Audit of SRHR laws and policies in SADC



Voice + Choice
Action and results for SRHR in SADC

SADC GENDER PROTOCOL ALLIANCE

GENDER LINKS
FOR EQUALITY AND JUSTICE

Contents

Acknowledgements 1
Acronyms 2
Executive summary 3

OVERVIEW SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS POLICIES AND LAWS 4-5

SECTION ONE: SEXUAL AND REPRODUCTIVE HEALTH 6
Menstrual Health 8
Maternal Health 10
Contraception and family planning 12
Comprehensive sexuality education 15
Teenage pregnancy 17
Safe abortion 19
Sexual diversity 21
Sex work 22
SECTION TWO: HIV and AIDS, and STIs 23
HIV and AIDS policies 15
Criminalising HIV transmission 25
New infections 27
SECTION THREE: CHILD MARRIAGES 28
Status of the age of marriage across SADC 19
Child marriage laws 29
SECTION FOUR: GENDER BASED VIOLENCE 33
Overview of laws on GBV across SADC 33
Conclusions and recommendations 34

References 35
ANNEX ONE: SOUTHERN AFRICA GENDER PROTOCOL ALLIANCE SRHR POLICIES AND LAWS SURVEY 36

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
DRC	Democratic Republic of Congo
GBV	Gender-Based Violence
FP	Family Planning
HIV	Human Immune Deficiency Virus
ICPD	International Conference on Population and Development
PoA	Plan of Action
IMR	Infant Mortality Rate
MHM	Menstrual Hygiene Management
MMR	Maternal Mortality Ratio
MDGs	Millennium Development Goals
MS	Member State
NGO	Non-Governmental Organisation
PAC	Post-Abortion Care
PNC	Postnatal Care
SADC	Southern African Development Community
SDGS	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United National Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Executive summary



Awaiting the decision on the decriminalisation of homosexuality in Botswana. *Photo: Mpho Molemisi*

The *Audit of SRHR Laws and Policies* in SADC provides a picture of region with a diverse legislative and policy landscape. In areas such as gender-based violence and HIV and AIDS there are strong legislative and policy frameworks. GBV, however, remains at crisis levels. There is need to step back in order to move forward. Current strategies are not working and urgent prevention strategies are needed. HIV and AIDS policies are woefully out of date. Reviews and updating to take into account new strategies such as the 90:90:90 and new areas such as HPV and increasing new infections amongst young women between ages 15 and 49.

In other areas such as abortion, sex work, decriminalising homosexuality and child marriages there has been little movement in the policy and legislative arena. None of the SADC countries have specific laws on child marriage despite all SADC states adopting the Model Law on Child Marriages. Similarly, 14 SADC countries criminalise sex work with Mozambique criminalising organising sex work.

Homosexuality remains a criminal offence in eight countries and a crime for people under 21 in Madagascar. Four countries, Angola, Botswana, DRC and Zimbabwe have prosecuted members of the LGBTI+ communities. Decriminalisation is an important first step towards developing social protections for the LGBTI+ community.

Only two countries provide for unrestricted abortion, South Africa and Mozambique. Uptake of safe, legal abortion in South Africa is less than 10%. The new legal provisions in Mozambique are not popularised and the Government does have a comprehensive roll out plan. Lobbying for unrestricted abortion in all SADC countries is critical to address high levels of maternal mortality and teenage pregnancies. The current maternal mortality rates (MMR) in SADC higher substantially higher than the 70 per 100 000 live births. Only two countries, Mauritius and Seychelles are below

that level. MMR levels in Zimbabwe, Angola, Lesotho, Mozambique, Malawi and DRC are between 400 and 700, this is unacceptably high.

Teenage pregnancies and menstrual health are inextricably linked to comprehensive sexuality education (CSE). Most SADC countries provide CSE. The question remains as to how effective the content and delivery is in the classroom. This also impacts on the SRH services young people know about and can access. The menstrual health discourse revolves around the provision and removal of value added tax (VAT) on sanitary ware. These are important considerations. The discourse must include strategies to provide water and sanitation to all schools.

The audit provides an overview SRHR policies in the SADC region. Some policies, such as Namibia 2001, are very old and some while very recent, contain regressive provisions such as in Madagascar where abortion is outlawed under

OVERVIEW SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS POLICIES AND LAWS

Table one: Summary of SRHR policies

Country	SRHR Policy/ Guidelines	Protect pregnant girls' right to stay in school or conditional re-entry	Marriage age over 18 for girls and boys without exceptions	HIV and AID Policy	Human trafficking law
Angola	No	No	No	Yes	Yes
Botswana	Yes	Yes	Yes	Yes	Yes
DRC	No	Yes	Yes	Yes	Yes
Eswatini	Yes	Yes	No	Yes	Yes
Lesotho	Yes	Yes	No	Yes	Yes
Madagascar	Yes	Yes	Yes	Yes	Yes
Malawi	Yes	Yes	Yes	Yes	Yes
Mauritius	Yes	No	No	Yes	Yes
Mozambique	Yes	Yes	No	Yes	Yes
Namibia	Yes	Yes	No	Yes	Yes
Seychelles	Yes	No	No	Yes	Yes
South Africa	Yes	Yes	Yes	Yes	Yes
Tanzania	Yes	No	No	Yes	Yes
Zambia	Yes	Yes	No	Yes	Yes
Zimbabwe	Yes	Yes	Yes	Yes	Yes
Yes	**13**	**11**	**6**	**15**	**15**
No	**2**	**4**	**9**	**0**	**0**

any circumstances. A strong policy framework that guides SRHR in all countries is a necessary foundation. Every country must lobby and advocate for changes to improve SRHR for citizens and particularly for key populations including amongst others youth, sex workers and LGBTI+ communities.



LGBTI People's Pride March - Johannesburg, South Africa.
Photo: Laurie Adams

and laws in 15 SADC countries

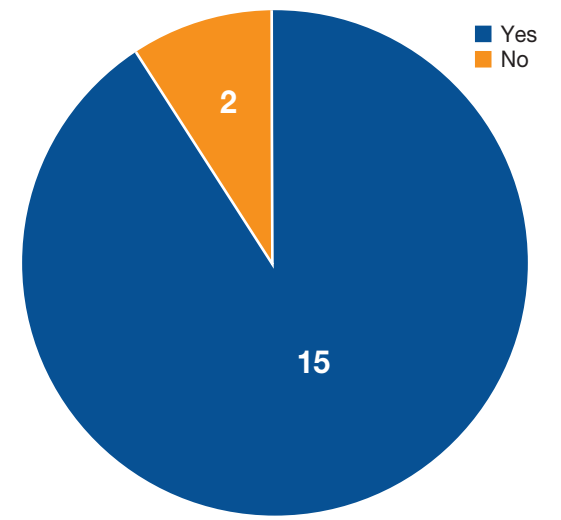
Sexual assault/ offences law	Domestic violence law	Sexual harassment law	Sex work decriminalised	Unrestricted abortion	Homosexuality decriminalised
No	Yes	No	No	No	Yes
Yes	Yes	Yes	No	No	No
Yes	No	Yes	No	No	Yes
Yes	Yes	Yes	No	No	No
Yes	No	Yes	No	No	No
Yes	Yes	Yes	No	No	No
Yes	Yes	Yes	No	No	No
Yes	Yes	Yes	No	No	No
Yes	Yes	Yes	No	Yes	Yes
Yes	Yes	Yes	No	No	No
No	Yes	Yes	No	No	Yes
Yes	Yes	Yes	No	Yes	Yes
Yes	No	Yes	No	No	No
Yes	Yes	Yes	No	No	No
Yes	Yes	Yes	No	No	No
13	**12**	**14**	**1**	**2**	**5**
2	**3**	**1**	**14**	**13**	**10**

SECTION ONE
SEXUAL AND REPRODUCTIVE HEALTH

Stand-alone SRHR policies and laws, ensures that countries focus on SRHR issues in line with global and regional commitments that aim to give voice and choice to women and men.

Figure one shows that 13 out of 15 SADC countries have stand-alone policies or guidelines on SRHR. Of the 13 countries, 11 have SRHR policies while Botswana and Tanzania have SRHR guidelines. Angola and the DRC do not have stand-alone policies or guidelines.

Figure one: Number of countries with stand-alone SRHR policies or guidelines



Source: Gender Links



Sixteen Days of Activism March against GBV - Orange Farm, Johannesburg, South Africa. *Photo: Thandokuhle Dlamini*

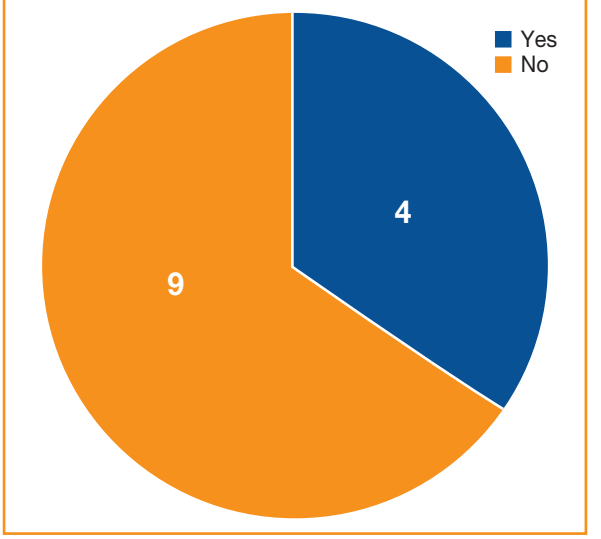
Table two: Status of SRHR policies in SADC		
Country	**Policies/Guidelines**	**Year**
SRHR policies		
Adopted more than five years old		
Namibia	National Policy for Reproductive Health	2001
Mauritius	National Sexual and Reproductive Health Policy	2007
Lesotho	National Reproductive Health Policy	2008
Zambia	National Reproductive Health Policy	2008
Malawi	National Reproductive Health and Rights Policy	2009
Zimbabwe	National Adolescent Sexual and Reproductive Health Strategy	2010 - 2015
Mozambique	National Sexual and Reproductive Health Policy	2011
Seychelles	Reproductive Health Policy for Seychelles	2012
Five years or less		
eSwatini	National Policy on Sexual and Reproductive Health	2013
South Africa	Sexual and Reproductive Health and Rights: Fulfilling our Commitments and "National Adolescent Sexual and Reproductive Health and Rights Framework Strategy"	2014 - 2019
Madagascar	Reproductive Health and Family Planning Law	2017
SRHR Guidelines		
Botswana	Policy guidelines and service standards for sexual and reproductive health	2015
Tanzania	SRHR guidelines and National Adolescent Reproductive Health Strategy	2011 - 2015
No SRHR policy or guidelines		
Angola	Included in the Constitution	1975
DRC	Included in the Constitution	2011

Source: Gender Links

Table two shows that eight SADC countries have SRHR policies that are more than five years old. Namibia's SRHR policy is 18 years old. These policies need urgent review and revision. South Africa, eSwatini and Madagascar have policies that are less than five years old. Madagascar adopted their SRHR policy in 2017. The new Madagascar SRHR Policy is a welcome development however it is important to note that the new policy prohibits abortion under any circumstances.

