SADC GENDER PROTOCOL 2019

BAROMETER



Colleen Lowe Morna, Kubi Rama
and Shamiso Chigorimbo

Southern Africa Gender Protocol Alliance

The Southern African Gender Protocol Alliance's vision is an inclusive, equal and just society in the public and private space in accordance with the SADC Protocol on Gender and Development. The Alliance campaigned for the adoption, implementation and review of the SADC Protocol on Gender and Development. The Alliance is now advocating for action and results in the implementation of the Protocol which is aligned to the Sustainable Development Goals (SDGs), Beijing Plus Twenty and the African Union Agenda 2063. The Gender Protocol is the only SADC Protocol with a Monitoring, Evaluation and Results Framework.

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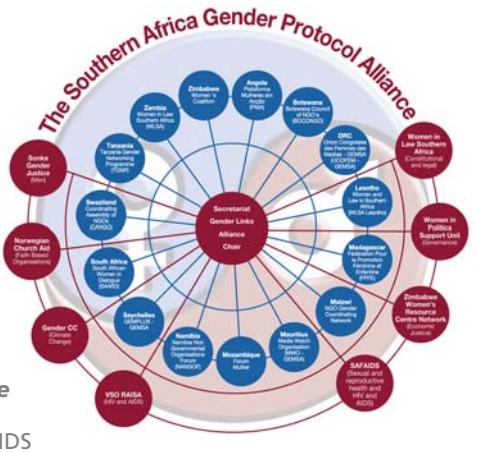
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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ART	Anti-Retroviral Treatment
ARVs	Anti-Retroviral Medication
ASC	Annual School Census
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AU	African Union
AYSRH	Adolescent and Youth Friendly Sexual and Reproductive Health
BMT	Buwala Makililo Trust
BOCONGO	Botswana Council of Non-Governmental Organisations
BPFA	Beijing Platform for Action
BPS	Botswana Police Service
CANGO	Coordinating Assembly of Non-Governmental Organizations
CAT	Convention on Torture
CBO	Community Based Organisations
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CEDEP	Centre for the Development of People
CEO	Chief Executive Officer
CHWs	Community health workers
CNN	Cable News Network
COWLHA	Coalition of Women Living with HIV and AIDS
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CRD	UN Centre for Regional Development
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive Sexuality Education
CSW	Commission on the Status of Women
CToP	Choice of Termination of Pregnancy
DBE	Department of Basic Education
DHS	Demographic and Health Survey
DMPA	Depomedroxyprogesterone
DRC	Democratic Republic of Congo
DTG	Dolutegravir
EBC	Elections and Boundaries Commission
ECHO	Evidence for Contraceptive Options and HIV Outcomes
EMB	Elections Management Board
EMIS	Education Management Information System
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
EU	European Union
FAWESWA	Forum for Africa Women Educationalists Swaziland Chapter
FGM	Female Genital Mutilation
FLE	Family Life Education
FP2020	Family Planning 2020
FPFE	Federation pour la Promotion Feminine et Enfintine
GBV	Gender Based Violence
GDI	Gender Development Index
GDP	Gross Domestic Product
GEMPLUS	Gender and Media Plus Association of Seychelles
GIZ	German Development Agency
GL	Gender Links
GMPS	Gender and Media Progress Study
GPS	Gender Progress Score
GRA	Gender Responsiveness Assessment
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of all forms of Racial Discrimination
ICESRC	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
IPV	Intimate Partner Violence
KAP	Knowledge, Attitudes and Practice
LAMBDA	Mozambican Organisation for the Defence of Sexual Minorities
LEGABIBO	Lesbians, Gays & Bisexuals of Botswana
LGBTI	Lesbian, Gay, Bisexual, Transsexual and Intersex
LSE	Life Skills Education

MHM	Menstrual Health Management
MIET	Media in Education Trust
MMR	Maternal Mortality Ratio
MNGCN	Malawi NGO Gender Co-ordinating Network
MOET	Ministry of Education and Training
MoHCC	Ministry of Health and Child Care
MSM	Men having sex with men
MSR	Most Significant Result
MTC	Mother to Child Transmission
MVA	Manual Vacuum Aspiration
MWECW	Ministry of Gender Equality and Child Welfare
NANGOF	Namibia Association of Non-Governmental Organisations
NAP	National Action Plan
NDWA	Namibia Diverse Women's Association
NGO	Non-Governmental Organisation
NGP	Tanzania Gender Networking Program
NUST	National University of Science and Technology
OECD	Organisation for Economic Co-operation and Development
OI	Opportunistic Infection
PAC	Post Abortion Care
PCOS	Polycystic Ovary Syndrome
PEP	Post Exposure Prophylaxis
PHIA	Population-based HIV impact
PLWHA	People Living with HIV and AIDS
PMA	Plataforma Mulheres em Acção
PMTCT	Prevention of mother-to-child transmission
PNC	Post Natal Care
POA	Plan of Action
PRB	Population Reference Bureau
PrEP	Pre-Exposure Prophylaxis
PSCE	Personal, Social and Civic Education
PSE	Personal and Social Education
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
REPSSI	Regional Psycho-social Support Initiative
RTIs	Reproductive Tract Infections
SABC	South African Broadcasting Corporation
SADC	Southern Africa Development Community
SADC-PF	Southern African Development Community Parliamentary Forum
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SAM	Social Accountability Monitoring
SASA	Start, Awareness, Support, Action
SAWID	South African Women in Dialogue
SDGI	SADC Gender and Development Index
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SHHH	Safe Haven Halfway Home
SIDA	Swedish International Development Agency
SIGI	Social Institutions and Gender Index
SOGIESC	Sexual Orientation, Gender Identity, Expression and Sex Characteristics
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
TV	Television
TVPA	Trafficking Victims Protection Act
UHC	Universal Health Care
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 Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UPR	Universal Periodic Review
UTH	University Teaching Hospital
VAC	Violence against Children
VAM	Violence against Men
VAT	Value Added Tax
VAW	Violence against Women
VAWG	Violence against Women and Girls
VMMC	Voluntary Medical Male Circumcision
WAG	Women's Action Group
WAR	Women against Rape
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WLA	Women Lawyers Association
WLSA	Women and Law in Southern Africa Research and Educational Trust
WSW	Women who have sex with Women
ZECF	Zambia Education Curriculum Framework
ZGC	Zimbabwe Gender Commission

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COUNTRY CO-ORDINATING NETWORK	EXPERT	DESIGNATION	ORGANISATION
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Mauritius Media Watch Organisation	Sharon Nemdharry	Member	Media Watch Organisation
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	Sheila Haudlhate	Coordinator	Forum Mulher member
	Rebeca Gomes	Coordinator	Mozambican Forum of Rural Women (FOMMUR)
	Aida Nhaveto	Getoa Decom	Forum Mulher member
	Mangia Mauacca	Activist	Forum Mulher member
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Foreword
to the 2019 ***#VoiceandChoice*** *Barometer*



Member of Parliament in Lesotho and Chairperson of the SADC Parliamentary Forum Women's Caucus

As chairperson of the SADC Parliamentary Forum (SADC PF) Women's Caucus I am acutely aware of the challenges facing women and girls in the Southern African Development Community (SADC). Poverty, child marriage, gender-based violence and maternal deaths affect large numbers of women and girls across the region.

One of the main objectives of SADC is to enhance the standard and quality of life of the people of Southern Africa. Sexual and Reproductive Health and Rights (SRHR) are central to people's wellbeing. From a policy and legislative perspective, the region has made substantial progress towards attaining the wellness goals of its citizens.

Most member states have signed up to global instruments such as the Sustainable Development Goals (SDGs) and International Conference on Population and Development (ICPD) Programme of Action. At a continental and regional level member states have adopted the Maputo Protocol and SADC Protocol on Gender and Development.

Women Members of Parliament held the first Women's Parliament in the Seychelles in July 2017. The Mahe Declaration made strong recommendations for greater parliamentary involvement in the ratification and domestication of relevant international and continental instruments relating to women, girls, HIV and SRHR. Parliamentarians committed to review, revise, amend or repeal all laws, regulations and policies including cultural and religious practises and customs that have a discriminatory impact on youths, especially girls and young women. In November 2018, SADC Health ministers adopted a ground-breaking SRHR Strategy and Scorecard 2019-2030.

It is incumbent on all SADC member states to work towards the attainment of the ten outcomes of the SRHR Strategy. The outcomes include maternal and neonatal mortality; GBV; safe abortion; teenage pregnancy; universal access to SRHR; strengthened health service; enabling environment for adolescent and youth access to SRHR; and removing all policy, cultural, social and economic barriers.

Some disadvantaged young girls miss a considerable time learning as they are mocked during menstruation and do not have access to sanitary ware. I seconded the motion proposed by Member of Parliament, Kose Makoa, in the Lesotho National Assembly to provide free menstrual products in schools in September 2018. I have also spoken out on the need for safe abortion laws and services in Lesotho, where 15 young girls are admitted every week at Maseru hospital with abortion-related complications.

Parliamentarians must acquaint themselves with the legal and policy environment in their countries with regards to HIV and SRHR. In addition, we need to know what gaps exist in the laws aiming at protecting the sexual and reproductive health rights of all, with a specific

focus on the most vulnerable. We have to develop strategies that will address the SRHR needs of sex workers, LGBTI communities, people living with disabilities, migrants, girls living in poverty and transgender persons amongst others.



I commend Gender Links and the Southern African Gender Protocol Alliance partners for rolling out the ***#VoiceandChoice*** campaign to lobby and advocate for the realisation of SRHR across the SADC region. Partnerships with women's rights organisations are vital in this massive task to improve citizens' wellbeing. As Members of Parliament we need to ensure that our governments implement the excellent SRHR provisions that we have signed up to; laws that we have passed and policies that we have developed. As elected decision-makers it is our responsibility to improve the wellbeing of our citizens.

We will study the findings of the inaugural **#VoiceandChoice** Barometer and use them as a roadmap to achieve universal access to SRHR for all citizens. Let us all exercise our voices and choices for a better SADC*!*

Kenako! The time is now!



Honourable Mats'epo Molise-Ramakoae
Member of Parliament, Lesotho
Chair of the Women's Caucus, SADC Parliamentary Forum

Voice + Choice
Action and results for SRHR in SADC

Voix + Choix
Action et résultats pour les SRHR dans la SADC

Vozes + Escolhas
Acção e resultados para SRHR na SADC

EXECUTIVE SUMMARY



SRHR march in Eswatini. Photo: Thandokuhle Dlamini

While Sexual and Reproductive Health and Rights (SRHR) is now firmly on the Southern African agenda, major gaps remain in data collection, legislation, policy, and service delivery, especially for women and girls. This is the major finding of the first Southern Africa Gender Protocol Alliance **#VoiceandChoice** or SRHR Barometer, that breaks new ground in scoring government performance and including a stand-alone chapter on sexual diversity.

The region has made significant strides with the adoption of the Mahe Declaration on SRHR by women parliamentarians in 2016, and the SADC SRHR Strategy by health ministers in November 2018. Women's Rights Organisations (WRO), buoyed by the global #MeToo and #TimesUp and South African #TotalShutdown movements have mounted energetic campaigns against GBV, HIV and AIDS and harmful practices; the rights of sex workers, LGBTI and other minority groups.

The 11th SADC Gender Protocol Barometer breaks with past tradition by focusing solely on SRHR, measuring 100 indicators in seven thematic areas: sexual and reproductive health; adolescent SRHR; safe abortion; GBV; HIV and AIDS; harmful practices and sexual diversity. It includes the first ever comprehensive chapter on LGBTI rights and access to SRHR.

The indicators used to measure the status of SRHR in SADC include 12 indicators out of the 20 indicators in the SADC SRHR scorecard that governments will be reporting against. The Barometer is the first civil society shadow report on the SADC SRHR strategy and its score card, a space that needs to be progressively expanded in order to hold governments accountable to their commitments.

A detailed explanation of the methodology used in the SRHR scorecard is included as a technical note at Annex A. The SRHR Scorecard rates countries using an index classifying performance based on quartiles. The dataset is divided into three sections using the interquartile range. Values above the first quartile is included in the 1st quartile under GREEN, anything between the 1st and 3rd quartile will fall under the YELLOW color while those below the 3rd quartile will fall under the RED color.[1] Green denotes that countries have met the required target, yellow means efforts are needed to achieve the target and red highlights countries that need urgent action to achieve the target.

Table I applies the colour coding across 15 SADC countries for which data could be obtained. Comoros, the 16th SADC country, will be included in the 2020 Barometer due to insufficient data on several indicators at the time of writing the 2019 Barometer. Table II summarises the findings per indicator, ranking these from best to least achieved.

[1] Score Card for Sexual and Reproductive Health and Rights in the SADC Region, Fast tracking the Strategy for SRHR in the SADC Region 2019-2030, SADC

Table I: Overview of countries by indicators, baseline 2019

INDICATORS	TARGET	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Maternal mortality	Global target 70 per 100 000	447	129	693	389	487	353	634	53	489	265	0	85	398	224	443
Neonatal mortality, institutional	Global target 12 per 100	29	25	29	17	38	18	23	8	27	18	9	11	21	22	22
Adolescent birth rate, 10-19 years of age	No target, countries measured against each other	152	30	124	77	90	110	140	27	135	74	57	43	115	83	104
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	0=Not in place 1=Exists	0	0	1	0	1	1	1	0	0	0	0	1	0	1	0
Unmet need for family planning (contraception)	No target, countries measured against each other	36	14	27	14	16	18	16	10	24	16	n/d	14	21	18	10
Percentage reduction in new HIV infections, females 15 - 24	No target, countries measured against each other	1.2	8.9	0.5	15.9	10.8	0.1	4.3	0.2	3	4.5	n/d	11.3	2.2	4.9	5.5
Mother to child transmission of HIV	No target, countries measured against each other	27.8	2.5	27	7.8	12.7	39.8	7.8	13.7	15	3.9	n/d	4.9	10.5	11.2	7.6
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age	No target, countries measured against each other	32	n/d	23	54	76	5	50	n/d	42	66	n/d	61	30	41	67
Minimum legal age of consent to marriage, 18 years for all irrespective	3=18 for women and men, no exception 2=18 for women and men, with exceptions 1=Below 18 for women and/or men	1	3	1	1	1	2	3	2	3	2	1	3	1	2	3
Legal status of abortion	2=Abortion on demand 1=Restricted abortion 0=Abortion not available	1	1	1	1	1	0	1	1	2	1	1	2	1	1	1
Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	No target, countries measured against each other	50	35	58	43	41		43	25	48	39	30	31	47	47	43
Percentage of annual budgets allocated to health sector	Abuja Declaration recommends 15%	5.4	9.1	3.7	15.25	10.1	17.8	9.8	9.8	8.3	13.8	10	13.3	9.5	7.1	14.5

Source: Gender Links, 2019

Table II: Summary of performance by indicator

Indicators	Green	Yellow	Red	No data	% Green
Percentage reduction in new HIV infections, females 15 - 24	8	4	2	1	53%
Mother to child transmission of HIV	7	5	2	1	47%
Adolescent birth rate, 10 - 19 years of age	6	6	3		40%
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	6		9		40%
Unmet need for family planning (contraception)	6	6	2	1	40%
Minimum legal age of consent to marriage, 18 years for all irrespective	5	4	6		33%
Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	4	8	3		27%
Neonatal mortality, institutional	3	8	4		20%
Maternal mortality	2	7	6		13%
Legal status of abortion	2	12	1		13%
Percentage of annual budgets allocated to health sector	2	9	4		13%
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age	1	10	1	3	7%
Total #	3	19	5	3	
Percentage of total	22%	53%	19%	11%	

Source: Gender Links

Table II shows that:

- Overall, only 22% of the 12 indicators that could be measured fall in the green category; 53% in the yellow category; 19% in the red category and 11% in the no data category.
- The largest number of greens (53%) is percentage reduction in new HIV infections among females 15 - 24 followed by reduction in Mother to Child transmission of HIV (47%). This is consistent with the enormous strides that have been taken in containing the HIV and AIDS pandemic over the last decade.
- The lowest percentages of green are maternal mortality (13%); legal status of abortion (13%); percentage of annual budgets allocated to the health sector (13%) and percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age (7%).



Campaigning for condoms for all. Photo: Gender Links

[1] Score Card for Sexual and Reproductive Health and Rights in the SADC Region, Fast tracking the Strategy for SRHR in the SADC Region 2019-2030, SADC

Figure I: Overview of country SRHR scores



Source: Gender Links, 2019

An analysis of each country's performance on the basis of the 12 indicators shows that South Africa with 67% green is in first position followed by Mauritius (50% green) and Botswana (42% green). Thirteen SADC countries have achieved less than 50% of the targets. The lowest ranking countries are Tanzania, Lesotho and DRC (17% green) and DRC, Zambia and Angola (17% green). Zambia, however, has the highest yellow score (83%) showing that it is most active in working to close the gaps. Angola, with a 75% red score, is in the gravest danger zone. Key factual highlights in each theme chapter of the Barometer include:

Sexual and reproductive health: Menstrual health is on the regional agenda. Five SADC countries (Botswana, Lesotho, Madagascar, Seychelles and Zambia) provide free sanitary ware at schools. Four countries (Mauritius, South Africa, Tanzania and Zambia) have removed VAT. A major concern is the lack of access to basic sanitation in most SADC countries. There is 50% or less access to basic sanitation in ten countries including Angola, DRC, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Tanzania, Zambia and Zimbabwe. Madagascar is lowest, at 10%. Only two SADC countries, Seychelles and Mauritius, meet the global target of less than 70 deaths per 100 000 live births for pregnant women and girls. The maternal mortality rate is ten times higher than this in the DRC. Most pregnant women and girls have access to at least one antenatal visit, fewer have four or more and very low proportions have postnatal visits. Health budgets remain below the recommended Abuja Declaration goal of 15% expenditure on health. Only Eswatini and Madagascar meet this target. SRHR services need to be integrated into universal health care (UHC).

Adolescent SRHR: Most SADC countries have a Comprehensive Sexual Education (CSE) programme in place that meets or is in the process of being aligned to international standards but implementation, monitoring and evaluation is still weak. Where CSE is implemented, young people are able take advantage of educational and other opportunities that will impact their lifelong well-being; avoid unwanted pregnancies and unsafe abortions; improve their sexual and reproductive health and protect themselves against Sexually Transmitted Infections (STIs), including HIV. Only six SADC countries (DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia) have stand alone ASRHR policies or strategies.

Only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) do not require parental consent for adolescents to access SRHR services. The age of access to contraceptives in SADC ranges from 12 in five countries to 18 in one. Adolescent fertility ratios in the region range from 27 per 1000 women in Mauritius to 152 per 1000 women in Angola. Tanzania's President John Magufuli has banned readmission of girls who get pregnant in school. He has also urged women to stop using contraception so that they can increase the country's population.



Safe abortion: The ability of a woman or girl to safely decide not to continue a pregnancy may be the key that unlocks numerous opportunities in life, including education, employment, financial security and good health. The SADC SRHR Strategy highlights that 24% of all pregnancies in Southern Africa end in abortion, with the vast majority of these unsafe and a major contributor to maternal mortality. Among the international instruments, only the Maputo Protocol mentions the right to abortion, in certain circumstances.

There are only two SADC countries in which abortion is available on demand in the first trimester (South Africa and Mozambique). Abortion is available under certain circumstances in all SADC countries, with varying degrees of restriction. Provision of good post abortion care reduces the mortality but is costly. The GL attitude survey shows that in almost all SADC countries less than half the respondents believe that a woman should be able to choose to terminate a pregnancy in the first three months. SAfAIDS has mounted the "My choice, our choice" campaign which seeks to influence the policy environment on unsafe abortion.



HIV and AIDS: Southern Africa is the epicentre of the HIV and AIDS pandemic globally. This varies considerably across the region. Four countries have a prevalence rate of 20% and above; four 10% and above and seven below ten percent.Women, and especially young women, comprise the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.

The region is seeing a reduction in HIV infections. Overall, Southern Africa has met 25 of the 45 UNAIDS 90-90-90 targets (15 countries x three targets each). The targets are: percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression. This means overall progress in achieving the UNAIDS targets in Southern Africa is 56%. In 2018, ARVs averted 682,000 deaths in Southern Africa, 330,000 of these in South Africa. However, the number of HIV positive children between ages 0 and 14 on anti-retroviral treatment (ART) is cause for concern. Less than 50% of HIV positive children in Angola, Botswana, DRC, Madagascar and Mauritius are on ARVs. Evidence from South Africa suggests that drug resistance is a threat to the expanded treatment programme. This requires vigilance from all. The AU is calling for two million more community health workers and for governments to ensure that they receive training, psychosocial support, remuneration and materials



Gender-based violence remains one of the most flagrant but under resourced and under reported violations of human rights in SADC. The availability of current data on the prevalence of GBV is a challenge. Information gathered through the Demographic Health Surveys are not regular. Police data is dependent on reported cases. Only seven SADC countries have undertaken dedicated GBV studies to determine the extent and effectiveness of responses to GBV. The region needs to identify effective surveillance systems to track GBV on an ongoing basis.

All countries in SADC have laws on human trafficking, but many do not have the data to track victims. All countries offer some form of services to survivors of GBV, yet under-resourced NGOs continue to do most of the work. Stakeholders have called for a regional approach to meet the goal of eliminating GBV by 2030.

Tanzania has approved a five-year budget of nearly 267 billion shillings (approximately US $119 million) to combat GBV. All SADC countries offer comprehensive treatment, including PEP, to survivors of violence. A study on TV media in South Africa shows that this medium lacks diversity, balance and sensitivity in the coverage of gender violence. Only 16% of TV news stories on GBV mentioned where survivors can go for help. South Africa broke new ground in 2018 with a presidential summit on ending GBV - one of the demands of the #TotalShutdown campaign.



Harmful practices: The average regional score for the Gender Responsive Assessments (GRA) of Constitutions and laws in SADC undertaken by peer review groups in every SADC country as part of the 2019 Barometer is just 57%. The lowest rated area (average 49%) is access to justice. This reflects the contradictions between statutory provisions for gender equality and the customary law that governs the lives of the majority of women in SADC.

While all SADC countries meet the requirement of the minimum age of 18 for marriage for men, only three countries (Malawi, Mozambique and South Africa) stipulate 18 as the minimum age of marriage for women and men with no exceptions, i.e. are compliant with the SADC Protocol on Gender and Development. In eight SADC countries (Angola, DRC, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe) over one third of all young women are married by the age of 18.

In Tanzania, the promulgation of a law prohibiting female genital mutilation in 1998 has not ended the practice. Widows in Southern Africa still face various forms of harmful cultural practices including forced widow inheritance, accusations of witchcraft including accusations of killing their deceased husbands, gender based violence, property grabbing and other forms of inhumane, humiliating and degrading treatment. In Swaziland widows are openly discriminated against by State institutions. Discriminatory practices include being barred from participating in politics and other public life/spaces, being barred from getting close to the King or the Queen mother or even obtaining mundane services like applying for a passport.



Sexual diversity: This groundbreaking chapter expands the narrow focus on decriminalising homosexuality to include protections and the recognition of LGBTI rights. Homosexuality is now legal in five (or about one third) of Southern African countries - South Africa, Seychelles, Angola, Mozambique and DRC. Botswana's High Court recently rejected sections of the country's penal code that criminalised same-sex relations. The Attorney General has signalled that he intends to appeal the High Court ruling.

Only South Africa allows for same sex marriages and civil unions. Three countries (Mauritius, Namibia and South Africa) allow LGBTI persons to change their gender markers. Mauritius and South Africa ban conversion therapy, which is known to cause extensive physical and psychological damage. Only one SADC country, Angola, has hate crimes legislation that explicitly protects LGBTI persons from violence and discrimination. Only South Africa has laws in place for protection of intersex people. There is a lack of targeted SRHR services for LGBTI people and a dearth of data to guide informed strategies.

Gender Links and Southern African Gender Protocol Alliance are working with LGBTI organisations from five countries - Botswana, Malawi, Mauritius, Namibia and Eswatini - to lobby for the decriminalisation of LGBTI people and social protection for their communities. The **#VoiceandChoice** campaign works to "leave no one behind" in the quest for SRHR and the well-being of all SADC citizens.

Introduction 1



Emma Kaliya, Chair of the SADC Gender Protocol alliance, leading an Alliance **#VoiceandChoice** campaign march. Photo: Colleen Lowe Morna

KEY POINTS

- The Barometer is the first comprehensive assessment of SRHR by civil society in SADC based on 100 indicators covering sexual and reproductive health; adolescent SRHR; HIV and AIDS; gender-based violence (GBV); harmful practices and sexual diversity.
- In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 SADC member states approved the ground-breaking SADC Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030 and corresponding Score Card to measure progress.
- A gender critique of the SADC SRHR Strategy and score card points to some limitations. For example they make no reference to menstrual health management (MHM).
- A contradiction in the Strategy is the focus on key populations such MSM; sex workers and transgender persons without the requisite focus on decriminalising the conditions in which these populations live.
- Out of the 20 indicators in the SADC SRHR score card, the Barometer only found reliable data on 12 indicators that have been scored for this Barometer. This raises concerns as to how governments will use this instrument.
- Data on Comoros is sparse in many cases and the Alliance is still identifying a partner network. Comoros will be included in the 2020 **#VoiceandChoice** Barometer.
- The 2020 **#VoiceandChoice** Barometer will develop a basket of weights using the 100 indicators identified to rank countries and thematic areas in the attainment of SRHR.
- The **#VoiceandChoice** Barometer should be read together with the *State of Gender Equality in SADC report* which the Alliance will launch annually at the SADC Heads of State summit.

The tenth edition of the SADC Gender Protocol Barometer, published in 2018, 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.

In 2019, Gender Links and the Southern African Gender Protocol Alliance (the Alliance) launch the first SADC SRHR **#VoiceandChoice** Barometer. The Barometer is the first comprehensive assessment of SRHR by civil society in SADC based on an assessment of 100 indicators covering sexual and reproductive health; adolescent SRHR; HIV and AIDS; gender-based violence (GBV); harmful practices and sexual diversity.

The SADC SRHR Barometer occurs against the backdrop of several key global and SADC developments including the 25th anniversaries of the International Conference on Population and Development (ICPD) and Beijing Platform for Action as well as the adoption of the SADC Regional Strategy and Scorecard on Sexual and Reproductive Health and Rights (2019 - 2030). The introductory chapter covers the global and SADC context, the SADC Gender Protocol Alliance and Centres of Excellence in Gender and local government ***#VoiceandChoice*** *campaign*, and explains the methodology underpinning the Barometer.

Global context

ICPD25

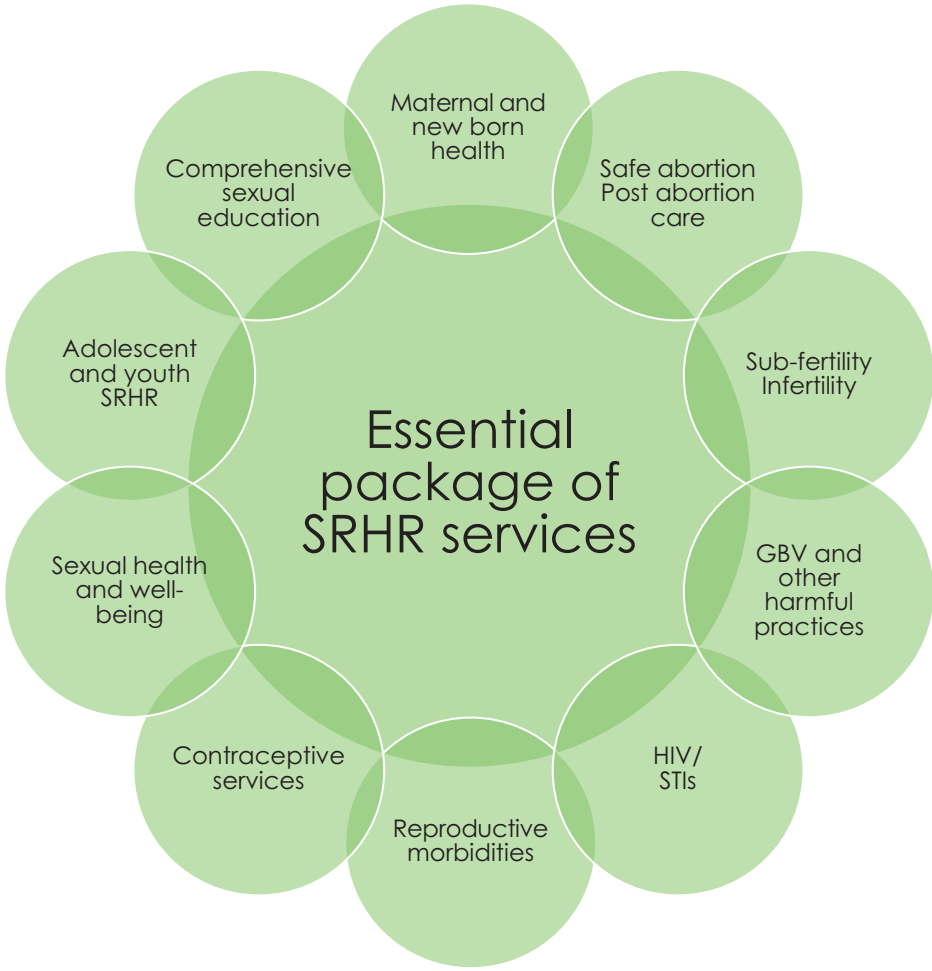
In 1994, 179 governments adopted a landmark Programme of Action (POA) at the International Conference on Population and Development (ICPD) in Cairo to empower women and girls to realise their well-being and full potential.

Implementation of the ICPD POA has varied across the globe. High levels of maternal mortality, gender-based violence and unmet need for contraception, amongst others, persist particularly in Africa. These factors impact on countries achieving their demographic dividend. Burgeoning youth populations across Africa receive low quality education, have inadequate access to health care and remain on the periphery of economic development. The status quo must change if Africa is to achieve the economic growth required to sustain the growing population. The deadline to achieve the Sustainable Development (SDGs) by 2030 adds impetus to the realising the ICPD POA. In November 2019 a high-level Summit in Nairobi, Kenya, will bring governments, civil society organisations, young people and other key stakeholders together to mobilise the political will and financial resources to implement the ICPD POA. The Summit will centre around achieving zero unmet need for family planning information and services, zero preventable maternal deaths, zero sexual and gender-based violence, and harmful practices against women and girls.

The ICPD Summit will cover five themes:

- Universal access to sexual and reproductive health and rights as a part of universal health coverage (UHC).
- Financing required to complete the ICPD Programme of Action, and to sustain the gains made.
- Drawing on demographic diversity to drive economic growth and achieve sustainable development.
- Ending gender-based violence and harmful practices.
- Upholding the right to sexual and reproductive health care in humanitarian and fragile contexts.

Figure 1.1: Essential package of SRHR services



The current Universal Health Care (UHC) package does not include comprehensive SRHR. The United Nations Population Fund (UNFPA), East and Southern Africa, model for the essential package of SRHR services includes ten key areas outlined in Figure 1.1. According to UNFPA East and Southern Africa Region (ESARO):

- Three out of the 10 SRHR elements (contraceptives; care during pregnancy, delivery and post-delivery; and RTIs, STIs and HIV) are partially covered under UHC in many countries.
- Progressively, at least seven SRHR elements (comprehensive inclusion of the above three elements plus Adolescent Sexual and Reproductive Health (ASRHR), safe-abortion and post abortion, reproductive cancer and sub-fertility and infertility) could potentially be made part of the UHC.
- Discussion is needed on how the health sector responds to the remaining three SRHR elements - Comprehensive Sexuality Education (CSE); Sexual Gender Based Violence (SGBV), Female Genital Mutilation (FGM), Child marriage; and, menstrual hygiene management within UHC.

The preparatory processes towards the ICPD25 is an important opportunity to discuss a comprehensive SRHR package in UHC. The final agreed upon conclusions must include a roadmap towards achieving universal access to SRHR across the globe. Governments, development partners, civil society and health institutions need to work together to achieve SRHR as part of UHC. The time for collective action is now to guarantee universal SRHR for all.

The Nairobi ICPD 25 conference will flow into the 25 year review of the Fourth World Conference for Women in Beijing which took place in 1995, or the Beijing Platform for Action (BPFA) Plus 25

meeting at the Commission on the Status of Women (CSW) in New York in 2020. BPFA +25 calls for revising existing policies to address emerging trends of violence against women and girls such as forced and coerced sterilisation and forced abortion of women living with HIV/AIDs. It also calls for implementing programmes that ensure men's shared responsibility, especially with regard to family planning, HIV and sexual and gender-based violence. Beijing +25 Review (B+25) calls for the review and revise national constitutions and legal systems to systematically remove all discriminatory laws, norms, practices and policies to make the legal framework conform to international and regional instruments on women's human rights. It also calls for building the capacity of the judiciary and law enforcement agencies in gender and women's human rights.

The African context



A variety of African normative frameworks provide for appropriate measures to promote adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas. The frameworks commit to reducing maternal mortality through the establishment and strengthening of existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

The **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** adopted in July of 2003 in Maputo, Mozambique (the **Maputo Protocol**) covers a wide range of women's rights including political, social, cultural, environmental, economic, civil and health and promises to eliminate discrimination against women. Article 14: Health and Reproductive Health Rights empowers women to control their fertility, decide whether to have children or not and the number thereof, provides the right to choose their preferred contraception, the right to self-protection and to be protected from STI's.

Additionally, women have the right to be informed of their health status and that of their partner and the right to family planning education. Women are further afforded the right to affordable and accessible health services, pre and post- natal as well as for delivery and nutritional services. Finally, women are granted the right to medical abortions in cases of sexual assault, rape, incest, in the event that the pregnancy endangers the mental and physical health of the mother, or the life of the mother or unborn child. Article 14; 2C is the only international instrument to provide for safe abortion, although this is limited to cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

Goal three of the **African Union Agenda 2063** aims to increase 2013 levels of Sexual and Reproductive Health (SRHR) Services to women by at least 30%. Goal 3 of the Sustainable Development Goals (SDGs) includes SRHR targets of reducing maternal mortality, child mortality, ending AIDS, tuberculosis, malaria, tropical diseases, hepatitis, and other communicable and water-borne diseases,[1] universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Agenda 2063 provides for equal, affordable and timely access to independent courts and judiciary that deliver justice without fear or favour. All reviewed frameworks provide for constitutional and legislative commitments to commit to gender equality and non-discrimination on the basis of gender. The 2009 AU Gender Policy provides for non-discrimination through its Commitment 2 on legislation and legal protection actions against discrimination, for ensuring gender equality

[1] Sustainable Development Goals

AU Agenda 2063 provides that all harmful social practices (especially female genital mutilation (FGM) and child marriages) will be ended and barriers to quality health and education for women and girls eliminated. All frameworks commit to appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of in particular; the girl child and women. The measures include specific legislature to end harmful practices such as child marriages and female genital mutilation. Some of these practices include but not limited to child marriage and the betrothal of girls and boys for marriage, polygamy, wife inheritance, wife kidnapping, sexual cleansing of widows, FGM and virginity testing.[2]

SADC context

SADC is a region of great political and economic contrasts, underpinned in all 15 countries by patriarchal norms that reflect in high levels of gender inequality, and low SRHR. In 2008, SADC became the first region in the world to adopt a legally binding Protocol on Gender and Development, bringing together African and global commitments to gender equality, updated in line with the Sustainable Development Goals in 2016.

The 2018 SADC Gender Protocol Barometer revealed that contraceptive usage in the region ranges from 5% and 6% in Angola and the DRC to 76% among women in Mauritius. The Barometer reports that only South Africa and Mozambique give women the choice to terminate pregnancy. Unsafe abortion contributes to high rates of maternal mortality across the region. While maternal mortality ratios are declining in other regions, in SADC they increased between 1990 and 2010 mainly as a result of HIV.

