to all women who desire it, considerably reduces maternal deaths and disability by at least 20 per cent.
- Early booking and regular antenatal care attendance. Minimum 8 antenatal visits.
- Health education on importance of institutional delivery.
- Availability and access to skilled birth attendants.
- Ensuring skilled birth attendance at all births for safe and timely emergency obstetric care when complications occur.
- Improved nutrition to ensure healthy bodies and prevent stunted growth which reduces size of pelvis leading to obstructed labour.
- Changes to traditional practices such as early marriages.

**Treatment, reintegration and follow-up**

- Reconstructive surgery is required to repair a fistula.
  - Two weeks or more are needed to ensure a successful outcome.
- Counselling and support for livelihood skills, literacy, job training and health education are necessary to help women reintegrate into their communities.
  - Rebuild their lives and regain their dignity and hope after treatment.
- Follow-up after treatment to ensure they do not develop the injury again during subsequent births.
The Campaign to End Fistula in Zimbabwe: Restoring the Dignity of Women and Girls

In Zimbabwe, Campaign to End Fistula began with a needs assessment carried out by Ministry of Health and Child Care (MOHCC) in 2009 revealed that obstetric fistula is a huge problem in Zimbabwe. In September 2015, Ministry of Health and Child Care in partnership with UNFPA and the Women and Health Alliance International (WAHA) conducted its first ever fistula repair camp at Chinhoyi Provincial hospital where about 30 women underwent corrective surgery. Thereafter camps have been held every quarter and the response has been overwhelming, with 565 women with fistula having been repaired by November 2018. Currently 54 women are on the waiting list.

Obstetric Fistula repair is a much needed intervention, since for so many years, women with this condition have been suffering in silence. Some of the women who have received this surgery have been living with the condition for more than 15 years. UNFPA is providing financial support for the fistula repair camps through:

- Procurement of fistula repair kits
- Procurement of hygiene kits for clients admitted for fistula repair
- Hospital administration fees paid to the institution conducting fistula repairs
- Supporting training of health workers (doctors and nurses) in pre and post-operative fistula management.
- Allowances for health workers (doctors and nurses) training in fistula management
- Client transport to and from repair sites

What needs to be done

- Obstetric Fistula affects women and girls living in extreme poverty who have no resources to pay for medical expenses. As a result of incontinence caused by fistula many women are face social isolation, women and girls are robbed of their dignity and status in society, robbed of their source of livelihoods by forcing them to be confined to the back of their homes. Without any intervention; women with Obstetric fistula are driven further into poverty. For this reason:
- Advocate for the prevention of child marriage
- Support all women to live healthy and productive lives without being victims of their maternal roles and with dignity and respect.
- More resources are required to reach women with this life changing surgery and support them with reintegration into society