Botswana and Tanzania need to review their guidelines and lobby for relevant longer term SRHR policies. Angola and DRC do not have SRHR policies. These are urgent as both countries are dealing with post conflict conditions.

Figure two: Number of countries reviewing SRHR policies



Source: Gender Links

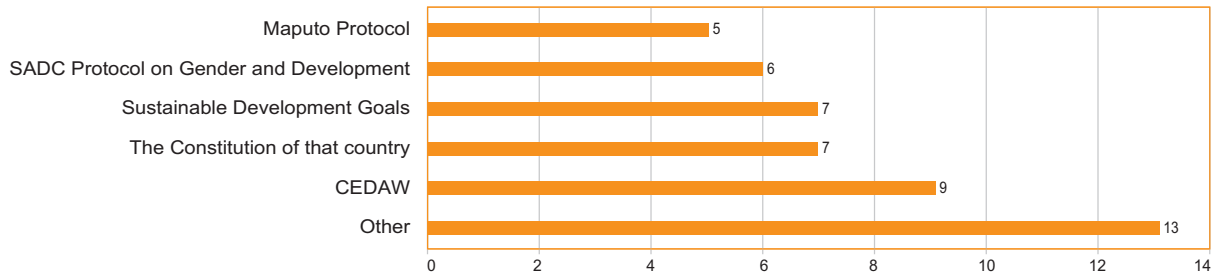
Out of the 13 countries that have stand-alone SRHR policies or guidelines, four (South Africa, Botswana, Namibia and Seychelles) are reviewing their SRHR policies. South Africa is in the final stages of adopting a new SRHR policy.

Moving forward all SADC countries should align their SRHR policies with the provisions of the SADC Protocol on Gender and Development and the SADC SRHR Strategy 2019-2030.

Linking SRHR policies with regional and global instruments

There are several global and regional instruments that address reproductive health, GBV, HIV and AIDS, and women's rights, country specific SRHR policies should refer to and align the targets of existing instruments for easier coordination.

Figure three: Global and regional instruments referenced in SRHR policies



Source: Gender Links

Figure three shows countries reference several global and regional instruments as overarching frameworks in their SRHR policies and guidelines. Five include the Maputo Protocol; six countries reference the and seven countries make reference to the SDGs and national constitutions. Thirteen countries cite other sources. These include the MDGs; Cairo 1994 International Conference on Population and Development (ICPD); the SADC minimum package for SRHR services; the global Family Planning 2020 framework and the Beijing Platform for action.

Menstrual Health

Research shows that 800 million women and girls menstruate every day, but menstruation remains shrouded in silence and taboos[1]. A key step towards demystifying menstruation is providing free menstrual products. This will enable girls to go to school and to do everyday activities without restriction.

Only four SADC countries, Botswana, Madagascar, Seychelles, and Zambia provide free menstrual products in schools. This affects the menstrual hygiene of girls and puts them at risk of using unhygienic methods[2] such as rags and newspapers. This is not only a health hazard but often leads to poor school performance. The provision of free menstrual products must be accelerated in all SADC countries as an integral part of adolescent sexual and reproductive health services.

The challenge that remains however is that out-of-school young women will not have access to free menstrual products. Governments need to plan for the SRHR needs of out-of-school youth. The provision of free menstrual products is the ultimate goal in all countries. While countries work on strategies to achieve this goal the removal of Value Added Tax (VAT) on menstrual products is a positive move in promoting access to affordable menstrual products for women and girls.

1 https://iwhc.org/2018/07/integrating-menstrual-hygiene-management-achieve-sdgs/
2 https://genderjustice.org.za/article/high-cost-sanitary-pads-puts-south-african-girls-education-risk/

Zimbabwe removes duty on menstrual products[3]



The lack of access to menstrual products and proper sanitation compromises girls' ability to go to schools.
Photo: Alliance Young Women

Government has removed duty on menstrual products, a move likely to get support from women as the price of basic toiletries is now beyond the reach of many. Gender activists and legislators have over the years pleaded with Government for duty free and subsidised sanitary ware, to no avail. Speaking during yesterday's pre-budget seminar in Bulawayo, Finance and Economic Development Minister, Professor Mthuli Ncube, said it was a 'done deal' and he would announce it in the 2019-budget statement. “The cost of sanitary ware and removing duty on it, consider it done,” he said. “We will have something on the budget on this issue of sanitary ware. Consider it done; there is no debate.”

In his presentation, chairperson of the portfolio committee on Budget, Finance and Economic Development Cde Felix Mhona had proposed a subsidy for sanitary ware. “Honourable Speaker Sir, concerns were raised over the cost of sanitary ware which is now beyond the reach of many and it was proposed that Government subside sanitary ware and consider giving it for free to all girls of school going age,” he said. MDC-T Bulawayo legislator (proportional representation) Mrs Priscilla Misihairabwi-Mushonga, who has been advocating for the cause for years, could not hide her joy at the news. “I'm excited, although it has taken us almost two decades to get to a point where Government has agreed and it is a legacy that this particular Minister will take with him for a very long time,” she said.

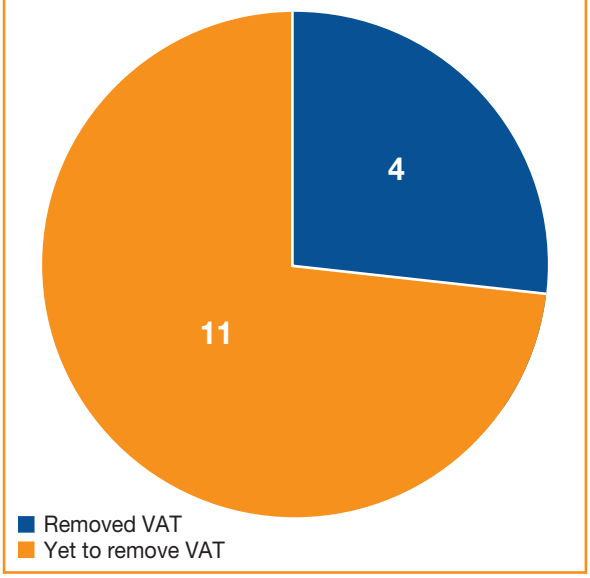
“There is no VAT (Value Added Tax). So, we are also not paying duty.” Mrs Misihairabwi-Mushonga caused a stir when she brought a sanitary pad to Parliament last year in a bid to emphasise her point. “So, from there we can now start talking of provision of free sanitary ware in primary and secondary schools because even for NGOs that wanted to assist, one of the major problems is that they were being hit by duty,” she said. The cheapest pack of sanitary pads costs more than $2, while expensive brands go for up to $10. Those who can afford the luxury of tampons have to fork out $4 for the cheapest one.

About 20 percent of girls in rural schools do not attend school during mensuration because they cannot afford sanitary ware. Some girls have to share the same piece of cloth with their mothers to stem menstrual flow, as they cannot afford proper pads. Some of them reportedly use leaves, newspapers and cow dung, which can cause thrush, bruises, discomfort and diseases like cancer.

Source: The Herald, Zimbabwe

3 https://www.herald.co.zw/govt-removes-duty-on-sanitary-ware/

Figure four: Status of VAT free menstrual products in SADC



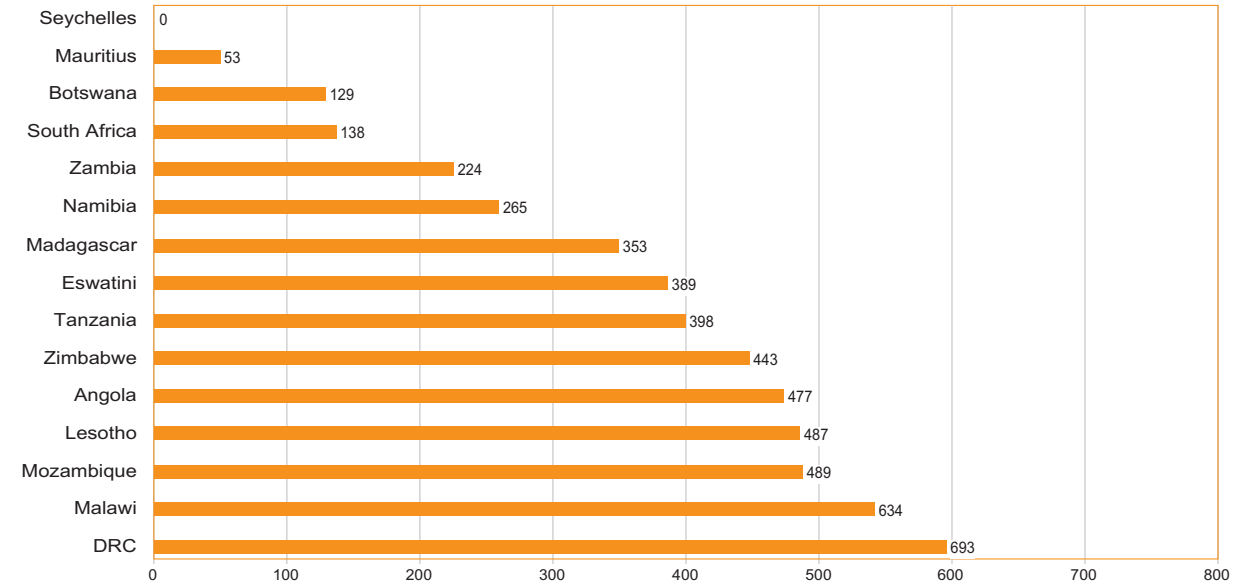
Source: Gender Links

As illustrated in figure four, by the end of 2018, four SADC countries (Mauritius, South Africa, Tanzania and Zimbabwe), removed VAT on menstrual products. This represents an important first step towards providing affordable menstrual products.

Maternal Health

The WHO defines maternal health as the health of women during pregnancy, childbirth and the postpartum period[4]. More often, women die because of lack of access to proper reproductive health care. The Maternal Mortality Ratio is an indicator for monitoring Sustainable Development Goal 3 Health and Wellbeing, target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births[5].

Figure five: Maternal Mortality Rate (MMR) per 100,000 by country, 2018



Source: Gender Links

4 https://www.who.int/maternal-health/en/
5 https://www.africanhealthstats.org/cms/?pagename=country&country=SC

Figure five shows that maternal mortality rates (MMR) vary by country. MMR is lowest in Seychelles and highest in DRC. The MMR for the Seychelles has substantially reduced over the last 10 years to a figure that cannot be computed out a 100 000 because it is so low. Mauritius is also below the target of 70 per 100,000 live births.