Women's lack of voice, choice and control in SRHR reflects in the high rates of GBV and HIV in the region. Violence Against Women Baseline studies conducted by GL in seven SADC countries show lifetime prevalence rates ranging from 25% in Mauritius to 86% in Lesotho. Southern Africa has the highest rates of HIV and AIDS in the world. Sexual violence against women and girls remains one of the major causes of HIV infection. Marital rape is pervasive and contributes to the HIV and AIDS pandemic. For every two people enrolled in HIV treatment, five become newly infected. Women account for 58% of those living with HIV in SADC.

Key SRHR concerns relating to youth include significant percentages of sexually active adolescents below the age of 16; multiple concurrent sexual relations; increasing trends of intergenerational sexual relations; low levels of consistent condom usage during sex; high levels of maternal mortality amongst young mothers; compromised quality of antenatal care to young mothers compared to older mothers; high levels of HIV and AIDS among young people, especially young women, and high levels of GBV. Punitive policies and restrictive laws against vulnerable groups create barriers to their access to SRHR services.

The **Southern African Gender Protocol Alliance** is a "network of networks" that campaigned for the adoption of the SADC Protocol on Gender and Development and its updating in 2016 to align to the SDGs. Attesting to the vital role of civil society in campaigning for gender justice in the region, the SADC Gender Protocol is the only one of the 26 SADC Protocols that have been updated; also the only Protocol that is accompanied by a Monitoring, Evaluation and Results Framework.



[2] Morna C, Dube S, Makamure L (2016) SADC Gender Protocol Barometer

A key gain in the updated Protocol is the inclusion of SRHR, with cross reference to the Maputo Protocol and principles of the ICPD. Another is 18 as the minimum age of marriage; an issue that became so divisive that Mauritius refused to sign the Protocol and is the only SADC country that has failed to do so. However, only one SADC country (Mozambique) has adopted a stand-alone child marriage laws. Only three SADC countries have water tight laws on child marriages. Evidence such as this, highlighted by the Barometer, has added grist to regional campaigns.

The first ever Women's Parliament held in July 2017 in Mahe, Seychelles organised by the SADC Parliamentary Forum Regional Women's Parliamentary Caucus (RWPC) and other partners, rallied female Members of Parliament around the SADC sponsored **UN Resolution 60/2 entitled "Women and the Girl Child and HIV and AIDS"** adopted in March 2016 at the Commission on the Status of Women (CSW) held in New York, USA.

The **Mahe Declaration** committed women MPs to champion SRHR in their countries including reviewing, revising, amending or repealing all laws, regulations and policies including cultural and religious practises and customs that have a discriminatory impact on youths, especially girls and young women. In a far reaching move, the MPs committed to lobby for safe abortion laws in their countries.

In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 SADC member states approved the ground-breaking **SADC Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030** and corresponding Score Card to measure progress. The Strategy provides a framework for the member states to fast-track SRHR in the region. It will support the vision of the SADC Regional Indicative Strategic Development Plan (RISDP) 2015-2020 of a shared future within a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom, social justice, peace and security for its peoples.[3]

The SADC SRHR Strategy builds on the Sexual and Reproductive Health Strategy 2006 - 2015. The current strategy moves from a service focus to a rights-based approach. This illustrates an important shift to recognising people's human rights as the centre of development and achieving higher levels of well-being in SADC. Ministers approved the first ever SADC **multi-sectoral score card** to measure progress in achieving implementation of the strategy and the SGDs.[4]



Celebrating the approval of the SADC SRHR Strategy in Namibia, 2018. Photo:Gender Links

[3] The SADC SRHR Strategy, 2019 - 2030
[4] https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval

Key targets

The key targets of the strategy are:

- Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG 3.1.).
- New born mortality ratio reduced to fewer than 12 deaths per 1,000 births (SDG 3.2.).
- HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.).
- Sexual and gender-based violence and other harmful practices, especially against women and girls, eliminated (SDGs 5.1, 5.2 and 5.3).
- Rates of unplanned pregnancies and unsafe abortion reduced.
- Rates of teenage pregnancies reduced.
- Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings, ensured (SDGs 3.7 and 5.6).
- Health systems, including community health systems, strengthened to respond to SRH needs; (SDG 5.6).
- An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6).
- Barriers - including policy, cultural, social and economic - that serve as an impediment to the realisation of SRHR in the region removed (SDGs 5.1 and 5c).

Gender critique of the SADC SRHR Strategy



Colleen Lowe Morna, GL Chief Executive Officer, highlighting the need for affordable sanitary ware in Tanzania. Photo: Tarisai Nyamweda

GL conducted a gender analysis of the strategy and found strong gender provisions. The SADC SRHR Strategy is an important milestone for the region and includes several gender aware provisions. These include legal unrestricted abortion; access to contraception without third party consent; tracking new HIV infections amongst females between 15 - 24 and the use of condoms by women and girls during the last high-risk sex and the number of women receiving the recommended dosage of human papillomavirus (HPV) vaccine.

However, there are a few critical gaps. For example the strategy and score card make no reference to menstrual health management (MHM). Some of the key MHM issues that impact women and girls are:

- Lack of support from teachers (who are frequently male).
- Teasing by peers when accidental menstrual soiling of clothes occurs.
- Poor familial support.
- Limited economic resources to purchase supplies.
- Inadequate water and sanitation facilities at school and work places.
- Menstrual cramps, pain, and discomfort.
- Lengthy travel to and from school and work places, which increases the likelihood of leaks or stains.[5]
- There needs to be a strategy to address educating of men and boys in menstruation.

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5482567/

The Strategy prioritises the SRHR needs of key populations. These include men having sex with men (MSM); people in prisons; people who use drugs; sex workers and transgender people. Young people will be a key population in every category. The strategy however does not mention strategies to address the specific SRHR needs of the key populations such as gender reassignment for transgender persons.

A contradiction in the strategy is the focus on key populations such MSM; sex workers and transgender persons without the requisite focus on decriminalising the conditions in which these populations live. Sex work is illegal in 14 SADC countries. MSM and transgender people are but part of a larger LGBTIQ community that is largely invisible in the strategy. Homosexuality is criminalsed in ten SADC countries. The key populations are linked to those who are deemed to be most vulnerable to HIV and AIDS. SRHR must address the needs of a broader group of people. For example, there is no mention of strategies to address the serious SRHR issues facing child brides. Moving forward, measuring progress must be disaggregated by different key populations and vulnerable groups.

The **#VoiceandChoice** campaign

Voice + Choice
Action and results for SRHR in SADC

Despite energetic advocacy campaigns, levels of GBV and HIV in SADC remain at alarming levels. In 2018 GL, local government and SADC Gender Protocol Alliance focal points from 15 SADC countries met to discuss how to move forward more effectively. The meeting identified the following key lessons:

- Sporadic initiatives such as the Sixteen Days of No Violence Against Women were not adequate. There is need for sustained year-long action. Something GL has been advocating for since 2010 under the banner *16 Days for life*.
- GBV prevention must be a subset of a basket of interventions to realise SADC citizens well-being. Ultimately the goal is to provide a holistic strategy that will address Sexual and Reproductive Health Rights (SRHR). These include rights-based issues such as age of consent for various matters and the challenges adolescents face in schools when they pregnant and violence in schools as well as the provision of effective services.
- In line with the ideology that ultimately women and men change their circumstances by exercising their agency, GL works with 1500 survivors of violence in ten SADC countries to increase their agency and economic power as a way of securing their futures.

The **#VoiceandChoice** campaign, launched in August 2018, builds on the global and regional momentum on SRHR. It moves the gender justice agenda from the Post 2015 era to include individual and collective voices to advocate for change. The agenda is driven by citizens demands and voices. By improving citizens' wellbeing, institutions and other stakeholders are building a critical citizenry that can hold governments accountable.

The objectives of the **#VoiceandChoice** campaign are to:

- Ensure that SADC citizens including key populations have access to an essential package of SRHR services and that these are included into Universal Health Care strategies.
- Contribute towards positive policy change that will ensure equal access to good quality SRHR across SADC.
- Contribute towards the attainment of SRHR concerns in regional, continental and global development instruments including amongst others the SADC Protocol on Gender and Development and SGDs.

- Foster a culture of inclusivity through embracing key populations and other vulnerable groups.
- Hold governments accountable on investment in health through ongoing monitoring, lobbying and advocacy.
- Use multi-media platforms to raise awareness of effective SRHR to key populations, women and adolescents.
- Create a strong network of SRHR advocates through the SADC Protocol Alliance SRHR cluster.
- Build a body of knowledge on good SRHR practices through national **#VoiceandChoice** summits.

Figure 1.2: Stages in the **#VoiceandChoice** campaign



The **Audit of SRHR Laws and Policies in SADC** provides a picture of a region with a diverse landscape. In areas such as gender-based violence (GBV) 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 and review 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 safe abortion, sex work, decriminalising homosexuality and child marriages there has been little movement in the policy and legislative arena.

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 of SRHR policies in the SADC region. Some policies, such as Namibia 2001, are very old and some, while very recent, are regressive such as in Madagascar where abortion is outlawed under 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. The findings of the Audit informed the development of the indicators for the SADC SRHR Barometer and are integrated into the individual chapters.

Key campaigns: Over the period from August 2018 to July 2019 and Alliance and local government partners developed SRHR campaigns eight thematic areas including menstrual health; maternal health; comprehensive sexual education (CSE) and services; teenage pregnancy, safe abortion; HIV and AIDS; child marriage; GBV and sexual diversity.

Table 1.1: Overview of **#VoiceandChoice** SRHR campaigns in SADC

Country	Menstrual health		Maternal health		CSE and services		Teenage pregnancy		Safe abortion		HIV and AIDS		Child marriage		GBV		Sexual Diversity		N	L
	N	L	N	L	N	L	N	L	N	L	N	L	N	L	N	L	N	L		
Angola	1		1								1								**3**	**0**
Botswana					1	15			1	15							1		**2**	**30**
DRC							1						1						**2**	**0**
Eswatini	1	4							1			4	1			4	1		**3**	**12**
Lesotho	1	5								1		5		5	1				**2**	**16**
Madagascar	1	10				10			1				1						**3**	**20**
Malawi			1						1				1						**3**	**0**
Mauritius																1	1		**0**	**1**
Mozambique		10												10					**0**	**20**
Namibia	1	1		3	1	1			1			2					1		**3**	**7**
Seychelles									1						1		1		**3**	**0**
South Africa		3		4						3			1		1	3			**2**	**13**
Tanzania	1		1																**2**	**0**
Zambia	1	5	1	5		5			1				1						**4**	**15**
Zimbabwe	1	10	1	10		10							1	10					**3**	**40**
TOTAL	**8**	**48**	**5**	**22**	**2**	**41**	**1**	**0**	**7**	**19**	**1**	**11**	**7**	**25**	**3**	**8**	**5**	**0**	***40***	***174***

N=National; L=Local

Source: Gender Links.

Partners developed 40 national and 174 local government SRHR campaigns. In addition, GL worked with 95 councils across ten countries to update their SRHR plans. The highest number of campaigns at national (eight) and local level (48) are on menstrual health. GBV also features prominently at national level.

Six countries and 16 local councils are implementing safe abortion campaigns where safe abortion is not available on demand. CSE is a priority in 41 local councils. It is noteworthy that 22 and 25 councils are implementing maternal health and child marriage campaigns respectively. Local level action will strengthen responses to these issues.

GL worked with 75 civil society organisations, including 39 youth and five LGBTI organisations, in 15 SADC countries to roll out the *#Voiceand Choice* campaign. The Campaign included 439 youth champions affiliated or working directly with local government councils. The youth champions include junior councilors, youth group leaders, local arts or drama group members, civil society representatives and students. Youth champions led advocacy on SRHR through community dramas.

GL and Alliance partners leveraged off social media platforms to increase knowledge and reach of SRHR information. Through the use of social media platforms including Facebook and Twitter content on SRHR reached many users and sparked conversation. To amplify its social media campaigns GL and Alliance partners initiated the **#VoiceandChoice** hashtag. The Campaign which generated content through sharing of news, events and messages related to SRHR.



SRHR workshop at a local council in Eswatini. Photo: Thandokuhle Dlamini

As part of its long standing "gender equality in and though the media" campaign GL trained **media practitioners** in 15 countries on SRHR reporting. Journalists produced innovative stories that were published on the GL website and disseminated through social media. A total of 103 media articles have been produced across the nine thematic areas. The stories are carried in the countries' media.

In 2019 GL and Alliance partners will host 15 national **#VoiceandChoice Summits** to share good SRHR practices. The 2020 SRHR Barometer will include an analysis of the case studies and highlight ways of working on SRHR that works.



An example of the momentum that is developing in the region on SRHR is the progress on decriminalising sexual diversity, one of the most contentious SRHR issues in the region. In 2015, only three SADC countries had decriminalised homosexuality - South Africa, DRC and Mozambique. South Africa is the only country in the world whose Constitution recognises sexual orientation. Since then Seychelles and most recently Angola have decriminalised homosexuality. A new generation of young people, and especially young women, is leading the march for **#VoiceandChoice** in the region.

Methodology

For ten years the Alliance has produced the Southern African Gender Protocol Barometer, tracking performance of the 15 SADC countries against the provisions of the 2008 SADC Protocol on Gender and Development, updated in 2016. The **2019 #VoiceandChoice Barometer** takes a radical departure from the past in that:

- It will focus on a specific cross cutting SRHR theme .
- It will measure progress against several relevant instruments, not just the SADC Gender Protocol. These include the SDGs, ICPD, the Maputo Protocol, and the SADC SRHR strategy.

The Alliance will, in addition to the Barometer, publish a shorter sister publication, **State of Gender Equality in SADC Report** based on the SADC Gender and Development Index; the Citizen Score Card; the Protocol knowledge quiz; the Gender Progress Attitudes Score and the Gender Responsive Assessment (GRA) of Constitutions and Laws. These traditional monitoring and evaluation tools administered by Alliance network provide a wealth of data on how governments are performing overall in the attainment of gender equality. Other traditional chapters of the Barometer, such as Economic Justice, Governance and Climate Change will be published as E books and coincide with key dates or events linked to these chapters. For example, by the end of this year five elections will have taken place in SADC (South Africa, Namibia, Botswana, Madagascar, and Mozambique). The Governance chapter will be published in early 2020.

Structure of the SRHR Barometer

Table 1.2: Breakdown of the SRHR Barometer

Chapters	Relation to previous Barometer Chapters
1. Introduction	
2. Sexual and reproductive health	Health
3. Adolescent SRHR	Education
4. Safe abortion	Constitutional and legal Rights
5. HIV and AIDS	HIV and AIDS
6. Gender-based violence	Gender-based violence
7. Harmful practices	Constitutional and legal rights
8. Sexual Diversity	New

Table 1.2 maps the eight chapters of the SRHR Barometer in relation to the original Barometer. The 2019 SADC SRHR Barometer introduces a new chapter on Sexual Diversity. The chapter measures 15 indicators relating to the status of LGBTI communities.

Normative frameworks

The regional, African and global frameworks mapped against each chapter include:

- SADC Protocol on Gender and Development (SGP)
- Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)
- United Nations Conference on the Status of Women Resolution 60/2 on Women, the Girl Child and HIV
- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)
- Beijing Platform for Action (BPFA)
- International Conference on Population and Development (ICPD)
- Sustainable Development Goals (SDGs)

The GL and the Alliance comprehensive **review of SRHR laws and policies** in 15 SADC countries provided in-depth information on policy and legislative frameworks; responses; services and prevention strategies in the different areas. These are integrated into the different chapters.

Each chapter begins with a table of key indicators

Developing indicators - quantitative measures

Each chapter begins with a table of key indicators for which data could be reliably obtained across the 15 countries. The three primary sources of these indicators are:

- **Empirical data** from credible sources to establish baselines and measure progress. This comes from UN Agencies such as UNAIDS, the WHO; UNFPA and UNESCO.
- **Public attitudes:** Each year Alliance partners administer the Gender Progress Score (GPS) or Attitudes Survey that gauges prevailing gender attitudes amongst the public using a 25-question survey. Eight of these questions are relevant to SRHR. They help to gauge public attitudes on topic issues such as safe abortion and sexual diversity, that in turn play a critical role in driving or deterring reform agendas. For the period 1 August 2018 to 31 July 2019 GL gathered 11 124 surveys, 6013 women and 5111 men.
- **The Gender Responsive Assessment (GRA) of Constitutions and Laws:** The GRA is a peer review of Constitutional rights, special measures, domestic legislation, equality in accessing justice, marriage and family rights, persons with disabilities, widows and widowers' rights, the girl and the boy child (Articles 4 to 11 of the SADC Gender Protocol). A group of legal and subject area experts meet and score the country using a standardised score sheet. These are acknowledged in the contributors section of the Barometer.

Table 1.3: Classification of indicators

Thematic area	Emperical data	Public attitudes	GRA	Quantitative indicators from the SADC SRHR Scorecard for which data could be sourced	Quantitative indicators in the SADC SRHR Score card
Sexual and reproductive health	20	0		5	11
Adolescent SRHR	5	0		1	1
Safe abortion	3	1		1	2
HIV and AIDS	23	1		3	3
Gender-based violence	12	4		1	2
Harmful practices	5	0	7	1	1
Sexual Diversity	15	2		0	0
TOTAL	***85***	***8***	***7***	***12***	***20***

Table 1.3 shows that:

- There are a total of 100 quantitative indicators that can be used to measure SRHR across the seven themes. The largest number of these (26) is HIV and AIDS followed by SRH (20).
- The **#VoiceandChoice** Barometer is unique in identifying 17 indicators for measuring sexual diversity. None of these feature in the SADC SRHR score card.
- Out of the 20 indicators in the SADC SRHR score card, GL identified 12 (60%) for which reliable data could be sourced across the 15 countries. This raises concerns regarding how governments will use this score card to measure themselves.
- Using the 12 indicators for which data could be sourced, Alliance partners have conducted the first shadow report of the SADC SRHR score card (see Executive Summary). This gives a preliminary indication of how SADC countries are performing, using the colour coding agreed for the score card. In the 2020 Barometer the Alliance will develop a weighted basket of measures for assessing **#VoiceandChoice** across countries and themes using the 100 indicators identified.

SADC Score Card indicators for which reliable data could not be found include:

3. Percentage of obstetric and gynecological admissions due to abortion, b) Facility records for the treatment of abortion complications.
5. Proportion of population accessing integrated SRH services (total population).
7. Percentage of primary and secondary schools that provided life skills-based HIV and sexuality education in the previous academic year.
12. Sexually transmitted infections (STIs) incidence rate, using the overall rate of syphilis, given the impact of syphilis on sexual and reproductive health outcomes.
13. Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (age).
17. Non-partner sexual violence prevalence
19. Health worker density and distribution for SRMNAH.
20. Proportion of services within the essential package of SRHR services covered by public health system.

Qualitative data

Two sources of qualitative data have been used:

- **Case studies:** GL put out a call for Alliance partners to share Most Significant Result (MSR). Evidence is also being gathered through the case studies presented at the #Voiceand Choice SADC Protocol@Work summits (in progress at the time of writing).
- **Media articles:** From the journalists trained in 15 countries on coverage of SRHR.

The quantitative findings are triangulated with relevant information, best practices and case studies from SADC countries to provide a nuanced, in-depth account of the successes, challenges and next steps.

Limitations

- Comoros became a full member of SADC at the 38th Summit of Heads of State and Government on August 2018 in Windhoek Namibia. Data on Comoros is sparse in many cases and the Alliance is still identifying a partner network. Comoros will be included in the 2020 #Voice andChoice Barometer.
- The 2019 **#VoiceandChoice** Barometer is an "out of the box" version of previous Barometers. Departing from previous norms and practices with limited human and financial resources is a risk, but one we considered worth taking to provide the necessary evidence base for our advocacy work.

Sexual and Reproductive Health 2



Youth take part in a World AIDS Day event in Manzini, Eswatini, in 2012. Engaging with young people on their sexual and reproductive health rights must be a priority in all SADC countries. Photo: Thandokuhle Dlamini

KEY POINTS

- Stakeholders should align sexual and reproductive health and rights (SRHR) policy and legislative frameworks against the targets of the SADC Protocol on Gender and Development and the SADC SRHR Strategy and Scorecard 2019 to 2030.
- Menstrual health campaigns must be rolled out in tandem with strategies to provide water, sanitation and hygiene across SADC. Only 10% of Madagascar's population has access to basic sanitation and most of this is available in urban areas.
- Only two SADC countries, Seychelles and Mauritius, meet the global target of less than 70 deaths per 100 000 live births for pregnant women and girls. The maternal mortality rate is ten times more in the DRC.
- Most pregnant women and girls have access to at least one antenatal visit, fewer have four or more and very low proportions have postnatal visits. Lawmakers must prioritise access to antenatal and postnatal maternal care.
- Family planning services must be expanded to include conditions such as polycystic ovarian syndrome and fibroids, which are on the rise and affect fertility.
- Stakeholders should view SRHR services in the paradigm of universal health care (UHC) and the provision of essential health services to ensure it is integrated.
- Health system and infrastructure financing remains below the recommended Abuja Declaration goal of 15% expenditure on health. Only Eswatini and Madagascar meet this target.

Introduction

Sexual and reproductive health is not merely the absence of disease, dysfunction or infirmity, but also a state of physical, emotional, mental and social wellbeing in relation to all aspects of sexuality and reproduction. A positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall wellness. All individuals have a right to make decisions governing their bodies and to access services that support that right.[1]

The Guttmacher-Lancet's definition of sexual and reproductive health and rights (SRHR) provides a comprehensive view that "integrates the full range of peoples' needs and services including sexual well-being and personal autonomy." In 2018, the SADC Gender Protocol Alliance launched the **#VoiceandChoice** campaign, recognising the need to move beyond a gender-based violence (GBV) agenda to a holistic one that addresses citizens' wellbeing.

Achieving sexual and reproductive health relies on realising sexual and reproductive rights, which are based on the human rights of all individuals to:

- Have their bodily integrity, privacy and personal autonomy respected;
- Freely define their own sexuality, including sexual orientation and gender identity and expression;
- Decide whether and when to be sexually active;
- Choose their sexual partners;
- Have safe and pleasurable sexual experiences;
- Decide whether, when and whom to marry;
- Decide whether, when and by what means to have a child or children, and how many children to have; and
- Have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.[2]

In 2018, Gender Links launched the **#VoiceandChoice** Campaign to address citizens' overall wellbeing

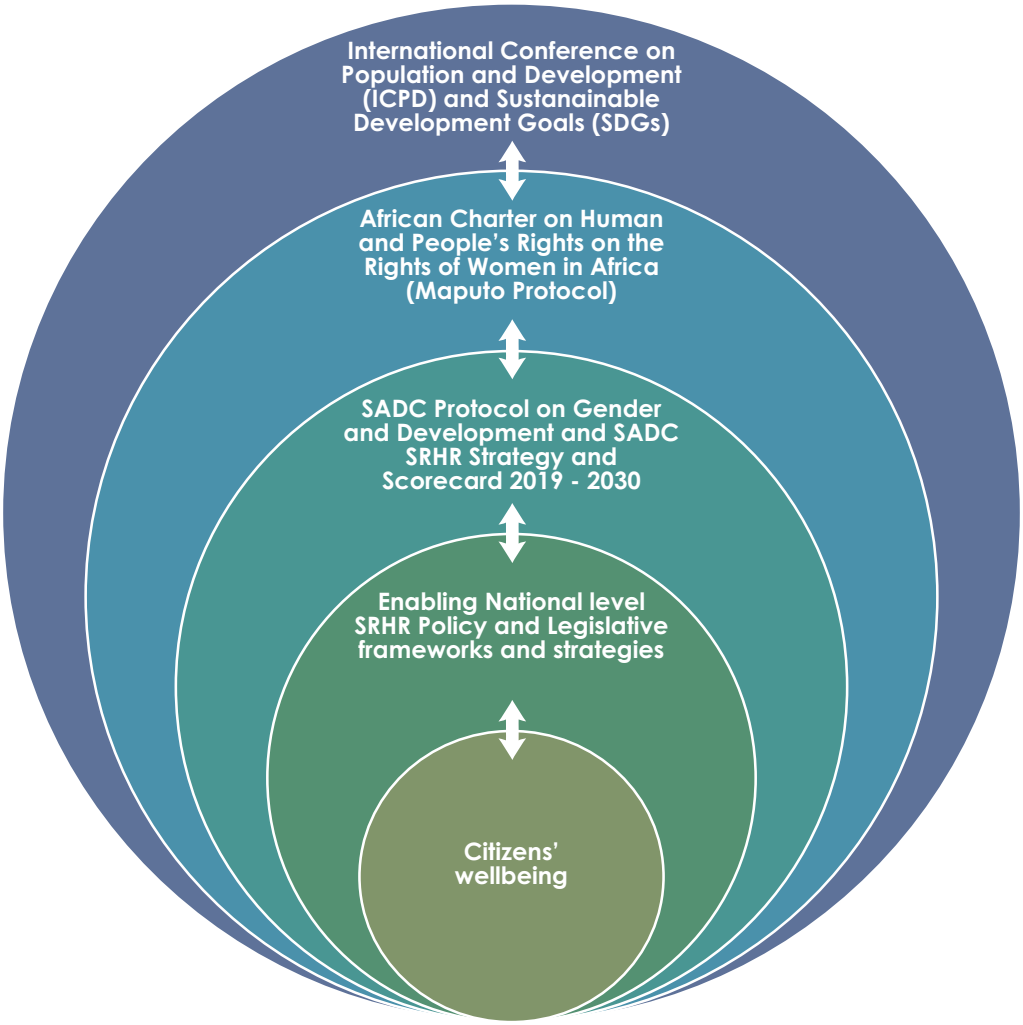
The 2019 SRHR Barometer occurs against the backdrop of three key developments. In November 2018, the Southern African Development Community (SADC) adopted the SADC SRHR Strategy and Scorecard (2019 to 2030). All SADC countries signed up to a regional roadmap to achieve key SRHR milestones. Additionally, the 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) has been in place for 15 years and 2019 marks the 25th anniversary of the International Conference on Population and Development (ICPD), a 1994 meeting in Cairo where 179 governments affirmed that women's reproductive health and rights would become central to global development efforts.

The three instruments, together with the revised 2016 SADC Protocol on Gender and Development and the Sustainable Development Goals (SDGs), include SRHR targets relating to or impacting on: maternal health, menstrual health, comprehensive sexuality education, teenage pregnancies, unrestricted safe abortion, contraception and family planning, SRHR services, GBV, HIV and AIDS, sexual diversity and sex work.

1 https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary
2 IBID

The nexus of these significant events provides an important opportunity to take stock, identify gaps and plan how to address them and include new areas to improve SRHR across the region. To establish baseline indicators for SRHR in 2019, Gender Links reviewed the targets in all the instruments and identified a set of about 100 indicators to measure SRHR progress in SADC from 2019 to 2030.

Figure 2.1: Visual representation of the SRHR context



As illustrated in Figure 2.1, stakeholders must leverage the global, continental and regional instruments to create enabling environments for effective SRHR. This will foster a critical citizenry that enjoys a high level of wellness and result in more people exercising choices about their lives and bodies, articulating their needs and holding duty-bearers accountable.

The vision of the SADC SRHR Strategy is to: "Ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realise and exercise their SRH rights, as an integral component of sustainable human development in the SADC region." The first hand account from Mauritius, which has one of the best developed public health systems in SADC, shows that there is still a long way to go in providing SRH services.

Table 2.1: Sexual and reproductive health baseline indicators in 2019

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
SRHR policy and legislative framework															
Existence of SRHR policies/ guidelines[3]	No	Guide-lines	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2015 -19 Policy	2011 -15 Guidelines	2008 Policy	2010 -15 Policy
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation[4]	No	No	2016 - 2020 Policy	No	2015 - 2020 Policy	2016 - 2020 Policy	2016 - 2020 Policy	No	No	No	No	2017 Policy	No	2016 - 2020 Strategy	No
Menstrual health															
Provision of free menstrual ware[5]	No	Yes	No	No	Yes	Yes	No	No	No	No	Yes	No	No	Yes	No
Removal of Value Added Tax (VAT) on menstrual ware[6]	No	No	No	No	No	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Basic drinking water status (%)[7]	41	79	42	68	72	51	67	100	47	79	96	85	50	61	67
Access to basic sanitation (%)[8]	39	60	20	58	44	10	44	93	24	34	100	73	24	31	39
Contraception															
Contraceptive preva-lence rate amongst women aged 15-49 (%)[9]	17	60	25	66	62	47	62	67	30	60	49	57	43	55	67
Unmet need for contraception amongst women aged 15-49 (%)[10]	36	14	27	14	16	18	16	10	24	16		14	21	18	10
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[11]	62		31	49	61	74	77	49	49	71			47	47	60
Age of access to contraception[12]	15	12	18	15	No age stipulated	12	16	16	16	12	15	12	12	16	16
Maternal mortality															
Maternal mortality ratio (per 100 000)[13]	447	129	693	389	487	353	634	53	489	265	0	85	398	224	443
Antenatal care visits (at least one visit) (%)[14]	82	94	88	97	95	82	95		91	97		94	91	96	93
Antenatal care visits (at least four visits) (%)[15]	61		48	76	74	51	51		51	63		76	51	56	76
Skilled attendance at birth (per 100)[16]	50	99	80	99	78	44	90	100	54	88	99	97	64	63	78
Postnatal care coverage (%)	23		44		88	62	42			69		84	34	63	57
Neonatal mortality (per 1 000)[17]	29	25	29	17	38	18	23	8	27	18	9	11	21	22	22
Nursing and midwifery personnel per 10 000 of the population[18]	13	33	5	20	7	1	3	34	4	28	32	35	4	9	12
Universal health coverage															
Proportion of population receiving essential health services (%)[19]	36	60	40	58	45	30	44	64	42	59	68	67	39	56	55
Health budgets															
Health expenditure as proportion of GDP (%)[20]	2.9	5.5	3.9	7.7	8.1	6.0	9.8	9.8	5.1	9.1	3.9	8.1	4.1	4.5	9.4
Health expenditure as proportion of total government expenditure (%)[21]	5.4	9.1	3.7	15.25	10.1	17.8	9.8	9.8	8.3	13.8	10.0	13.3	9.5	7.1	14.5

Source: Gender Links, 2019.

First-hand account of SRHR health services in Mauritius[22]

On 28 March 2019 a private doctor diagnosed me with menorrhagia; a state of prolonged menstrual bleeding characterised by heavy blood flow and abdominal cramps. I was advised to go to Jawaharlal Nehru Public Hospital in Rose Belle for medical tests.

I had never been to a public hospital before but given the severity of the situation I followed the doctor's advice. Upon my arrival I was admitted and the necessary examinations were made and different tests done by the gynaecologist who was on call.

A series of blood samples were taken and after all those the nurse showed me to bed and I was told not to eat anything until the tests were done the following morning. Before the doctor came to see me that morning, I decided to freshen up and then went to the bathroom in the same ward. To my horror the toilet and bathroom area smelled so badly I could not stand being in that room. Instead of a hospital bathroom, which I expected to be clean, I felt like I was in pig sty. To my shock I returned to my bed with total disgust without using those facilities.

The patient next to me who had the same diagnosis ran out of sanitary towels and had to ask for one from one of the nurses, she came back in disarray with a piece of cotton wool. I went to change my sanitary pad in the toilet and to my surprise only one of the toilets was working and had a drizzle of water from the tap. There was no toilet paper and no soap; too much of a luxurious commodity I suppose.



Sheistah Bhundhoo making her voice heard.
Photo: Anushka Virahsawmy

It is totally unacceptable that in a hospital ward where approximately 25 women are admitted with gynaecological issues and heavy bleeding, there is no running water and sanitation facilities are non-existent. Bed sheets and pillow covers are only changed if they are stained and toilets and bathrooms are not cleaned as they should be. This was a perfect bacterial breeding place. There are no sanitary bins, instead a huge uncovered bin near the toilet area is filled with used sanitary pads, stained cloths and cotton wool.

This experience with the public health sector has triggered a few alarm bells. As an advocate for gender equality and SRHR, that includes menstrual health, I believe that our public system needs to be studied by our leaders. It is not people-centred and the service is deplorable. Women's sexual and reproductive health is a right and it is totally unacceptable to get such abysmal service.

Source: Sheistah Bhundhoo, Gender Links News Service, 2019

3 GL Audit of SRHR Policies and Laws in SADC, 2019
4 aho.afro.who.int/profilesinformation/index.php/
5 GL Audit of SRHR Policies and Laws in SADC, 2019
6 IBID
7 WHO/UNICEF (2017) Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline
8 IBID
9 https://www.unfpa.org/data/world-population/
10 IBID
11 https://www.unfpa.org/data/world-population/
12 GL Audit of SRHR Policies and Laws
13 Maternal and Newborn Health Coverage Database, UNICEF, 2019
14 IBID
15 IBID
16 IBID
17 https://childmortality.org/data
18 http://apps.who.int/gho/data/view.main.HWFNURv
19 http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv
20 https://databank.worldbank.org/data/source/world-development-indicators#
21 IBID
22 https://genderlinks.org.za/news/mauritius-public-hospitals-and-poor-srhr-services-for-women/

SRHR policy and legislative framework in SADC

Article 6.1 (a) of the SADC SRHR Strategy obliges member states to establish a multisectoral coordinating entity that includes civil society, networks of youth, adolescents and key populations, and development partners, to domesticate, implement, monitor and evaluate their national SRHR strategies.

Ensuring that member states align their SRHR policies and laws with global and regional commitments, as well as international human rights standards, is the first step towards addressing the legal and policy gaps that perpetuate gender inequality and impact on SRHR in the region. Many SADC countries ratify international and regional instruments, but they lag in domestication and implementation. During the next 11 years, governments must implement programmes to achieve their targets linked to each of their SRHR commitments.

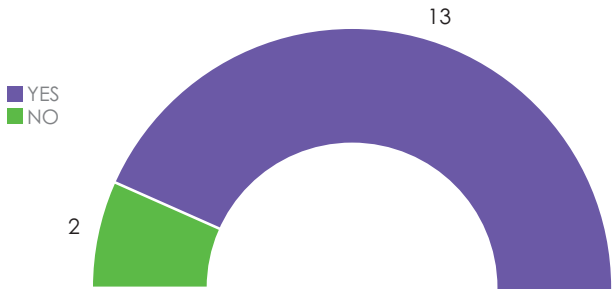
The promotion and realisation of women and girls' reproductive rights and access to SRH often entails long-term processes of legal reform, policy change and institutional transformation as well as social norm change. Transformation and reform at all these levels is necessary for women and girls to enjoy the exercise their SRHR.[23] SRHR policies and laws ensure that countries focus on SRHR issues in line with global and regional commitments aimed at fostering equitable development outcomes.

13 out of 15 SADC countries have standalone policies or guidelines on SRHR

Status of SRHR policies and laws in SADC

Figure 2.2 shows that 13 out of 15 SADC countries have standalone 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 standalone policies or guidelines.

Figure 2.2: Countries with standalone SRHR policies or guidelines



Source: Audit of SRHR policies and laws Gender Links, 2019.

[23] https://www.ippfar.org/sites/ippfar/files/2018-09/SOAW-Report-Chapter-7-Sexual-and-Reproductive-Health-and-Rights.pdf

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Adopted more than five years ago		
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 fewer		
Eswatini	National Policy on Sexual and Reproductive Health	2013
South Africa	Sexual and Reproductive Health and Rights: Fulfilling our Commitments and the 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		
DRC	Included in the Constitution	2011
Angola	Included in the Constitution	1975

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2019.

Table 2.2 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 newer policies. Madagascar adopted its SRHR policy in 2017. The new Madagascar SRHR policy is a welcome development; however, it is important to note that it 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 that compromise citizen's access to SRHR.

Madagascar adopted an SRHR policy in 2017, yet it still prohibits abortion



Unmet needs and growing inequality in Angola[24]



Young women take part in educational and recreational activities at a UN-supported women-friendly space in the Lóvua refugee settlement in Angola in 2018. Photo: Tiril Skarstein

In 2014, reports estimated the population of Angola to be 19.8 million, of which youth aged 10 to 24 represented 33%. The high total fertility rate of 6.4 children per woman and the low modern contraceptive prevalence rate of 12.8% (both statistics from 2010), contribute to Angola's annual population growth rate of 3.52%, one of the highest in the world.[25] Adolescent fertility is also very high at 152.1 per thousand women aged 15 to 19. This contributes to high maternal mortality and morbidity, including from obstetric fistula, stillbirths and unsafe abortions.

The main reason for Angola's high adolescent fertility rate is due to the limited availability of, and access to, youth-friendly sexual and reproductive health services and information. This also explains the high incidence of unprotected sex, estimated at 70%.

While most recognise the prevalence of adolescent sexual relationships, there remains inadequate provision of appropriate behavioural change education and youth-friendly reproductive health services and information. Instructors do not have the skills to teach sexual and reproductive health classes and no specific policies exists to integrate sexuality education in school curricula. Consequently, only 44.6% of youth have accurate knowledge about HIV and AIDS and only 14.9% know their HIV status.

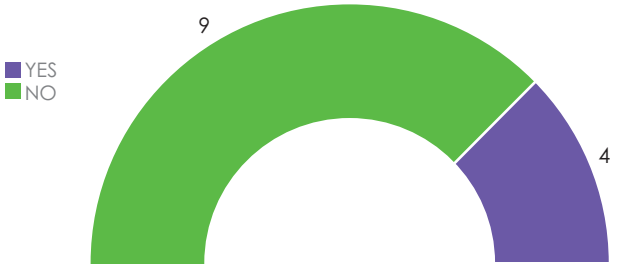
The United Nations Population Fund (UNFPA) puts maternal mortality in Angola at 450 women per 100 000 live births. This high ratio stems from a combination of the low percentage of deliveries attended by qualified health personnel nationally (49%) and in health units (42%), the low ratio of population to qualified health care providers (one doctor per 10 000 people), and the low capacity of health facilities to provide emergency obstetric care services. Leaders established the National Audit Committee for the Prevention of Maternal and Neonatal Deaths in March 2012 to implement the recommendations of the Campaign for Accelerated Reduction of Maternal Mortality in Africa. However, it is not yet functional.

Lawmakers also approved a National Policy for Gender Equality and Equity in 2013 by Presidential Decree No. 222/13. Yet gender stereotypes and GBV remain widespread and no systematic coordination mechanism exists to address these harmful attitudes and practices.

Source: Final country programme document for Angola, UNFPA, 2014

[24] https://www.unfpa.org/data/transparency-portal/unfpa-angola
[25] https://www.statista.com/statistics/264687/countries-with-the-highest-population-growth-rate/

Figure 2.3: Number of countries reviewing SRHR policies



Source: Audit of SRHR policies and laws Gender Links, 2019.

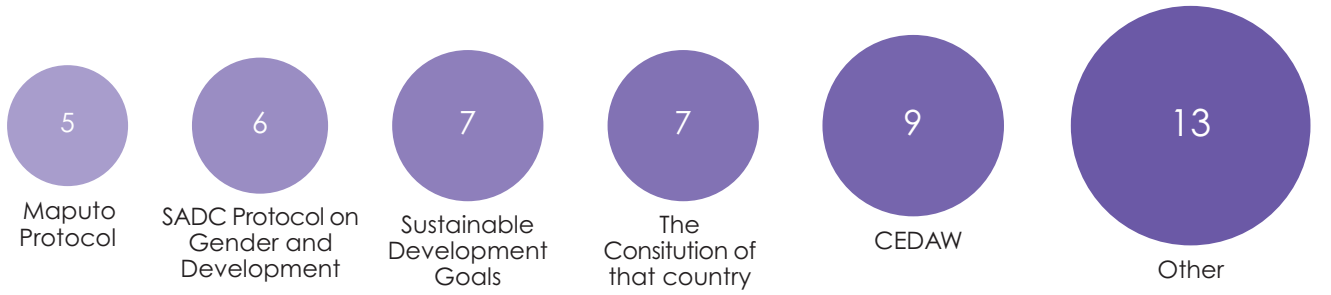
Figure 2.3 shows that, out of the 13 countries that have standalone SRHR policies or guidelines, four (Botswana, Namibia, Seychelles and South Africa) are reviewing them. South Africa is in the final stages of adopting a new SRHR policy.

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 and Scorecard 2019-2030.

Linking SRHR policies with regional and global instruments

Several global and regional instruments address reproductive health, GBV, HIV and AIDS, and women's rights. SADC member state SRHR policies should refer to, and align with, the targets of these existing instruments for easier coordination.

Figure 2.4: Global and regional instruments referenced in SRHR policies



Source: Audit of SRHR policies and laws, Gender Links, 2019.

Figure 2.4 shows that SADC 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 SADC Protocol on Gender and Development; and seven refer to the SDGs and national constitutions. Thirteen countries cite other sources. These include the Millennium Development Goals (MDGs); the 1994 International Conference on Population and Development (ICPD); the SADC minimum pack-age for SRHR services; the global Family Planning 2020 framework; and the Beijing Platform for Action.



Support group members take part in a GBV campaign event at Matukeng Clinic in Lesotho in April 2019.
Photo: Kelello Rakolobe

SADC countries reference global and regional instruments as overarching frameworks in their SRHR policies and guidelines

The challenge for all SADC member states is how countries domesticate and harmonise these regional and global instruments with national laws and policies. This is the process of creating common standards across the region for adolescent sexual and reproductive health rights. Leaders base harmonisation on international and regional conventions and commitments that they have already ratified or signed linked to adolescent SRHR.[26]

Many countries struggle with both implementation and overcoming contradictions between regional and global commitments and national laws and policies. Despite these challenges, harmonisation and domestication remain urgent priorities in the region.

Adolescent SRHR

Children and youth younger than 24 constitute a majority of the population living in most countries in the region, except for Mauritius and Seychelles. If the region is to reap the benefits of this demographic dividend and advance social and economic development, lawmakers must prioritise investments in SRHR, particularly for adolescents and young people.[27] It is imperative that countries in SADC develop focused adolescent SRHR strategies and policies.

Table 2.3: Overview of adolescent and youth SRHR policy frameworks across SADC[28]

Country	Standalone 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 2017
Tanzania	No
Zambia	Yes, National Adolescent and Youth Health Strategy (2016-2020)
Zimbabwe	No

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2019.

Table 2.3 shows that only six SADC countries have standalone SRHR policies or strategies: DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia. They include adolescent SRHR in these national SRHR policies, strategies or guidelines. Going forward, it will remain important for stakeholders to analyse if these strategies have improved SRHR for young people in those countries.

[26] https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf
[27] Strategy for Sexual and Reproductive Health and Rights in the SADC region, 2019-2030
[28] aho.afro.who.int/profiles_information/index.php/

Table 2.4: Countries with laws and policies requiring parental consent for adolescents to access SRH services in SADC[29]

Country	Consent not required	Yes, if younger than 14	Yes, if younger than 16	Yes, if younger than 18
Angola				✗
Botswana			✗	
DRC[30]				✗
Eswatini				✗
Lesotho		✗		
Madagascar	✗			
Malawi		✗		
Mauritius		✗		
Mozambique	✗			
Namibia	✗			
Seychelles				✗
South Africa	✗			
Tanzania	✗			
Zambia			✗	
Zimbabwe			✗	

Source: UNAIDS data, 2018.

As illustrated in table 2.4 only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) do not require parental consent for adolescents to access SRH services. Youth must get parental consent for these services in Lesotho, Malawi and Mauritius if they are younger than 14; this applies to Botswana, Zambia and Zimbabwe if youth are younger than 16. Meanwhile, in Angola, DRC, Eswatini and Seychelles youth younger than 18 cannot access SRHR services without parental consent. Adolescents and young people face many barriers in accessing SRH services, including health centre staff with disapproving attitudes towards sexually active unmarried youth, inconvenient opening times and locations for clinics, lack of privacy, fear of lack of confidentiality and high cost.[31] Lobbying for unrestricted access to SRHR services on the part of adolescents is an important strategy to address key regional issues such as increasing HIV infections amongst young people, early pregnancies and marriages, menstrual health and unsafe abortions.



A body mapping exercise for adolescents at a workshop on SRHR in Botswana in December 2018. Access to SRHR information helps reduce HIV infections and early pregnancies.. Photo: Keletso Metsing

Menstrual health

Research shows that 800 million women and girls menstruate every day, but menstruation remains shrouded in silence and taboos.[32] A key step towards demystifying menstruation is providing free menstrual products. This will enable girls to go to school and engage in everyday activities without restriction.

[29] http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf
[30] https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html
[31] https://esaro.unfpa.org/sites/default/files/pub-pdf/SYP%20Annual%20Report%202017%20V2.pdf
[32] https://iwhc.org/2018/07/integrating-menstrual-hygiene-management-achieve-sdgs/

Table 2.5: Status of menstrual products in SADC

Country	NO VAT on sanitary ware	Provides free sanitary ware in schools
Angola	No	No
Botswana	No	Yes
DRC	No	No
Eswatini	No	No
Lesotho	No	Yes
Madagascar	No	Yes
Malawi	No	No
Mauritius	Yes	No
Mozambique	No	No
Namibia	No	No
Seychelles	No	Yes
South Africa	Yes	No
Tanzania	Yes	No
Zambia	Yes	Yes
Zimbabwe	Yes	No

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2019.

As illustrated by figure 2.5, five SADC countries (Lesotho, Mauritius, South Africa, Tanzania, Zambia and Zimbabwe), have removed VAT on menstrual products. The removal of VAT on menstrual products, while welcome, should be seen as a first step: burgeoning costs due to economic recession means that the base cost of menstrual products continues to rise.

Only five SADC countries, Botswana, Lesotho, Madagascar, Seychelles, and Zambia, provide free menstrual products in schools. A lack of safe products puts young girls at risk of using unhygienic methods such as rags or newspapers.[33] This is a health hazard and 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 SRH services. Only Zambia provides free sanitary ware in schools and has removed VAT on sanitary ware elsewhere.

Only five SADC countries provide free menstrual products in schools



eZulwini Municipality Mayor's walk 2018. Photo: Gender Links

[33] https://genderjustice.org.za/article/high-cost-sanitary-pads-puts-south-african-girls-education-risk/



Lesotho provides free sanitary ware in schools[34]



Thabo Morena distributes sanitary pads at Mamantso Council in Mafeteng, Lesotho, in 2019. Photo: Ntolo Lekau

Reports indicate that some girls in Lesotho use old clothes, socks and sheep skin during menstruation instead of safe sanitary products (World Vision, 2018). So the government's decision to provide free sanitary ware in schools on 12 March 2019 came as a relief to many girls and women. Menstrual health talk in public remains largely taboo in Lesotho. However, Lesotho National Assembly member Kose Makoa challenged this barrier when he moved the motion on sanitary towels and provide them for free to all girls.

'Makhotso Akhosi, a nurse from Lesotho Defence Force Clinic, believes that this move will reduce many illnesses caused by unhygienic material used during menstruation, allowing her clinic to use the money typically spent on this for other things. However, the next step is to remove VAT on sanitary ware as a step towards improving adolescent health. Many girls and women still cannot afford sanitary towels.

The government and civil society need to come up with strategies to ensure that disadvantaged women have access to free sanitary towels provided in convenient places. Menstrual health is a vital component of SRHR and it is the role of the Ministry of Health and other relevant stakeholders to create a healthy country by ensuring a healthy populace.

Source: Gender Links News Service, 2019

Water and sanitation



Article 26 (c) SADC Gender Protocol: Ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.
SDG 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.
Article (15a) Maputo Protocol: Provide women with access to clean drinking water, sources of domestic fuel, land, and the means of producing nutritious food.

[34] https://genderlinks.org.za/casestudies/lesotho-government-scraps-tax-from-sanitary-wear/



A young girl in Sharpeville, South Africa, accesses water outside her home in 2007. Safe water provision has improved in the region over the past decade, but many still do not have access to clean drinking water. Photo: Colleen Lowe Morna

Women continue to bear the primary responsibilities linked to water, sanitation and hygiene (WASH). Yet communities often leave women out of decision-making on water provision. Similarly, the sphere of administration - local government - that controls the provision of water and sanitation seldom engage in strategic national-level discussions on WASH.

The lack of WASH compromises health and safety and affects all aspects of daily life, including school attendance. Safe water and sanitation facilities at home and at school are particularly important for girls who are menstruating.

While discussions about provision and cost of menstrual products is important and receiving substantial attention currently, there is also an urgent need to focus on WASH as a critical SRHR concern. It is important to include local government in national, regional and global strategies to ensure that all communities have access to good quality WASH.

Table 2.6: Access to basic drinking water in SADC

Country	National basic drinking water status (%)	Urban basic drinking water status (%)	Rural basic drinking water status (%)
Angola	100	100	100
Botswana	96	-	-
DRC	85	97	63
Eswatini	79	95	58
Lesotho	79	97	63
Madagascar	72	87	66
Malawi	68	95	60
Mauritius	67	87	63
Mozambique	67	94	54
Namibia	61	86	44
Seychelles	51	82	34
South Africa	50	79	37
Tanzania	47	79	32
Zambia	42	70	21
Zimbabwe	41	63	23

Source: Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline, WHO/UNICEF, 2017.

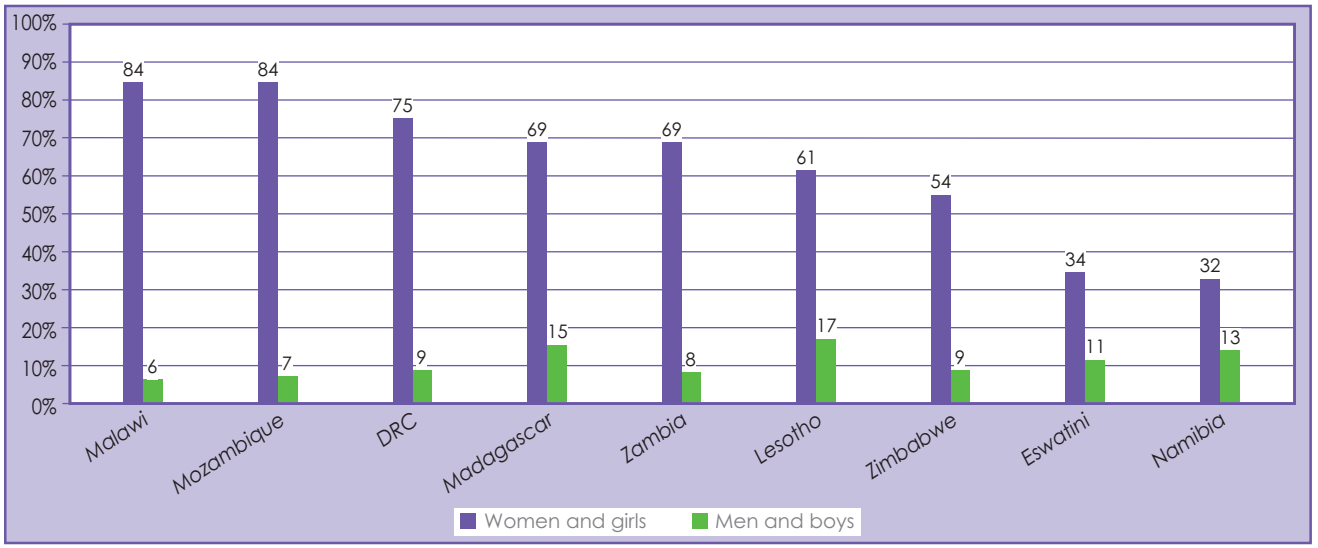
As shown in Table 2.6, four SADC countries - Angola, DRC, Mozambique and Tanzania - have less than 50% coverage for basic drinking water. Meanwhile, Eswatini, Madagascar, Malawi, Zambia and Zimbabwe have between 50-68% coverage, with only Mauritius, Seychelles and South Africa enjoying more than 80% coverage.

While this scenario points to serious concerns about access to water, the picture in rural areas is most alarming. Water provision and access in urban areas is between 63% and 100%, but in stark contrast it sits as low as 21% in rural areas in the DRC followed by 23% in Angola. Mozambique, Madagascar, Tanzania and Zambia have between 32% and 44% access to basic drinking water in rural areas.

South Africa is a relatively well-resourced country, but it has not met the basic needs of its citizens in terms of water supply, particularly in rural areas: 97% of communities have access to water in urban areas as opposed to 63% in rural areas.

There is a need for amplified lobbying and advocacy to push for increased water provision. It is important to continue to monitor how governments meet their promises on this front.

Figure 2.5: Gender division of labour for water collection in nine SADC countries



Source: Safely managed drinking water, UNICEF, 2017.

Figure 2.5 illustrates data from a 2017 report by UNICEF on safely managed drinking water. The report assesses access to water in countries where at least one in ten households have water off premises. In Mozambique and Malawi, it found that 84% of women and girls collect water for the household as opposed to 6% and 7% percent men and boys, respectively.

In the nine countries studied, more women and girls collect water than men and boys without exception. This has an impact on women and girls' time, safety, health and general wellbeing. These findings provide urgent impetus for accelerated safe water provision.

The link between water, sanitation and gender equality is clear. Limited access to water compromises the provision of sanitation. The lack of sanitation in communities and particularly schools impacts the quality of education, girls' attendance and access to education facilities.

In nine SADC countries studied, substantially more women and girls collect water than men and boys without exception

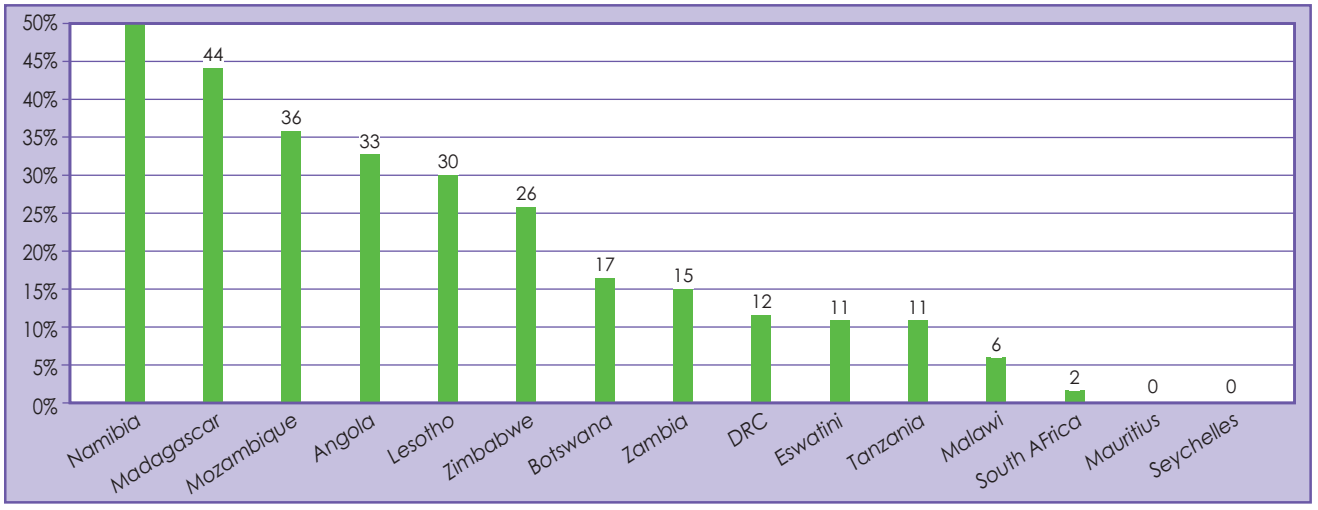
Table 2.7: Status of access to basic sanitation in SADC

Country	National access to basic sanitation (%)	Urban access to basic sanitation (%)	Rural access to basic sanitation (%)
Seychelles	100	-	-
Mauritius	93	94	93
South Africa	73	76	69
Botswana	60	75	39
Eswatini	58	58	58
Lesotho	44	46	43
Malawi	44	49	43
Angola	39	62	21
Zimbabwe	39	54	31
Namibia	34	55	15
Zambia	31	49	19
Mozambique	24	47	12
Tanzania	24	37	17
DRC	20	23	18
Madagascar	10	16	6

Source: Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline, WHO/UNICEF, 2017.

Table 2.7 shows that ten SADC countries provide basic sanitation for less than half of their citizens. Madagascar, with 10% coverage, sits at the bottom in the region, while Seychelles, with 100%, sets a gold standard. Governments clearly prioritise sanitation services in urban areas. Four countries (DRC, Madagascar, Mozambique and Tanzania) provide basic sanitation to less than 25% of the population.

Figure 2.6: Percentage population practicing open defecation



Source: https://data.worldbank.org/indicator/SH.STA.ODFC.ZS. Accessed 23 May 2019.

The lack of proper sanitation services and, significantly, open defecation present serious health challenges in the region. Figure 2.6 shows that, at 50%, Namibia has the highest proportion of people practicing open defecation, followed by Madagascar at 44%. Many people also still practice open defecation in Angola, Lesotho, Mozambique and Zimbabwe. While the levels drop in other countries, the practice of open defecation remains a concern in the absence of proper sanitation.



Tanzania: Sanitation is a right, not a "nice to have"[35]

"Sometimes having your period is a challenge. It stops girls from going to school."

Rebeca, who was 17 when she spoke to Human Rights Watch in 2016, should know. She and other schoolgirls in Tanzania told the international advocacy group that they lacked menstrual supplies, toilets with privacy, and information needed to handle menstruation. They described taunts and humiliation when they leaked blood, missing school as a result.

Girls around the world face the same challenge - often with the same, dispiriting result.

The right to sanitation entitles everyone to sanitation services - including the management of menstruation - that provide privacy, ensure dignity, and are safe and hygienic. Human Rights Watch research from 2005 to 2017 documented obstacles people encounter when trying to perform the simple acts of relieving themselves or managing menstruation safely and with dignity.

In almost every setting researchers examined, including schools, prisons and jails, and refugee camps, they found that discrimination based on caste, gender, disability, age, or other status makes it even harder for some people to access adequate sanitation services than others. They found women and girls often lack safe and private sanitation facilities and materials to manage their menstruation. This can undermine their health, education, work, and gender equality.



Female and male latrines at a secondary school in Mwanza, north eastern Tanzania, in 2016. Many students told Human Rights Watch that they had to use dirty and congested pit latrines. Photo: Elin Martínez, Human Rights Watch

A lack of access to safe and accessible sanitation facilities can also impact the rights of people with disabilities, older adults, and transgender and gender non-conforming individuals. To ensure adequate sanitation for all people, governments need to do more than simply commit new funding and resources. They also need to address discrimination and distinctive challenges for certain populations that prevent some people from accessing sanitation.

Sanitation is a human right for all people. Governments need to be treating it that way.

Source: Annerieka Daniel, Human rights Watch, 2017

[35] https://www.hrw.org/news/2017/04/19/sanitation-right-not-nice-have

Access to contraception



SDG 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
Article 14 (b): CEDAW: To have access to adequate health care facilities, including information, counselling and services in 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, and see more stability and security - and less gender inequality.[36] 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 contraception. Early pregnancies severely impact young women and their futures. SADC states should have separate strategies on the provision of contraception and family planning. The first addresses the need for all women across all ages to access contraception. The second helps women who want to have children to plan in a way that does not negatively affect their wellbeing from a health, social or economic perspective. This is a key policy imperative.

Stories like the alleged suicide in 2018 of Blessing Mangena, a Zimbabwean female university student, over an unplanned pregnancy, provide stark reminders of how major gaps in the provision of reproductive health services impact women's lives. The National University of Science and Technology (NUST) learner chose a painful way to die, being crushed by a train, instead of carrying the "shame" of an unwanted child. The death robbed her family, community and the nation of a future statistician who could have contributed to building the country.

At a global level, the DRC, Lesotho, Mozambique, Tanzania, Zambia and Zimbabwe have committed to the Family Panning 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 SDGs 3 and 5. FP2020 supports the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health.[37]

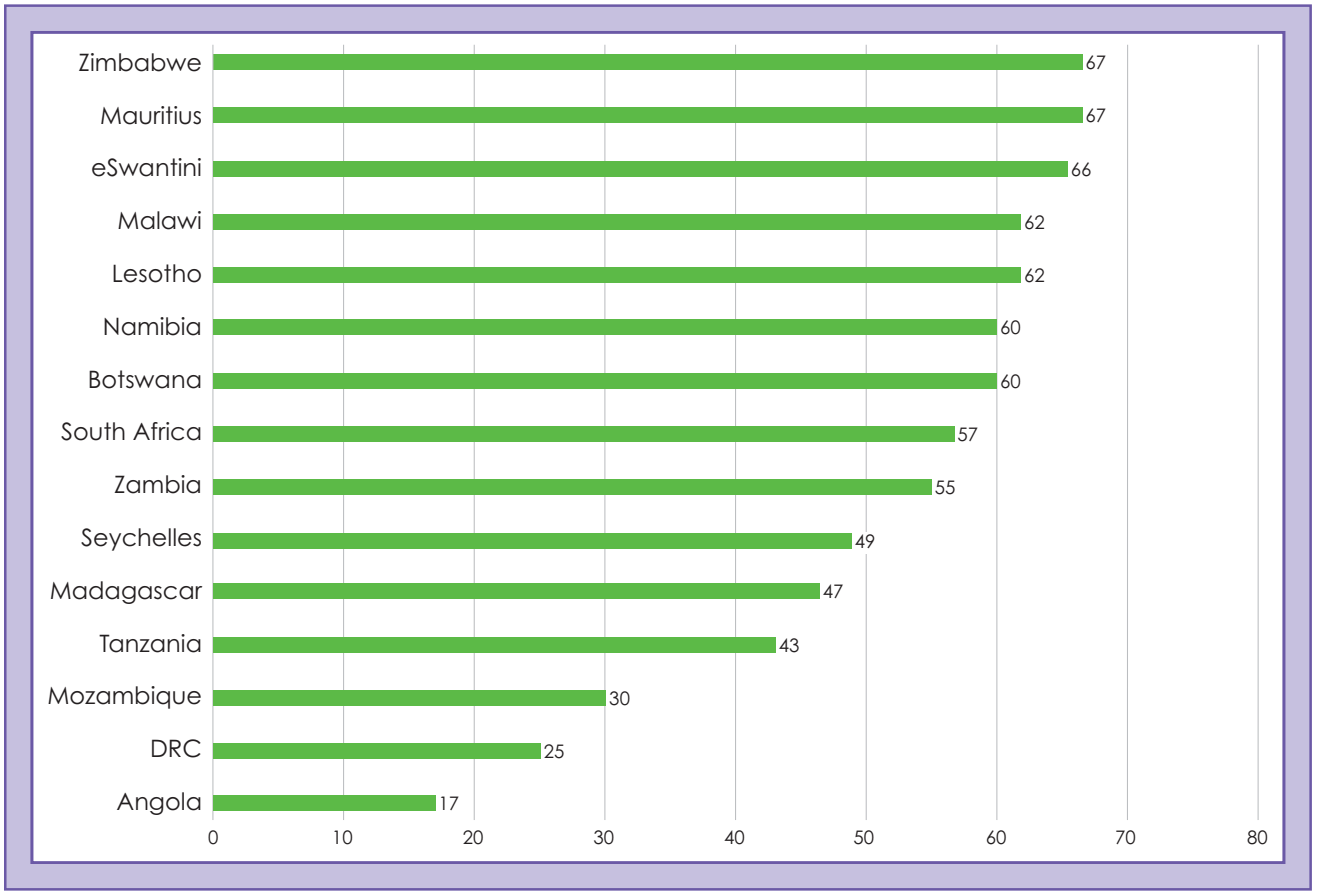
The contraceptive prevalence rate (CPR) is an important indicator of health, population and women's empowerment

[36] https://mariestopes.org/media/2146/time-to-invest.pdf
[37] https://www.familyplanning2020.org/about-us

Contraceptive prevalence rates

The contraceptive prevalence rate (CPR) shows the percentage of women between ages 15 and 49 in marital or consensual unions who use, or whose sexual partner uses, a traditional or modern method of contraception. The CPR is an important indicator of health, population and women's empowerment.[38]

Figure 2.7: Contraceptive prevalence in SADC



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 25 May 2019.

Figure 2.7 shows wide disparities in contraceptive prevalence rates across SADC countries. The CPR is highest in Zimbabwe and Mauritius (67%) and lowest in Angola (17%). It is critical for governments to identify the groups of women not accessing contraception in order to target local and regional lobbying and campaign efforts. Failure to provide contraceptive care has huge implications for unintended pregnancies, unplanned births, abortions, and miscarriages, increasing levels of maternal mortality in countries.

[38] https://www.africanhealthstats.org/cms/?pagename=indicator&indicator=RMNCH3



Malawi: Spike in unwanted pregnancies following contractive shortages[39]

Thirty-year-old Doris Chikwina from Chigwaja village in Blantyre is furious. She has just discovered that she is pregnant again. "I am fuming yet I am supposed to be happy with this bundle of joy news. But I am not," she says. "I did not expect this pregnancy. I am already nursing a year and half old baby, and I have four other children. I was supposed to be on injectable (Depo-IM), but last time I went to my health centre I came back emptyhanded as I was told that the clinic had run out of this family planning method."

Chikwina said she was receiving an injectable contraceptive at Chigwaja clinic, but she has been off them since the shortage. "I visited three clinics including one at Chilomoni. They were all out of stock and the staff were not sure when the situation would return to normal."

Elsewhere in Chikwawa, two teenage girls say they are one month pregnant because their clinic is also out of contraceptives. They say they had been taking contraceptive pills until last month. The girls, who did not want to be named, said they are sad because they will now not be able to write exams because they are pregnant.

The story is the same for Chilomoni-based Chikondi Phiri, a sand collector who is also pregnant following her inability to access an emergency contraceptive pill. The clinic had run out. "We were told that we had to buy on our own, but I did not have money. I already have nine kids and it is not easy to feed them all in this economy."



Many Malawi clinics have run out of contraceptives like injectable Depo-IM.
Photo: Mayo Foundation

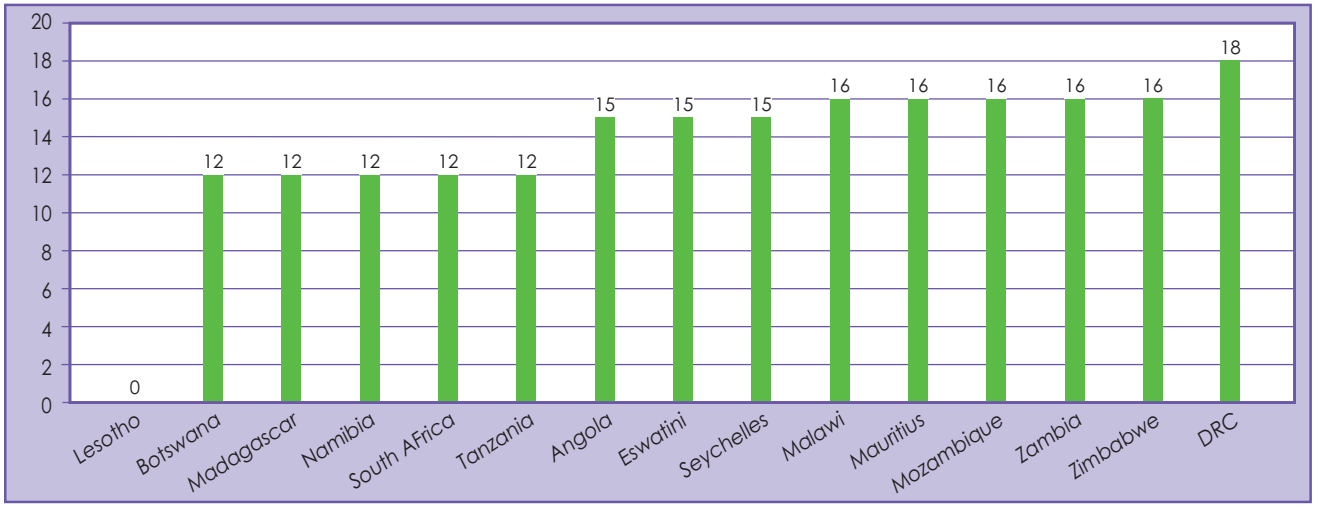
In recent years, lawmakers have attempted to address Malawi's high birth rate by providing better access to contraceptives like those used by Chikwina and Phiri. These recent shortages pose a threat to any gains they've made in reducing the soaring birth rate.

Health rights activist Mary Mbonela said in an interview that worries of the brief shortage of all contraceptives, coupled with the absence of access to abortion services in many parts of the country, had put women at increased risk of unwanted pregnancy and undermined their reproductive and contraceptive health rights.

Source: Penelope Kamanga-Paliani, Gender Links News Service

[39] https://genderlinks.org.za/news/malawi-shortage-of-contracptives-hits-women-hard/

Figure 2.8: Age of access to contraceptives



Source: Audit of SRHR laws and policies in SADC, Gender Links, 2019.

As is evident in figure 2.8, five SADC countries (Botswana, Madagascar, Namibia, South Africa and Tanzania) provide contraceptives to young people from the age of 12. Angola, Seychelles and Eswatini start at age 15, while all other countries allow for contraception from age 16 and up. The SADC SRHR Strategy provides for contraception from age 10. Given the high level of early pregnancies in the region, the age of consent for contraception should be lowered in those countries where it is higher than 12 years.

Lesotho does not stipulate any age for access to contraception because the country recognises access to contraception as a right and it must be available to anyone at any age.

While the approach provides much needed open access, it is concerning because it can be open to interpretation by health care providers and facilities.

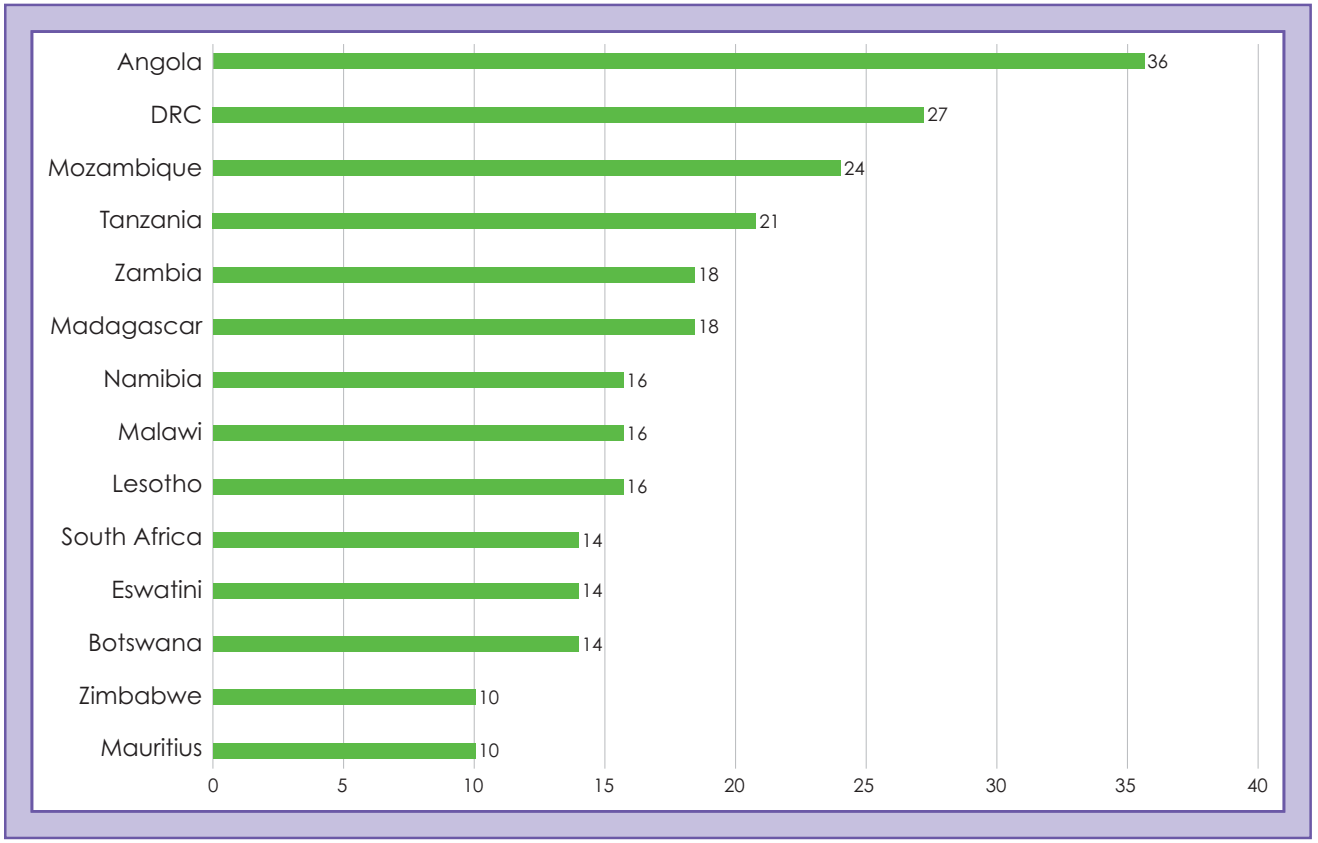
There is a need to interrogate the cultural practices and social norms that hinder youth access to contraceptives and integrate them into strategic SRHR planning. Experts define the unmet need for family planning as the percentage of women of reproductive age, either married or in a union, who have an unmet need for contraception. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception.[40]



She Decides launch August 2018. Photo: Colleen Lowe Morna

[40] https://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf

Figure 2.9: Unmet need for contraceptive use amongst women aged 15 to 49



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 25 May 2019.