Thirteen countries in SADC are above the target with the DRC being almost ten times higher than the required standard. Improvements in SRHR are critical in reducing maternal mortality, as well as ensuring social and economic development for women. There is need for the SADC region to improve health outcomes for women by providing access to comprehensive maternal health care, family planning and HIV and AIDS services.

Table three: Provisions for antenatal, post-natal care, and skilled attendants at birth

Countries	ANC (%)		Post-natal care (%)	Skilled birth attendants (%)
	At least one visit	At least four visits		
	2010 - 2015			
Angola	82	61	23	50
Botswana	94	73		99
DRC	88	48	44	80
eSwatini	99	76	88	88
Lesotho	95	74	62	78
Madagascar	82	51		44
Malawi	95	51	42	90
Mauritius	-	-		100
Mozambique	91	51		54
Namibia	97	63	69	88
Seychelles	-	-		99
South Africa	94	76	84	94
Tanzania	91	51	34	64
Zambia	96	56	63	63
Zimbabwe	98	76	57	78

Source: Gender Links

Table three shows that between 82 and 99% of pregnant women and girls across all SADC countries have at least one antenatal visit. A much lower proportion of women have at least four antenatal visits. The figures in Botswana, eSwatini, Lesotho, South Africa and Zimbabwe are encouraging with over 70% of pregnant women and girls having at least four antenatal visits.

Very low proportions (between 44 and 54%) of women and girls have skilled birth attendants during delivery in Angola, Madagascar and Mozambique. Five SADC countries (Botswana,

Malawi, Mauritius, Seychelles and South Africa) provide skilled birth attendants to over 90% or more of pregnant women and girls.

Contraception and family planning

Contraception changes lives. When contraception increases, states can have higher levels of economic growth, become less dependent on foreign aid, see more girls continue their education, are more stable and secure, and have less gender inequality.[6] The ability to control when, where, how many and under what conditions to have children are key indicators of women's agency and decision making power. This impacts on every aspect of a woman's life.

In Southern Africa, women's ability to control their fertility is compromised by high levels of sexual violence, customary laws and lack of access to the contraception. Early pregnancies are severely impacting young women and their futures. There is need to have separate strategies on the provision of contraception and family planning. The first will address the need for all women across all ages to access contraception.



The second should address women who want have children to plan in a way that does not impact their wellbeing from a health, social or economic perspective. This is a key policy imperative moving forward.

There is a need for further research on the what SRHR policies provide for in regard to contraception provision and an analysis of which countries have stand-alone contraception and family planning policies. For example, Zambia has a *Comprehensive Condom Programming Strategy and Operation Plan*, it is important to understand what this policy covers and what is in place for women.

At a global level, the DRC, Lesotho, Mozambique, Tanzania, Zambia and Zimbabwe have committed to the Family Planning 2020 (FP2020) initiative. FP2020 works with governments, civil society, multilateral organisations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

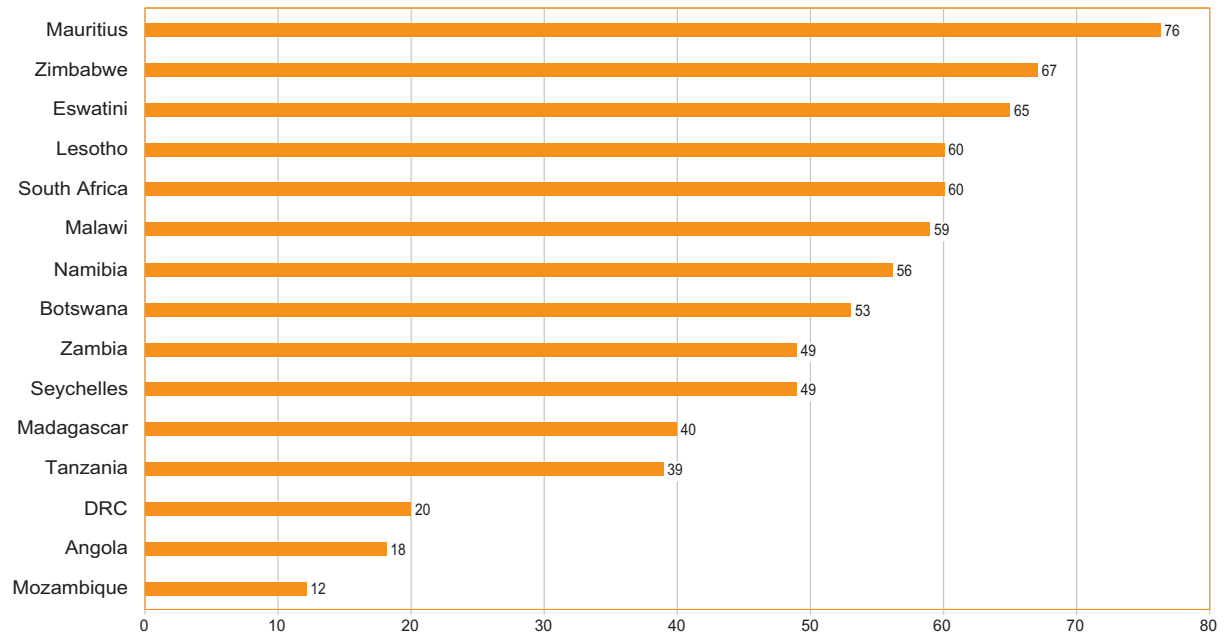
Achieving the FP2020 goal is a critical milestone to ensuring universal access to sexual and reproductive health services and rights by 2030, as laid out in Sustainable Development Goals 3 and 5. FP2020 is in support of the UN Secretary-General's **Global Strategy for Women's, Children's and Adolescents' Health**.[7]

Contraceptive prevalence rates

The contraceptive prevalence rate (CPR) shows the percentage of women between ages 15 and 49 in marital or consensual unions who are using or whose sexual partner is using a traditional or modern method of contraception. The CPR is an important indicator of health, population, and women's empowerment[8].

6 https://mariestopes.org/media/2146/time-to-invest.pdf
7 https://www.familyplanning2020.org/about-us
8 https://www.africanhealthstats.org/cms/?pagename=indicator&indicator=RMNCH3

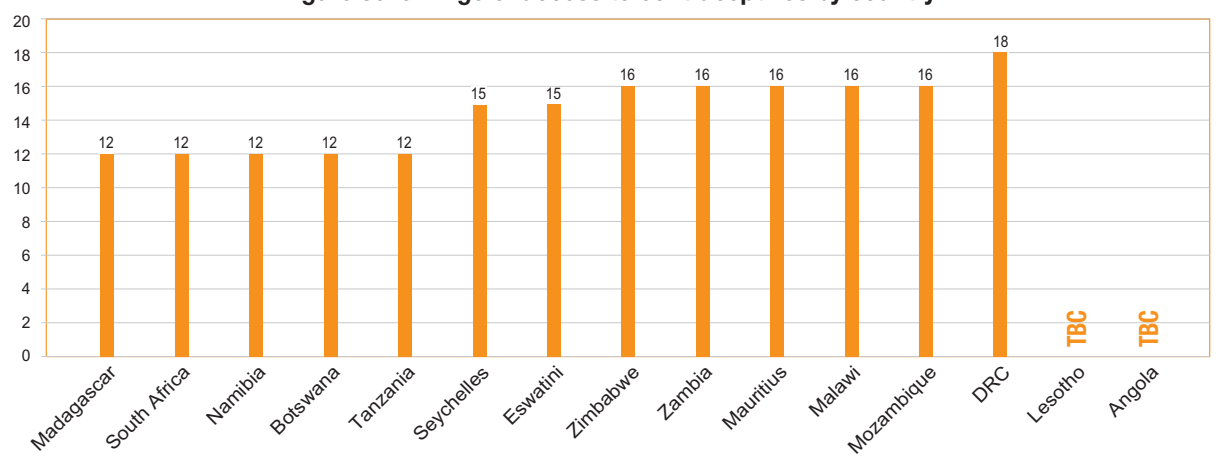
Figure six: Contraceptive prevalence rates in SADC countries



Source: Gender Links

Figure six shows wide disparities in contraceptive prevalence rates across SADC countries. The CPR is highest in Mauritius (76%) and lowest in Mozambique (14%). It is critical for the alliance SRHR cluster to identify the groups of women not accessing contraception in order to target local and regional lobbying and campaign efforts. The failure to provide contraceptive care has huge implications for unintended pregnancies, unplanned births, abortions, and miscarriages increasing levels of maternal mortality in countries.

Figure seven: Age of access to contraceptives by country



Source: Gender Links

As is evident in figure seven five SADC countries (Madagascar, South Africa, Namibia, Botswana and Tanzania) provide contraceptives to young people from the age of 12. The Seychelles and Eswatini start at age 15. Five countries (Zimbabwe, Zambia, Mauritius, Malawi and Mozambique) allow for contraception from age 16 and the DRC at 18. Data for Angola and Lesotho needs to be confirmed. The SADC SRHR Strategy provides for contraception from age 10. Given the high level of early pregnancies the age of consent for contraception should lowered in the countries where the age of consent for contraception is higher than 12.

Adolescent SRHR

It is imperative that countries in SADC develop focused Adolescent SRHR strategies and policies to address the needs of young people.

Table four: Number of countries with adolescent and youth SRHR policies across SADC[9]

Country	Stand-alone policy or strategy
Angola	No
Botswana	No
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020
eSwatini	No
Lesotho	Yes, National Health Strategy for Adolescents and Young People 2015-2020
Madagascar	Yes, Adolescent and Youth Health Strategy (2016-2020)
Malawi	Yes, National Youth Friendly Health Services Strategy 2015-2020
Mauritius	No
Mozambique	No
Namibia	No
Seychelles	No
South Africa	Yes, Adolescents and Youth Health Policy 2016 - 2020
Tanzania	No
Zambia	Yes, National Adolescent and Youth Health Strategy (2016-2020)
Zimbabwe	No

Source: African Health Observatory

Only six SADC countries have stand alone ASRHR policies or strategies, these include DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia. Adolescent SRHR is included in the national SRHR policies, strategies or guidelines in other SADC countries. It is important to explore how these strategies have improved SRHR for young people in those countries.

9 aho.afro.who.int/profiles_information/index.php/

Table five: Countries with laws and policies requiring parental consent for adolescents to access sexual and reproductive health services, eastern and southern Africa, 2018[10]				
Country	**Not required**	**Yes, if under age 14**	**Yes, if under age 16**	**Yes, if under age 18**
Angola				✗
Botswana			✗	
DRC[11]				✗
eSwatini				✗
Lesotho		✗		
Madagascar	✗			
Malawi		✗		
Mauritius		✗		
Mozambique	✗			
Namibia	✗			
Seychelles				✗
South Africa	✗			
Tanzania	✗			
Zambia			✗	
Zimbabwe			✗	

Source: UNAIDS

As illustrated in table five only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) in SADC do not require parental consent for adolescents to access SRHR services. In Lesotho, Malawi and Mauritius parental consent is required if you are under age 14, this applies to Botswana, Zambia and Zimbabwe if you under age 16. In Angola, DRC, eSwatini and Seychelles adolescents cannot access SRHR services. Anyone under the age of 18 cannot access SRHR services without parental consent.

Adolescents and young people face many barriers in accessing sexual and reproductive health services, ranging from the judgmental attitudes of staff towards sexually active unmarried youth, inconvenient opening times and locations, lack of privacy, fear of lack of confidentiality, and costs.[12]

Lobbying for unrestricted access to SRHR services by adolescents is an important strategy to address key challenges such as increasing HIV infections amongst young people, early pregnancies and early marriages, menstrual health and unsafe abortions.

Comprehensive sexuality education

There is growing need to provide comprehensive sexuality education (CSE) to adolescents and young people. CSE is a rights-based approach

10 http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf
11 https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html
12 https://esaro.unfpa.org/sites/default/files/pub-pdf/SYP%20Annual%20Report%202017%20V2.pdf

to sexuality education. It promotes the acquisition of knowledge, skills and positive values of sexuality and reproductive health. One of the objectives of the voice and choice: from local to regional action by Gender Links and the Alliance is to promote better information and greater freedom of choice for adolescents and young people about their sexuality through schools, community media, and innovative technology.

In 2015, UNESCO conducted a global review of CSE in 48 countries across the world. The sample included 12 SADC countries. The review excluded Madagascar, Mauritius and Seychelles. The findings were published in a report entitled, '*Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education - A Global Review 2015*'.

Table six: Breakdown of CSE in 12 SADC countries[13]

Country	CSE place in the curriculum	Reflects international standards	Offered at		Mandatory or optional	Teacher training	National policy
			Primary	Secondary			
Angola	In progress - stand-alone	Under review to meet standards	Yes	Yes	Mandatory	Yes	Yes
Botswana	Integrated	Under review to meet standards	Yes	Yes	Integrated into mandatory subjects	Yes	Yes
DRC	Integrated	No	Yes	Yes	Mandatory and examinable	Yes	Yes
eSwatini	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes	Yes
Lesotho	Integrated - primary Stand-alone - secondary	Yes	Yes	Yes	Mandatory	Unknown	Yes
Malawi	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes	Yes
Mozambique	Integrated	Under review to meet standards	Yes	Yes	Mandatory and examinable	Unknown	Yes
Namibia	Stand-alone	Yes	Yes	Yes	Mandatory and assessment	Yes	Yes
South Africa	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes	Yes
Tanzania	Integrated	Yes	Yes	Yes	Mandatory and examinable	Yes	Yes
Zambia	Integrated	Yes	Yes	Yes	Mandatory and examinable	Unknown	Yes
Zimbabwe	In progress	Under review to meet standards	Yes	Yes	Mandatory and examinable	Yes	Yes

Source: UNESCO

13 https://unesdoc.unesco.org/ark:/48223/pf0000243106

The summary of the UNESCO review in table four shows that 12 SADC countries offer CSE in primary and secondary schools and have national CSE policies in place. Despite the strong CSE framework levels of teenage pregnancy and HIV infections amongst young women are rising. It is estimated that the current SADC population is 341 789 910 with two thirds of these under age 35.[14] The burgeoning youth population requires urgent attention. The quality and delivery of CSE is of concern.

Young people out of school are harder to reach with CSE and this requires greater effort. The out-of-school CSE framework will complement the in-school CSE curriculum and by so doing, support a holistic approach to ensuring consistency of rights-based and gender-sensitive information provided to all young people.[15]

Teenage pregnancy

According to the UNFPA, every day in developing countries, 20 000 young girls under 18 give birth. This amounts to 7.3 million births a year. Southern Africa has the highest level of adolescent pregnancy. It is estimated at 101 births per 1000 woman.

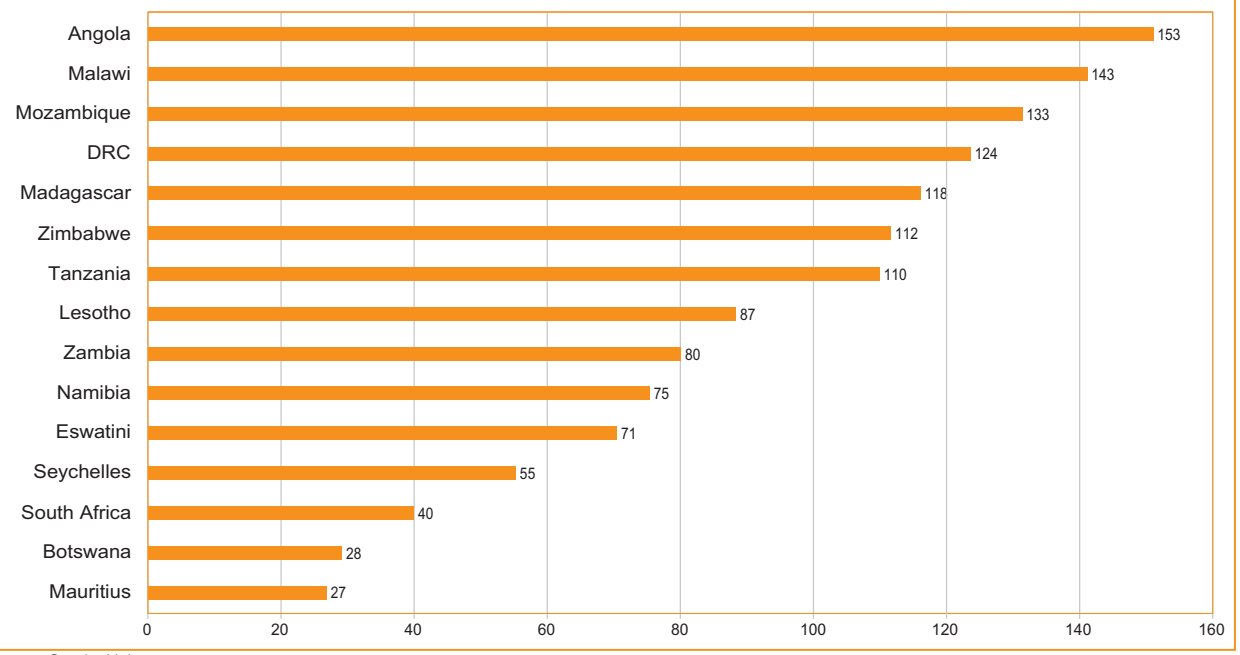
When a girl becomes pregnant, her life can change radically. Her education may end and her job prospects diminish. She becomes more vulnerable to poverty and exclusion, and her health often suffers. Complications from pregnancy and childbirth are the leading cause of death among adolescent girls.

Adolescent pregnancy is generally not the result of a deliberate choice - these girls often have little say over decisions affecting their lives. Rather, early pregnancy is a consequence of little or no access to school, information or health care.[16]



14 https://ineng.co.za/list-of-sadc-countries-in-2018/
15 https://esaro.unfpa.org/en/news/empowering-out-school-youth-cse
16 https://www.unfpa.org/adolescent-pregnancy

Figure eight: Adolescent live births per 1000 population



Source: Gender Links

Figure eight clearly illustrates that in seven SADC countries (Tanzania, Zimbabwe, Madagascar, DRC, Mozambique, Malawi and Angola) over 100 adolescent girls of every 1000 are having children. This represents 10% of adolescent girls of every 1000 whose education and future are compromised very early in their lives. While lower the figures Lesotho, Zambia, Namibia, eSwatini and Seychelles are also of concern.

Table seven: Breakdown of teenage pregnancy and school policies in SADC[17]

Protect pregnant girls' right to stay in school	Conditional re-entry	Expulsion	No policy
• DRC	• Botswana	• Tanzania	• Angola
• Lesotho	• Madagascar		• Mauritius
	• Malawi		• Seychelles
	• Mozambique		
	• Namibia		
	• South Africa		
	• eSwatini		
	• Zambia		
	• Zimbabwe		

Source: Human Rights Watch

17 https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and

The DRC and Lesotho have policies in place that protect pregnant girls' rights to stay in school. Botswana, Madagascar, Malawi, Mozambique, Namibia, South Africa, eSwatini, Zambia and Zimbabwe provide for conditional re-entry of pregnant girls. Tanzania expels pregnant girls and Angola; Mauritius and Seychelles have no policies in place for pregnant girls.

The policies on teenage pregnancy deal primarily with the girl with little focus on the father. In addition, while re-entry is possible in most SADC countries young mothers face many challenges including economic constraints and social barriers. All policies on teenage pregnancy must provide for social protections as well as economic support.

South Africa: Draft National Policy on the Prevention and Management of Learner Pregnancy

A review of the literature gathered during the mapping SRHR Policies and laws shows that South Africa has a draft national Policy on the Prevention and Management of Learner Pregnancy, which aims to tackle:

- high rates of pregnancy among learners
- family and social context within which this occurs
- options for reduction of unintended and unwanted pregnancies
- management of its pre- and post-natal implications
- limitation of associated stigma and discrimination
- and, importantly, the retention and re-enrolment of affected learners in schools

Further, to reduce the occurrence of unplanned teenage pregnancies, South Africa has embarked on the ***Mmoho Campaign***: a nationwide advocacy campaign that uses a positive, rights-based approach to change the conversation about teenage pregnancy as well as advocating for comprehensive and accessible sexual and reproductive health (SRHR) services for young women and men[18].

Source: Mmoho Campaign

Safe abortion

Unsafe abortion accounts for 10% to 13% of maternal mortality in the SADC region[19]. Women's lack of voice, choice and control in SRHR reflects in their failure to access safe abortion services despite several campaigns both virtual and physical campaigns in the recent past. To increase their agency and choice for reproductive health outcomes all women including adolescent girls need access to contraception care and unrestricted abortion. The provision of post abortion care is crucial in reducing the maternal and infant mortality rates.