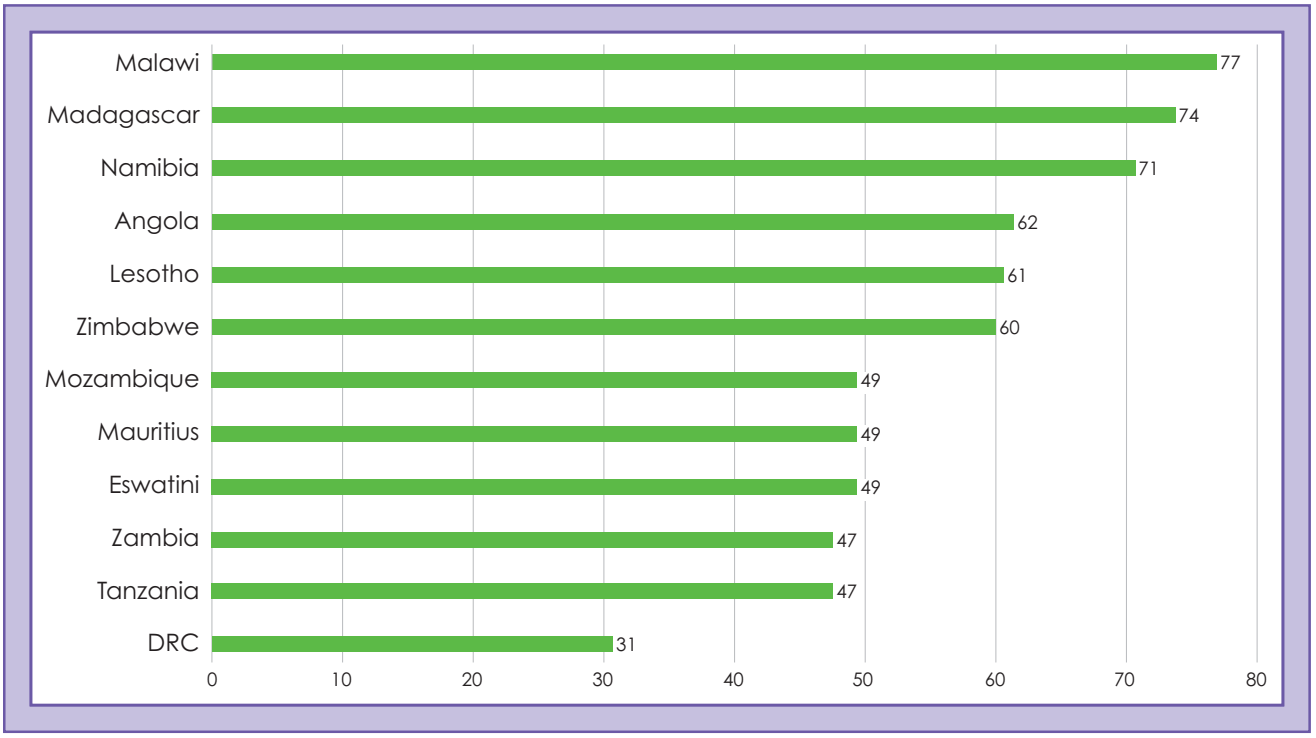
Figure 2.9 shows that Angola, at 36%, has the highest unmet need for contraceptive use. The DRC, Mozambique and Tanzania rank between 21% and 27% in terms of unmet needs. The unmet need for contraceptive use amongst women coupled with the criminalisation of abortion in 13 SADC countries results in elevated levels of unwanted pregnancies and compromises women's ability to have control over their bodies.

Angola has the highest unmet need for contraceptive use



Explaining contraception at the Basic Health center in Tsaralalana, Madagascar.
Photo: Gender Links

Figure 2.10: Females involved in decision-making for contraceptive use amongst women aged 15 to 49



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 25 May 2019.

Malawi has a high proportion of women involved in decision-making about contraceptive use at 77%, followed by Madagascar and Namibia with 74% and 71% respectively. In DRC, Eswatini, Mauritius, Mozambique, Tanzania and Zambia less than 50% women between 15 to 49 using contraceptive are involved in decision-making. The DRC, at 31%, ranks as the lowest in the region. No data exists for Botswana, Seychelles and South Africa.

Maternal health

State parties shall, in line with the **SADC Protocol Article 26(a)** and other regional and international commitments by member states on issues relating to health, adopt and implement legislative frameworks, policies, programmes and services to enhance gender sensitive,

SDG 3.1: Reduce maternal mortality to fewer than 70 deaths per 100 000 live births.

Maputo Protocol Article 14.1: Ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

a) The right to control their fertility;

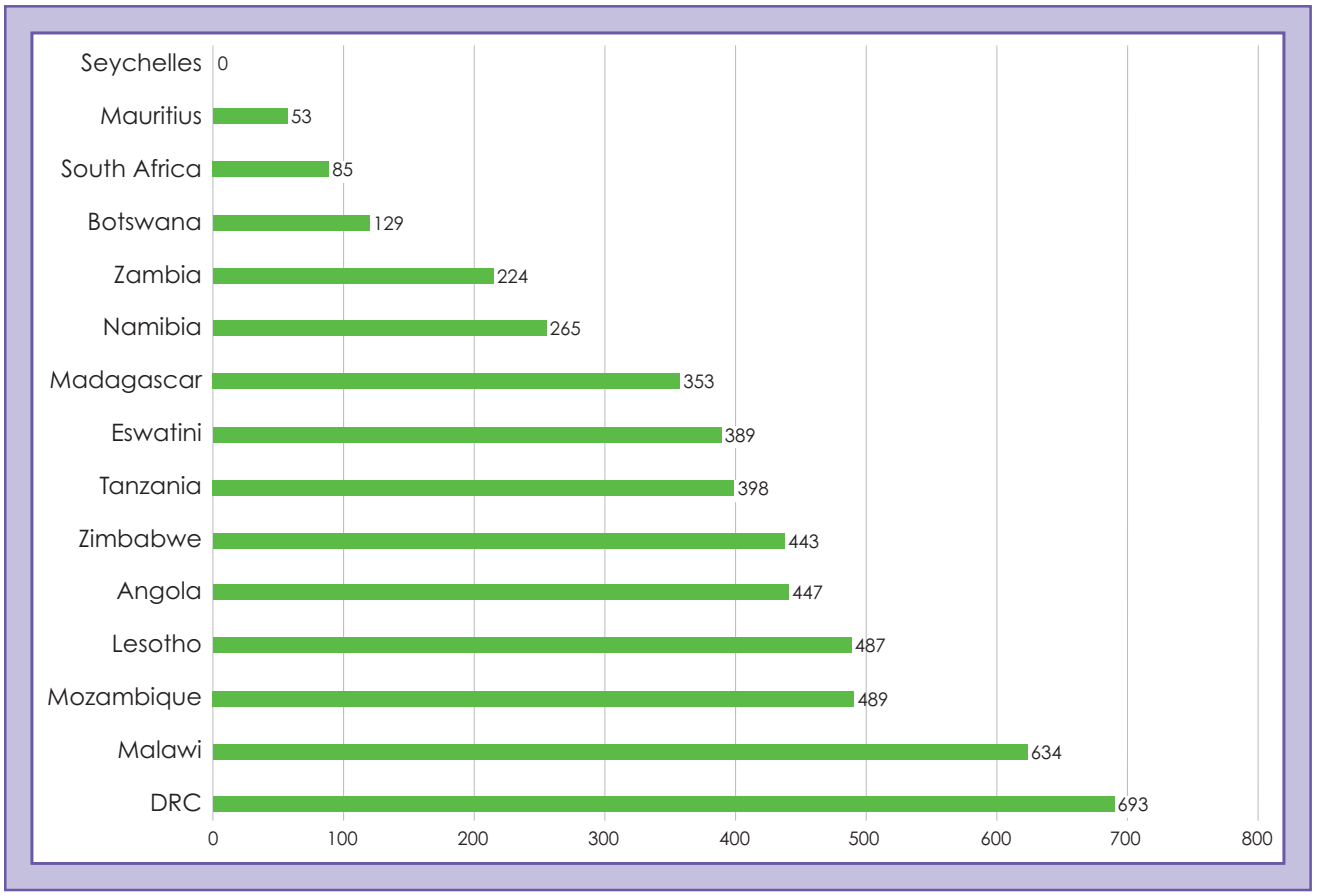
b) The right to decide whether to have children, the number of children and the spacing of children; and

c) The right to choose any method of contraception.

Maternal Mortality Ratio

The WHO defines maternal health as the health of women during pregnancy, childbirth and the postpartum period.[41] The Maternal Mortality Ratio (MMR) represents the number of women of childbearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy; from any cause related to or aggravated by the pregnancy or its management (but not from accidental or incidental causes) per 100 000 live births.[42] More often, women die because of lack of access to proper reproductive health care.

Figure 2.11: MMR per 100 000 in SADC



Source: Maternal and Newborn Health Coverage Database, UNICEF, 2019.

Figure 2.11 shows that MMR varies considerably by country: it is lowest in Seychelles and highest in the DRC. The MMR for the Seychelles has substantially reduced over the last ten 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 remain above the target, with the DRC being almost ten times higher than the required target. Improvements in SRHR are critical in reducing maternal mortality, as well as ensuring social and economic development for women. There is a need for the SADC region to improve health outcomes for women by providing access to comprehensive maternal health care, contraception, family planning, HIV and AIDS services and unrestricted abortion.

[41] https://www.who.int/maternal-health/en/
[42] UNICEF MMR definition



Mozambique is one of the most dangerous places in the world to have a child[43]

"Who wants to give birth here?" asked the midwife, as she threw open the door of the maternity ward: a mud-and-straw hut, baking hot under the merciless sun in Ngapa village, Mueda district, in northern Mozambique.

Four beds, two mattresses, a torn, ramshackle gynaecological bed, a rusty stand holding a plastic pail, and little more. The midwife had no aspirator, no electricity and no running water.



A young woman sits in the Chiquque hospital in Mozambique's Inhambane province after suffering a severe hemorrhage following a miscarriage.

Photo: Mercedes Sayagues

And she was tired. Diabetic, a few months away from retirement, worn by a hard life, bitter because she had been promised a brick house with running water but was living in a *pau-a-pique* (mud) hut, not much different from the maternity ward. She had not bothered to register any of the births or deaths in the last three months.

In remote rural clinics in the remote Mueda plateau, along the border with Tanzania this is what I saw:

- In Imbuo village, the clinic is freshly painted red and white, but a woman in labour must bring her own water, food, sheets and a paraffin lantern. To request an ambulance from the district capital 50 kms away, a relative must ride a bike for 15 minutes to find cell phone reception.
- In Mpeme, instruments cannot be sterilised properly between patients for lack of gas canisters.
- In Namatil, the nurse can diagnose HIV but the nearest centre for antiretrovirals is US$5 and two hours on a bad road away. Most rural people survive on one dollar a day.

Until when will rural Mozambican women have to live as if biology and geography determine their destiny? As if their destiny is to risk their lives with every birth, to give birth more than is healthy (on average, more than six births per woman, while fertility rates are climbing, an anomaly in Africa), and to have the babies in a place, whether a home or a rural clinic, that makes it unsafe to bring life into this world?

Source: Mercedes Sayagues, Daily Maverick, 2014

[43] https://www.dailymaverick.co.za/article/2014-06-19-maternal-mortality-in-mozambique-who-wants-to-give-birth-here/

Access to health services

Table 2.8: Provisions for antenatal and postnatal care

Country	At least one ANC (%)	At least four visits (%)	Postnatal care (%)
Angola	82	61	23
Botswana	94	73	
DRC	88	48	44
Eswatini	99	76	-
Lesotho	95	74	88
Madagascar	82	51	62
Malawi	95	51	42
Mauritius	-	-	-
Mozambique	91	51	-
Namibia	97	63	69
Seychelles	-	-	-
South Africa	94	76	84
Tanzania	91	51	34
Zambia	96	56	63
Zimbabwe	93	76	57

Source: Maternal and Newborn Health Coverage Database, UNICEF, 2019.

Table 2.8 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 more than 70% of pregnant women and girls having at least four antenatal visits. But an area of serious concern is postnatal care. Only Lesotho and South Africa provide postnatal care to more than 80% of women. The MMR will only decrease if women receive high quality and more frequent antenatal and postnatal care.

Many women in SADC do not receive postnatal care, which is a serious concern

Table 2.9: Availability of skilled health personnel

Country	Skilled birth attendants (%)	Nursing and midwifery personnel per 10 000 of the population
Angola	50	13
Botswana	99	33
DRC	80	5
Eswatini	99	20
Lesotho	78	7
Madagascar	44	1
Malawi	90	3
Mauritius	100	34
Mozambique	54	4
Namibia	88	28
Seychelles	99	32
South Africa	97	35
Tanzania	64	4
Zambia	63	9
Zimbabwe	78	12

Source: Maternal and Newborn Health Coverage Database, UNICEF, 2019; https://www.who.int/gho/health_workforce/nursing_midwifery_density/en/. Accessed 25 May 2019.

Exceptionally low proportions (between 44% and 54%) of women and girls have skilled birth attendants during delivery in Angola, Madagascar and Mozambique. Six SADC countries (Botswana, Eswatini, Malawi, Mauritius, Seychelles and South Africa) provide skilled birth

attendants to more than 90% of pregnant women and girls.

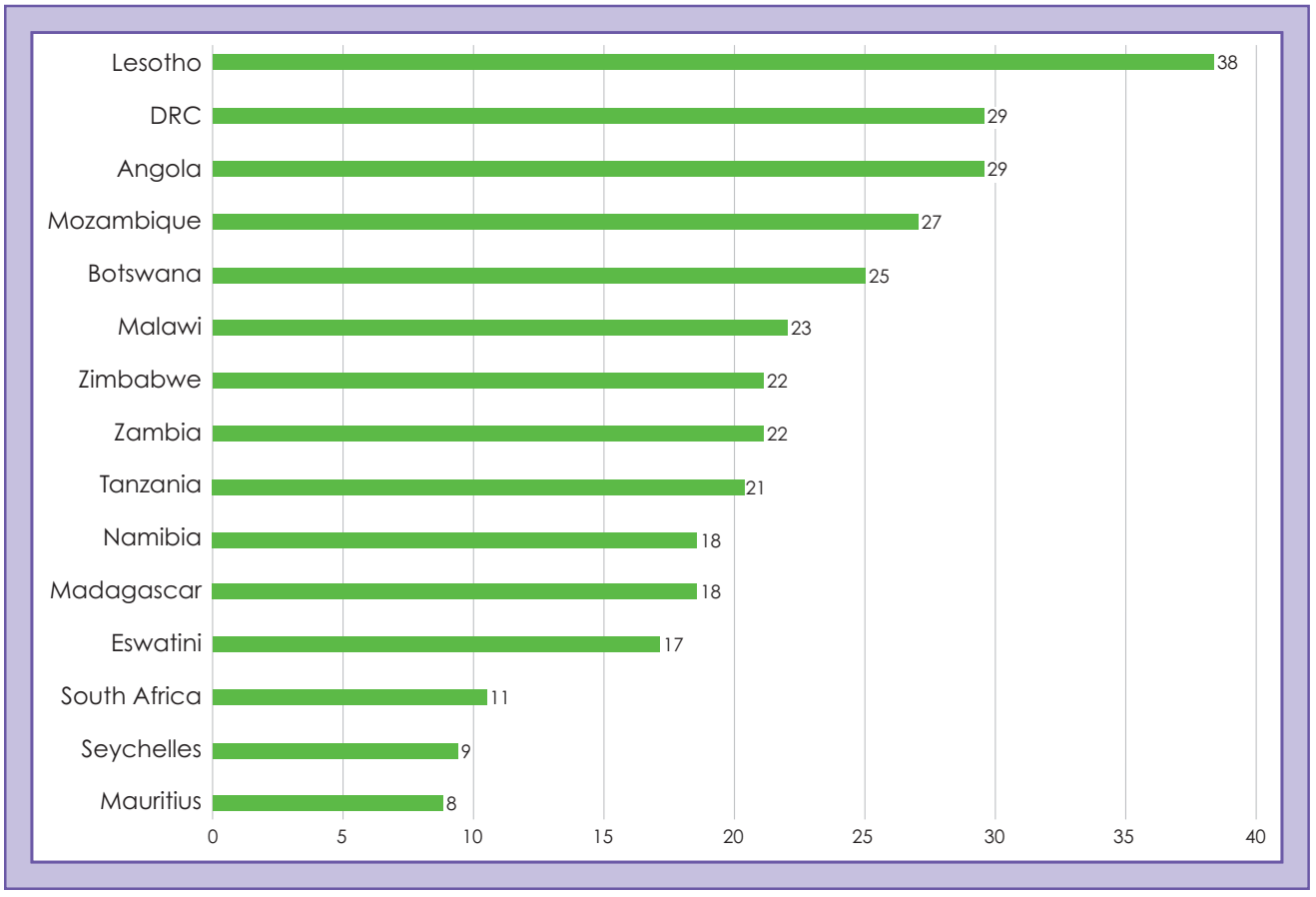
The bigger concern across the region is the lack of nursing and midwifery personnel. The World Health Organisation (WHO) recommends at least 5.9 skilled health professionals (midwives, nurses and physicians) per 1000 population as the workforce requirement as part of the Ending Preventable Maternal Deaths initiative, which entails reducing global maternal deaths to 50 per 100 000 live births by 2035.[44]

Based on current data, none of the countries in SADC reach that goal. South Africa comes closest with 3.5 nurses and midwives per 1000. DRC, Madagascar, Malawi, Mozambique and Tanzania have five or fewer nurses or midwives per 10 000 people. Madagascar is facing a health personnel crisis with only one nurse or midwife per 10 000 people.

Neonatal mortality

Neonatal mortality refers to the number of deaths during the first 28 completed days of life per 1 000 live births in a given year or period. Neonatal deaths subdivide into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.[45]

Figure 2.12: Neonatal mortality per 1000 live births



Source: http://apps.who.int/gho/data/view.main.HWFNURv. Accessed 25 May 2019.

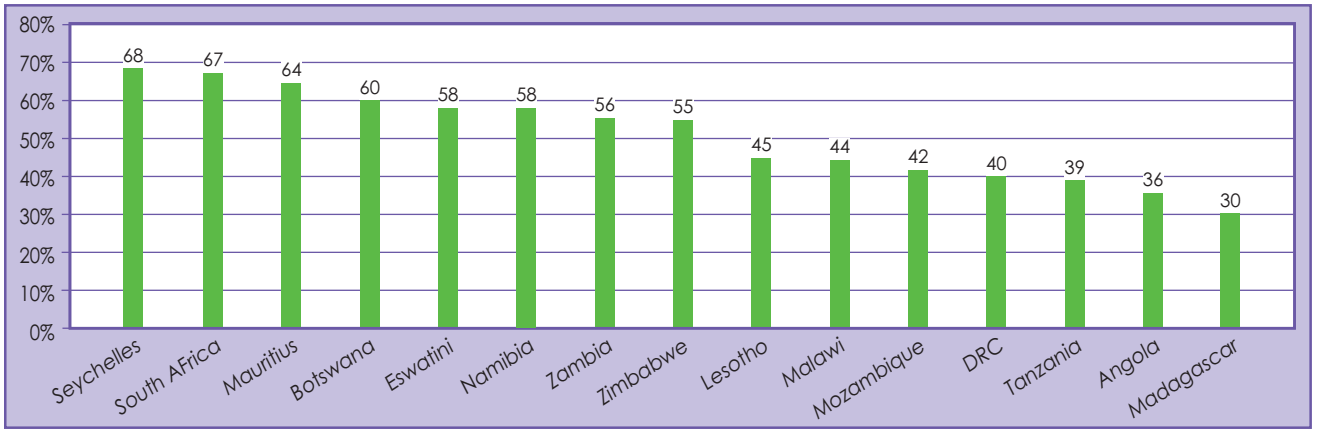
[44] https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-?sequence=1
[45] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf

Figure 2.12 shows that Lesotho has the highest rate of neonatal deaths, 38 out 1000 live births. Angola, Botswana, DRC, Malawi, Mozambique, Zambia, Zimbabwe and Tanzania follow, with between 21 and 29 neonatal deaths per 1000. Neonatal mortality in SADC is attributable to low levels of antenatal and postnatal care for pregnant women and newborns.

Universal health care

Universal Health Coverage (UHC) ensures that all people and communities, without leaving anyone behind, receive the quality services they need, and are protected from health threats without suffering financial hardship.[46] To achieve UHC, governments need to create health provision policies, develop strategies and plans and allocate realistic budgets. The process requires the collective conceptual capacity, skills and will of government, civil society organisations, citizens, business and other stakeholders.

Figure 2.13: Percentage of the population receiving essential health services



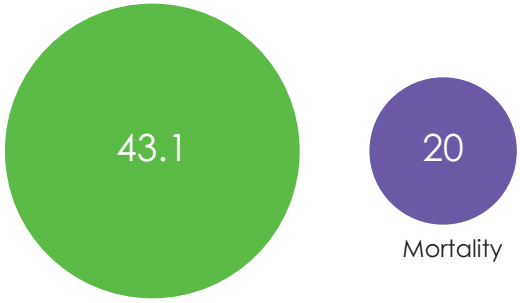
Source: http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv. Accessed 26 May 2019.

Figure 2.13 shows that SADC countries provide essential health services to less than 70% of their citizens. Angola, Madagascar and Tanzania provide essential health services to between 30% and 39% of their populations. These statistics send important warning signals about the extent of essential health services available to people living in SADC. The associated impact will be that SRHR services will be available to low proportions of the SADC population.

When defining an essential package of health services, it is critical to include key SRHR services. Stakeholders must expand these essential SRHR services to include cervical and uterine cancer as well as Polycystic Ovarian Syndrome (PCOS) and fibroids. The human papillomavirus or HPV is the most common sexually transmitted infection. HPV is usually harmless and goes away by itself, but some types can lead to cancer or genital warts. Provision of the HPV vaccine prevents cervical or uterine cancer.

[46] https://uhcpartnership.net/about/

Figure 2.14: Cervical and uterine cancer prevalence and mortality rates per 100 000 in SADC



Source: http://gco.iarc.fr/today/data/factsheets/cancers/23-Cervix-uteri-fact-sheet.pdf. Accessed 26 May 2019.

Figure 2.14 shows the current incidence rates of cervical and uterine cancer at 43.1 per 100 000 women of all ages. While this figure is not at crisis, these cancers have emerged as a leading cause of death amongst women. The mortality rate in SADC is 20%.

These cancers are preventable with the HPV vaccine. SADC countries must start rolling out the HPV vaccine as a routine part of the inoculation regime. There is an opportunity to stop cervical and uterine cancer before they reach crisis levels.

Issues such as fibroids and PCOS are becoming more commonplace and many women do not yet have the resources or knowledge to make informed decisions. The public health system must include treatments for these conditions in the SRHR package of services in essential health services.



Seychelles: Reproductive health complications[47]

Significant numbers of women and adolescent girls live with either cysts or fibroids in Seychelles. These two health conditions attack ovaries and challenge women's ability to have children. At the moment, the Ministry of Health does not have any statistics on the number of cases reported at the hospital and district clinics. Educators also do not discuss these issues in schools.



Young girls need information and knowledge to make informed choices about their bodies. Photo: Gender Links

Jasmine Talma is a 25-year-old living with polycystic ovarian syndrome without really knowing anything about the condition. "At the age of 14, I got my period, but it was irregular, sometimes I did not get my periods for six months. At the age of 16, I began to worry and went to see a gynaecologist to see what was going on" she says.

Talma affirmed that aside from the internal change, her physical appearance also changed: she gained weight without any explanation and her face became covered with pimples. "When I visited the doctor, I was told that I have a cyst on my ovaries and got contraceptive pills to regulate my period. I went back to the doctor at the age of 23 in January last year (2018), and only then did the doctor explain what was really going on with my body and told me what polycystic ovarian syndrome (PCOS) was exactly.

"I suspected that something was wrong with my reproductive health, it only confirmed my suspicion, it made me feel sad but at the same time relieved because I finally I got a name for my condition, and became more aware of what I should do. I feel ready to have a child and I keep trying but I do not get pregnant. It has been one and a half year since I have been trying to have a child. We did reproductive health in science class at school but did not address the topic of causes of infertility."

Source: Juliette Dine, Gender Links News Service, 2019

[47] https://genderlinks.org.za/news/seychelles-i-suspected-something-was-wrong-with-my-reproductive-health/

Health expenditure analysis

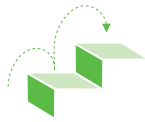
Experts use two measures to assess health financing: the level of health spending as a proportion of the total government spending and health spending as a proportion of the country's Gross Domestic Product (GDP). The GDP is the total value of everything produced in the country. It does not matter if citizens or foreigners produce it - if they operate within the country's boundaries, their production is included in GDP.[48]

Table 2.10: Health financing analysis

Country	Health expenditure as % of total government expenditure	Health expenditure as % of GDP
Madagascar	17.8	6
Eswatini	15.3	7.7
Zimbabwe	14.5	9.4
Namibia	13.8	9.1
South Africa	13.3	8.1
Lesotho	10.1	8.1
Seychelles	10	3.9
Malawi	9.8	9.8
Mauritius	9.8	9.8
Tanzania	9.5	4.1
Botswana	9.1	5.5
Mozambique	8.3	5.1
Zambia	7.1	4.5
Angola	5.4	2.9
DRC	3.7	3.9

Source: https://databank.worldbank.org/data/source/world-development-indicators#. Accessed 26 May 2019.

Table 2.10 shows that only Eswatini and Madagascar meet the recommended Abuja Declaration goal of 15% expenditure on health.[49] Zimbabwe is close at 14.5%. Angola and DRC allocate the lowest budgets to health at 5.4% and 3.7% respectively. All SADC countries allocate less than 10% of their GDP to health. Angola, DRC, Seychelles, Tanzania and Zambia allocate less than 5% of their GDP to health expenditures. This has a negative impact on women's health and the push to achieve SDG 3 globally, not to mention the attainment of the targets in the SADC SRHR Strategy 2019 to 2030. There is a need to advocate for increased spending on health across SADC.



Next steps

Key recommendations and next steps to ensure governments continue to improve the health of their populations include:

- Update policy and legislative frameworks to align with the provisions of the SADC SRHR Strategy and Scorecard 2019-2030 and SRHR provisions in the SADC Protocol on Gender and Development.
- Develop national menstrual health policies and strategies that cover the provision of menstrual products and changing attitudes on menstruation.
- Develop plans to accelerate the rollout of water and sanitation to all communities, particularly in rural areas.
- Ensure that contraception is available to women and girls on demand in all health centres.
- Identify communities where women who need contraceptives do not have access to them and develop access and provision strategies.
- Provide family planning services to women who would like to have children.
- Review and identify the package of essential health services, including SRHR services, that stakeholders need to roll out to achieve universal health coverage (UHC).
- Develop partnerships that will facilitate the roll out of UHC, including SRHR services.
- Expand the scope of traditional SRHR services to include, amongst others, the provision of the HPV vaccine and treatment of polycystic ovarian syndrome (PCOS) and fibroids.
- Increase the scope and quality of services available to pregnant women and girls and newborns.
- Lobby politicians in SADC to invest in health systems and infrastructure.
- Conduct regular monitoring and evaluation of SRHR services and strategies to ensure that the quality and scope of services meet the needs of the those who use them.

[48] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038
[49] https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf

Adolescent Sexual and Reproductive Health and Rights 3



Students attending the launch of Womens day ceremony at Jwaneng, Botswana. Photo: Keletso Serole

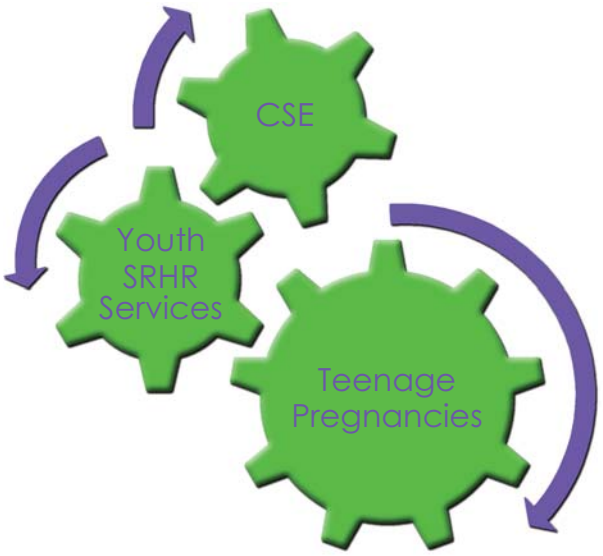
KEY POINTS

- Most SADC countries have a Comprehensive Sexuality Education (CSE) programme in place that meets or is in the process of being aligned to international standards but implementation, monitoring and evaluation is still weak.
- Where CSE is implemented, young people are able take advantage of educational and other opportunities that will impact their lifelong well-being; avoid unwanted pregnancies and unsafe abortions; improve their sexual and reproductive health and protect themselves against STIs, including HIV.
- Young people who are not in schools are harder to reach with CSE, requiring different approaches and greater effort.
- Only six SADC countries (DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia) have stand alone Adolescent Sexual and Reproductive Health and Rights (ASRHR) policies or strategies. Only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) in SADC do not require parental consent for adolescents to access SRHR services.
- The age of access to contraceptives in SADC ranges from 12 in five countries to 18 in one.
- Adolescent fertility ratios in the region range from 27 per 1000 women in Mauritius to 152 per 1000 women in Angola.
- Tanzania's President John Magufuli has banned readmission of girls who get pregnant in school. He has also urged women to stop using contraception so that they can increase the country's population.

Introduction

Sixty percent of SADC's population is below the age of 25. It follows that youth should be the major focus of any SRHR campaign. Yet, to quote Save the Children: "As adolescents around the world enter puberty, taboos, discomfort and fear prevent parents and other trusted adults from teaching relevant information to help adolescents navigate the complexities of their emerging sexuality."[1]

Key SRHR concerns relating to youth in Southern Africa include significant percentages of sexually active adolescents below the age of 16; high levels of teenage pregnancies; multiple concurrent sexual relations; increasing trends of intergenerational sexual relations; low levels of consistent condom usage during sex; high levels of maternal mortality amongst young mothers; compromised quality of antenatal care to young mothers compared to older mothers; high levels of HIV and AIDS among young people, especially young women, and high levels of GBV. Child marriages remain a huge concern with an increasing number of adolescent girls faced with the challenge (see Chapter seven).



As adolescents around the world enter puberty, taboos, discomfort and fear prevent parents and other trusted adults from teaching relevant information to help adolescents navigate the complexities of their emerging sexuality

This chapter covers the efforts made in different Southern African countries in implementing the SADC Gender Protocol articles that relate to three interlinked areas: Comprehensive Sexual Education (CSE), access to SRHR services for young people and teenage pregnancies.

The United Nations Education, Scientific and Cultural Organisation (UNESCO) defines CSE as a "curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives."[2]

The term "comprehensive'"emphasises an approach to sexuality education that encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality.[3] CSE is a rights-based approach to sexuality education. It promotes the acquisition of knowledge, skills and positive values of sexuality and reproductive health.

1 https://www.savethechildren.org/us/what-we-do/global-programs/health/adolescent-sexual-and-reproductive-health
2 https://en.unesco.org/news/why-comprehensive-sexuality-education-important
3 Ibid

Table 3.1: Key CSE and Teenage Pregnancy Indicators

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum that reflects international standards[4]	Partial	Partial	No	Yes	Yes	N/A	Yes	N/A	Partial	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives	N/A	12	18	15	N/A	12	16	16	16	12	15	12	12	16	16
Legal age to consent to sex (M)[5]	18	16[6]	18	16	16	14[7]	16	16	18	14	18	16	18	16[8]	16
Legal age to consent to sex (F)[9]	16	16	14	16	16	14	16	16	18	14	18	16	15	16	16
Adolescent fertility rate (births per 1000 women, 15-19 years of age)[10]	152	30	124	77	90	110	140	27	135	74	57	43	115	83	104

Source: Gender Links, 2018.

Table 3.1 shows that:

- Most SADC countries have a CSE programme in place that meets or is in the process of being aligned to international standards.
- The age of access to contraceptives in SADC ranges from 12 in five countries to 18 in one.
- The legal age of consent to sex ranges from 14 to 18. It is higher for men in three countries - Angola, Tanzania and DRC. This parameter is important because sex before the legal age of consent is statutory rape. Lowering the age for women essentially lowers the bar for statutory rape for women and is discriminatory. Coerced sex is a major contributory factor to high rates of teenage pregnancy.
- Adolescent fertility ratios in the region range from 27 per 1000 women in Mauritius to 152 per 1000 women in Angola. There is a directly inverse correlation between levels of development and levels of adolescent fertility; this reflects the importance of socio-economic factors in bringing down adolescent fertility.

In a region which has over 158 million young people aged between 10-24 a strengthened CSE curriculum with age appropriate and sensitive information will help improve adequate knowledge on the matter among children and adolescent groups. Although school-based sexuality education and HIV prevention are not enough by themselves to prevent HIV and ensure the rights of young people to sexual and reproductive health, school-based programmes are a very cost-effective way to contribute to these aims.[11]

Inadequate access to comprehensive and age-appropriate information about sex and sexual health among adolescents is recognised as a contributing factor to high teenage pregnancy rates. Teenage pregnancies are often a contentious socio-political issue. As the ones disproportionately affected girls' access to education during pregnancy and thereafter is often jeopardised.

Multiple laws and policies have been put in place reflecting the intersection between sexual education and teenage pregnancy, yet some of these laws and policies undermine girls' right to education. UNESCO states that the education sector has an obligation to minimise teenage pregnancies by providing adequate knowledge, information and skills and by ensuring that pregnant girls and adolescent mothers have the right to continue their education.

Low educational levels are themselves responsible for high rates of teenage pregnancies. For example, a 2018 *Situation Analysis on Early and*

4 UNESCO, Emerging Evidence, Lessons and Practise in Comprehensive Sexuality Education, a Global Review, 2015
5 https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf
6 https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf
7 https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf
8 https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf
9 https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf
10 https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BW-CD-AO-LS-MG-MW-MU-NA-MZ-ZA-SC-SZ-TZ-KM-ZM-ZW
11 Review of the evidence on sexuality education: report to inform the update of the UNESCO International technical guidance on sexuality educationhttps://unesdoc.unesco.org/ark:/48223/pf0000264649?posInSet=12&queryId=222e6166-0557-4ca6-98d3-46d3f2315ca3

Unitended Pregnancies in East and Southern Africa[12] carried out by UNESCO shows that in Tanzania, Malawi and Zambia, more than 50% of girls with no education had experienced a pregnancy. Furthermore, school dropout (including due to pregnancy) is linked to fewer livelihood options, limited economic independence, and a lack of any additional potential benefits of school attendance, such as increased self-confidence and life skills.[13] Therefore, education - including CSE - needs to be considered as both an instrument to prevent teenage pregnancy and a means towards better life chances.[14]



CSE is empowering: **#VoiceandChoice** workshop in Mbabane, Eswatini.
Photo: Thandokuhle Dlamini

The United Nations Population Fund (UNFPA) notes that where CSE is implemented, young people are able take advantage of educational and other opportunities that will impact their lifelong well-being; avoid unwanted pregnancies and unsafe abortions; improve their sexual and reproductive health and protect themselves against STIs, including HIV; understand and question social norms and practices and contribute to society.[15] This shows that CSE is interlinked with the broader aspects of adolescents' life and contributes to them becoming active and empowered citizens.

Comprehensive Sexual Education

SDG 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. SDG 5.6.2 indicator measures 'number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education'.

ICPD paragraphs 4.29, 7.37, 7.41, and 7.47 Sexuality education to promote the well-being of adolescents; it specifies key features of such education.

- Education should take place both in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision-making, and specifically aim to improve gender inequality.
- Such programmes should address specific topics, including gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life and sexually transmitted infections (STIs), HIV and AIDS prevention.

The East and Southern Africa (ESA) Ministerial Commitment 15 Southern African countries have also signed the East and Southern Africa (ESA) Ministerial Commitment which was endorsed and affirmed in 2013 by 20 countries. Education and Health Ministers in SADC committed to accelerate access to CSE and health services for young people in the region. The only SADC country which is not part of the commitment is Comoros.

[12] UNESCO. 2018. Situational analysis on early andunintended pregnancy in Eastern and Southern Africa
[13] https://www.youngpeopletoday.org/wp-content/uploads/2019/04/Unesco_EUP_Report_2018_LOW_RES.pdf
[14] https://en.unesco.org/news/early-and-unintended-pregnancy-what-role-education
[15] https://southafrica.unfpa.org/sites/default/files/pub-pdf/UNFPA_CSE_report_web.pdf

SADC Protocol Article 11: Ensure that the girl and the boy child have equal access to information, education, services and facilities on sexual and reproductive health and rights.
Adopt laws, policies and programmes to ensure the development and protection of the girl and the boy child.
The SADC SRHR Strategy for ensuring Comprehensive Sexuality Education (CSE) is that Member States should accelerate and improve delivery of quality comprehensive sexuality education for in and out of school youth by the education and youth sectors. The strategy further specifies that;

- Member States should ensure that young people and adolescents are prepared, supported and provided with education and all the information and skills to make safe and healthy decisions about their life and future. This includes ensuring that adolescents and young people in-school and out-of-school have access to quality, comprehensive, age-appropriate, scientifically accurate life skills-based comprehensive sexuality education (CSE) with linkages to youth-friendly sexual and reproductive health (SRH) services and the youth sector more broadly.
- Strengthening the capacity of educators at all levels specifically to provide age, gender and culturally appropriate rights-based CSE that includes core elements of knowledge, skills and values as preparation for adulthood and, wherever possible, making in school CSE programmes intra-curricula and examinable is key.
- Building and strengthening the skills of those working in wider youth and community interventions will expand the capacity within Member States to reach out-of-school youth.
- Creative approaches should be explored to build the capacity of different forms of media, including radio, to reach out-of-school youth.

The right to sexuality education is grounded in universal human rights - including the right to education and to health - as established in numerous international agreements. SADC countries have signed up to various international and regional agreements including the UN Convention on the Elimination of All forms of Discrimination Against Women (CEDAW, 1979); the International Conference on Population and Development (ICPD, 1994); and the Maputo Plan of Action.

The importance of CSE is recognised in the Sustainable Development Goals (SDG) monitoring framework under SDG 5, global indicator 5.6.2 which refers to "number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education'.[16]

It is also recognised in the SADC Gender Protocol Article 11 which encourages state parties to adopt laws, policies and programmes that ensure the girl and boy child have equal access to information, education services and facilities on SRHR and that state parties shall develop concrete measures to prevent teenage pregnancies.[17] This article of the Protocol also calls on member states to "ensure that the girl and the boy child have equal access to education and health care, and are not subjected to any treatment which causes them to develop a negative self-image."

The right to sexuality education is grounded in universal human rights

[16] https://sustainabledevelopment.un.org/sdg5
[17] SADC Gender Protocol Barometer 2018



Students in Zimbabwe discuss SRHR during a GL workshop.
Photo: Tapiwa Zvaraya

The Gender Responsive Assessment (GRA) survey of constitutions and laws found that in **Malawi**, there are differences in treatment accorded to boys and girls which negatively affects their access to education and health care, girls being the ones largely affected. **Mozambique** noted that there are policies on equal access for girls and boys to education, but there is still a need to intensify this action in rural communities, where girls are still facing cultural barriers in accessing education. **Zambia** noted that there are usually more girls enrolled in primary school, but the concern is retention. The reviewers noted the need to take into consideration the different needs of girls and boys. **Angola** noted that in rural and peri-urban areas girls' access to education favours the boy child. Differential access to education for boys and girls may mean that girls have lower chances of receiving CSE as they may not be in school or are not remaining in school.

The SADC SRHR Strategy has strong provisions for ensuring that Member States provide CSE in primary and secondary schools. The roll-out of CSE, with a strong emphasis on integrating rights into the curriculum while linking with AYSRHR services, is a critical element of an accelerated response to SRHR in SADC[18]. This will increase the voice and choice, and promote better information and greater freedom for adolescents and young people about their sexuality in and out of schools. This will ultimately increase levels of knowledge of HIV infection among adolescents and young people, reducing early and unintended pregnancies, and will raise awareness and response to the sexual exploitation of children and adolescents.

UNESCO and partners developed international technical guidelines[19] on sexuality education in 2009 which were revised in 2018. These seek to assist national education authorities and stakeholders in the development and implementation of CSE programmes and materials. This provides a roadmap for countries to develop context relevant CSE strategies as they move towards achievement of country, regional and international CSE goals.

Policies and practice

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

[18] SADC Strategy 2019-2030
[19] https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf

Table 3.2: Breakdown of CSE in 12 SADC countries[20]

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

Source: Emerging evidence, lessons and practice in comprehensive sexuality education: A global review, 2015.

Table 3.2 shows that:

- 12 SADC countries have national CSE policies in place and offer mandatory CSE in primary and secondary schools.
- All except DRC reflect international standards. In four countries, (Angola, Botswana, Mozambique and Zimbabwe) CSE is under review to reflect international standards.
- Teacher training is provided in nine countries, but could not be verified in Lesotho, Mozambique and Zambia. Without CSE as a compulsory subject in teacher training programmes, or compulsory quotas for CSE teachers in schools, effective delivery cannot be guaranteed. It was also noted that most curricula did not mention access to guidance, supervision or reporting requirements for teachers who encountered disclosure of sexual abuse during delivery of sexuality education programmes, pointing to a critical lack of supervision and support.[21]

Within SADC, CSE goes by several different names such as prevention education, relationships and sexuality education, sexual and reproductive health (SRH) education, population and family life education (FLE), healthy lifestyles and the basics of life safety in other Southern African countries. The **Zimbabwe** School Health Policy (2018) defines CSE as a formal curriculum that is part of a comprehensive school health education approach that addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality.[22] The **Zambia** Education Curriculum Framework (ZECF) identifies CSE as a cross-cutting issue, and the vehicle through which topics such as Population and Family Life Education and Reproductive Health and Sexuality are to be implemented. The ZECF states that "Learning institutions should, therefore, equip learners with knowledge, skills, values, and positive attitudes about their reproductive health and sexuality for their benefit and that of society."[23]

[20] https://unesdoc.unesco.org/ark:/48223/pf0000243106
[21] https://unesdoc.unesco.org/ark:/48223/pf0000243106
[22] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/zshp_final_signed_march_2018_reduced.pdf
[23] https://unesdoc.unesco.org/ark:/48223/pf0000247268



Zambia: Challenges in delivering CSE[24]

Having a CSE policy is just the start. According to Matildah Mhango, 30, a teacher at Petauke Day Secondary School in Eastern Province lack of teaching materials is a challenge in the delivery of sexuality education.

"Teachers, especially in rural areas, face challenges in delivering CSE to pupils because of cultural barriers and lack of appropriate CSE materials to teach the subject across different grades," she said. Mhango said while teachers were perceived by pupils as the most credible and trustworthy people who can talk about anything, including sexuality, it is difficult to share the right information with them when the teachers themselves are ignorant about sex education.

She said there is a need for sufficient and proper training programmes on how to teach CSE in schools as well as social support from community members. Mhango explained that most of the pupils at her school come from homes where it was traditional for sex related issues to be taught to them only by their grandparents or traditional counsellors. "Pupils find it really difficult to learn, especially if the teacher is of the opposite sex, because their culture does not allow. It is disrespectful for them.

"Some parents, especially in the rural areas, have a myth that educating children in the area of sexual behaviour and morality should belong to parents alone," Mhango said. The integration of CSE into both optional and compulsory subjects at higher grade levels raises questions about whether the "dose" of CSE offered varies especially with the continuous cases of child pregnancies.

Panos Institute Southern Africa Executive Director Lillian Keifer said CSE is an important aspect of the curriculum because it enables young people to make sound decisions and take the right actions in relation to sexuality. Keifer said for this to be possible, CSE must be taught in a manner that is open and enables the learners to open up, and freely discuss issues such as HIV prevention, human rights, sexual and reproductive health, relationships and human rights.

"Age appropriateness is therefore critical and must be taken into account in the administration of CSE to young people," she said. Keifer said the implementation of CSE must not take a one-size-fits-all approach, but needs to take into account the socio-cultural and economic factors at play in each context, which, if not properly addressed, may result in people withholding information.

Keifer said the materials and methodologies used for CSE must be simplified so that learners are able to relate with the subject." The implementation of CSE should also not be confined to learners at schools, but should also be extended to the wider community through structures like parent teacher associations, and church or religious groups, among others," Keifer said. Chief Mkanda of the Chewa people in Eastern Province said parents should be the first teachers in sexuality education apart from teachers at school. The chief said sexuality education, which is taught in school, is enough such that parents should take it up from there in sensitising the children.

Source: Dorothy Chisi, Gender Links News Service, 2019

[24] https://genderlinks.org.za/news/zambia-cse-boosts-school-success/

The **Eswatini** Education and Training Sector Policy, 2011 and the National HIV Prevention Policy, 2012 make provision for CSE but the National Policy on Sexual and Reproductive Health (2013) and National Youth Policy fall short of mentioning sexuality education in school. However, the Ministries of Education and Training; Health; Sports, Culture and Youth Affairs developed a draft Cabinet Paper for the implementation of Comprehensive Sexuality Education (CSE) and Sexual and Reproductive Health (SRH) activities following the ESA Commitment Conference in December 2013. This has strengthened the government's capacity to jointly collaborate on CSE issues for young people.



Secondary School in Bricaville, Madagascar.
Photo: Razanandrateta Zotonantenaina

The **Madagascar** Ministry of Education decided that CSE would be infused into all subjects, from Malagasy to Physical Education. It would also cover all levels and ages, from early childhood to adolescence. It is divided into four age brackets: 5-8 years, 9-12 years, 12-15 years, and 15+, in accordance with the official education programme.[25] In Seychelles, sexual education is included in the curriculum of Personal and Social Education (PSE) taught in state schools from primary to secondary levels.[26] Finally, UNFPA has documented that there is an absence of a CSE curriculum in Comoros, which when combined with the lack of a legal framework for adolescent SRHR services and the inadequacy of existing youth-friendly centres to provide these services, has resulted in the country continuing to face early sexual debut and unprotected sexual activity expose young girls to unwanted pregnancies, sexually transmitted infections, including HIV/AIDS, abortions and higher rates of maternal mortality.[27]

In **Seychelles**, sexuality education is covered under the Personal, Social and Civic Education (PSCE) curriculum. Schools have both PSCE teachers and counsellors. While the counsellors are more at ease talking to students about sexuality, sexual health, contraceptives and relationships, the PSCE teachers purposely avoid these topics when they are meant to teach them. They prefer to use the PSCE lessons to catch up on maths, language and science lessons. The students are thus not taught what is clearly in the curriculum. Adults, on the other hand, being of a different generation have not been sufficiently exposed to information on sexual and reproductive health and rights. Therefore, there is a need for action to engage children, youth, adults, parents, teachers and the public in general about SRHR.

Resistance to CSE

A lack of understanding and knowledge on CSE has resulted in many viewing CSE in schools as radical sexualisation of children, mainly encouraging young people to engage in premature sexual activity. This misperception has influenced the emergence of some counter campaigns on CSE in the region.

A lack of understanding and knowledge... encouraging young people to engage in premature sexual activity

[25] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_scale_up_in_practice_june_2017_final_.pdf
[26] http://www.seychellesnewsagency.com/articles/8134/Sexologist+in+Seychelles+wants+comprehensive+sex+education%2C+sex+positive+society.
[27] https://www.unfpa.org/sites/default/files/portaldocument/DP.FPA_.CPD_.COM_.6Finalcountryprogrammedocumentfortheomoros.pdf



Malawi's Life Skills Education suffers setbacks[28]

Deep-rooted conservatism, misconceptions, culture, and religious beliefs appear to be some of the factors currently throwing off the track efforts to improve young people's access to correct and comprehensive sexuality information through Life Skills Education in Malawi. With stunning revelations indicating that between 2010 and 2017 close to 30,000 female learners dropped out of secondary schools due to early marriage or pregnancy, commentators are questioning the effectiveness of Life Skills education in the country.

First introduced in primary schools in the 1990s, Life skills education was meant to be a way of empowering children with appropriate information and skills in the fight against HIV infections and AIDS and for them to deal with various other everyday social and health problems affecting them, including early pregnancies.

> Life skills education was meant to be a way of empowering children

Findings suggest that the teaching of life skills in the country's schools is generally constrained by a variety of social and structural contextual factors. For example, rural communities consider life skills education estranges their children from their cultural roots by discouraging the children to attend initiation schools. Parents in rural communities oppose the use of illustrations on sexual development in the learning material and discourage learners from reading such content.

One parent said, "I think some of the materials using in teaching Life Skills education arouse the learners' sexual feelings and end up having a sexual relationship and getting pregnant." Some students believe that cultural beliefs also dilute school learning by allegedly reinforcing sexual relationships, the very issues which life skills education confronts.

"Some church-run schools think the subject goes against the church's moral teaching, but SAFE's view is that some teachers in church-run schools believe the subject goes against the church's moral," Makala said.

There is another challenge: A study on the implementation of Life Skills Programme in public secondary schools in Malawi conducted in the South Eastern Educational Division (SEED) showed that lack of teaching and learning materials, non-examinability of the subject and inadequate teacher training were, among others, major factors that are hindering effective implementation of the programme.

There is a shortage of trained CSE teachers at secondary level and in some countries at primary level. Research shows that many teachers do not hold the same beliefs as to what to teach on sexuality, when it should be taught and at what age learners should be introduced. Cultural sensitivities are also often a barrier.

Source: Winstone Mwale, Gender Links News Service, 2019

[28] https://genderlinks.org.za/news/malawis-life-skills-education-inadequate/

Recently news broke out that the **South Africa** Department of Basic Education (DBE) had introduced "sex lessons for modern grade 4s in new life orientation curriculum" which includes "...yoga, masturbation and LGBTI+ all part of a new curriculum." This caused an uproar on mainstream and social media of what kind of education system the government will be offering.[29] Although the department distanced itself from the article,[30] this response shows how short-sighted most conversations on CSE can become. Such responses also overlook that children and young people get information about sex from many places, some of which may be ill-informed and more promotive of sexualised activity. There has been a boom of sexualised imagery in the media where young people may get ideas of sex and relationships. Young people also turn to other children for information, and speaking amongst themselves about sex may influence peddling of inaccurate information.

In **Lesotho** a study by Dr Khau (2012) found that sexuality education is hindered by the beliefs of teachers. Another study by Rakolobe (2017) shows that sexuality education is negatively affected by religious and cultural believes of teachers as sex is taboo and religion encourages abstinence and does not allow for the education on the use of condoms and other contraceptives. Malawi finds itself in a similar situation to Lesotho the article above details how beliefs and misconceptions are impacting negatively on delivery of CSE. The Government of Lesotho, through the Ministry of Education and Training (MOET) is a signatory to the SADC Comprehensive Education Policy. MOET introduced Life Skills education in the curriculum at both primary and secondary schools levels. In addition, a new textbook has been introduced to secondary schools in Grade 8. This encourages the teaching of body parts in Sesotho to demystify sex and sexual education among Basotho learners[31].



Marching for equality: Bonhomme High School children. Photo: Ntolo Lekau

In **Botswana** the political and legal environment has been conducive to the implementation of CSE because of the synergies with existing strategies and programmes including:

- The Ministry of Education and Skills Development HIV and AIDS Strategic Framework (2011-16), which provides for CSE to be introduced from pre-school through to tertiary education. Specific reference is also made to the integration of Sexuality and Life Skills Education into teacher education.
- The National Strategic Framework for HIV and AIDS (2009-2016), which has prioritised the prevention of new infections, especially among young people.
- The ASRH Implementation Strategy (2012-2016) and the SRH Policy Guidelines and Service Standards. The ESA Commitment, which Botswana endorsed in December 2013 and adopted in January 2014, provides a policy framework with set short- and long-term targets to facilitate the scale up of CSE.[32]

[29] https://www.timeslive.co.za/sunday-times/news/2019-05-12-sex-lessons-for-modern-grade-4s-in-new-life-orientation-curriculum/
[30] https://www.education.gov.za/Newsroom/MediaReleases/English/tabid/2322/ctl/Details/mid/8493/ItemID/6885/Default.aspx
[31] Kelello Rakolobe, SADC Protocol@Work case study
[32] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_scale_up_in_practice_june_2017_final_.pdf

Monitoring and Evaluation of CSE

Monitoring and Evaluation (M and E) is an essential mechanism to track performance of countries on their implementation of CSE. Countries are undertaking various efforts in integrating M and E frameworks from local to national levels. Table 3.3 details the measures being taken in SADC countries to monitor CSE, where this is integrated into existing curriculum as well as where it is stand alone.

Table 3.3: Monitoring and Evaluation strategies across SADC[33]

Country	Approach to CSE	How M and E conducted
Botswana	Integrated	• Adapted 11 out of the 15 HIV core indicators into the Annual School Census (ASC) in Botswana to enable them to monitor CSE delivery. • Training of 30 education officers EMIS regional officers to form regional teams to coordinate the process.
Lesotho	Integrated	• Assessment packages have been developed for each of the grades where CSE is taught; • HIV-related indicators have been incorporated into the EMIS; • HIV and AIDS knowledge indicators have been incorporated into the National Education Assessment. There are also plans to include CSE-related indicators in inspection tools.
Mozambique	Intergrated	• Joint planning and monitoring of activities with government takes place on a regular basis. The main departments involved are the Department of School Health (Departamento de Saúde Escolar) and the National Directorate of Teacher Training (Direcção Nacional de Formação de Professores).
Tanzania	Integrated	• School inspectors have been trained as district CSE trainers and 8 were oriented on CSE indicators. • 10 indicators for measuring the education sector's response to HIV have been integrated into the EMIS.
Zambia	Integrated	• Zambia conducts an ASC which contains some directly relevant CSE indicators, based in part on the global HIV and AIDS indicators developed by UNESCO.
Eswatini	Stand alone	• The regional education officers routinely visit schools to monitor and support the teaching of LSE. • There are classroom and school-based monitoring tools in the form of LSE lesson attendance registers, as well as feedback sessions by learners and teachers through focus group discussions. • Baseline and end-line knowledge, attitude and practice (KAP) studies.
Malawi	Stand alone	• Joint planning and monitoring of government and stakeholder activities is taking place. In addition, the inclusion of staff from the Department of Inspectorate and Advisory Services in all training activities ensures that division managers are involved. Six division inspectors have been trained so far. This ensures that trained teachers are regularly supported and supervised. To improve supervision, the MoE, with support from UNESCO, has developed a CSE monitoring tool.
Namibia	Stand alone	• Sexuality education indicators are integrated in the EMIS, and responsible officers are trained in the collection and reporting of these indicators. In addition, the school health programme is monitored through the Ministry of Health monitoring systems.
South Africa	Stand alone	• The Life Skills and Life Orientation curricula are assessed and monitored by curriculum specialists within DBE and through the implementation of the Curriculum Assessment and Policy Statement. • Regular training and capacity-building is provided to teachers to ensure quality implementation and up-to-date information and methodology are used. • The DBE provides quarterly monitoring visits to provinces and schools through the national coordinator of the Life Skills Programme. • Inter-provincial meetings are held on a six-monthly basis to share information and best practice, and to assess progress and gaps on implementation.
Zimbabwe	In progress	• Periodic joint field visits and supporting integration of HIV indicators into EMIS (ongoing).

[33] UNESCO.2017 CSE Scale Up in Practice : Case studies from Eastern and Southern Africa. https://hivhealthclearinghouse.unesco.org/library/documents/cse-scale-practice-case-studies-eastern-and-southern-africa.

Engaging out-of-school youth

Young people who are not in school are harder to reach with CSE, requiring different approaches and greater effort. Although schooling offers the best possibility to reach massive numbers of young people, many children in the region, especially girls, are out of school. For example, in DRC more than 50% of primary school-aged children are not in primary school, and there are low levels of enrolment in secondary school.[34]

> Out-of-school children and youth are a population that needs to be engaged

Out-of-school children and youth are a population that needs to be engaged if CSE programmes are to work. Lack or non-delivery of CSE to this population may influence increasing proportions of teenage pregnancy, as well as other poor SRHR outcomes for young people. UNFPA notes that having an 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.[35]

UNESCO has documented different approaches taken by countries to engage out-of-school youth. For example in Madagascar the Ministry of Employment, Technical Education and Vocational Training, the Ministry of Youth and Sports, and the Ministry of Agriculture and Farming (MAE) integrate CSE as a cross-cutting issue in their vocational training for reaching out-of-school youth with sexuality education. In Tanzania, community radio is used to broadcast CSE programmes that enable rural and hard to reach young people including out-of-school youth to hear information about sexual and reproductive health. In Malawi, the Ministry of Youth, with support from UNFPA, developed a CSE manual for out-of-school youth, and district youth officers were trained on CSE to enable them to deliver CSE to out-of-school youth.[36]



EmaSwati Youth Pledge towards a GBV free Eswatini during the Walk in her Shoes Campaign.
Photo: Thandokuhle Dlamini

[34] SADC Gender Protocol Barometer 2018
[35] https://esaro.unfpa.org/en/news/empowering-out-school-youth-cse
[36] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_scale_up_in_practice_june_2017_final_.pdf



Seychelles championing SRHR through social media[37]

The Sexual and Reproductive Health Seychelles has been active since its creation in the Ministry of Health, conducting outreach activities in schools, public places, and communities. Its Facebook page is active, with weekly posts which include pictures of their local activities and links from organisations, such as the World Health Organisation (WHO). The ministry officers reach students, young people and adult employees of various workplaces to inform them of their sexual and reproductive health and rights. They do lively interactive presentations, using props and visual aids. They also distribute male and female condoms, lubricating gel and leaflets. SRHR issues are still taboo in Seychelles; young people especially, do not have ready access to correct information about their bodies, their sexual health, contraceptives, abortion, sexual diversity, and dating.

SRHR issues are still taboo in Seychelles

Sexual and Reproductive Health Seychelles has thus been conducting sessions and running a Facebook to reach as many people as possible, in a friendly, engaging and non-threatening manner. The aim is to inform for better personal decision-making. Direct sessions and social media are used to reach a diverse population through three main approaches:

- Conduct sessions in schools, communities, workplaces and with specific population groups, e.g., drug users, and sex workers. These sessions usually last one hour with brief presentations and time for questions and answers.
- Roadshows or outreach activities in workplaces or in specific outdoor sites. These outreach activities are sometimes combined with a promotion being done by a private company. While the company is promoting its products, the Sexual and reproductive health Seychelles give customers information and offer voluntary HIV testing and counselling. Sometimes, the HIV tests are combined with other health issues, such as diabetes, hypertension and cardiovascular problems. These activities are engaging and fun for the public who willingly participate as the tests are done freely and the results given immediately.
- Using social media, such as the Facebook page, to send links from other sites (WHO, for example) and to give information about sexual and reproductive health and rights. The page also gives information about world days and weeks, such as World AIDS Day, World Hepatitis Day, World Health Day. The three methods allow the organisation to reach a wide variety of people and to tailor their information and messages to the target audiences. Therefore, the information given to secondary school students differ slightly in content, context and emphasis to the ones given to adults in their workplaces.

The use of social media has also helped to ensure that the programme of activities is successfully implemented; reaching a wide variety of populations. These include young people, students, parents, employers, employees and even policy-makers as they read and monitor the content of the Facebook page.

Source: Benjamin Vel, SADC Protocol@Work case study

[37] https://genderlinks.org.za/casestudies/seychelles-championing-sexual-and-reproductive-health-through-social-media/

Youth friendly SRHR Services

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, to costs.[38]

To be effective, CSE must be accompanied by access to youth friendly services. These in turn need to be provided for in stand along youth SRHR policies. UNFPA reports that the majority of countries in the region do not have laws and policies that determine the age of consent to medical treatment, including access to contraceptives, HIV counselling and testing and termination of pregnancy.

This creates challenges along the chain from the individual who wants to seek the service right up to the health care provider who may end up making their own judgement to provide or not to provide the service. A clear age of consent to access treatment and service is important in improving access to SRHR services by adolescents.

Table 3.4: SADC countries with adolescent and youth SRHR policies across SADC[39]

Country	Stand-alone ASRHR Policy or Strategy
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020
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
South Africa	Yes, Adolescents and Youth Health Policy *2016 - 2020*
Zambia	Yes, National Adolescent and Youth Health Strategy (2016-2020)
Angola	No
Botswana	No
Eswatini	No
Mauritius	No
Mozambique	No
Namibia	No
Seychelles	No
Tanzania	No
Zimbabwe	No

Source: African Health Observatory.

Table 3.4 shows that only six SADC countries (DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia) have stand alone ASRHR policies or strategies. Thirteen countries have institutionalised youth-friendly SRH service training programmes for health and social workers and ten countries offer the standard minimum package of AYFSRH services[40].

Lesotho uses the Adolescent Health Policy to address issues of Teenage pregnancy. The policy aims to:

- Reduce maternal mortality rates among adolescents by 30%.
- Reduce genital fistulae of obstetric origin in adolescents by 80%.

[38] https://esaro.unfpa.org/sites/default/files/pub-pdf/SYP%20Annual%20Report%202017%20V2.pdf
[39] aho.afro.who.int/profiles_information/index.php/
[40] UNESCO Fulfilling our Promise to Young People Today 2013 - 2015 Progress Review - The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people 2016

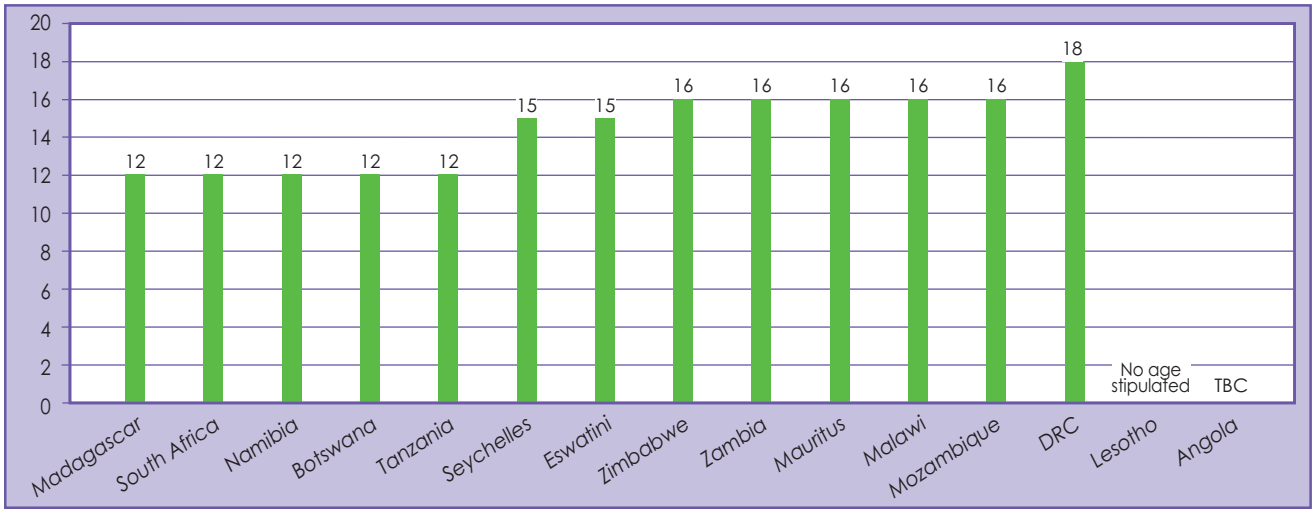
- Reduce prevalence of anemia among expectant adolescents by 20%.
- Increase post-natal care attendance among adolescents by 50%.
- Reduce maternal deaths, resulting from unsafe abortions among adolescents, to less than 10% of the national maternal mortality rates.
- Reduce teenage pregnancies by 30% of the current national levels.
- Provide adolescent couples and individuals with the knowledge and tools of reproductive health to ensure appropriate spacing of births.
- Raise the contraceptive use in sexually active adolescents by 20%.

The Ministry of Education and Training has introduced sexuality education in the curriculum by making Life Skills a compulsory subject in schools. There are adolescent health corners in some health facilities that are meant to cater for the health of adolescents especially their health in relation to sexual and reproductive health rights. The Lesotho Education Act also states that there should be continuation of education after a girl becomes pregnant, meaning that pregnant girls and school going mothers should continue with their education. However research shows that, despite the act, there appears to be no guidelines in terms of how school-going mothers should be treated. What is prominent in the policy is that they must return to continue with their education.[41]

... everyone's but nobody's responsibility

Malawi's National Youth Policy of 2013[42] seeks to ensure the provision of comprehensive sexuality education that promotes abstinence, mutual faithfulness and condom use, uptake of family planning services amongst the youth sexual and cultural practices that promote the spread of STIs including HIV and AIDS, early marriages and teenage pregnancies are discouraged. It also advocates for increase in the legal age of marriage, regulations and enforcement of laws that advance youth reproductive health including sexual violence. However, research shows that Malawi's re-entry policies, are in a form of government circulars with little direction on rights and responsibilities of different actors to facilitate effective re-entry. Therefore this leaves the implementation to chance making it everyone's but nobody's responsibility.

Figure 3.1: Age of access to contraceptives across SADC countries



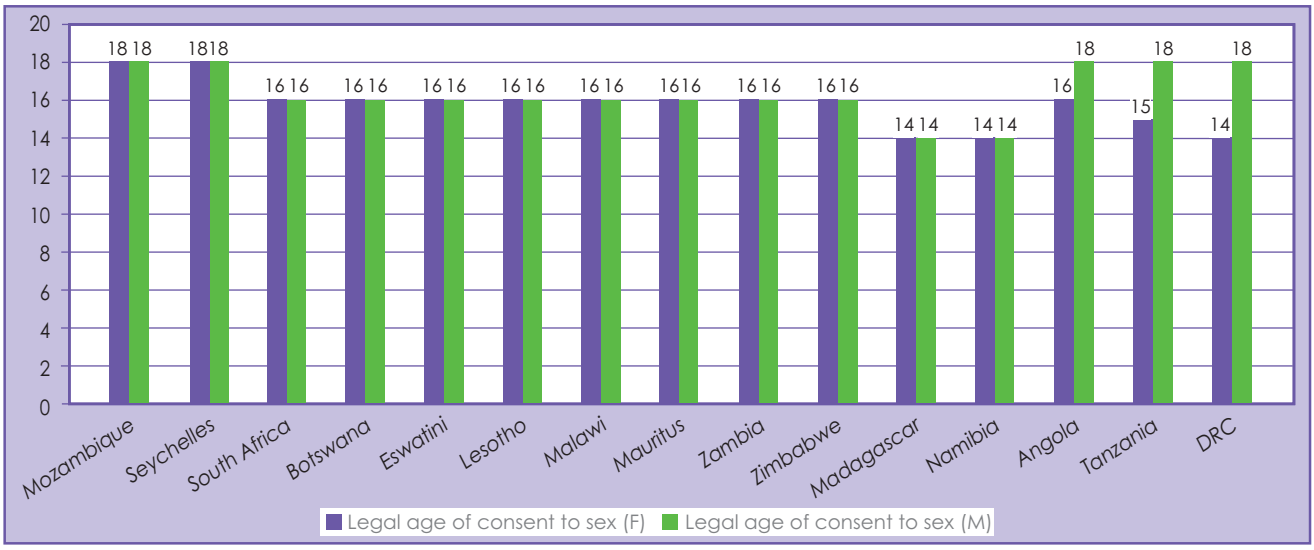
Source: Gender Links.

[41] C.M. Molapo J. D. Adams Miss S P Zulu Schooling-Going Mothers' Experiences in Relation to Teachers: A Case of High Schools in Leribe District, Lesotho https://www.mcser.org/journal/index.php/mjss/article/viewFile/3859/3776
[42] http://www.youthpolicy.org/national/Malawi_2013_National_Youth_Policy.pdf

Figure 3.1 shows that 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 needs to be confirmed and Lesotho does not stipulate any age.

Figure 3.2: Legal age of consent to sex in SADC



Source: Audit of SRHR laws and policies in SADC, 2018.

Figure 3.2 shows that the legal age of consent to sex in SADC ranges from 14 for young men and women in Madagascar and Namibia, to 18 for young men and women in Mozambique and Seychelles. In the majority of SADC countries (eight), the age of consent for young men and women is 16. In three SADC countries (Angola, Tanzania and DRC), the age of consent for young men is higher than for young women. The biggest gap is in DRC, where the age of consent is 18 for young men and 14 for young women. According to the SADC Gender Strategy: "This perpetuates gender inequality and reinforces unhealthy gender norms that disempower girls."

The gap in between age of access to contraceptives and legal age of consent to sex is a contentious point in many countries. In six SADC countries (Botswana, Madagascar, Mozambique, Namibia, South Africa and Tanzania) contraceptives are legally available to adolescents younger than the legal age of consent. This is in recognition of the fact that young people below the age of legal consent are having sex. The dilemma that arises is that sex below the age of consent is by definition statutory rape. But what if this is consensual, and occurs between two persons below the age of consent?

In **South Africa** Parliament has adopted the Criminal Law (Sexual Offences and Related Matters) Amendment Act which states that consensual sex of teenagers older than 12 years is legal. The Amendment Bill does not change the age of consent to have sex, which remains at 16. Welcoming the amendment, Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), an organisation dedicated to children's rights said: "The Bill is a call to action to support adolescents to make informed life choices especially in relation to sexual decision making."

SAFAIDS Launches Mobile SRHR App[43]

SAfAIDS is empowering adolescents and youths to engage in social accountability monitoring of Sexual Reproductive Health (SRH) services through MobiSAfAIDS, an innovative mobile application.

The organisation is empowering disadvantaged adolescents and youths in rural Hwange District with knowledge and skills on how they can engage health service providers towards enhancing SRH services delivery for young people. This is meant to promote youth participation in SRH services policy transformation conversation.

The regional organisation in partnership with the Sweden (Sida) and Buwalo Matalikilo Trust (BMT) launched a Youth Friendly Corner at Lukosi Hospital in Hwange where they are piloting a Mobile Social Accountability Monitoring [MobiSAfAIDS] Platform for Sexual Reproductive Health services in rural Hwange. The pilot initiative is also being done in Lesotho, Malawi, Eswatini, South Africa and Zambia.

The MobiSAfAIDS application is available for download on Google play store and there is also a desktop version. Users have to register in order to access the application, once one registers they can interact with a health facility administrator who has been trained to deal with issues being raised via the mobile application. This is being supported under the Regional Transforming Lives Programme.



Promoting use of technology for Social Accountability Monitoring for young people through the use of the MobiSAfAIDS application. Photo: SAFAIDS

Percy Ngwerume a Social Accountability Specialist with SAfAIDS said their interest is around prevention of early unplanned pregnancy among young women, sexual and gender based violence and also tackling issues of unsafe abortion."We might not have statistics on unsafe abortion, it's something that is a reality in our communities, it's happening but we are not talking much about it so we want to say let's have this conversation so that we can prevent unsafe abortion and unplanned pregnancies," said Mr Ngwerume.