Mercy Jaravani, WCoZ programs officer participating in a SRHR workshop in Zimbabwe. *Photo: Tapiwa Zvaraya*

18 http://www.mmoho.co.za/campaign/
19 http://genderlinks.org.za/news/press-release-sadc-organisations-call-for-safe-and-legal-abortion/

A snapshot of the provisions on abortion in the SADC region

- All SADC countries provide for abortion in some circumstances. This ranges from **South Africa** and **Mozambique**, where abortion is available on demand, to **Zimbabwe, Zambia, Botswana, Lesotho, Mauritius and Namibia**, where abortion is only available in certain circumstances; to **Seychelles, Tanzania, Eswatini, Malawi, Angola** and **DRC** where abortion is only available in extremely limited circumstances, to **Madagascar**, where abortion is totally outlawed.
- In **South Africa**, despite strong pro-abortion laws, access to the service remains a challenge, with only 7% of the country's health facilities providing abortions.[20] Research shows that many health workers refuse to perform the procedure, with government unable to do anything about it. Information about where and how to acquire the service remains limited.[21]
- **Mozambique** amended the Penal Code decriminalising abortion in 2015. The country has not popularised the new law nor has it operationalised the service.
- In **Lesotho**, government acknowledges the devastating effects of unsafe abortions on girls and women. Instead, it surreptitiously advises women to go across the border into South Africa where abortion is legal. The irony is not lost on human rights lawyer Lineo Tsikoane, who has said of the Ministry of Health: “They know abortion is illegal, but they're telling us to advise girls to go elsewhere, and [yet] won't change our own law.”
- The most common circumstances in which abortion is provided for are incest and rape; related to that, threat to the mother's mental well-being. Evidence of possible child deformities may also be grounds for abortion.
- While allowing for abortion in limited circumstances, **Zimbabwe** passed a law in 2012 that allows for post-abortion care. A much more cost-effective option would be to provide for safe abortion.
- It is clear that many of the laws governing abortion in SADC are inherited from the colonial era and are out of sync with modern rights-based laws. For example, the Abortion and Sterilization Act 2 of 1975 in **Namibia** dates back to 1975. One of the few grounds for abortion is where “a woman has been deemed to be an idiot or an imbecile as per the Immorality Act of 1957, which makes sex with her illegal.”
- On 24 February 2018, **Angola**'s parliament approved an amendment to the abortion law, making all abortions, without exception, illegal and punishable by between four to ten years' imprisonment. This is part of the process of replacing Angola's 1886 penal code. Parliamentary debate on the amendment stalled following a public outcry over it, leading to the ruling party proposing a revised version of the legal amendment. The revised version retained the legality of abortion in cases of rape or maternal health risk.[22]

20 Skosana, I (2017), 'Less than 7% of health facilities nationwide offer abortions - Amnesty International', available at: http://bhekisisa.org/article/2017-02-14-00-only-260-health-facilities-nationwide-offer-abortions-amnesty-international/ (accessed 26 February 2019)
21 Amnesty International (2018), Amnesty International Report 2017/2018, Amnesty International, London
22 The Citizen (2017), 'Angola Backs Down on Total Abortion Ban' available at https://citizen.co.za/news/news-africa/1542075/angola-backs-total-abortion-ban/ (accessed 23 March 2019)

Sexual diversity

Most SADC countries criminalise homosexuality. This impacts the ability of LGBTI+ communities in accessing sexual and reproductive health services and to fully realise their sexual and reproductive rights.

Table eight: Status of homosexuality in SADC countries[23]		
Homosexuality decriminalised	Homosexuality criminalised	
	Up 14 years in prison	Up to 30 years in prison
Angola	Botswana	Tanzania
DRC	eSwatini	Zambia
Lesotho	Namibia	
Madagascar - people over 21	Madagascar - people over 21	
Mozambique	Malawi	
Seychelles	Mauritius	
South Arica	Zimbabwe	

Source: The Citizen, South Africa



Some world leaders have called on African countries to recognise the rights of LGBTI people. *Photo: Luiz DeBarros*

Seven countries (Angola, DRC, Lesotho, Madagascar for over 21s, Mozambique, Seychelles and South Africa) have decriminalised homosexuality. Nine countries have laws in place criminalising homosexuality, in Madagascar homosexuality is a crime for people under 21.

Of the seven countries that have decriminalised only South Africa provides social protections and equal right for LGBTI+ communities. Same sex couples are able marry. LGBTI+ communities may adopt children and have equal access to all SRH services. In January 2019, Angola's High Court decriminalised homosexual relationships following the adoption of the new penal code by the country's parliament. The country's courts went further, making it a criminal act to discriminate another person on the basis of sexual orientation, with punishment of up to two years' imprisonment[24].

23 HIVOS, 2019
24 https://www.iol.co.za/news/africa/angola-lifts-ban-on-homosexuality-18965269

The Botswana High Court heard the matter of a gay man, LM, challenging the constitutionality of sections 164(a), 164(c) and 167 of the Botswana Penal Code in March 2014. These provisions criminalise same-sex sexual conduct between consenting adults in Botswana and impose a maximum sentence of seven years' imprisonment. The judgement will be provided on the 11 June 2019.

Strategic litigation is an important to challenge discriminatory laws and polices in countries that criminalise homosexuality. However, these initiatives must be accompanied by social protection strategies for LGBTI+ communities.

Sex work

Sex work is a crime in 14 SADC countries. Mozambique decriminalises organising sex work and soliticitation.[25] Female sex workers face many barriers to accessing sexual and reproductive health (SRH) care because of stigma and discrimination, which increase their vulnerability and impede their right to access health services. Other factors contributing to poor SRH outcomes include high sexually transmitted infections (STI) prevalence, HPV infection and thus risk for cervical cancer, unintended pregnancies, repeated physical and emotional abuse, high mobility and frequently an illegal immigrant status.



Sex worker populations are heterogeneous. Local health programmes must prioritise services that reflect the variety and complexity of sex worker needs and behaviours, and should be designed in consultation with sex workers. Segmenting sex worker populations according to age, country of origin and place of service delivery, and training healthcare providers accordingly, could help prevent new HIV infections, improve adherence to antiretroviral treatment and increase uptake of SRH services.[26]

25 https://www.nswp.org/sex-work-laws-map
26 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5498862/

SECTION TWO
HIV and AIDS, and STIs

Sub Saharan Africa continues to bear the burden of HIV and AIDS and STIs. This places a significant impact on the ability of SADC countries to meet the SDGs and other regional commitments. Sound SRHR policies hinge upon the effective management of the impact of HIV and AIDS, and STIs. Thus, in order for countries to address SRHR issues in a holistic manner, there is need to have adequate and up to date policies.

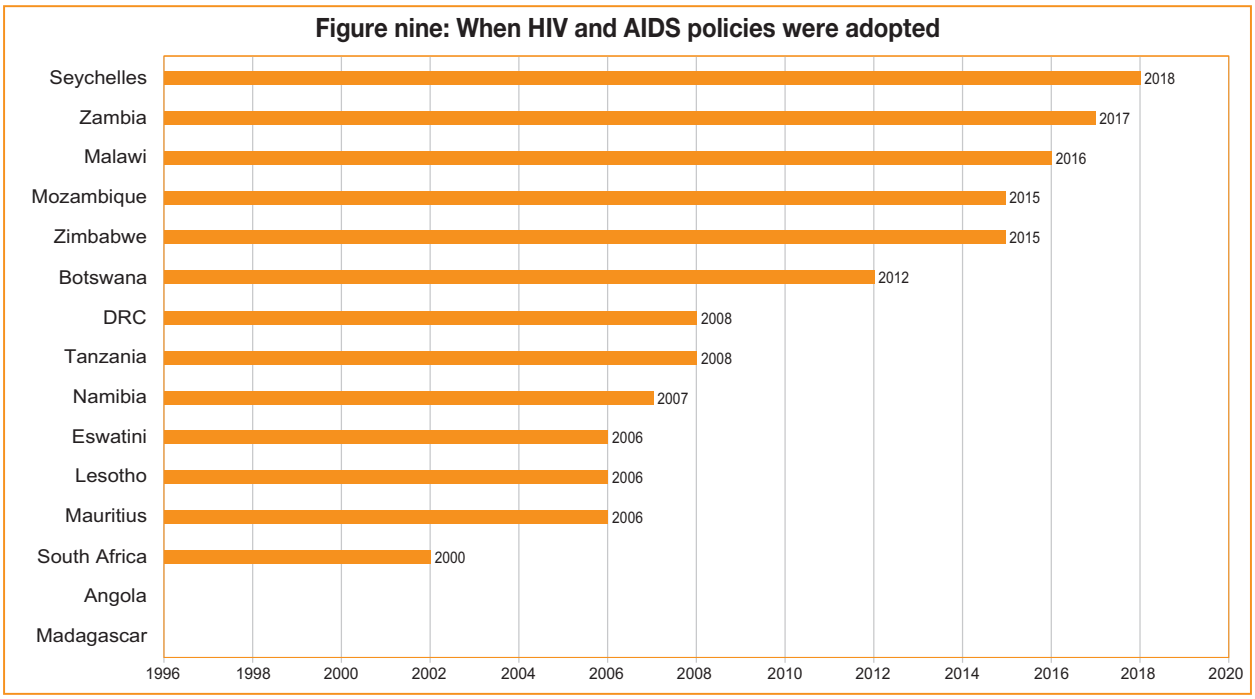
HIV and AIDS Policies

Table nine: No of countries with a stand-alone HIV and AIDS policy or strategy

Country	Country has stand-alone HIV and AIDS policy or strategy	HIV and AIDS policy includes other STIs
Seychelles	Yes	Yes
Zambia	Yes	Yes
Malawi	Yes	Yes
Mozambique	Yes	Yes
Zimbabwe	Yes	Yes
Botswana	Yes	Yes
DRC	Yes	Yes
Tanzania	Yes	Yes
Namibia	Yes	Yes
Eswatini	Yes	Yes
Lesotho	Yes	Yes
Madagascar	Yes	Yes
Angola	Yes	Yes
South Africa	Yes	Yes
Mauritius	Yes	No

Source: Gender Links

Table nine shows that all the SADC countries have a stand-alone HIV and AIDS policy. With the exception of Mauritius, the HIV and AIDS policies for all countries include other STIs. Having all countries with stand-alone HIV policies is a positive finding for the region, which is line with the SDG 3.3 to end HIV and AIDS as a public health threat by 2030.

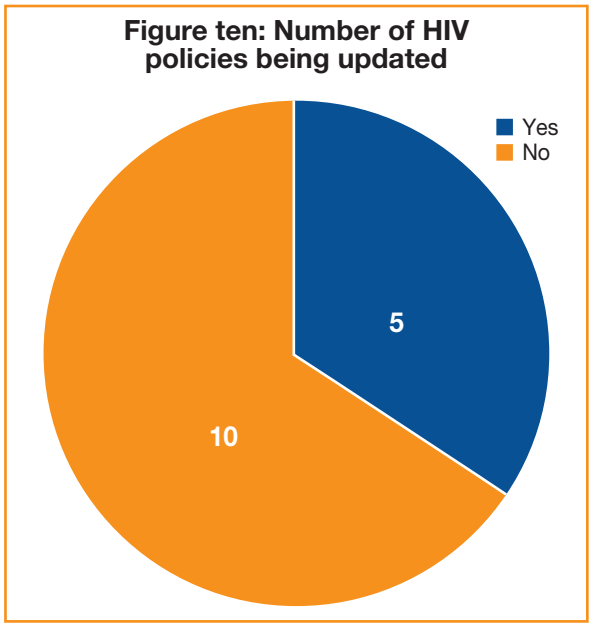


Source: Gender Links

Figure nine shows that countries adopted stand-alone HIV and AIDS policies between 2000 and 2018. Seychelles is the newest country to adopt a stand-alone HIV and Policy. By 2000, South Africa had already adopted a stand-alone HIV and AIDS policy.