Ngwerume says a research that they carried out in Hwange District revealed that only 7% of young people have had an opportunity to engage or interact with service providers. The application will thus provide a safe and anonymous environment for young people to engage with health service providers. Were service issues warrant policy transformation, young people have been equipped with the skills to analyse data from the application and package this for further policy advocacy.

"Our young people do not really have the confidence to engage health service providers around issues to do with services being provided," he said.

Anna Mandizha Ncube the executive director for BMT said cases of unsafe abortion, school drop outs due to teen age pregnancies are a cause of concern in Ward 20 that they chose to work in.

"We are targeting the ages between 10 to 24 years because this is when a lot of abortions are taking place and this is when early sexual debut are happening. Some parents in the community are complaining that we are concertizing young children on Sexual Reproductive Health issues but the truth of the matter on the ground is children as young as 10 years old are engaging in sexual activities and the constitution of the country allows them to access information on Sexual Reproductive Health," said Mrs Ncube.

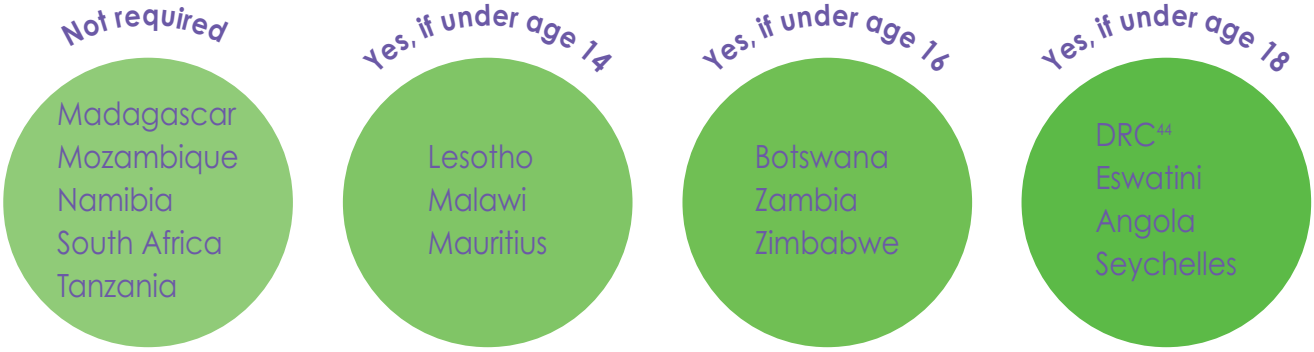
"Our mobile application (MobiSAfAIDS) will allow the young boys and girls to put across complains or compliments in a private way as compared to suggestion boxes," said Mrs Ncube.

Hwange District Medical Officer Dr Wisdom Kurauone, speaking on behalf of the Ministry pf Health and Child Care (MoHCC), welcomed the initiative. "The community does not have access to a lot of things that urban young people are exposed to, we welcome the initiative and we hope to have more youth friendly facilities in Hwange District," said Dr Kurauone.

BMT supported by SAfAIDS trained 20 young boys and girls, known as Social Accountability and Monitoring [SAM] champions, in Hwange District. The champions are drawn from seven villages namely Chilanga, Bangale, Iubwedile, Dicki, Change, Mpongola and Gamba 1 & 2. Under the guidance of Buwalo Matalikilo Trust, SAM Champions will act as key deliverers of SRH information to their peers in the community as well as Social Accountability Monitors. They will facilitate engagement with service providers and policy makers to advocate for policy transformation in SRH service delivery based on evidence generated through the MobiSAfAIDS.

Source: Health Times, 2019

Figure 3.3: Requirements for Parental consent for ASRHR in SADC[44]



Source: UNAIDS.

As illustrated in Figure 3.3, 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 anyone under the age of 18 cannot access SRHR services without parental consent.

Laws and policies that require parental consent to access sexual and reproductive health services discourage adolescent girls from accessing the services they need to stay healthy. Removal of these requirements is needed, as is the rapid scale-up of intensive combination prevention programme packages, including elements that improve school attendance and empower young women to mitigate their own risk.[46]

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.

[43] https://healthtimes.co.zw/2019/04/23/safaids-launches-mobile-srhr-app/
[44] http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf
[45] https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html
[46] https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf

Teenage pregnancy

With the increasing rates of teenage pregnancy in the region[47], one of the SADC Strategy outcomes is to reduce the rates of teenage pregnancies by ensuring that:

- All stakeholders work collaboratively to define a national minimum package of social, behavioural, structural, and biomedical interventions that will reduce early and unintended adolescent pregnancies, unsafe abortion, unsafe abortion, STIs and HIV among adolescent and youth, and to scale up this package of interventions.
- Member States to consider policies on the readmission and retention of pregnant girls in schools so that they can reach their full potential.
- Tracking adolescent fertility rate.
- Comprehensive sexuality education.
- Counselling and services for a broad range of modern contraceptives.

The levels of teenage pregnancies amongst adolescent girls remain a public health concern in Southern Africa exacerbated by lack or limited CSE, low use of contraceptives, limited access to services, early sexual debut, child marriages, Gender Based Violence (GBV) as well as intergenerational and transactional relationships fuelled by poverty.

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. With an average of 101 births per 1000 woman between the ages Southern Africa has the highest level of adolescent pregnancy.

> The levels of teenage pregnancies amongst adolescent girls remain a public health concern

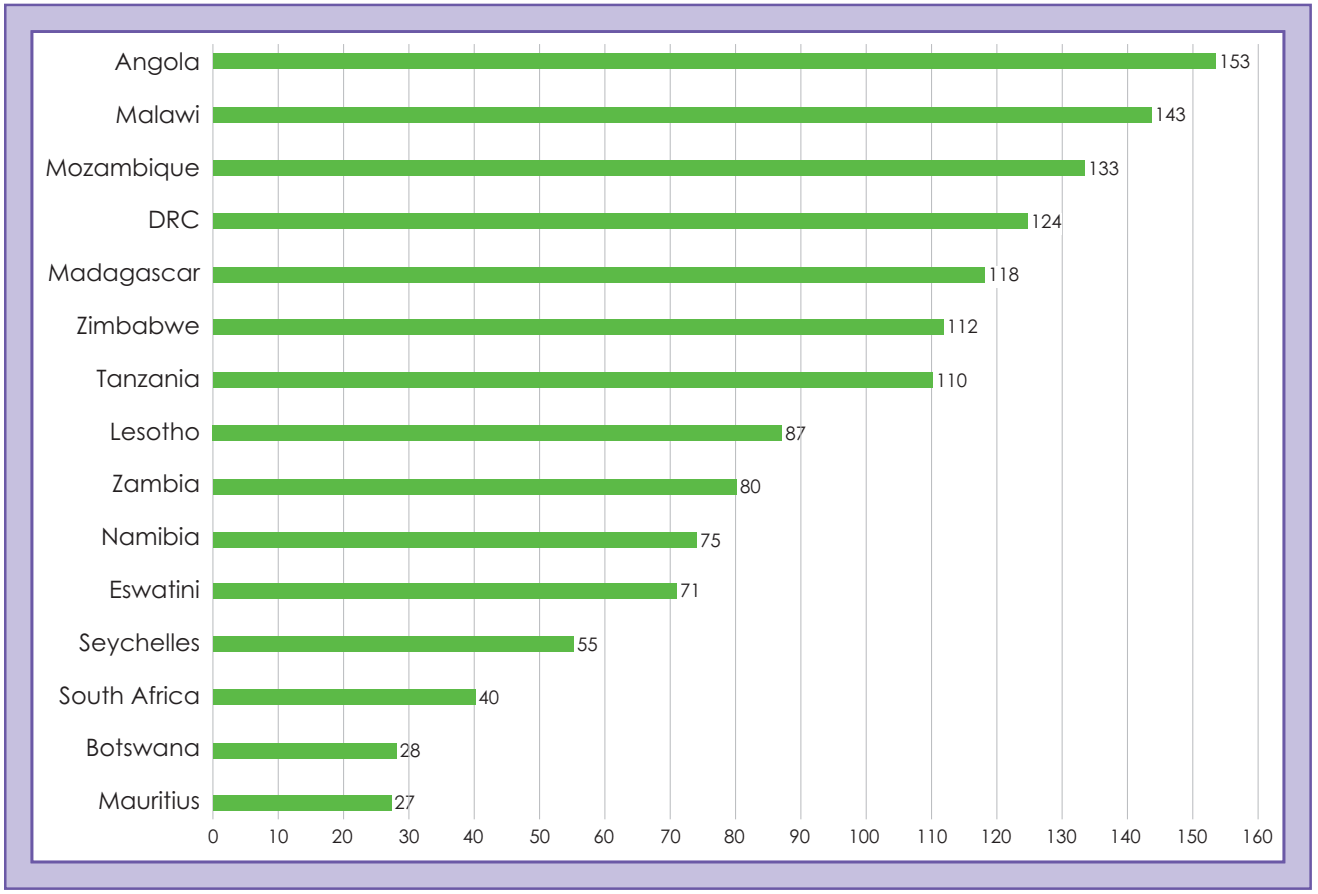
Teenage pregnancies burden female and male youth with obligations beyond their ability to manage, both financially and psychologically. For teenage fathers, the financial expectation to provide economic support is an added obstacle in their completion of secondary education. On the other hand, teenage mothers, who are expected to take care of the child, are more likely to stay home after childbirth, thus impacting their ability to access secondary education or complete it.

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.[48] Teenage pregancnies are also a result of an unmet need for contraception. The Guutmacher institute reports that in Southern Africa, 32% of sexually active adolescents have an unmet need for contraception.[49] It is important to include access to services such as contraceptive methods that could prevent teenage pregnancies in the CSE curriculum to enable adolescents to make informed decisions. The response to teenage pregnancies by the education sector through policies and laws becomes important if girls are to stay in school.

[47] SADC Gender and Development Monitor 2016
[48] https://www.unfpa.org/adolescent-pregnancy
[49] https://www.guttmacher.org/fact-sheet/adding-it-meeting-contraceptive-needs-of-adolescents-sub-saharan-africa

Figure 3.4: Adolescent live births per 1000 population



Source: Southern Africa Gender Protocol Alliance mapping of SRHR Policies and Laws, 2018.

Figure 3.4 shows that in seven SADC countries (Tanzania, Zimbabwe, Madagascar, DRC, Mozambique, Malawi and Angola) over 100 out of 1000 (10%) of adolescent girls are having children. Although lower, the figures Lesotho, Zambia, Namibia, Eswatini and Seychelles are also of concern. Teenage pregnancies and girls drop out of school are interlinked with both influencing the other.

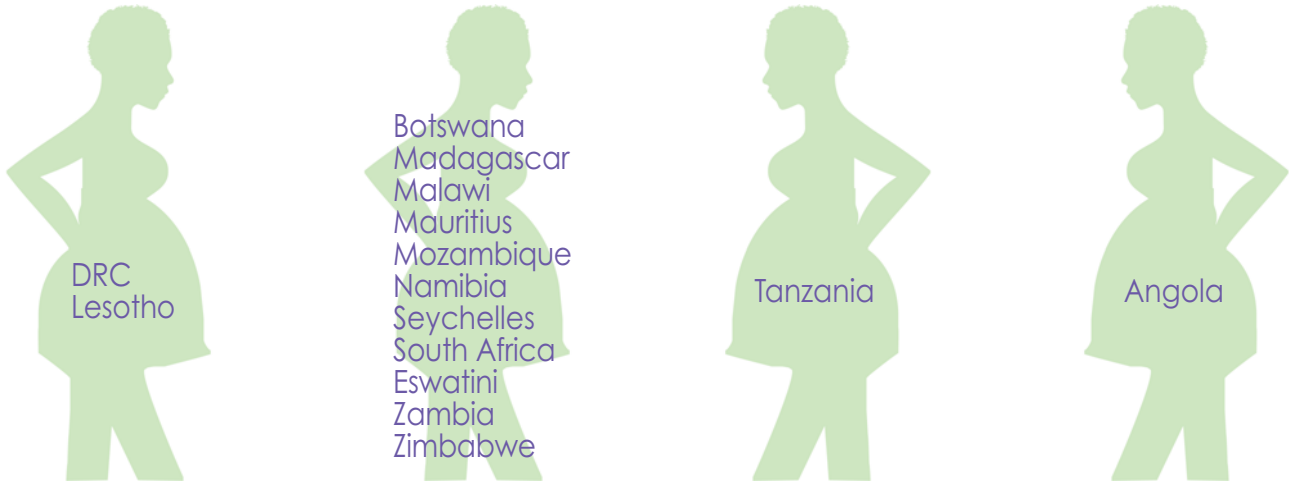


Teenage pregnancies compromise young girls futures, urgent action is needed.
Photo: Gender Links

Policies on adolescent pregnancy

Policies on teenage pregnancy deal primarily with the girl with little focus on the father of the unborn child. In addition, while conditional re-entry is possible in most SADC countries, young mothers face many challenges including economic constraints and social barriers. Conditional re-entry creates a situation where although there are provisions for girls going back to school these provisions may not be absolute and are dependent on certain terms being met. All policies on teenage pregnancy must provide for social protections as well as economic support and allow girls to be easily integrated back into the education system.

Figure 3.5: Breakdown of teenage pregnancy and school policies in SADC[50]



Source: Human Rights Watch Report 2018, Leave No Girl Behind in Africa Discrimination in Education against Pregnant Girls and Adolescent Mothers.

The DRC and Lesotho have policies in place that protect pregnant girls' rights to stay in school and do not prescribe any mandatory conditions to be met. However, Lesotho lacks policies on how to enforce that right. Thus, in the absence of guidance, schools may still expel pregnant girls.[51]

Botswana, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Eswatini, Zambia and Zimbabwe have re-entry policies for pregnant girls. Human Rights Watch notes that in Botswana, Eswatini and Zambia, girls are excluded from school for between 6 and 18 months after giving birth. They are often not allowed to return to the same school. Tanzania outrightly expels pregnant girls while Angola has no policies in place for pregnant girls.

Re-entry is extremely difficult for girls on account of factors such as poverty, stigma and discrimination, and limited support mechanisms for the girls to overcome these.[52] The Gender Responsive Assessment (GRA) Survey analysis on whether students and teenage mothers are allowed to continue with their education across different countries. Only Lesotho, Malawi and Botswana scored the maximum point of two per country.

Respondents in the GRA noted that in Lesotho girls are allowed to continue with their education as per the provisions of the Education Act no's of 2010. However, some Christian schools still have a reservation regarding that. In Angola although the Constitution is non-discriminatory, respondents noted the in some school's internal regulations do not allow pregnant girls and adolescents to study in the daytime. Namibian respondents noted that although there is a policy, responsibility in terms of who ensures that the learner returns to school is not legislated. Emotional and financial support is needed in most cases especially in the more rural parts of Namibia.

Re-entry is extremely difficult for girls on account of factors such as poverty, stigma and discrimination, and limited support...

[50] https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and
[51] UNESCO. 2019. Global Education Monitoring Report - Gender Report: Building bridges for gender equality. Paris, UNESCO.
[52] https://www.youngpeopletoday.org/wp-content/uploads/2019/04/Unesco_EUP_Report_2018_LOW_RES.pdf



Tanzania continues to exclude teenage mothers from education[53]

The 2015-2016 Tanzania Demographic Health Survey (DHS) shows that in the teenage child-bearing category the percentage of women aged 15-19 who have either had a birth or are pregnant is 27%.[54] Despite this high proportion of teenage pregnancies, the country banned teenage mothers from continuing their education or returning to any state-run school following child birth. This was a blow to the girl child's right to education.

Tanzania's President John Magufuli reinforced this ban and added that the government should imprison men involved in teenage pregnancies. A few years on there has been no paradigm shift in Tanzania where the policy of expulsion and non-readmission of girls who get pregnant in school regardless of the circumstances they fall pregnant under continued.

In 2018, girls were further disempowered following a public pronouncement by President Magufuli for women to stop using contraception so that they can increase the country's population labelling those who use contraception "lazy". Access to information on SRHR and services was curtailed when government ordered the suspension of family planning advertisements on TV and radio stations in the country.[55]

In a country where CSE is not a standalone subject access to information on contraception was curtailed. This ban has had ripple effects stopping a loan meant to benefit the education sector. In November 2018, the World Bank withheld a US$300 million loan for secondary education in Tanzania, expressing concern over its exclusion of pregnant girls and teenage mothers.[56]



"Evelina," 17, with her 3-year-old daughter "Hope," in Migori county, western Kenya. Evelina is in Form 2, the second year of lower secondary school. After her baby was born, a friend encouraged her to go back to school. Although Evelina cannot afford to pay school fees, the school's head teacher allows her to stay in school. Photo: © 2018 Smita Sharma for Human Rights Watch

Human Rights Watch reports that following discussions between the World Bank and President Magufuli, the government committed to finding ways for the girls to return to school. But the government has not fulfilled this commitment, leaving thousands of girls out of school. On 16 June 2019, the Day of the African Child, the Centre for Reproductive Rights and the Legal and Human Rights Centre (LHRC) turned up the pressure and filed an official complaint before the African Committee of Experts on the Rights and Welfare of the Child challenging the ban on teenage girls in public schools.

Source: Human Rights Watch, 2018

[53] https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and
[54] https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf
[55] https://edition.cnn.com/2018/10/11/health/tanzania-pregnancy-test-asequals-intl/index.html
[56] https://www.theguardian.com/global-development/2018/nov/15/world-bank-pulls-300m-tanzania-loan-over-pregnant-schoolgirl-ban

In the **DRC**, many girls are left pregnant after sexual violence due to war. According to *Girls Not Brides*, the UN estimates that 200,000 girls and women have experienced sexual violence in the DRC since 1998. Military conflict in eastern DRC has increased the vulnerability of young girls being forced into marriage by armed combatants. Some girls who are raped are then forced to marry perpetrators in the hope that it might bring stability to children born out of wedlock.[57] DRC has a policy that protects young mothers' right to return to school, but needs education policies to make sure the laws are enforced.[58]

In **Eswatini**, the policy on teenage pregnancy is vague. It stipulates that a pregnant mother has a right of admission into the school she was attending prior to pregnancy, or any other school. In the inadequate policy environment schools have developed differing approaches to the issue. Some schools allow pregnant pupils to continue attendance until the pregnancy is visible whereupon they stay home and are allowed to return to write examinations. Some schools also allow teenage mothers to return to the same school. However, citing concerns around stigma and negative attitudes towards mothers (including parent concerns about "negative influence" of the teenage mother) some schools recommend a change of school after birth of the child. Eswatini still does not encourage the distribution of condoms in schools although there are campaigns and recommendations by civil society to show the benefits of this including reducing teenage pregnancies.

In October 2017, the Forum for Africa Women Educationalist Swaziland Chapter (FAWESWA) called "upon the government at service delivery level through Ministries of Health and Education to strengthen SRHR and Comprehensive Sexuality Education (CSE) within schools to reach school-attending youth, empower them with knowledge to delay sex in order to ensure they finish school and get better opportunities in life". FAWESWA also urged parents to "talk sexuality and sex with their children at home" and youth "also to take responsibility for their lives."

FAWESWA also urged parents to "talk sexuality and sex with their children at home" and youth "also to take responsibility for their lives

Zimbabwe has drafted an Education Amendment Bill introduced in February 2019. This bill guarantees protection for girls who become pregnant from being excluded. The bill's provision that "no child shall be discriminated against on the basis of pregnancy" is a positive step towards keeping the girl child in school in a country where over 24% of girls between 15 and 19 become pregnant each year. The bill, whose second reading in parliament was in June 2019, has evoked emotionally charged exchanges in parliament. One parliamentarian declared that "Our schools must not be turned into maternity homes… A rotten apple spoils the barrel. I want to say, it will not be good for other pupils as well." Another parliamentarian argued that protecting girls from expulsion encouraged child marriages, and that it meant "we are saying let us let our children get pregnant at school".[59]

[57] https://www.girlsnotbrides.org/child-marriage/democratic-republic-of-the-congo/
[58] https://www.hrw.org/news/2019/06/16/africa-pregnant-girls-young-mothers-denied-school
[59] https://zimfact.org/factsheet-corporal-punishment-pregnancy-and-the-new-education-bill/

In December 2018 the **Mozambique** Ministry of Education revoked a decree of 2003 which ordered all pregnant schoolgirls to attend night classes, and banned them from day classes.[60] The scrapping of the 2003 decree took effect at the start of the 2019 school year. The removal of this decree is a significant step towards keeping the girl child in school.

Botswana utilises a re-entry policy inscribed in the Botswana Education Regulations passed in 1978. In 1995, a government circular standardized the re-entry process per the original guidelines. The policy stipulates that pregnant girls are to be withdrawn from school and re-admitted in the same school or to a different school. Sooner than twelve months after the cessation of the pregnancy pupils are not allowed to sit for examinations while pregnant or within six months of delivery, and their re-entry to school or ability to sit for examinations is contingent upon approval from the Minister of Education.



A pregnant learner at Seme Secondary school in Daggakraal, Mpumalanga, South Africa. Photo: ENCA

In **South Africa** the National Policy on the Prevention and Management of Learner pregnancies represents one of the most progressive and far reaching efforts to prevent teenage pregnancies and support learners who fall pregnant. According to the Statistics South Africa report on *Recorded Live Births* 10.9% of births in 2017 were to adolescent mothers aged 10 to 19. 3 261 girls aged between 10 and 14 and 119 645 were registered as mothers in South Africa in 2017.[61] In the new policy on teenage pregnancies, the Department of Basic Education (DBE) notes that unintended pregnancy amongst learners is not new to the basic education but its scale and impact have reached the point where it requires a systemic policy and structured implementation planning.[62] This policy intends to address:

- high rates of pregnancy among learners;
- the familial 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;
- retention and re-enrolment of affected learners in school.

Furthermore, it will ensure the accessible provision of information on prevention; choice of termination of pregnancy (CToP); care, counselling and support; frameworks for impact mitigation; and guidelines for systemic management and implementation. It also places an emphasis on the education systems commitment to role players to providing the CSE which crucial to optimal sexual and reproductive health.

South Africa has relaunched 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. The campaign also provide information on SRHR, and documents stories from teens in their own voices, and updates and events from the campaign.[63]

[60] https://allafrica.com/stories/201812240530.html
[61] https://www.iol.co.za/dailynews/news/97-143-teenage-mothers-gave-birth-last-year-says-stats-sa-16813377
[62] https://www.education.gov.za/Portals/0/Documents/Policies/Draft%20Pregnancy%20Policy%202018.pdf?ver=2018-06-26-142235-687
[63] http://www.mmoho.co.za/campaign/

Next steps

Some laws and policies, as well as attitudes and perceptions, continue to create barriers in the realisation of ASRHR in the region. On the other hand, there are now many progressive policies, strategies and legislation in place to support CSE as well as reduce teenage pregnancies. This creates a solid foundation going forward. The best practices, case studies, policies and campaigns detailed in this chapter attest to a changing and more enabling environment for ASRHR. Key next steps include:

- **Strengthen CSE provisions:** Countries need to upscale their CSE provisions and strengthen the CSE curriculum from all angles including training educators, materials policies. Enhance provision of CSE to out-of-school youth.
- **Engage young men in ending early and unintended pregnancies:** Young men have been seldom been part of the equation in ending teenage pregnancies. The involvement of young men has not been considered as a contributing factor to the high teenage pregnancy rate often there is no clear policy in engaging young men who maybe drivers of teenage pregnancy.[64] Therefore, if young men are not involved at different levels in strategies and campaigns to end teenage pregnancies this may be a missed opportunity to create holistic approach to reduce teenage pregnancies.
- **Distribution of condoms:** Governments can remove hindrance on provision of female and male condoms in schools he prevention. Some countries prohibit the distribution of condoms in schools noting that it will encourage early sexual debut and immorality.
- **Creating an enabling and supportive educational environment** where the psychological and physical conditions of the learner is recognised and supported. In Zambia, for example, girls are being provided with a choice of access to morning or evening classes.
- **Strengthen social protection policies:** Governments can remove financial barriers so that girls can go back to school. In South Africa for example the government offers social grants for adolescent mothers which can help girls take care of their children financially as they continue with their education. This should also include child care centers so that girls can remain in school.

[64] Amoo EO, Igbinoba AO, Imhonopi D, et al. Trends, drivers and health risks of adolescent fatherhood in sub-Saharan Africa. SOCIOINT 2017 - 4th International Conference on Education, Social Sciences and Humanities, held in Dubai, United Arab Emirates, 10 - 12 July 2017. Acceshttp://www.scielo.org.za/pdf/sajch/v12nspe/08.pdf

Safe Abortion 4



March in Johannesburg on 28 September - International Day for Safe Abortion. Photo: Shamiso Chigorimbo

KEY POINTS

- The SADC SRHR Strategy highlights that 24% of all pregnancies in Southern Africa end in abortion. Among the international instruments, only the Maputo Protocol mentions the right to abortion, in certain circumstances.
- There are only two SADC countries in which abortion is available on demand in the first trimester (South Africa and Mozambique). Abortion is available under certain circumstances in all SADC countries, with varying degrees of restriction.
- Safe and legal abortion is an SRHR right. The ability of a woman or girl to safely decide not to continue a pregnancy may be the key that unlocks numerous opportunities in life, including education, employment, financial security and good health.
- Abortion is almost always the result of an unintended pregnancy. Improving access to contraception to reduce unintended pregnancy is critical to reduce demand for abortion.
- More restrictive legislation does not reduce the abortion rate. Abortion rates are slightly higher in countries with restrictive legislation than in those with less restrictive legislation. More restrictive legislation drives women to clandestine abortion providers and unsafe abortions.
- Provision of good post abortion care reduces the mortality but is costly.
- The GL attitude survey shows that in almost all SADC countries less than half the respondents believe that a woman should be able to choose to terminate a pregnancy in the first three months.
- The SAFAIDS "My choice, our choice" campaign seeks to influence the policy environment on unsafe abortion.

Introduction

Induced abortion is a procedure for terminating an unintended pregnancy. It is considered to be medically *safe* when WHO-recommended methods, appropriate for the pregnancy duration, are used by trained persons, *less safe* when only one of those two criteria is met and *least safe* when neither is met. Induced abortion, safe or unsafe, legal or illegal, is a universal phenomenon and has existed throughout recorded history.[1] Unintended pregnancies are often the result of unmet need for contraception and also result from rape. When faced with an unintended pregnancy many women choose abortion, whether legal or safe. The SADC SRHR Strategy highlights that 24% of all pregnancies in Southern Africa end in abortion. Unsafe abortions contribute an estimated 10 to 13% of maternal mortality.

Deciding whether and when to have children, and being able to act on that decision, is a fundamental human right. The ability of a woman or girl to safely decide not to continue through a full pregnancy may be the key that unlocks numerous opportunities in life, including education, employment, financial security and good health.[2] Further, the psychological impact on both woman and the child of being forced to carry a pregnancy that has resulted from rape is enormous.



Young marchers in Orange Farm, Johannesburg. Photo: Colleen Lowe Morna

[1] Shaha. I, E Åhmana & N Ortaylib, 2014. Background paper # 3, ICPD Beyond 2014 Expert Meeting on Women's Health - rights, empowerment and social determinants 30th September - 2nd October, Mexico City. Access to Safe Abortion: Progress and Challenges since the 1994 International Conference on Population and Development (ICPD). UNFPA Unpublished paper. https://www.unfpa.org/sites/default/files/resource-pdf/Safe_Abortion.pdf Accessed 10 June, 2019

[2] IPPF. 2018. Her in charge: Medical abortion and women's lives - A call for action. London. https://www.ippf.org/herincharge/downloads/IPPF_Her_In_Charge_Report_2018.pdf accessed 10 June, 2019.

A UNFPA briefing paper for the *International Conference on Population Development (ICPD) Beyond 2014* conference estimated that there had been a decline in global abortions between 1995 and 2008 from 46 million to 44 million which corresponded to a decline in overall abortion rate from 35 to 28 per 1000 women in reproductive age 15-44 years. In the same period it was estimated that the decline in unsafe abortion was only from 15 to 14 per 1000 women of reproductive age 15-44 years while the rate of safe abortion dropped from 20 to 14.[3] The report also noted that there was insufficient data on occurrence of abortion and recommended that this needed to improve.

In the twenty five years since the ICPD conference, the number of countries globally which do not permit abortion on any ground declined from 8% to 3%. Countries where abortion is permitted on request increased from 22% to 30%. During this period, 70 countries made grounds for abortion more liberal while 11 increased the restrictions on grounds for abortion. Abortions occur as frequently in countries where abortions are banned outright or allowed only to save the woman's life (37 per 1000 women) as in countries which are least-restrictive (34 per 1,000 women).

In much of the world, 20-24-year-old women have the highest abortion rate of any age-group. Adolescent abortion rates in developed regions are fairly low (e.g., 3-16 per 1,000) but are much higher in developing regions.[4] However, where abortion is highly restricted, the incidence of unsafe abortion and related mortality is high. Legal restrictions also result in major inequity in access to safe providers, as women in urban areas and those who can afford to pay can access physicians or travel abroad to procure abortion. Those that are most likely to access unsafe abortions, with attendant morbidity, disability and even mortality, are poor, rural and young. Though ICPD was clear that access to safe abortion is imperative for public health, organised opposition to abortion has intensified and hampered progress to make safe abortion available.[5]

Health management information systems rarely collect data which is disaggregated by spontaneous abortions (or miscarriages) and induced abortions even in countries where abortion is legal. In countries where abortion is not legal it is very difficult to find data. Rates of abortion are therefore estimated, based on a variety of data such as care for post abortion cases. As a result of data gaps and the lack of reliability of data, there are few graphs or even tables in this chapter. In fact, much of the data that is available is for all of Sub-Saharan Africa or all developing regions. Some is a little dated. One of the calls of this chapter is for more routine collection of data, but this is difficult in an era of an expanded Mexico City Policy (or Gag Rule) blocking any US government funding to organisations that give women access to or even information about, safe abortion.

The Gag Rule will impact many women's' lives negatively

[3] Shaha et al. 2014. Op Cit
[4] Singh, S. et al. Op Cit
[5] Shaha etal Op Cit

Table 4.1: Key facts on abortion in Southern Africa

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
	Penal Code 2014	Penal Code 1991	Penal Code 2004	Penal Code 2005	Penal Code 2010	Penal Code 1998	Penal Code	Criminal Code 2012	Penal Code 2013	Abortion and Sterilisation Act 1975	Termination of Pregnancy Act 1994	Termination of Pregnancy Act 1996	Penal Code	Penal Code 2014	Abortion Law 1977
Laws															
Abortion on demand									Yes			Yes			
Save the Woman's Life	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Economic or Social reasons											Yes	Yes		Yes	
Foetal impairment	Yes	Yes		Yes	Yes			Yes	Yes	Yes		Yes		Yes	
Rape		Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes		Yes	Yes
Incest		Yes	Yes	Yes	Yes				Yes	Yes	Yes	Yes		Yes	Yes
Intellectual disability				Yes						Yes	Yes	Yes		Yes	
Mental Health	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes		Yes	
Physical Health	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes			
Response															
Strengthen access to contraceptives		Yes		Yes				Yes							
SRH education	Yes	Yes		Yes			Yes		Yes	Yes		Yes			Yes
Decriminalise abortion					Yes	Yes						Yes			
Safe abortion health			Yes		Yes				Yes		Yes		Yes	Yes	
Comprehensive post abortion care guidelines		Yes				Yes	Yes		Yes			Yes	Yes	Yes	Yes
Attitudes															
% who say a woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy	47%	24%	10%	30%	51%	15%	27%	35%	16%	15%	41%	28%	15%	47%	28%

Source: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey.

Table 4.1 shows that:

- There are only two SADC countries in which abortion is available on demand in the first trimester (South Africa and Mozambique).
- Abortion is available under certain circumstances in all SADC countries, most commonly to save the woman's life; foetal impairment; rape; incest, mental or physical health.
- In some countries (for example Angola, Madagascar, Malawi and Tanzania), the circumstances under which abortion is allowed is extremely limited.
- Only three countries (South Africa, Seychelles and Zambia) allow for abortion for economic and social reasons.
- The response to abortion has been largely reactive. Eight countries (Botswana, Madagascar, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe) have Comprehensive Post Abortion Care Guidelines. All evidence shows that safe abortion procedures would be much cheaper than post abortion care.
- The GL attitude survey shows that in almost all SADC countries less than half the respondents believe that a woman should be able to choose to terminate a pregnancy in the first three months. Even in South Africa, where abortion is legal, only 28% of those polled agree with this statement. However, attitudes on this very emotive subject are changing. For example, in neighbouring Lesotho, 51% of respondents agreed with the statement, as did 47% in Zambia.

Abortion incidence

The Guttmacher Institute has used the best available data to estimate abortion rates per 1000 women aged 15 to 44 for different regions and times (in series of 5 year intervals). It is estimated that abortion rates in Southern Africa increased from 32 in 1990 - 1994 to 35 in 2010 - 2014, compared to a decrease of 40 to 35 globally; a decrease of 39 to 37 in developing countries overall and decrease of 46 to 27 in developed countries.

The Institute estimates that 25% of pregnancies globally, and 24% in Southern Africa, end in termination. In the period 2010-2014, an estimated 8.2 million abortions occurred in Africa every year, an increase from the estimated 4.6 million in the 1990 - 1994 period. The rate of unintended pregnancy in Africa is estimated at 89 per 1000 women aged 15 to 44.[6] It recognizes comprehensive safe abortion care (including post abortion care), as a key element of SRHR.

SAfAIDS has conducted a knowledge, attitudes and practice (KAP) survey among 2993 respondents (2186 young women and 805 young males) across 16 SADC member states. Although there were poor response rates in some countries to some questions, this data collected provide some indication of the state of abortions across SADC.

Table 4.2: SAfAIDS Safe Abortion KAP survey responses

Country	% who knew 1 - 5 friends who had an abortion		% who knew someone that died from an abortion	Person responsible for an abortion	
	Male	Female		Named as	By %
Angola	na	na	19.50	Doctor Self-induced Herbs	60 22 10
Botswana	na	na	47.1	Self-induced Traditional healer Friends	74 13 9
DRC	na	na	16	Doctor	93
Eswatini	60.8		34.8	Self-induced Traditional healer Friend	30.2 5.7 17
Lesotho	90.5		28.5	na	na
Madagascar	56		na	na	na
Malawi	64.4	58.9	45 males 38 females	na	na
Mauritius	na	na	na	na	na
Mozambique	91.2		28.3	na	na
Namibia	89.6		31.5	Self-induced Traditional healer Doctor	64.4 12.9 9.9
Seychelles	na	na	33.3	Self-induced Herbs Doctor	60.9 10.4 13.9
South Africa	na	na	na	na	na
Tanzania	na	na	na	na	na
Zambia	84.9		36.3	Self-induced Doctor/Nurse Pharmacist	46.2 17.5 15.6
Zimbabwe	17.5	63	na	na	na

Source: SAfAIDS. 2019. Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. Final Report.

[6] Singh, S. et al. 2017. Abortion Worldwide 2017. Guttmacher Institute. New York.

Table 4.2 shows that where data was available, a high proportion of those surveyed knew 1-5 friends who had an abortion. This ranged from 17.5% in Zimbabwe to 90% in Lesotho. Of these, anywhere from 19.5% of those surveyed (Angola) to 47% (Botswana) knew of someone that died of an abortion. Self- induced abortions featured highest except in DRC where doctors were said to perform 93% of abortions.



Zimbabwe: Incidence Study shows high rate of abortion[7]



Overall, 40% of pregnancies in Zimbabwe were unintended, and one-quarter of all unintended pregnancies ended in abortion in 2016, according to the Abortion and Posabortion Care study.[8]

The study estimates that here were an estimated 677,277 pregnancies in Zimbabwe in 2016, resulting in a pregnancy rate of 180 per 1,000 women of reproductive age. Even though Zimbabwe has one of the highest contraception prevalence rates in Sub-Saharan Africa, the estimated national unintended pregnancy rate was found to be 71.1 per 1,000 women of reproductive age. Overall, 40% of pregnancies in Zimbabwe were unintended, and one-quarter of all unintended pregnancies ended in abortion.