Figure ten shows that there are only five countries currently updating their HIV and AIDS policies. These are Seychelles, Botswana, the DRC, Namibia, and Angola.



Source: Gender Links

Malawi passes progressive HIV legislation

Activists and civil society organisations from Malawi and across southern Africa applaud the government of Malawi for showing leadership in its HIV response and upholding human rights standards, with the recent passing of a new HIV/AIDS (Prevention and Management) Act No. 12 of 2017, which came into force on 1 February 2018. The Act has been received with approval by various stakeholders including, women's groups, movements of people living with HIV, and national, regional and international human rights organisations fighting against human rights infringements in national responses to HIV, including the criminalisation of HIV.

The HIV and AIDS (Prevention and Management) Act has been a standing item on Parliament's agenda for almost a decade now. Previous versions of the Bill contained provisions that were inconsistent with international good practice and violated fundamental human rights. The Bill, which had its origins in a 2008 Law Commission Report, included provisions to make HIV testing and treatment mandatory for select populations on a discriminatory basis, and provisions that criminalise HIV exposure and transmission.

As a result of concerted advocacy from civil society organisations in Malawi and beyond, powerfully led by women living with HIV in Malawi, the HIV and AIDS (Prevention and Management) Act that recently passed into law is free of these punitive and rights-infringing provisions. Parliament's willingness to remove these provisions and to pass the law in its current form is evidence of Malawi's commitment to promoting a human rights based response to HIV based on the best available scientific evidence and represents a significant step in moving the country closer to realising the 90-90-90 targets set by UNAIDS of having 90% of all people tested for HIV, 90% of these initiated on antiretroviral treatment and 90% of these having a suppressed viral load.

"We are greatly indebted to the parliamentarians for passing the HIV and AIDS Prevention and Management Act that will ensure that all Malawians, especially women and girls living with HIV, have equal access to quality HIV and AIDS services that are provided in an environment free of stigma and discrimination and in which human rights are protected," said Edna Tembo, Executive Director of the Coalition of Women Living with HIV/AIDS in Malawi (COWLHA).

"This is a moment to celebrate the women of the Coalition of Women Living with HIV/AIDS (COWLHA) who, with assistance in legal empowerment from the Women Lawyers Association (WLA) and others, were able to engage with the parliamentarians and sit in the House when the bill was read out and amended line by line," said Sarai Chisala-Tempelhoff of the WLA. *Source: South African Litigation Centre*

Criminalising HIV transmission

There are currently six SADC countries that criminalise HIV transmission.

Table ten: Countries that have criminalise HIV transmission and have prosecuted for HIV transmission[27]	
Countries with laws criminalising HIV transmission	**Countries that have prosecuted people for HIV transmission between 2013 and 2015**
Angola	✓
Botswana	✓
DRC	✓
Madagascar	
Mozambique	
Zimbabwe	✓

Source: HIV Justice Network

Criminalising people for having HIV is a violation of human rights that undermines public health efforts to control the epidemic. Prosecutions for HIV-specific crimes often flout core legal principles such as intent and causation. There is no evidence that applying the criminal law to HIV reduces its spread. Rather, such approaches promote fear and stigma about HIV, can adversely affect relationships between patients and health-care providers, and can discourage people from seeking HIV testing and treatment.

HIV criminalisation has particularly profound effects on women. Because women are often the first in a household to learn their HIV status, they can become vulnerable to blame and violence. The threat of prosecution is a potential disincentive for women to leave abusive relationships, and some laws are so broad that they criminalise transmission of HIV during pregnancy and breastfeeding.[28]



Addressing new HIV infections amongst young women is critical. *Photo: Thandokuhle Dlamini*

28 https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(18)30219-4/fulltext
29 http://www.southernafricalitigationcentre.org/2018/02/13/news-release-our-bodies-our-rights-activists-welcome-the-passing-of-the-malawi-hiv-and-aids-prevention-and-management-act/

New infections

There is growing evidence in SADC that new HIV infections are higher amongst women than men.

Table eleven: New HIV infections amongst women and men as at 2018[30]		
Country	**Women over age 15**	**Men over age 15**
South Africa	150 000	110 000
Mozambique	63 000	46 000
Tanzania	30 000	24 000
Zambia	23 000	17 000
Zimbabwe	20 000	17 000
Malawi	19 000	14 000
Angola	14 000	7 100
Lesotho	7 500	5 900
Botswana	7 200	6 000
Namibia	3 900	2 900
eSwatini	3 500	2 600
Madagascar	1 500	3 500
TOTAL	**342 600**	**256 000**
PERCENTAGE	**57%**	**43%**

Source: UNAIDS

Table eleven illustrates the differences in new HIV infections amongst women and men over age 15 in 12 SADC countries. New infections amongst women and men are higher than the requisite targets to meet the 90/90/90 targets. However, the number of new infections amongst women are substantially higher. Women make up 57% of new infections as opposed to 43% for men. There is need for urgent, targeted strategic interventions to reduce new HIV infections in SADC.

30 http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf

SECTION THREE
CHILD MARRIAGES

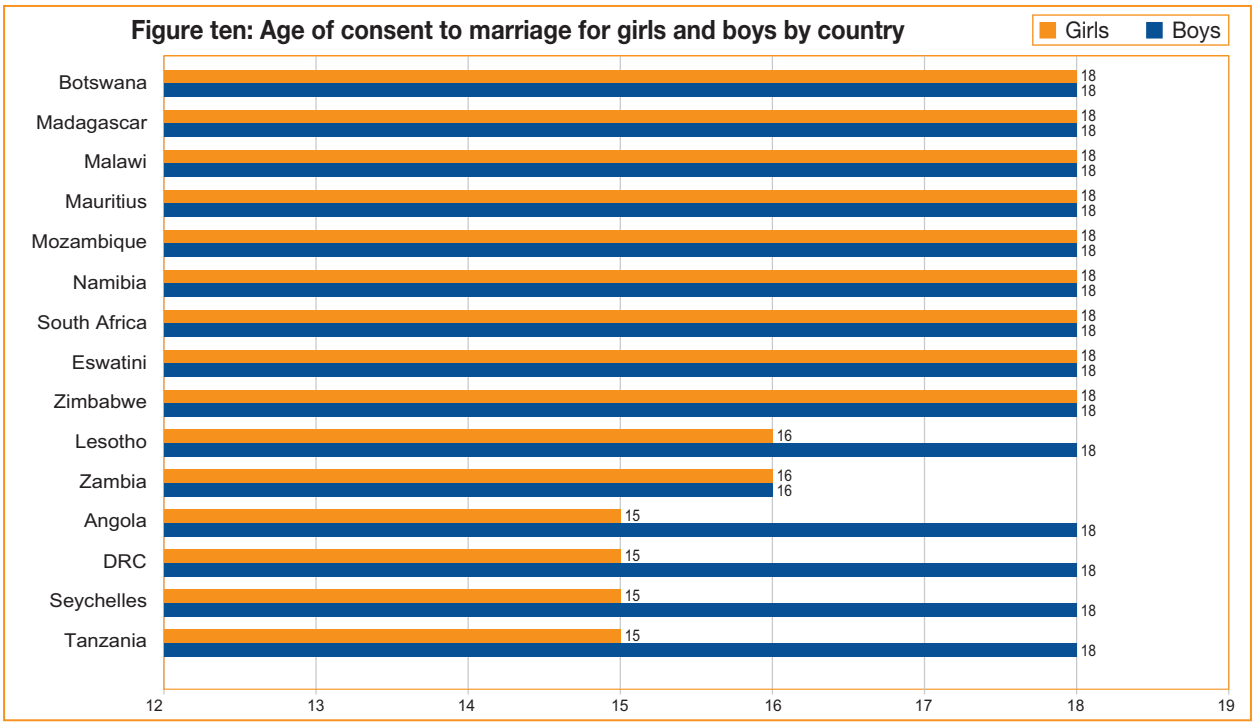
Article 20.1b of the SADC Protocol on Gender and Development, and the SADC Strategy on SRHR urges governments to remove political, cultural, social and economic barriers so that all people, in particular women and girls, are able to make decisions about their bodies including eliminating child marriage and gender-based violence.

Status of the age of marriage across SADC

Table twelve: Status of marriage age across SADC	
Marriage age over 18 for girls and boys without exceptions	**Marriage age for girls and boys not 18 or with exceptions**
Botswana; DRC; Madagascar; Malawi; South Africa; Zimbabwe	Angola; eSwatini; Lesotho; Mauritius; Mozambique; Namibia; Seychelles; Tanzania; Zambia

Source: Gender Links

Seven SADC countries stipulate that the minimum age of marriage girls and boys is 18. In eSwatini and Mauritius there are exceptions. Girls and boys can marry before 18 with parental consent or permission from the relevant court authority.



Source: Gender Links

In Lesotho the minimum age for marriage is 16 for girls and 18 for boys. In Zambia the minimum age for marriage for boys and girls is 16. In Angola, DRC, Seychelles and Tanzania the minimum age for marriage for girls is 15 and 18 for boys. The marriage age in Zambia is 21, however, girls and boys can marry with consent from parents if aged between 16-21 years. Girls and boys below 16 need the consent of a court judge.

Child marriage remains a problem in Southern Africa due to a variety of factors. In at least five countries in the Southern African Development Community (SADC), almost 40% of children are married before they are 18 years of age. Malawi and Mozambique are amongst 10 countries in the world with the highest rates of child marriage. In both countries over 50% of children are married before they are 18 years of age.[31]

Case study: Olufuko festivals, Northern Namibia

Olufuko is Aawambo tradition where girls often as young as 12 are prepared for womanhood, including marriage and pregnancy, and caring for families. Olufuko festivals are prevalent especially in the northern part of Namibia. Older men bid for young maidens on parade. The highest bidder can marry as many maidens as he wants.

Olufuko is a ceremony in which young girls are "declared" eligible for marriage, but in reality, it is nothing about that. Traditionally, Olufuko was a ceremony where concerned parents sent their young girls if they showed signs of rebelliousness and sexual promiscuity. Becoming pregnant out of wedlock is a huge shame in traditional Aawambo culture, so to avert shame the family, sends an unruly daughter to the Olufuko ceremony. Olufuko is a spiritual wedding ceremony. The girls are not wedded to men, but to a spiritual force that now has legal right to do with them whatever it likes. After having gone through the ceremony, girls are declared married. After this, they are free to have sexual intercourse with whomever they want. If they fall pregnant, it is no longer a shameful act. Olufuko is very much a spiritual ceremony, and the Namunganga facilitating it knows exactly what he will be doing: by opening the girls' lives to the influence of a dangerous spiritual force intent on using their bodies for their own purposes, he is an opener of doors, inviting evil spirits into the girls' lives. This does not enrich the young women's lives; instead, they are damaged and unable to maintain a healthy relationship or marriage. They tend to become sexually promiscuous, they are never at peace, and are terribly unhappy. This ceremony contributes to the rampant spread of HIV, gender-based violence, and the breakup of marriages.

Source: Gender Links

Child marriage laws

None of the SADC countries have specific laws on child marriage. Child marriages are criminalised through other legislation such as the law on Sexual Assault in the DRC, the Constitution in Malawi and the Marriage Acts in various countries. The challenge in 14 SADC

31 https://www.girlsnotbrides.org/resource-centre/sadc-model-law-child-marriage/

countries except South Africa, is the existence of dual legal systems. Statutory legal provisions do not apply to customary laws. Laws on child marriages must regulate statutory and customary legal provisions on marriage.

SADC states adopted the model Law on Child Marriages in June 2016. Member states need to domesticate the provisions of the model law as a matter of urgency.

Table twelve: Guide to implementing the SADC Model on Child Marriages[32]

AREA OF GOVERNMENT	GOVERNMENT ACTOR	ROLES AND RESPONSIBILITIES
Legislative branch	Parliament or legislature	Legislative Branch Parliament or legislature The Legislative Branch is the state sphere where laws are created or reformed. It materialises in the form of parliaments and congresses and each country has established specific parliamentary processes for the creation or reform of laws.
Some of the actions that the legislative branch can take to prohibit child marriage and protect children from the harmful effects of child marriage are: • Enact laws to prohibit child marriage and the betrothal of girls and boys and allow for the voidance of child marriages under certain circumstances; • Enact laws that specify the minimum age for marriage; • Enact laws that guarantee the right to registration at births and marriage; • Enact laws that prohibit discrimination against a child on any grounds; • Enact laws that guarantee reproductive rights and access to reproductive health services for girls and boys; • Enact laws that ensure children are treated equally before national laws and are accorded equal protection and rights regardless if they were born inside or outside marriage; • Enact laws that protect children from abuse, neglect and harmful practices; • Enact laws that ensure the right to education; • Enact laws to ensure that girls can stay in school after marriage, during pregnancy and after having children; and • Enact laws to guarantee the right privacy and confidentiality of the child.		
Executive Branch	Office of the President or Prime Minister, Government Ministries, Institutes and Agencies	The Executive Branch is the state sphere where Government actions are carried out. This is called public policy. Public policy may include sectoral plans or policies that can involve more than one Ministry, or Government programs or actions. The Executive Branch includes the various Government Ministries and agencies whose role is to transform social problems through public policies and budgets to address them.

32 https://www.girlsnotbrides.org/wp-content/uploads/2018/12/SADC-Model-Law-Toolkit.pdf

AREA OF GOVERNMENT	GOVERNMENT ACTOR	ROLES AND RESPONSIBILITIES
National Institute of Statistics and data collection and production sections of relevant Ministries	The National Institute of Statistics and the data collection arms of Ministries are responsible for verifying, approving, administering and publishing basic national statistical data and to regularly disseminate it to the general public. Some of the actions that data collection agencies can take prevent child marriage and protect children from the harmful effects of child marriage are: Collect and publish disaggregated data on the prevalence of child marriage, number and status of children already in marriage, causes of death of girls aged between 12 and 18 years of age, maintain an up-to-date record of information on the nature and magnitude of child marriage and keep track of emerging child marriage concerns to inform the development, implementation and monitoring and evaluation of public policies.	
Ministry responsible for registration of births	Needs to come up with criteria to determine the age of the person that is to get married when no birth certificate is available.	
Ministry responsible for labour	The Ministry or Department of Finance is responsible for developing and implementing economic policies.	
Some of the actions that the Ministry of Labour can take to prevent child marriage and address the needs of children in marriage and those that are victims of child marriage: • Develop and implement youth centred macroeconomic policies that includes regulation of the informal economy, ensure children are appropriately trained to take part in the formal labour market and get appropriately-timed career guidance and establish measures to ensure full participation in economic life for children in marriages and victims of child marriages; and • Promote entrepreneurship for children in marriages and victims of child marriages.		
Ministry responsible for social protection	The Ministry responsible for social protection is responsible for putting in place policies, measures and interventions to ensure that a child has access to adequate social protection and social security services.	
Ministries in charge of enforcing prohibition on child marriage	To ensure implementation of laws that prohibit child marriage, the Ministries should appoint public officers as child marriage prohibition officers or as a committee that can prevent child marriage. They should: • Collect evidence to prosecute people who break the law; • Raise awareness and sensitise communities of the consequences and effects of child marriage and advise them not to promote, help, or allow child marriage; • Gather and share statistics on children in marriage, including areas with high prevalence.	
Ministry responsible for Education	The Ministry of Education is responsible for the design, implementation, monitoring and evaluation of educational legislations, policies and programs and ensuring that all children have access to free and compulsory primary and accessible secondary education. In some countries it oversees the structures, human resources, budget and administrative and management of the education sector.	
Some of the actions that the Ministry of Education can take to prevent child marriage and address the needs of children in marriage and those that are victims of child marriage: • Ensure that every child has access to free and compulsory primary and accessible secondary education; • Enact policies and programs to ensure that pregnant girls continue and complete their education and take measures to ensure all children have equal access to education, including eradicating discrimination against a pregnant or married child, or victim of child marriage; • Ensure that the curriculum for all educational institutions integrates principles of equality and equity, incorporates life skills and comprehensive sexuality education; and introduces subjects that enhance the integration of the girl child in made dominated disciplines.		

AREA OF GOVERNMENT	GOVERNMENT ACTOR	ROLES AND RESPONSIBILITIES
Ministry responsible for Health	The Ministry of Health is the Government agency responsible for protecting and promoting public health and providing welfare and other social security services. They are responsible for the design, implementation, monitoring and evaluation of health policies, programs and guidelines.	
Some of the actions that the Ministry of Health can take to prevent child marriage and address the needs of children in marriage and those that are victims of child marriage: • Put in place child centred health policies that ensure access to health and medical services including quality comprehensive sexual and reproductive health services and information; • Enact programs to reduce infant and child and adolescent mortality, combat disease and malnutrition and abolish harmful practices; • Enact policies and programs that provide comprehensive maternal health services including ante-natal, post-natal and obstetric care, post abortion care, immunisation and nutrition programs to a child - who is pregnant or has given birth; • Prevent mother to child transmission of HIV and AIDS by enacting policies and programs to ensure access to HIV and AIDS counselling, testing, treatment and family planning for pregnant and in marriage children and victims of child marriage; and • Ensure and uphold the child's right to privacy and confidentiality of his or her personal information.		
Judicial System	Court System	The Ministry of Health is the Government agency responsible for protecting and promoting public health and providing welfare and other social security services. They are responsible for the design, implementation, monitoring and evaluation of health policies, programs and guidelines.
Some of the actions that the Judicial System and Courts can take to prevent child marriage and address the needs of children in marriage and those that are victims of child marriage: Courts should/can: • Define rules and procedures for the distribution of property acquired during a prohibited marriage and the dissolution/annulment of a voidable child marriage; • Issue a restraining order to anyone that knows or is about to engage or marry a child, independently of what customary or religious laws and practices say; and • Provide legal aid and legal services to victims of child marriage. **Courts should ensure the rights of child brides are respected including:** • On petition of a child, adult person or third-party dissolve/annul the marriage that was contracted before the commencement of the law; • Provide custody, access and maintenance to the offspring; and • Ensure respect of citizenship acquired through marriage.		

SECTION FOUR
GENDER BASED VIOLENCE

There is a strong legislation framework for GBV in SADC. Despite the strong legislative framework levels of GBV are rising across the region. Prevention must take centre-stage moving forward.

Table thirteen: Overview of laws on GBV across SADC

Country	Human trafficking law	Sexual assault/ offences law	Domestic violence law	Sexual harassment law
Angola	Yes	No	Yes	No
Botswana	Yes	Yes	Yes	Yes
DRC	Yes	Yes	No	Yes
Eswatini	Yes	Yes	Yes	Yes
Lesotho	Yes	Yes	No	Yes
Madagascar	Yes	Yes	Yes	Yes
Malawi	Yes	Yes	Yes	Yes
Mauritius	Yes	Yes	Yes	Yes
Mozambique	Yes	Yes	Yes	Yes
Namibia	Yes	Yes	Yes	Yes
Seychelles	Yes	No	Yes	Yes
South Africa	Yes	Yes	Yes	Yes
Tanzania	Yes	Yes	No	Yes
Zambia	Yes	Yes	Yes	Yes
Zimbabwe	Yes	Yes	Yes	Yes
Yes	**15**	**13**	**12**	**14**
No	**0**	**2**	**3**	**1**

Source: Gender Links

All 15 SADC countries have Human Trafficking laws in place. Angola does not have a Sexual Assault/Offences or Sexual Harassment laws. Seychelles has not adopted a Sexual or Offences law. Three countries (DRC, Lesotho and Tanzania) do not have Domestic Violence laws. All SADC countries have National GBV Action Plans in place to eradicate GBV.

The 2018 SADC Gender Protocol Barometer put a spotlight on the inter-linked gender justice issues of our time including menstrual health,

comprehensive sexual education, teenage pregnancies, safe abortion, maternal health, GBV, HIV and Aids, and sexual diversity. Strategies to address the high levels of GBV will beyond GBV to include all sexual and reproductive health and rights (SRHR) that fundamentally affect citizens' well-being and opportunities for a productive future.

This will ensure that SRHR and GBV is on the agenda 365 days a year. Prevention. The high levels of GBV places increased pressure on states to provide responses and support to GBV. Prevention is relegated in the face of crisis levels of GBV. Prevention strategies need to be prioritised as a matter of urgency.