Among all pregnancies in Zimbabwe, half (50%) ended in intended birth, 24% in unintended birth, 16% in miscarriage, and 10% in abortion.

The study found 25,245 Post Abortion Care (PAC) cases treated in facilities annually, of which 13,138 were estimated to be second trimester miscarriages, resulting in an estimated 12,107 PAC cases as a result of induced abortions. This translated to a 3.2 women per 1,000 women age 15-49 treated with PAC for induced abortions.

The study also identified gaps in the provision of PAC. Thus, though Zimbabwe has a relatively low abortion rate, unsafe abortion may still be contributing to a very high maternal mortality ratio. The study concluded that greater steps must be taken to fully implement the National Guidelines for Comprehensive Abortion Care.

Source: PLOS One, 2018

In 2016, 37,865 women were treated in health facilities for complications of abortion in Kinshasa, **DRC**. Further it was estimated that those that sought treatment were 25% of those that had accessed an abortion. Thus, it was estimated that 146,713 abortions were performed; corresponding to an abortion rate of 56 per 1,000 women aged 15-49. It was also estimated that there were more than 343,000 unintended pregnancies which is in an unintended pregnancy rate of 147 per 1,000 women aged 15-49.[9]

An estimated 53% of pregnancies in **Malawi** are unintended and 30% of unintended pregnancies end in abortion.[10] It is estimated that between 6-18% of abortions outside the health system in Malawi are associated with severe complications while 60% result in complications that require

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6200425/
[8] https://www.guttmacher.org/article/2018/10/severity-and-management-postabortion-complications-among-women-zimbabwe-2016-cross
[9] Chae S, Kayembe PK, Philbin J, Mabika C, Bankole A. The incidence of induced abortion in Kinshasa, Democratic Republic of Congo, 2016. PLoS One. 2017;12(10):e0184389. Published 2017 Oct 2. doi:10.1371/journal.pone.0184389
[10] Polis CB, Mhango C, Philbin J, Chimwaza W, Chipeta E, Msusa A. Incidence of induced abortion in Malawi, 2015. PLoS One. 2017;12(4):e0173639. Published 2017 Apr 3. doi:10.1371/journal.pone.0173639

attention from a health service provider.[11] One third of women in Malawi who had abortions do not receive the required treatment which leaves them in dire circumstances.

The 2012 Reproductive Health Policy[12] states that the number of terminations increased from 443 to 562 between 2006 and 2010. 58,8% of abortions were in women aged 20 to 34. Out of 237 reported teenage pregnancies in Seychelles in 2017, 31.7% ended in termination, according to the Ministry of Health. Traditional healer and friend-induced terminations are the highest cause of abortion related deaths in **Seychelles**[13].

Tanzania experienced an estimated 405,000 induced abortions in 2013, equivalent to a national rate of 36 abortions per 1,000 women age 15-49 or a ratio of 21 abortions per 100 live births. Only one in seven women who underwent an abortion received care.[14]

The 2018 Government of **Botswana** Relationship Study, carried out by Gender Links, offers insight into the nexus between sexual assault, pregnancy and abortion. 4224 women participated in the nationwide survey that included approximately equal numbers of women and men.

Table 4.3: Botswana Relationship Study Key facts on Abortion

Number of women in the study	4224						
Number and % who fell pregnant as a result of rape	72 (1.7% of the sample of women)						
Number and % who sought abortion	40 (56% of those who fell pregnant)						
Number and % who sought a legal abortion	7 (17.5% of those who sought an abortion)						
Age	Below 17	18-20	21-24	25-29	30-39	40-44	Total
	2	20	6	5	5	2	40
Who performed the abortion?	Doctor	Nurse	Mid wife	Self	Other	No one	
	5	18	2	6	9		40
Who examined you after the abortion procedure?	5	21	2			12	40
Where did the abortion take place?	Hospital	Clinic	Private surgery	Home			
	6	12	1	21			40
Views on abortion					Yes		No
Do you think that women who get pregnant as a result of rape or sexual assault should be allowed to have an abortion?					37%		63%
Do you know the circumstances that allow for legal abortion in Botswana?					32%		68%

Source: Botswana Relationship Study 2018.

Table 4.3 shows that:

- 72 or approximately 1.7% of the women interviewed became pregnant as a result of sexual assault.
- Of these 40, or 56% sought an abortion.
- Of the 40 who said they had an abortion, 18 went to a nurse; 6 self- induced and 9 sought "other" means. The latter is a worrying measure of lack of safety.
- The largest number of abortions took place in the home setting, and more than half had no follow up care, again raising concerns regarding safety.
- Only 37% of the women agreed that a woman who gets pregnant as a result of rape or sexual assault should be allowed to have an abortion. Only 32% knew the circumstances under which an abortion can be legally obtained in Botswana.

The rigid abortion laws in Botswana have forced abortion underground spawning a huge black market in 'Abortion Pills' that can be purchased for about $60. Dangers of backyard abortions include a ruptured uterus and uncontrollable bleeding that in most cases is fatal within a few hours.[15]

[11] Ibid
[12] http://www.health.gov.sc/wp-content/uploads/REPRODUCTIVE-HEALTH-POLICY-2012-last-version.pdf Accessed 22 June, 2019
[13] SAfAIDS. 2019. Rapid Assessment on the Adolescent Sexual and Gender Based Violence (SGBV) Related Policy Environment and Unsafe Abortions Seychelles Report Draft
[14] Keogh SC, Kimaro G, Muganyizi P, et al. Incidence of Induced Abortion and Post-Abortion Care in Tanzania. PLoS One. 2015;10(9):e0133933. Published 2015 Sep 11. doi:10.1371/journal.pone.0133933
[15] http://www.sundaystandard.info/botswana-turns-huge-underground-abortion-clinic

Three African countries (Ghana, Gabon and Congo Republic) were among 14 countries with data on the reason for an abortion. In women under the age of 25 the main reasons in all three sub-Saharan countries were: socio economic concerns, too young and partner related, while in women over 25 the major reasons were: socio economic concerns, partner related, wants to postpone or space births and maternal health related.[16]

A small qualitative study with women who received post abortion care in Kenya found that the main reasons for induced abortion were socio-economic stress, a lack of support from the male partner and deviation from family expectations. The male partner was influential in the abortion decision by declining his financial or social responsibilities or by demanding termination. In some cases, the male partner arranged for an unsafe abortion without the woman's consent. Stigma about an abortion resulted in women only confiding in very few people, which made them more vulnerable to complications and delayed seeking of help.[17]

The case study from South Africa illustrates how male partners, family and service providers influence decision-making on abortion.



South Africa: Who decides?[18]

When Charmaine, 22, arrived at the social work department accompanied by her boyfriend (Sam) he wanted to her terminate her pregnancy. Charmaine reported that she did not want to as she had an abortion before due to high blood pressure. However, in this case she was planning to keep her pregnancy.

The social worker enquired about whose decision it was. Charmaine was hesitant to answer and she responded it was her boyfriends' decision. At this point the social worker highlighted to the couple that, the decision should be made by the mother- to-be.

Sam is married and he only told Charmaine about wife and kids when he discovered that Charmaine was pregnant. The social worker re-emphasised to Sam that termination of pregnancy cannot be provided to Charmaine based on the fact that he wants her to have it and that he wants to take the easier way out of his responsibilities.

In a different case, Vanessa, a 23 year old young woman discovered that she was pregnant. Although her boyfriend was willing to take care of the baby Vanessa had decided that she could not keep the baby as she has no one to help her with the child and she wants to finish school. When Vanessa went to the hospital she was referred to a social worker for pre-counselling. The social worker asked Vanessa why she wanted to terminate her pregnancy when there were so many people who want to have children? Vanessa had no answer for the social worker as she felt judged. Vanessa was dismissed and told to come back later.

On return she was told by the social worker that she cannot have TOP as she was now 14 weeks pregnant rather than 12 weeks. Vanessa then resolved to private illegal clinic. She was assisted on the same day that she went.

These scenarios bring attention some of the factors that contribute to unsafe Termination of

[16] Chae S et al., Reasons why women have induced abortions: a synthesis of findings from 14 countries, Contraception, 2017, 96(4):233-241
[17] Rehnström Loi et al, Decision-making preceding induced abortion: a qualitative study of women's experiences in Kisumu, Kenya. Reproductive Health (2018) 15:166 https://doi.org/10.1186/s12978-018-0612-6
[18] https://genderlinks.org.za/news/sa-women-must-make-own-choices-on-safe-and-legal-abortion/

Pregnancy (TOP). Many women and girls in South Africa suffer in silence when families and partners infringe on their sexual reproductive health rights when they are pregnant. Thei families or partners feel that the choice is theirs to dictate what happens to a woman's body.

Termination of pregnancy is often forced on these young women and young girls. Families and partners often take them to the hospital to request termination of pregnancy (TOP) on their behalf.

Source: Vuyo Makapela, Gender Links News Service, 2018

Generally, there are still very high levels of stigma associated with abortion and especially abortion for adolescents. Some of this stigma is associated with attitudes to the morality of sex outside of marriage, or socially unaccepted pregnancy.

Other stigma is related to social norms of womanhood which perceive a women's role as being primarily to reproduce and ascribe negative attributes to women who choose not to.

Normative frameworks



BPFA +20 Africa declaration3 (d) Expand the provision of family planning services and contraceptives and access to safe and legal abortion services in accordance with national laws and policies, and protect the reproductive rights of women by authorizing medical abortion in the case of sexual assault, rape, incest, in line with the Maputo Protocol to the African Charter on Human and Peoples' Rights;

ICPD 7.5 (b) to enable and support responsible voluntary decisions about child bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so

8.25: All governments, and relevant intergovernmental and NGOs are urged to strengthen their commitment to women's health to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved Family Planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion.

Maputo Protocol Article 14 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.

14.2. States Parties shall take all appropriate measures to:

c) Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

SADC SRHR Strategy 2018-2030. Rates of unplanned pregnancies and unsafe abortion are reduced.

Very few global, regional or continental instruments mention abortion. The adoption of Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa in July of 2003 in Maputo, Mozambique signalled a shift for women's' rights across the African continent. The protocol entered into force after a total of 15 ratifications were obtained in 2005.

The Maputo Protocol covers a wide range of women's rights provisions including political, social, cultural, environmental, economic, civil and health and promises to eliminate discrimination against women. Most prominent and highly contemplated, discussed and critiqued is Article 14: Health and Reproductive Health Rights. The article empowers women to control their fertility, decide whether to have children or not and the number thereof, provides the right to choose their preferred contraception, the right to self-protection and to be protected from STI's.

Additionally, women have the right to be informed on one's health status and that of their partner and the right to family planning education. Women are further afforded the right to affordable and accessible health services, pre and post- natal as well as for delivery and nutritional services. Finally, women are granted the right to medical abortions in cases of sexual assault, rape, incest, in the event that the pregnancy endangers the mental and physical health of the mother, or the life of the mother or unborn child.



GL Staff marching on the the Global Day of Action for Safe and Legal abortion.
Photo: Gender Links

Article 14; 2C has been debated all over Africa, even in the case of states who already have similar provisions through different policies (even if these are not included in penal codes). Though countries have signed the Protocol, there is no obligation for countries to make the protocol legally binding. This remains an expectation, or a best practice.

The **Democratic Republic of Congo** signed the Protocol in 2003 and ratified it in 2008. After months of advocacy initiatives by civil society groups in conjunction with the Ministry of Gender the DRC finally ensured access to abortion for women by publishing the ratified Maputo Protocol in the Gazette on March 14, 2018. Abortions are now obtainable in cases of rape, incest, assault, and mental and physical endangerment of the woman and/or her child.

> The adoption of Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa entered into force after a total of 15 ratifications were obtained in 2005

The revised Maputo Plan of Action 2016 - 2030 (which follows the original Maputo Plan of Action, 2007 - 2015) is a continental framework for universal access to comprehensive Sexual and Reproductive Health Rights and Services. The African Commission on Human and Peoples' Rights adopted General Comment No 2 to interpret provisions of Article 14 of the Protocol to the African Charter on the Rights Women in 2014 in Luanda, Angola. The provisions relate to women's rights to fertility control, contraception, family planning, information and education, and abortion. Civil society and human rights advocates can use the General Comment to hold states accountable for implementation of treaty obligations.[19]

The current deadline for all states to ratify the Maputo Protocol is 2020. If this is achieved, there will be more reason for abortion and post abortion services to be available for all women and girls who need them.To date, Botswana has not signed nor ratified the Protocol. Madagascar has not ratified, even though it has signed and South Africa, Mauritius and Namibia have ratified the Protocol with reservations.[20]

Legal and policy provisions for abortion in SADC

As times change, there remains hope that SADC countries can all legalise abortion in less restrictive ways. The table details the legal provisions in SADC regarding abortion.

Table 4.4 below shows that most SADC countries provide for abortion in some circumstances. This ranges from South Africa and Mozambique, where abortion is available on demand, to Zambia where abortion is legal in some circumstances, to Seychelles where the law appears very restrictive but regulations in the Reproductive Health Policy of 2012 enable abortion and even include statistics of safe abortions conducted, to Zimbabwe, Botswana, Lesotho, Mauritius and Namibia, where abortion is illegal except in certain circumstances; to Tanzania, Eswatini, Malawi, Angola and DRC where abortion is only available in extremely limited circumstances, to Madagascar, where abortion is totally outlawed. Penalties vary. In four countries (Zambia, Botswana, Tanzania and Malawi) the penalties apply to both those who have an abortion and those who aid the process. Penalties range from three years in prison (or fine) to life imprisonment.

[19] Ngwena, C. E Brookman-Amissah, P. Skuster, "Human rights advances in women's reproductive health in Africa". International Journal of Gynecology and Obstetrics 129 (2015) 184-187

[20] https://au.int/en/newsevents/20180129/high-level-consultation-ratification-maputo-protocolhttps://www.howtouseabortionpill.org/blog/maputo-protocol-DRC-howtouse/ http://www.achpr.org/instruments/women-protocol/#14 https://reproductiverights.org/worldabortionlaws https://www.ipas.org/news/2018/July/legal-access-to-abortion-expands-in-democratic-republic-of-congo

Table 4.4: Legal provisions regarding abortion in SADC[21]

Country	Law	Abortion on demand (yes/no)	Conditions under which an abortion may be granted			Childs life	Time frame	Consent	Penalties
			Rape/incest	Mothers life	Mothers Mental state				
ABORTION AVAILABLE ON DEMAND									
South Africa	Choice on Termination of Pregnancy Amendment Act No. 1 of 2008[22]	Yes - specifies available to any woman who wants to terminate out of choice, including counselling					Within the first trimester	Right to terminate without consent of other parties apart from medical practitioners	No punishment as abortion is legal
Mozambique	Amended Penal Code	Yes					On demand up to 12 weeks; incest, up to 16 weeks; foetal anomalies, up to 24 weeks	A certified practitioner must perform the termination at designated facilities[23]	No punishment - abortion is legal
ABORTION AVAILABLE IN CERTAIN CIRCUMSTANCES									
Zimbabwe	Termination of Pregnancy Act of 1977, Chapter 15: 10[24]	No	If conception is deemed unlawful (instances of rape)	Only under circumstances where the life of the mother is in danger		Where the child will suffer from complications after birth		A magistrate must grant permission	Five years in prison and or fine not exceeding $5000
Zambia	Termination of Pregnancy Act, 13 October 1972 Amended 2005 (ToP)	No		If the pregnancy will cause death	Mental or physical damage to the woman.	Child at risk of mental and physical deformities		Once three medical practitioners have agreed	7 years for person who administers; 7 years for woman who administers own abortion
Botswana	Penal Code (Amendment) Act, 1991 - Section 160	No	Rape or incest	If the mother's life is at risk or may cause harm to her mentally	✓	If the unborn child will suffer or later develop physical or mental abnormality	Termination has to be performed before 16 weeks[25]		3 years for procurement; 7 years for aiding

[21] This table is reproduced from Gender Links 2019 Abortion Fact Sheet
[22] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[23] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[24] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[25] http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions/ https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm http://www.wipo.int/wipolex/en/text.jsp?file_id=238601

Lesotho	The Penal Code (2012)[26]	No	If pregnant due to incest or rape	To save the life of a pregnant woman		To prevent the birth of a child who will be seriously physically or mentally handicapped		Performed by a registered medical professional, with the written opinion of another registered medical professional	A fine of M5000-M10000 or imprisonment of up to three years
Mauritius	Penal Code 1983 Criminal Code Amendment Act 2012[27]			To save the life of a pregnant woman; or from permanent physical damage		If the foetus may suffer severe malformation or abnormalities	The pregnancy is within 14 weeks and the girl is younger than the age of 16		Imprisonment of up to ten years
Namibia	Abortion and Sterilization Act 2 of 1975	No	Where two other medical practitioners confirm that the woman has been raped or is a victim of incest	The pregnancy poses a threat to the physical and mental health of the pregnant	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[28]	The unborn child is at risk of a serious mental or physical deformity and handicap		Two medical practitioners must approve in writing that the pregnancy is a risk	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	No		When a woman's life is deemed to be in danger or if the cost of carrying the foetus is greater than the pregnant woman's physical and mental health		Termination can be carried out if the child is at risk of serious mental and physical deformities[29]		If three medical practitioners agree in good faith, termination can be undertaken at Victoria Hospital, Mahe	Imprisonment of 3-14 years
Tanzania	Penal Code 1981[30]			Woman is at risk of death, pregnancy threatens the mental and physical wellbeing of the woman	Pregnancy threatens the mental and physical wellbeing of the pregnant woman				7 years for procurement; 3 years for suppliers

[26] https://lesotholii.org/ls/legislation/num-act/6
[27] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[28] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[29] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[30] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf

ESwatini	The Constitution			Only possible where the life of the pregnant woman is in danger[31]					Life imprisonment
Malawi	Penal Code and The Law Commission of Malawi has drafted the Termination of Pregnancy Bill to legalise safe abortion in the event of incest, rape or severe foetal abnormalities[32]	No		Currently, Malawi only allows abortion to save a woman's life					14 years for having an abortion; 3 years for supplying instruments to conduct an abortion
Angola	Penal Code 2017[33]			Termination only permissible to save the life of a woman					4-10 years' imprisonment
DRC	Penal Code 2004			Abortion is illegal except in cases where a woman's life is in danger[34]					5-15 years' imprisonment
Madagascar	Reproductive Health and Family Planning Law 2017		Abortion under any circumstance remains illegal	In Criminal Procedure law, an abortion can be performed to save the life of a woman					Not explicit, but death, forced labour or life are most severe punishment

Source: Gender Links, with data from UNAIDS 2019.

[31] http://srhr.org/abortion-policies/country/swaziland/
[32] http://www.satregional.org/wp-content/uploads/2018/05/Age-of-consent-Malawi.pdf
[33] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf
[34] https://www.google.co.za/#safe=off&q=abortion+bill+1991+democratic+republic+of+Congo (UN Publication)



South Africa: Why the backstreet abortions?[35]

An estimated 260,000 abortions take place in South Africa yearly. In a country where this is legal, more than half of these abortions are illegal. There has, however, been over 90% decline in abortion- related mortality in South Africa between 1994 and 1998 - 2001.[36]

One factor that contributes to the high level of illegal abortions is poor or no access to services. In 2017, Amnesty International found that less than 7% of South Africa's 3,880 public health care facilities actually perform pregnancy terminations.

Knowledge plays a vital role in women's access to safe abortion, simply because women need to know where to access a safe abortion up to 12 weeks. Many women remain uneducated on abortion. What are easily accessible however are the innumerable flyers offering back-door abortion. Many women are also unable to tell the difference between a safe and unsafe abortion provider. These can be seen advertised on every street corner in many towns and cities. When women do have information, they have to travel far and wide to seek a legal abortion from their remote areas or areas where their local clinics do not offer termination.

Furthermore, the majority of those needing the services are young women between the ages



15 to 19[37]: mostly school going girls who do not have access to youth friendly facilities that would afford them a safe abortion.

Even with the progressive law, there is still stigma, taboo and myth surrounding the topic of abortion. Stories of spiritual punishment are told to girls in numerous communities, to deter them from having sex, and in the event that they fall pregnant, to deter them from terminating. Refusal by health care professionals is unregulated in South Africa and therefore a choice based on cultural, religious or moral grounds, which further jeopardises the chances of girls and women accessing the termination they opt for. Health care professionals who offer services in their areas therefore face the reality of becoming overwhelmed with the number of patients that need to acquire an abortion. Although the South African Constitution guarantees the right to freedom of conscience,[38] this applies only to the direct provision of services, and not to pre - or post-abortion care. It also does not apply in circumstances where a woman's life or health is at immediate risk.

The many gaps around abortion in South Africa sparked the *#My Body, My Choice* campaign led by Global Health Strategies in which the SADC Gender Protocol Alliance is a partner. The first march took place on September 28, 2018 on the Global Day of Action for Safe and Legal abortion. The campaign has surfaced devastating stories of women turned away to rethink getting an abortion even where the pregnancy is a result of rape. The *My Body, My Choice* campaign aims to inform and educate by "providing values clarification and training to all healthcare providers to help them critically reflect on and challenge their deeply-held beliefs and attitudes regarding abortion."

Source: Amnesty International, 2018

[35] Shaha et al Op Cit
[36] Shaha et al Op Cit
[37] https://www.who.int/gho/women_and_health/diseases_risk_factors/situation_trends_unsafe_abortion/en/
[38] Abortion Fact Sheet My Body, My Choice: https://www.mybodymychoicesouthafrica.org/

Mozambique amended the Penal Code decriminalising abortion in 2015 as part of a comprehensive review of the code. Women can now terminate their pregnancies during the first 12 weeks, except in the case of rape, which would extend the legal period to 16 weeks. The amended law also stipulates that abortions would have to be carried out in approved health centres by qualified practitioners. Abortion is available as a free service.

Women over the age of 16 provide consent for themselves. Anyone below the age of 16 requires consent from someone over 21 (age of majority in Mozambique) to have an abortion. The person may be a parent or trusted adult. There is a 48-hour waiting period before a woman receives an abortion. The 2015 Penal Code criminalises unsafe abortion. The Code stipulates that the provider, person requesting and anyone forcing the person to do an unsafe abortion will be prosecuted.

A small qualitative study with women aged 15 - 24 who had accessed abortion in Mozambique (Maputo and Quelimane) found poor knowledge of the law on abortion as well as poor access to safe abortion in health facilities. Factors which influenced the decision to have an abortion included partner rejecting responsibility, parental refusal to help with the child, wanting to pursue studies, poverty and inability to care for a child. Young women had little autonomy in the decision to have the abortion or the decision on what form of abortion to have. They had little counselling and poor support in accessing post abortion contraception. Consequently, some of the 14 participants in the study had had more than one abortion.[39] Uptake by health providers and women and girls themselves is minimal. Reassurance, training, trust and action are needed in a country where abortion has been illegal for longer than it has been legal.

The lack of information and awareness raising has resulted in a lack of uptake of the service. Boane Health Centre, sees about 20 patients per month who are admitted after unsafe abortions. Nurses are refusing to do abortions on religious or cultural grounds. If this occurs the nurse is moved to her another department because the Ministry is upholding the right to freedom of choice and association. This is creating shortages in the number of health professional available to do abortions in health centres.

The health centres are currently not administratively equipped to do abortions. There are no consent forms. Nurses write a form of words on a piece of paper that the patient signs. This is a legal risk and requires an urgent intervention. This links with issues confidentiality. The better resourced health centres have stand-alone facilities that guarantee confidentiality. Others require patients to come through a common reception making them vulnerable to identification.

Lack of knowledge of the law impacts women's access to safe abortion

[39] Frederico, M. K Michielsen , C Arnaldo P Decat "Factors Influencing Abortion Decision-Making Processes among Young Women", Int. J. Environ. Res. Public Health 2018, 15, 329

Advancing Abortion Rights[40]

By Rita Badiani


Rita Badiani

As the country representative for Pathfinder in Mozambique, I know first-hand how challenging it can be to advance abortion access and rights in settings with restrictive laws. Until 2014, abortion was permitted in Mozambique only to save the life of the woman and to preserve her physical health (and even those criteria were not widely known or acknowledged by civil society or most in positions of authority).

Recognising the shortcomings of this law, in 2011, we formed a coalition with other likeminded organisations to advocate for broader abortion rights. Pathfinder firmly believes that a woman's right to terminate a pregnancy is fundamental to her right to choose whether and when to have a child.

To achieve this goal, the coalition developed a strategy that spanned several fronts. We held awareness raising and opinion-changing events with government bodies, we developed and submitted inputs to parliament for a revised penal code, and we implemented a comprehensive media engagement strategy that recruited and trained journalists in sexual and reproductive health and rights.

A revised penal code with a less restrictive abortion law was approved and signed into law in 2014. Efforts from various stakeholders in the country including many civil society stakeholders, as well as the Ministries of Finance, Education, Planning, Youth, Gender and Health are underway to raise awareness of the provisions of the Protocol. This needs to continue, and intensify, to save lives of women and improve the choices women can make. The Coalition for Sexual and Reproductive Rights which mounted a sustained campaign to review the Penal Code and decriminalise abortion from 2011 continues the advocacy for access.

Source: Pathfinder, 2016

In **Lesotho**, government acknowledges the devastating effects of unsafe abortions on girls and women. Rather than make safe abortions available, women are often advised 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."

[40] https://www.pathfinder.org/advancing-abortion-rights-lessons-from-mozambique/



Lesotho: Unsafe abortion next door to a country with safe abortion laws[41]

"I woke up this morning and a nurse told me that I have been I a coma since I came in," says Ntsoaki* from her bed in Lesotho's only referral hospital. "I don't know where I will go when I leave the hospital. I do not have money to pay and I do not have any clothes with me. I was not trying to abort the baby, I was trying to commit suicide using rat poison because my boyfriend did not want the baby and my mother said she could not support us. Unfortunately for me I survived and only my baby died."

In September 2018 Lesotho Minister of Health Nkaku Kabi announced that the hospital is bursting at the seams with 15 young women admitted each week following abortion complications. According to the World Health Organisation (WHO), 35 out of 1000 pregnancies in Southern Africa end in abortions; one of the highest rates in the world. Almost all of these are backstreet. Abortion is the third highest cause of already high rates of maternal mortality. Yet, according to WHO, safe abortion is one of the simplest and most effective procedures to administer.

South Africa and Mozambique are the only Southern African Development Community (SADC) countries in which abortion is available on demand. Madagascar outlaws abortion under all circumstances.



Looking for SRHR solutions in Lesotho. Photo: Ntolo Lekau

In the other 13 SADC countries, abortion is only legal in limited circumstances including rape, incest, or danger to the life of the mother or child. In Namibia, which generally has a strong human rights record, the pre-independence Abortion and Sterilization Act 2 of 1975 (still in place) gives as one of the few grounds for abortion "if a woman has been deemed to be an idiot or an imbecile... which makes sex with her illegal." Zimbabwe has a policy on post abortion care even though abortion is illegal: a de facto recognition of the reality on the ground.

Explaining why she sought an abortion despite it being illegal in Lesotho, Matumelo*, 23, says: "I already know that the police are going to arrest me as soon as I leave the hospital. The reason I underwent a backstreet abortion using pills I got from a Facebook acquaintance is because when I told my boyfriend of six years that I was pregnant, he told me he does not want the baby as my pregnancy will negatively affect his family. I never knew that he had a wife and children. As such I could not raise a child alone as I am not working."

Itumeleng*, a 15 year old rape victim, should have been able to have a safe abortion in Lesotho based on her circumstances, but the system failed her. "My case was referred to the children's court where the magistrate ordered some tests to be done on me," she recalls. "All the other tests came back negative except for the pregnancy test that indicated that I was six weeks pregnant. The magistrate gave an order for a termination of such pregnancy. At the hospital where I was supposed to be assisted with the abortion as dictated by the Penal Code, I was thrown from pillar to post. At one time I was told the order should not be hand written but typed. When I came back with a typed order I was told the stamp was too vague. When that was corrected, I was told the signature did not

[41] https://mg.co.za/article/2018-09-28-00-abortion-sa-must-speak-up

seem legitimate. This continued until I was six months pregnant and was no longer eligible for abortion. Today I have to raise a child I did not choose to have. I am raising a child when I am also a child myself. If abortion were legal in Lesotho, I would not have suffered like this." Rather than fix the system and change the laws, Lesotho officials are known to surreptitiously advise women to go across the border for safe abortions in South Africa. Few women can afford that; South Africa is not coping; and exporting the problem sidesteps the central issue of the right of women to make choices about their bodies and lives, not only when they are violated, but always. Lesotho, a deeply Catholic country, could learn from the recent referendum on abortion in that most Catholic of countries - Ireland - that resoundingly put rights above religion or morality.

South Africa needs to learn that choice without the services to make the choices is a violation of the Constitution. And rather than become a place of refuge for women seeking abortion from the region, South Africa has a duty to speak up and speak out for women's rights, at home and in the region.

*Pseudonyms have been used for survivors of abortion to protect their identity.
Source: Colleen Lowe Morna and Manteboleng Mabetha, Gender Links News Service, 2019

The most common circumstances in which abortion is provided for are incest and rape; related to that, threat to the mother's life and 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.



Zimbabwe: Stepping up campaign for access to safe abortion services[42]

Abortion in Zimbabwe has been taboo due to social stigma and the restrictive law governing provision of safe abortion services. Research done in 2016 revealed that 66,800 abortions took place in Zimbabwe.

Zimbabwean legislation on abortion is restrictive. Abortion is allowed when the continuation of pregnancy endangers the life of the woman, cases where the foetus was conceived as a result of unlawful intercourse, including rape, incest. Obtaining a legal abortion is a long and fraught process in Zimbabwe. If a woman is raped, she must obtain a certificate to terminate from a magistrate in that area. Communities and health workers are not aware of this law.

Abortion contributes to high maternal mortality rate in Zimbabwe. Furthermore, getting a legal abortion in Zimbabwe is a costly process which requires one to go through several medical examinations and approvals by physicians.

The Women's Action Group (WAG) implemented a project whose ultimate goal is to empower women and girls to utilise the law for access to safe abortion services without stigma, to reduce unsafe abortion related deaths and morbidity in Zimbabwe. The project sought to raise awareness on the Termination of Pregnancy Act (1977) through community dialogues. A national survey on abortion attitudes, knowledge and practice was conducted. A coalition of all organi-

[42] https://genderlinks.org.za/casestudies/zimbabwe-stepping-up-campaign-for-access-to-safe-abortion-services/

sations working on abortion was formed and meets twice a year. Dialogues with Parliamentarians were conducted. Health workers have been trained on the TOP Act and post abortion care. These strategies were used to reduce abortion stigma, as well as bring the issue for discussion at policy level. Awareness on the fact that abortion is already allowed by law in specific circumstances was raised.

The initial activity was a survey to understand attitudes on stigma and practices on abortion. Community dialogues on abortion were held targeting women and traditional leaders. Values clarification exercises were used. Discussions focused on the current situation with regards to abortion, myths about abortion, abortion stigma and the current shortcomings of the law. The broad aim was to address negative attitudes and stigma related to abortion.

Positive media attention has been received on abortion through Radio programmes and print media. This was done to bring visibility to abortion as a reproductive justice issue in Zimbabwe and influencing public and decision-making opinion. WAG has also made presentations on abortion at regional and international conferences.

WAG has partnered with Population Reference Bureau (PRB) to develop a multimedia communication tool that will be used by the abortion coalition for advocacy. Another approach is sensitization of members of parliament on the impact of unsafe abortion and how this is contributing to maternal mortality in Zimbabwe. WAG offered psychosocial support and financial support for those who require legal termination after unlawful sexual intercourse.



Zimbabwe SRHR Strategy workshop led by the Women's Action Group.
Photo: Tapiwa Zvaraya

WAG partnered with several organisations. Some members of the Women's Coalition are part of the abortion Coalition. Ministry of Health and Child Care have assisted with information on the situation in the health institutions. Health workers are feeding in information on the challenges faced by women and girls as they try to access abortion services. The Swedish Embassy has also provided space and some technical expertise to the group that meets at the embassy. Zimbabwe Women Lawyers Association has continued to offer technical expertise in the analysis of the law and identifying gaps.

Research institutions such as Guttmacher Institute have provided data on abortion incidence and morbidity in Zimbabwe. WAG has started lobbying parliamentarians so that they support access to safe abortion. Lobbying has included supporting members of parliament to support the SADC sexual and reproductive health strategy which has access to safe abortion as one of the indicators.

Source: Ednah Masiyiwa, Women's Action Group, SADC Protocol@Work case study

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.

Unsafe abortion

Overall, the legal frameworks for abortion in Africa are unaccepting, which drives the majority of abortions to unsafe methods and providers. Of all abortions:

- An estimated 55% are safe (i.e., done using a recommended method and by an appropriately trained provider);
- 31% are less safe (meet either method or provider criterion, or done using outdated methods like sharp curettage even if the provider is trained, or if women using tablets do not have access to proper information or to a trained person if they need help)
- 14% are least safe (neither a recommended method nor a trained provider, or when they involve ingestion of caustic substances or untrained persons use dangerous methods such as insertion of foreign bodies, or use of traditional concoctions).

This is a staggering 25 million unsafe abortions globally, of which 8 million are least safe, every year.[43] It is estimated that 3 of every 4 abortions in Africa were unsafe. In 2008, 51% of all unsafe abortions in Africa were among young women aged 15-24 years. The more restrictive the legal setting, the higher the proportion of abortions that are least safe- ranging from less than 1% in the least-restrictive countries to 31% in the most-restrictive countries. The report for ICPD beyond 2014 found that, while unsafe abortion rate declined between 1990 and 2008 in all regions, it remained constant in Africa at a rate of 28 per 1000 women in reproductive age 15-44 years.

In developing countries where unsafe abortion is prevalent, up to 40% of women who have an abortion develop complications. Complications of unsafe abortion include haemorrhage, infection, peritonitis, and trauma to the cervix, vagina, uterus (including perforation), and abdominal organs. Some of the least safe methods of abortion include inserting dangerous objects such as knitting needles, or even glass, into the vagina. Worldwide, unsafe abortion mortality is the third major cause of maternal death after haemorrhage and sepsis in childbirth.

The risk of death as a result of an abortion is highest in Africa

The burden of mortality from unsafe abortion is much higher in Africa than in other parts of the world. It is estimated that there are 30 deaths for each 100 000 unsafe abortions in developed regions, 220 deaths per 100 000 unsafe abortions in all developing regions, but 520 deaths per 100 000 unsafe abortions in Sub Saharan Africa. Africa accounts for 29% of global unsafe abortion

[43] WHO. 2018. Preventing unsafe abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion. Accessed 10 June, 2019.

but suffers 62% of unsafe abortion related mortality.[44]

According to the SAFAIDS Situation Analysis[45], there are five barriers that inhibit access to safe abortions:

- ***Policy and legislative restrictions*** that prevent women from accessing abortion, even in cases where they want to abortion. In the case of countries which have legalized or made concessions for circumstances that may lead to abortion, or make an abortion acceptable, uptake by service providers is often slow.
- ***Lack of information and knowledge:*** The Analysis has found that in countries where abortion is less restrictive, information does not reach those who could legally access abortions. In addition to this, healthcare providers do not always know when they are legally permitted to administer an abortion.
- ***Health workers are sometimes judgmental and negative*** regarding abortion, they are reported to refuse to administer abortions. In some rural areas health workers have even been reported to violate privacy of patients. This leads to restrictions of access to abortion, especially for adolescent girls and young women.
- ***A prevalent view that "Abortion is sin".*** This means that conversations about abortion are in many cases completely out of bounds, let alone even considering or administering one.
- ***Gender norms in SADC*** are restrictive, which results in women being marginalized. This marginalization further means that men are in control of women's bodies. Abortion is seen as a threat to men's power, and therefore, abortion is restricted.