CONCLUSIONS AND RECOMMENDATIONS

- Almost all SADC countries have stand-alone policies on SRHR and GBV but there is a low focus on safe abortion, menstrual health and harmful practices. All national SRHR policies must be updated in line with the SADC SRHR Strategy 2019-2030.
- The absence of child marriage laws in all SADC countries is a setback for the adolescent SRHR in SADC. All SADC countries need to adopt specific laws on child marriage using the SADC Model law on Child Marriages as a guide.
- The minimum age for marriage must be standardised in line with the SADC Protocol on Gender and Development at 18 in statutory and customary legal systems with no exceptions.
- Unrestricted abortion must be available in all countries to mitigate high levels of teenage pregnancies and reduce maternal mortality.
- Homosexuality is outlawed and this is vigorously enforced in the majority of southern African countries. This has negative implications for the advancement of gender equality as well as the development of adequate SRHR provisions for such key populations.
- Efforts to provide free and remove VAT on sanitary ware to young women must be accelerated. This must be accompanied by a vigorous campaign to provide safe water and sanitation in all schools in SADC.
- The study shows high-unmet need for contraception for Southern Africa countries. The failure to provide contraceptive care has huge implications for unintended pregnancies, unplanned births, abortions, and miscarriages. The provision of contraceptives is central to women's and girls' right to exercise voice and choice over their bodies.
- There is a fair coverage of comprehensive sexuality education in both primary and secondary schools across SADC, but other countries do not offer CSE at all for the primary and secondary school children. The quality and delivery of the CSE requires review and revision.
- Only two countries, DRC and Lesotho, protect the rights of pregnant learners and secure their right to stay in school. Tanzania expels pregnant while Angola, Mauritius and Seychelles have no policy. The other countries have conditional re-entry for pregnant learners. All countries should move towards policies that protect the right of pregnant learners to stay in school.
- Despite strong regulatory frameworks on GBV the levels of GBV are increasing. There is need to re-strategise and focus on prevention as a key focus to reducing GBV.
- Homosexuality must be decriminalised in all SADC countries. This must be accompanied by concerted social protection campaigns for LGBTI+ communities. This will promote a holistic approach to sexual diversity needed in order to ensure gender equality and adequate reach of SRHR services to key populations.

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ANNEX ONE
SOUTHERN AFRICA GENDER PROTOCOL ALLIANCE SRHR POLICIES AND LAWS SURVEY

Welcome to the Alliance audit of national SRHR Policies and Laws. The survey is in five parts:

1. SRHR
2. HIV and AIDS
3. Harmful practices
4. GBV
5. General

SECTION 1: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

1. Does the country have a stand- alone SRHR Policy?
   - Yes
   - No
2. Name of policy.
3. When adopted (Drop down - 1995 to 2018)?
4. Please upload the policy.
5. Is the policy being reviewed and updated?
   - Yes
   - No
6. If there is a draft available please upload.
7. What regional and international instruments are referenced in the policy?

	Tick
The Constitution of that country	
SADC Protocol on Gender and development	
Maputo Protocol	
CEDAW	
The SDGs	
Others	Please specify

8. What is covered in the policy? **NB:** If there is a draft updated policy please work from this:

	Yes	No	Comment
Sexual heath - sexual desire, pleasure and function			
Sexual and reproductive rights			
Menstrual health			
Fertility management including pregnancy testing			
Maternal Health			
Cancers of the reproductive system			
Menopause			
Comprehensive Sexual Education			
Services, especially adolescents and youth			
Teenage pregnancy			
Safe abortion			
Sex work			
HIV and other STIs			
Harmful practices			
Sexual and gender based violence			
Other			

9. What are the strengths of the policy?
10. What are the weaknesses, and how are these being addressed, especially if the policy is being reviewed?

Menstrual health

11. Has the country removed VAT on sanitary ware?
    - Yes
    - No

    Explain, including any laws, policies and campaigns underway.
12. Does the country make sanitary ware freely available in schools?
    - Yes
    - No

    Explain, including any laws, policies or campaigns underway.
13. What measures are in place to ensure adequate water and sanitation in schools?
14. Upload any evidence on progressive practices on menstrual health.

Maternal health

15. What is the rate of maternal mortality per 100,000? Please state the source.
16. Has this changed over time? Why?
17. Where is maternal health referenced, in policies/laws?
18. If this is different from any of the attached policies/laws, please upload.
19. Does the policy/laws have provision for.

Fertility management

20. Does the country have a stand-alone family planning policy?
    - Yes
    - No
21. What is the prevalence of contraceptive usage in the country (drop down 40-100%)?
22. What plans are in place to meet the unmet need?

Access to services, especially for youth

23. What is the minimum age of consent to sexual activity (drop down 12 -21)?
24. Where is this stipulated?
25. What is the minimum age at which contraceptives can be accessed? (drop down 12 -21)
26. Where is this stipulated?
27. Please upload the relevant policy/law/excerpt.
28. Is there a debate or discussion in the country on the age at which contraceptives can be accessed? Please describe briefly.
29. Is there a specific policy on adolescent access to SRHR?
    - Yes
    - No
30. If yes, what is this called?
31. If yes, please upload a copy
32. Please comment on the effectiveness of this policy, or if there is no policy, on access by youth to SRHR facilities generally?

Comprehensive Sexual Education

33. Does the country provide CSE in primary school?
    - Yes
    - No
34. Does the country provide CSE in secondary school?
    - Yes
    - No
35. Where is this provided for (law or policy).
36. Comment on the quality and effectiveness of CSE.

Teenage pregnancies

37. Where is the issue of teenage pregnancies covered (law/policy/other)? Please specify.
38. Please upload the relevant policy or excerpt.
39. Do the policy/law/regulations allow for learners who fall pregnant to re-enter the same or any other school?
    - Yes
    - No
40. Does it cover teenage fathers?
    - Yes
    - No
41. Please summarise the key provisions of the policy on teenage pregnancy.
42. How do these provisions work in practice? Please cite evidence.
43. Are there any existing campaigns on teenage pregnancy?
44. How can these be strengthened?

Safe abortion

45. Where is the issue of abortion covered (Constitution, laws? policies)?
46. Please upload the relevant documents or excerpts.
47. Please summarise the key provisions.
48. Which statement best describes the provisions?
    a. Abortion is illegal except in the case of rape, incest or where the life of the mother or child is at risk as certified by a medical practitioner.
    b. Abortion is illegal except in the case of rape or incest.

c. Abortion is illegal except where the life mother or child is at risk as certified by a medical practitioner.
d. Abortion is legal on demand up to the first trimester of pregnancy.
e. Other - please explain.

49. Is there provision for Post Abortion Care?
    - Yes
    - No
50. Where is this found?
51. What is the reality of abortion on the ground? What is the response to it?
52. Are there existing campaigns for safe abortion? What have they achieved?
53. How can campaigns for safe abortion be strengthened?

Sexual diversity

54. Where is the issue of sexual diversity covered (Constitution, laws? policies).
55. Please upload the relevant documents or excerpts.
56. Please summarise the key provisions
57. Which statement best describes the provisions and their practice:
    - Homosexuality is outlawed and this is vigorously enforced.
    - Homosexuality is outlawed but this is not vigorously enforced.
    - Homosexuality is outlawed but recent court cases have opened the door to decriminalisation.
    - Homosexuality is legal but same sex unions are not recognised in law.
    - Homosexuality is legal and same sex marriages are recognised.
    - Other - please explain.
58. What is the reality of sexual diversity on the ground? What is the response to it?
59. Are there campaigns for recognition of sexual diversity? What have they achieved?
60. How can campaigns for recognition of sexual diversity be strengthened?

Sex work

61. Where is the issue of sex work covered (Constitution, laws? policies)?
62. Please upload the relevant documents or excerpts.
63. Please summarise the key provisions.
64. Which statement best describes the provisions and their practice:
    - Sex work is outlawed and this is vigorously enforced.
    - Sex work is outlawed but this is not vigorously enforced.
    - Sex work is outlawed but recent court cases or other occurrences have opened the door to decriminalisation.
    - Other - please explain.
65. What is the reality of sex work on the ground? What is the response to it?
66. Are there existing campaigns for legalisation of sex work? What have they achieved?
67. How can campaigns for legalisation of sex work be strengthened?
68. Does the country have a stand-alone HIV and AIDS policy or strategy?
69. What is the HIV and AIDs policy or strategy called?
70. Does this include other STIs?
    - Yes
    - No
71. When was the HIV and AIDS policy/ strategy adopted? (Drop down - 1995 to 2018).
72. Please upload the HIV and AIDS policy or strategy.
73. Is the policy being reviewed and updated?
    - Yes
    - No
74. If there is a draft available please upload?

75. What provision are in place for of comprehensive, accurate knowledge of HIV and AIDS?
76. What strategies are in place to reduce the growing new cases of HIV and AIDS among young women, partly as a result of cross generational sex?
77. What provision are in place for of voluntary medical male circumcision (VMMC)?
78. What provisions are in place for Pre-exposure Prophylaxis (PEP)?
79. What provisions are in place for prevention of mother-to-child transmission (PMTCT)?
80. What provisions are in place to increase testing for HIV?
81. What strategies are in place to increase HIV and AIDS treatment and adherence?
82. What support is there for care workers including remuneration and psycho-social support?

III. HARMFUL PRACTICES

83. What is the age of consent to marriage for girls? (Drop down 12 to 21, include not specified).
84. What is the age of consent to marriage for boys? (Drop down 12 to 21, include not specified).
85. Where is the age of marriage specified?
86. How widespread is the practice of child marriages?
87. Is there a law on Child Marriage?
    - Yes
    - No
88. If yes, does it comply with the SADC/ PF Model Law on Child Marriages?
    - Yes
    - No
89. If no is there an active campaign on child marriages and what does this involve?

SECTION 3: HIV AND AIDS AND STIs

90. Is there a high level of forced marriages?
91. How are forced marriages addressed in policies or laws?
92. Please upload relevant excerpts.
93. How widespread is the practice of Female Genital Mutilation (FGM)?
94. What other harmful cultural practices concerning SRHR prevail?
95. How are these addressed in the Constitution/policies and laws?

SECTION 4: GENDER VIOLENCE

96. Does the country have a stand- alone GBV policy/strategy?
    - Yes
    - No
97. Name of GBV policy/strategy.
98. When was the GBV policy/strategy adopted (Drop down - 1995 to 2018)?
99. Please upload the GBV policy/ strategy.
100. Is the GBV policy/strategy being reviewed and updated?
    - Yes
    - No
101. If there is a draft updated GBV policy/strategy available please upload.
102. Does the country have a sexual offences law?
    - Yes
    - No
103. Name of the sexual offenses law.
104. When was the Sexual Offences law enacted? (Drop down - 1995 to 2018).

105. Please upload the sexual offenses law.
106. Does the country have a domestic violence law?
    - Yes
    - No
107. Name of the domestic violence law.
108. When was the domestic violence law enacted (Drop down - 1995 to 2018)?
109. Please upload the domestic violence law.
110. Does the country have a law on trafficking?
    - Yes
    - No
111. Name of the trafficking law.
112. When was the trafficking law enacted (Drop down - 1995 to 2018)?
113. Please upload the law.
114. If the country does not have a stand- alone trafficking law where is trafficking covered in legislation?

GENERAL

115. Any other comments.
116. Any other documents, photos or videos to upload?



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