The SADC SRHR Strategy reports that deaths related to unsafe abortion contribute significantly to maternal mortality in SADC. The highest abortion-related deaths globally are in Africa, where an estimated 3.9 million unsafe abortions take place annually among girls aged 15-19 years, leading to death and enduring health problems. 24 per cent all pregnancies in Southern Africa end in abortion. In Botswana, complications relating to post-abortion care were the third leading cause of maternal deaths.[46]

There are safer methods of abortion, such as manual vacuum aspiration and medical abortion consisting of mifepristone and misoprostol, which are both on the WHO essential medicines list which are being used even for illegal abortions. Misoprostol is widely available and inexpensive but only results in a complete first trimester abortion 75-90% of the time if used correctly. When combined with mifepristone, which is less widely available and more expensive effectiveness for complete abortion at nine weeks of pregnancy is between 95-98% when used correctly.[47]

Further, 140 countries have approved emergency contraception. This has resulted in lower morbidity, disability and mortality from unsafe abortions. The number of deaths globally due to unsafe abortion declined from 69 000 in 1990 to 47 000 in 2008; which is an annual decline in unsafe abortion-related mortality ratio of 1% in Africa, 4% in Asia and over 6% in Latin America. The case-fatality rate of unsafe abortion declined globally at about 3% annually.

However, mortality due to unsafe abortions in developing countries is still much higher than mortality as a result of safe abortions in developed countries. The risk of death as a result of an abortion is highest in Africa. Sub Saharan Africa accounted for 61% of all deaths resulting from unsafe abortions in 2008, with a case fatality rate of 520 per 100 000 unsafe abortions.[48]

A USAID funded programme in **Botswana** which sought to support government initiatives to reduce maternal mortality identified the top three causes of maternal mortality as: postpartum haemorrhage, severe pre-eclampsia/eclampsia, and post-abortion complications. The project found the abortion ratio was 209 per 1,000 live births which is higher

[44] https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion, 19 February 2018. Accessed 10 June, 2019
[45] Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey
[46] Melese T, Habte D, Tsima BM, Mogobe KD, Nassali MN (2018) Management of post abortion complications in Botswana -The need for a standardized approach. PLoS ONE 13(2): e0192438. https://doi.org/10.1371/journal.pone.0192438
[47] IPPF. Op cit.
[48] Shaha et al 2014. Op Cit

than the global abortion ratio of 148 per 1000 live births estimated in the World Health Report 2005. This is despite the incidence of abortion being based only on data of complicated abortions that needed medical attention, which is not including abortions that did not receive emergency management. Francistown and Gaborone had the highest levels, with an abortion ratio of 555 and 361 per 1,000 live births respectively.[49]

Madagascar: According to the 2018 Statement of the Minister of Public Health, unsafe abortion induced deaths are the second highest cause of maternal death registered in the health system after complications from antenatal and post-partum haemorrhage. In the same year, studies in hospitals indicated that adolescent girls and young women aged between 15 and 24 years are the most affected by complications from unsafe abortions. A study in 2016 found that though abortion is completely illegal in Madagascar, misoprostol is widely and relatively easily available. However, the dosages and regimens that the 19 women in the study used were extremely variable and none were in accordance with WHO guidelines. This resulted in failed or incomplete abortion, heavy bleeding and even sepsis[50]. None of the women, family members or friends, formal or informal health care providers that were consulted had accurate information which led to many complications.

A study in five major hospitals in **Zambia** in 2008 found that the number of women treated in these hospitals for complications following an unsafe abortion was 85 times more than those that accessed safe abortions at the same hospitals. Those that accessed safe abortions were more likely to be older, with children, while those treated for unsafe abortion complications were younger and less likely to be married. There were high levels of stigma in health providers against adolescents accessing abortion.[51]

The SAfAIDS[52] study found that there are short term, medium term and long term impacts of unsafe abortion:

- Stigma associated with abortion: Women who had an abortion faced stigma from family and friends. This contributed significantly to misinformation surrounding women's sexual and reproductive rights.
- Contribute to high maternal mortality ratios.
- Immediate complications included severe bleeding, uterine perforation, tearing of the cervix, severe damage to the genitals and abdomen, internal infection of the abdomen and blood poisoning.
- Medium-term complications range from reproductive tract infections and pelvic inflammatory disease to chronic pain.
- Long-term complications include increased risks of infertility and ectopic pregnancies, and miscarriages or premature deliveries in subsequent pregnancies.



Promoting SRHR Services through the MobiSAfAIDs Social Accountability Monitoring for young People. Photo: SAFAIDS

The study also found six enabling factors that increase access to safe abortion:

- Human rights protocols such as the Maputo Protocol, are recognized and ratified in the region. Ratifying protocols provides justification to calls for abortion legislation to mirror abortion delivery or services.

[49] Sinvula M, Insua M. 2015. Botswana Maternal Mortality Reduction Initiative. Final Report. Published by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. Bethesda, MD: University Research Co., LLC (URC).
[50] Pourette, D, C. Mattern, R Ratovasan, P. Raharimalala. "Complications with use of misoprostol for abortion in Madagascar: between ease of access and lack of information". Contraception 97, 2. 2018. 116-121. https://doi.org/10.1016/j.contraception.2017.12.005
[51] Likwa RN, Biddlecom AE and Ball H, Unsafe abortion in Zambia, In Brief, New York: Guttmacher Institute, 2009, No. 3.
[52] SAfAIDS, op cit

- Though certain policy makers may be against the notion of abortion, the same policy makers can also be receptive to related issues, such as economic and human costs of post abortion complications and high maternal mortality rates.
- Younger men are less conservative than their older counterparts and their views on abortions are not as restrictive as older men.
- Discussions around abortion increasingly include discourse on the services that are required for survivors of rape resulting from conflict. This has resulted in a moral shift that is opening up discussions to the public.
- As women become more educated on their rights, particularly regarding SRHR, they are able to exercise more agency over their own bodies and their reproductive health rights.
- Countries which have less restrictive abortion laws provide an opportunity for girls and women from bordering countries with restrictive laws to travel across the border to access abortion and post abortion services.

Access to safe abortion services



To increase access to safe abortion the SADC SRHR Strategy encourages Member States to advance the SRHR of adolescents through:

- Ensuring that all adolescents are able to access people-centred integrated SRHR services, including HIV services (testing, counselling, accessing treatment), information, contraceptives, safe abortion, build the capacity of health-care providers to provide services with respect to privacy and confidentiality.
- Engaging with the need for safe abortion services as a human right for women and exploring ways in which the policy and legal environment can protect the health, lives, and rights of women and girls is an important area, while ensuring that policies facilitate the provision of comprehensive post-abortion care in all contexts.
- Improved realisation of quality, comprehensive, integrated SRHR, GBV and HIV and AIDS package that meets the needs of all women, men, adolescents, youth and key populations in SADC.
- Providing safe abortion services and treatment of complications of unsafe abortion.

From a gender perspective, lack of access to safe abortion promotes stigma around abortion. Stigma itself is directly related to gender inequality. In addition, lack of access to safe abortion limits women and girls' reproductive rights, and significantly contributes to maternal mortality in the region. Further, outcome five of the strategy seeks to achieve the reduction in the rates of unplanned pregnancies and unsafe abortions. However, the question that needs to be understood is how is this possible when abortion is illegal in most countries? Legalising abortion is seen as an important step in providing safe and accessible services.

Research has shown that there is much disparity in quality of abortion services, both in countries where abortion is legal and where it is illegal. If a country provides safe abortion services, this is a powerful indicator of relative gender equality. Countries which score highly on the UN Gender and Development Index (GDI) tend to provide

good access to safe abortion services, whereas countries with low GDI scores are likely to have higher levels of abortion-related mortality. However, it is important to note that, once abortion is legal, abortion services need to be provided as part of a quality-assured SRHR package and reviewed regularly from different perspectives (community, client, and health provider), to see how they can be better improved or addressed. A number of civil society organizations are expanding their work to include outreach and advocacy for fewer restrictions to abortion and access to quality services.

SAfAIDS *My Choice, Our Choice* a campaign to End Unsafe Abortion in SADC

The "Transforming Lives" programme will be implemented by SAfAIDS and its partners until 2021, and seeks to influence the policy environment in three important areas of SRHR: sexual gender-based violence (SGBV), adolescent unintended pregnancy, and unsafe abortion. The programme seeks to contribute towards a more conducive policy environment that enables positive SRHR outcomes among adolescent girls and young women. SAfAIDS is following a four-step approach that brings together key stakeholders in the region to plan, analyse data, build consensus and advocate for action.

1. **Evidence-Based Planning:** Outline unsafe abortion problem, agree methodologies for systematically analysing data.
2. **Analysis:** Commission research, compile findings and share with national and regional stakeholders.
3. **Building Concensus:** Convene stakeholders to discuss findings, agree positions, develop action plans and guidelines.
4. **Support Action:** Advocate for policy shift, service delivery and harmonisation; monitor progress.

Access to post abortion care services

Only 7 countries provide post-abortion care

Some countries are beginning to at least make post abortion care available. Post-abortion care which is an important component of comprehensive abortion care is comprised of five essential elements:

- Treatment of incomplete and unsafe abortion as well as complications.
- Counselling to identify and respond to women's emotional and physical health needs.

- Contraceptive and family planning services to help women prevent future unintended pregnancies.
- Reproductive and other health services that are preferably provided on site or via referrals to other accessible facilities.
- Community and service provider partnerships to prevent unintended pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.[53]

Table 4.5: Policies and Guidelines on Post Abortion Care

Country	Policies or Guidelines on Post Abortion Care
Botswana	Comprehensive Post Abortion Care Reference Manual, Ministry of Health; Botswana Essential Drug List 2012; Botswana Sexual and Reproductive Health Policy Guidelines
Malawi	Malawi Standard Treatment Guidelines 2015; Post-Abortion Care Strategy, Ministry of Health
Mozambique	Clinical guidelines on abortion and post abortion care, 2017; Ministerial Decree on abortion, 2017; National Medicines Form 2007
South Africa	Standard Treatment Guidelines and Essential Medicines List for South Africa, May 2017; Regulations related to Choice of Termination of Pregnancy Act; Medicines and Related Substances Control Act No.101 of 1965 as amended by inter alia
Tanzania	Comprehensive Post-Abortion Care Guideline Training Manual 2016; Standard Treatment Guidelines and Essential Medicines List
Zambia	Register of Marketing Authorisations, 2015; Essential Medicines List, 2013; Standard Treatment Guidelines, Essential Medicines List and Essential Laboratory Supplies; Zambia Standards and Guidelines for Comprehensive Abortion Care 2017
Zimbabwe	National Guidelines for Post-Abortion Care May 2018; Essential Medicines List and Standard Treatment Guidelines for Zimbabwe, 2011; Register for Approved Human Medicines, 2015

Source: SAfAIDS. 2019. Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. Final Report.

Post-abortion care is very expensive in the case of unsafe abortions

Table 4.5 outlines the guidelines which are available on post-abortion care. UN human rights standards call on countries to provide immediate and unconditional treatment to anyone seeking emergency medical care. There is an urgent need therefore for all countries to develop PAC guidelines and to offer this service. Post abortion care has a huge burden on the national fiscus. The case study from Zambia estimates that the country is spending up to $1,5 million a year more on treating consequences of unsafe abortion than it would if it were to provide safe abortions to those that need them.

[53] IPPF. Op Cit

The Cost of unsafe abortion to the Zambian health system[54]

A woman should receive post abortion care (PAC) following either a safe or an unsafe abortion In instances in which all the products of a pregnancy have been expelled, such care may be simply a physical check up with counselling for and access to contraception. Where the abortion has been incomplete, PAC ranges from evacuation of the uterus through complicated care for internal damage, haemorrhage, infection and shock.

The Government of Zambia estimated in 2009 that unsafe abortion contributed as much as 30% of maternal mortality. A study conducted in 2015 at the University Teaching Hospital (UTH) in Lusaka, Zambia, compared the costs for providing safe abortion with the costs of PAC from the medical records of 107 women who received either of these between July 2012 and June 2013. UTH is the largest gynaecological and obstetrics training hospital in the country and, thus, the largest provider of both safe abortion and PAC. UTH provided medical abortion using mifepristone and misoprostol from 5 to 9 weeks gestation; and using manual vacuum aspiration (MVA) from 10 to 14 weeks gestation. PAC for induced abortion ranged from treating incomplete abortion to treating life threatening sepsis and shock.

The Government of Zambia estimated in 2009 that unsafe abortion contributed as much as 30% of maternal mortality

Between July 2012 and June 2013 223 safe abortions were performed and 4246 women were treated for PAC, which is not disaggregated according to spontaneous and induced or as a result of a safe abortion. A previous study had found 231 safe abortions and 4794 PAC cases in 2010. The study conducted key informant interviews with key staff from which it was estimated that 50% of PAC cases were for unsafe abortion. Further, it was found that all unsafe abortion cases had incomplete abortion. 18% had sepsis and 3% were treated for shock.

The study found that the total cost of a medical abortion using mifepristone and misoprostol in 2013 at UTH was $33 and using MVA was $39. The cost of treating incomplete abortion was $33. However, the costs for more critical problems rose steeply to $98 for sepsis and $162 for a case of shock. Thus, the average cost for a safe abortion is between $37 and $39. The average cost of treatment for the consequences of an unsafe abortion is $47 to $56. These figures were extrapolated to national costs, using best available estimates of the number of safe and unsafe abortions. These concluded that the annual cost of safe abortion is between $221 000 and $701 000, while the annual cost of PAC for unsafe abortion is between $403 000 and $3.5 million.

The savings if all abortions were safe is therefore between $660,000 and $1.5 million. This is a substantial portion of the Zambia health budget and does not include the costs associated with women's wellbeing which are also significant.

Source: Parmer, D., Leone, T., Coast. E., Murray. S.F., Hukin, E. & Vwalika, Global Public Health, 2015.

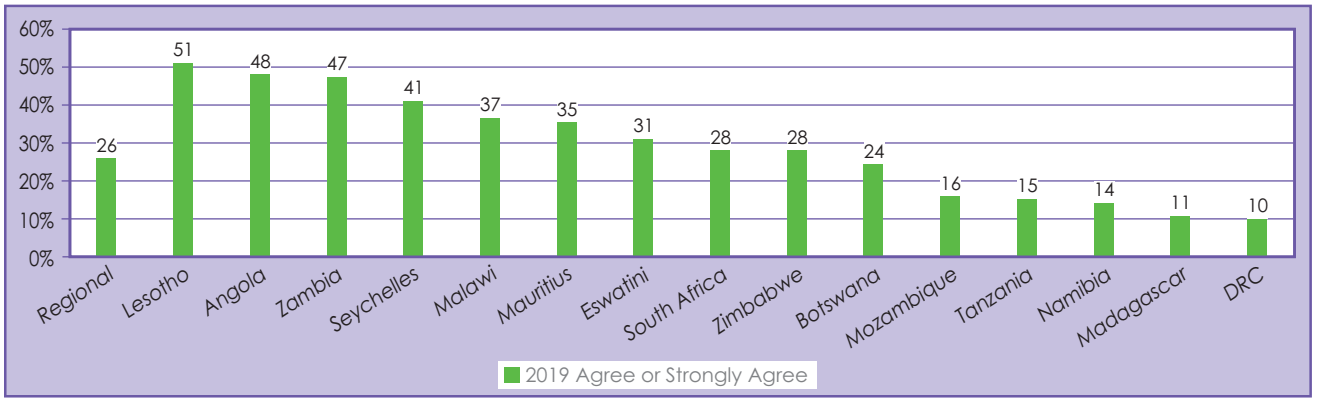
[54] Derived from: Parmer, D, T. Leone, E. Coast. S. Murray. E. Hukin, and B. Vwalika. 2015. Costs of abortion in Zambia: comparison of safe abortion and post abortion care for unsafe abortion. Global Public Health, 10.1080/17441692.2015.1123747.

Public education and awareness

Findings from the Gender Progress Score or attitude survey administered by Alliance partners points to some progress, but still many gaps in advocacy on safe abortion.

There is still too much stigma surrounding abortion

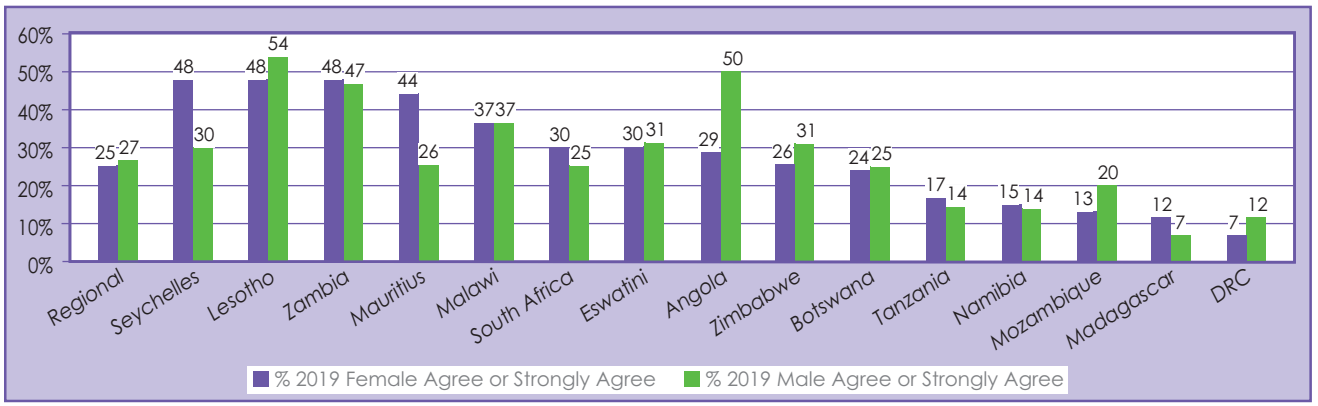
Figure 4.1: A woman should be able to choose to terminate a pregnancy



Source: Gender Links Attitudes survey, 2019.

Figure 4.1 shows that the regional average of those that agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months of the pregnancy is 26%, ranging from upper levels in Lesotho (51%), Angola (48%), Zambia (47%) to lows of 14% in Namibia, 11% in Madagascar and 10% in DRC. This is a strong indication of the high levels of stigma that exist in relation to abortion.

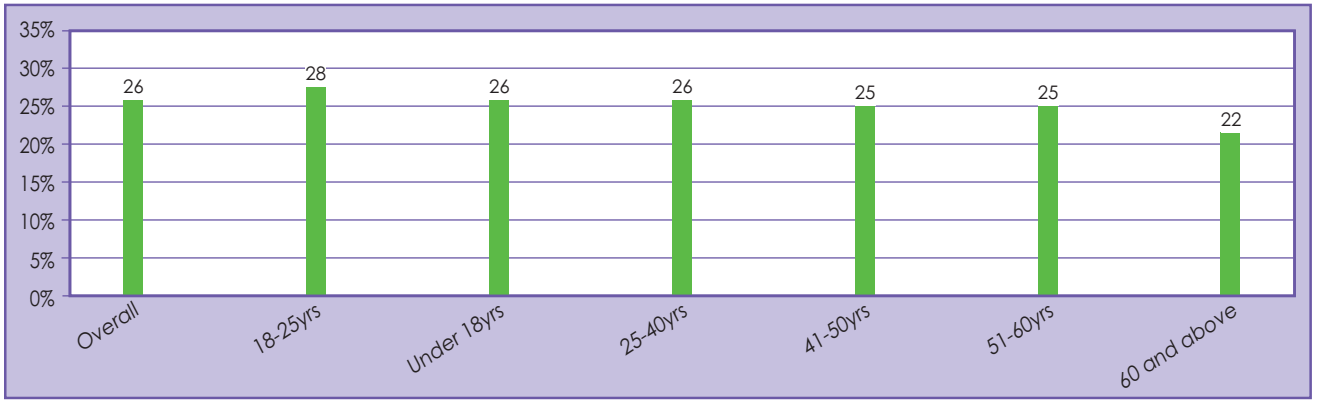
Figure 4.2: Women and men's attitudes on abortion



Source: Gender Links Attitude Survey, 2019.

Figure 4.2 shows the differences in attitudes between men and women in 2019 in relation to the same question. The attitudes of men and women are quite similar in Zambia, Malawi, Eswatini, Botswana and Namibia. Women are much more likely to agree or strongly agree that a woman has a right to terminate a pregnancy in the first three months in Seychelles and to a lesser extent in Tanzania and Madagascar. Interestingly, more men agreed or strongly agreed, particularly in Angola, and to a lesser extent in Lesotho, Zimbabwe, Mozambique and DRC.

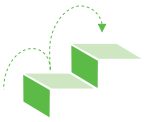
Figure 4.3: Safe Abortion Score 2019



Source: Gender Links Attitudes survey, 2019.

Figure 4.3 shows the difference in responses to this question, disaggregated by age. There is little distinction between age bands with the lowest agreement being in the 60 and over group at 22% and the highest being 18 - 25 year old group at 28%. The table shows that generally across the age groups there are conservative views to the question, "*A woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy*". This is comes through as is evident in all the statistical research in the SADC region, abortion stigma is marred by conservative cultural barriers.





Next steps

Key recommendations and next steps to ensure governments legalise abortion are:

- Governments in SADC need to pay attention to the high levels of unsafe abortion, particularly amongst younger women, including through:
  - Reducing unintended pregnancy and thus the demand for abortion.
  - Reviewing legislation and provision of services to make safe abortions more readily available.
- All SADC Member States, particularly those with low contraceptive rates of less than 50%, Angola (17%), DRC (25%), Comoros (27%), Mozambique (30%), and Tanzania (43%), need to urgently consider making contraception accessible to all women of reproductive age, and particularly those that are not usually reached such as younger women, sex workers, women living with disability and women in rural areas. This would reduce unintended pregnancies and the subsequent backyard abortions.
- All SADC Member States should prioritise comprehensive sexuality education for all adolescents to reduce early and unintended pregnancy.
- All SADC Member States should consider making conditions for accessing safe medical abortion easier by relaxing the required number of doctors from 3 to 1 when trying to access safe abortion and ensuring that women who report having been raped have access safe abortion without the difficulty of proving the rape.
- SADC Member States should consider harmonising the legal ages of sexual consent with the legal ages of access to contraceptives to reduce rates of unwanted pregnancies.
- To save lives, all SADC Member States should provide post-abortion care to all women with abortion complications.
- All SADC Member States should increase the number of health facilities that offer Safe Abortion facilities including building the capacity of health personnel to change attitudes to women seeking safe abortion services.
- There is an urgent need for much better data to inform decision making on the emotive issue of abortion. The data needs include: access to contraception by all who need it (not only women and men in marriage), rate of legal abortions performed, demand for abortion and reason for the demand; rate of illegal abortions performed; rate of unsafe abortions.

HIV and AIDS 5



Men and boys during Sixteen Days of Activisim walk in Botswana. Photo: Gomolemo Rasesigo

KEY POINTS

- Southern Africa is the epicentre of the HIV and AIDS pandemic globally. This varies considerably across the region. Four countries have a prevalence rate of 20% and above; four 10% and above and seven below ten percent.
- In 2019, 54% of all new infections globally were among key populations - sex workers, people who use drugs, gay men, and men who have sex with men, transgender people and prisoners and their partners. In Southern Africa, where the pandemic is largely heterosexually driven, these categories accounted for 25% of the total.
- Women, and especially young women, comprise the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.
- Three SADC countries have achieved the UNAIDS 90-90-90 targets (percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression). Seven countries have achieved two targets. Three countries have not met any of the three targets.
- Overall, the region has met 25 of the 45 targets (15 countries x three targets each). This means overall progress in achieving HIV and AIDS targets is 56%.
- A total of 26,247 people accessed Pre exposure Prophylaxis or PrEP in 2018. An important application of this prevention strategy is in cases of sexual violence.
- In 2018, ARVs averted 682,000 deaths in Southern Africa, 330,000 of these in South Africa.
- Evidence from South Africa suggests that drug resistance is a threat to the expanded treatment programme. This requires vigilance from all.
- The AU is calling for two million more community health workers and for governments to ensure that they receive training, psychosocial support, remuneration and materials.

Introduction

"We have the knowledge and tools to end AIDS. We cannot change the virus, but we can change inequalities, power imbalances, marginalization, taboos, stigma and discrimination. We can change behaviours and societies"

Gunilla Carlsson, UNAIDS Executive Director, Global Aids Update 2019

SADC is the epicentre of the HIV epidemic. It is the only region in the world where HIV prevalence rates are above 10%. The global average prevalence is only 0.8% and most regions of the world have prevalence below 1%. Four SADC nations (Eswatini, Lesotho, South Africa and Botswana) have prevalence above 20%; four more between 10 and 20% (Zimbabwe, Mozambique, Namibia and Zambia). Southern Africa is home to 54% of the world's people living with HIV.

Globally, there have been many twists and turns in the HIV saga over the last four decades. HIV flourishes in conditions of secrecy, prejudice, stigma, discrimination and shame. It is enhanced by poverty, migration, mismanagement of resources, weak health systems, insufficient political will and support. The latest UNAIDS report states that: "Gains continue to be made against HIV, especially in testing and treatment. Nearly four in five people living with HIV globally knew their serostatus in 2018; almost two thirds of all people living with HIV in 2018 were receiving life-saving antiretroviral therapy, and more than half had suppressed anti-viral loads."[1]

The report notes that in sub-Saharan Africa, condom use has increased, and countries are gradually adopting pre-exposure prophylaxis (PrEP) as an additional HIV prevention option. It also notes that there has been remarkable progress towards the 2020 target of voluntary medical male circumcision (VMMC). AIDS-related mortality in Southern Africa has declined by 44% from 2010 to 2018.[2]

The most marked gains in the last fifteen years are in relation to expanded access to treatment. South Africa's President Cyril Ramaphosa has committed to expanding HIV treatment to an additional two million people by 2020. With 4.5 million people on treatment South Africa is already treating 20% of the global total of people on HIV therapy. The Cheka Impilo programme was launched on World AIDS Day 2018 as a multi-disease national wellness campaign to screen and test for HIV, TB, sexually transmitted infections and non-communicable diseases, including hypertension and diabetes[3].

There are huge costs in maintaining such large treatment programmes. Much of the cost is subsidised by international donors. The ever present possibility of drug resistance means that investment is continuously required in developing new and more effective drugs. Furthermore, the UNAIDS report cautions against complacency, noting that many countries and regions (including Southern Africa) have not reached the targets in the UN General Assembly 2016 Political Declaration on Ending AIDS.[4]

1 "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p3
2 Ibid
3 https://www.unaids.org/en/resources/presscentre/featurestories/2018/december/south-africa-access-hiv-treatment
4 Ibid

In 2014 UNAIDS called on the global community to set ambitious targets for the post 2015 period that would lead to an end of AIDS by 2030. This resulted in the ambitious 90 - 90 - 90 targets which were endorsed by the 2016 high level meeting. The vision of the strategy is **Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths**. The strategy has three overall strategic directions:

- HIV prevention.
- Treatment, care and support.
- Human rights and gender equality for the HIV AND AIDS response.



The ten targets of the five-year plan include:

1. 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads;
2. Zero new HIV infections among children, and mothers are alive and well;
3. 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV;
4. 90% of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services;
5. 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men;
6. 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services;
7. 90% of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV;
8. 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings;
9. Overall financial investments for the AIDS response in low- and middle-income countries reach at least US$ 30 billion, with continued increase from the current levels of domestic public sources;
10. 75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection.

South Africa has the largest HIV Treatment Programme in the world

The SDGs do not place as much emphasis on HIV as the MDGs did but do include target 3.3: "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases." Ending AIDS as a Public health threat will contribute to good health (SDG 3); reduce inequalities (SDG 10); the achievement of gender equality (SDG 5); promotion of just and inclusive societies (SDG 16). Ending HIV and AIDS is closely linked to revitalised global partnerships (SDG 17), ending poverty (SDG 1) and ensuring quality education (SDG 4).

Table 5.1: Key HIV data 2019

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV and AIDS Prevalence															
Overall prevalence (%)	2	20	0.8	27	23.6	0.3	9.2	1.3	12.6	11.8		20.4	4.6	11.3	12.7
Women who are HIV positive as a % of total	59	55	59	58	59	46	59	28	58	60	42	60	61	52	58
Women aged 15 to 49 HIV prevalence rate	2.7	24.6	1.1	34.8	28.8	0.2	11.1	0.9	15.1	14.1		25.8	5.7	13.8	15.4
Men aged 15 to 49 HIV prevalence rate	1.2	16.2	0.4	19.2	18.5	0.4	7.3	1.8	10	9.3		15	3.5	8.8	10
HIV prevalence among young women (15-24)	1.2	8.9	0.5	15.9	10.8	0.1	4.3	0.2	3	4.5		11.3	2.2	4.9	5.5
HIV prevalence among young men (15-24)	0.3	4.9	0.2	3.1	4.1	0.2	2	0.2	3	2.6		3.7	1.2	2.4	3.1
Sex workers															
HIV prevalence (%)	8	42.2	5.7	60.5	71.9	5.5	55	15		40.7	4.6	57.7	15.4	48.8	41.4
Condom use (%)	71.7	75.7	69	82.9	62.3	62.8	65	67.2			16	86.1	70	78.5	96.1
Men who have sex with men															
HIV prevalence (%)	2	14.8	3.3	12.6	32.9	14.9	7	17.2			13.2	18.1	8.4		31
Condom use (%)	59.1	77.5	77.4		46.4	57.2	44	53.1				97.9	13.9		
Prevention															
Proportion of people age 15+ who know their HIV status															
Women age 15+ who know their HIV status	47	95	64	93	89	21	94	19	80	95		93	82	88	94
Men age 15+ who know their HIV status	44	89	79	93	82	7	89	23	61	87		88	73	87	86
Condom use at last high risk sex															
Condom use at last high risk sex - women	32	N/A	23	54	76	5	50	N/A	42	66		61	30	41	67
Condom use at last high risk sex - men	63	N/A	32	67	77	13	76	N/A	47	80		73	47	56	85
Elimination of mother-to-child transmission															
Coverage of pregnant women who receive ARV for PMTCT (%)	38	95	44	79	77	25	95	95	95	95		87	93	95	94
Mother to child transmission rate	27.8	2.5	27	7.8	12.7	39.8	7.8	13.7	15	3.9		4.9	10.5	11.2	7.6
Knowledge															
Comprehensive knowledge of HIV and AIDS	32	47	20	50	36	24	42	32	31	58		46	43	44	46
Knowledge about HIV prevention among young women aged 15-24	32.5	47.4	18.6	49.1	37.6	22.9	41.1	4.4	30.8	61.6		46.1	40.1	41.5	46.3
Knowledge about HIV prevention among young men aged 15-24	31.6	47.1	24.9	50.9	30.9	25.5	44.3	30	30.2	51.1		45.6	46.7	46.7	46.6
Attitudes															
% of women who say a woman has the right to insist on a man using a condom	55%	26%	11%	53%	61%	67%	58%	36%	17%	18%	50%	50%	63%	60%	59%
Treatment - Antiretroviral therapy (ART)															
% of those living with AIDS who are on ARV treatment	27	83	57	86	61	9	78	22	56	92		62	71	78	88
Women aged 15 and over receiving ART	59	95	91	95	73	75	92	95	79	95		71	95	95	95
Men aged 15 and over receiving ART	32	80	93	85	66	95	76	95	69	88		63	77	79	95
Children aged 0 to 14 receiving ART	13	38	25	76	70	5	61	45	60	78		62	72	78	76

Source: UNAIDS Data 2019 except for Attitudes which comes from the GL Gender Progress Score (GPS).

Table 5.1 shows that:

- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.
- Women are much more likely than men to be aware of their HIV status.
- Prevention of Mother to Child Transmission (PMTCT) is high but still lacking in poor, post conflict countries such as Angola and DRC, and is not a priority in the islands, since this is not a primary means of transmission.

- The response among women to the question "a woman has the right to insist on a man using a condom" varies widely, from 11% in DRC to 67% in Madagascar.
- Coverage of adults and children receiving Antiretroviral Therapy has improved dramatically, but ranges from 9% in Madagascar to 92% in Namibia. In all SADC countries (except the islands) women are more likely than men to be on ART.

Table 5.2: Progress towards achieving the 90-90-90 in SADC

Country	Status first 90	Status second 90	Status third 90	Achieved all three 90s	Total	%
	% people living with HIV who know their status	% people who know their status on ART	% people on ART who achieve viral suppression			
Botswana	91	92	95	1	3	100%
Eswatini	92	93	95	1	3	100%
Namibia	91	95	95	1	3	100%
Lesotho	86	71	93		2	67%
Malawi	90	87	89		2	67%
South Africa	90	68	87		2	67%
Seychelles		90	90		2	67%
Tanzania	78	92	87		2	67%
Zambia	87	89	75		2	67%
Zimbabwe	90	95	0		2	67%
DRC	62	92	0		1	33%
Mauritius	22	95	73		1	33%
Angola	42	63	0		0	0%
Madagascar	11	84	0		0	0%
Mozambique	72	77	0		0	0%
	8		8	3	25	56%

Source: Gender Links, with data from UNAIDS Data 2019.

Table 5.2 shows that:

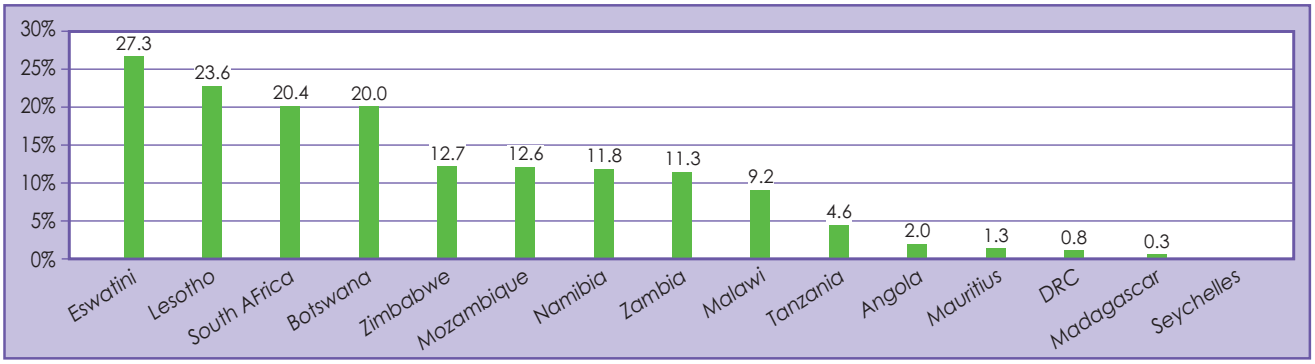
- Three SADC countries have achieved the UNAIDS 90-90-90 targets (percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression). These three countries are Botswana, Eswatini and Namibia.
- Seven countries Lesotho, Malawi, South Africa, Seychelles, Tanzania, Zambia and Zimbabwe) have achieved two targets.
- Three countries (Angola, Madagascar and Mozambique) have not met any of the three targets.
- Overall, the region has met 25 of the 45 targets (15 countries x three targets each). This means overall progress in achieving HIV and AIDS targets is 56%.

There is renewed effort to map epidemics more effectively so that interventions are targeted at districts with the greatest need.[5] It is clear that the world cannot treat itself out of the HIV epidemic and there is renewed emphasis on primary prevention to reduce new infections. Areas of focus for prevention in SADC must be: adolescent girls, young women and their partners, including adolescent boys; key populations, including sex workers, prisoners, men that have sex with men, injecting drug users; expanded condom distribution; expanded voluntary medical male circumcision; access to PreP and continued development of prevention of mother to child transmission programmes. This chapter covers prevalence; policies; prevention; treatment and care of HIV in Southern Africa over the last year, with a particular focus on the gender dimensions of the pandemic, and its link to SRHR more broadly.

[5] See for instance Dwyer-Lindgren, L. et al. Mapping HIV prevalence in sub-Saharan Africa between 2000 and 2017. Nature. May 2019. doi: 10.1038/s41586-019-1200-9

Prevalence and drivers of the pandemic

Figure 5.1: Overall prevalence of HIV



Source: Gender Links, with data from UNAIDS Data 2019.

The highest rates of HIV and AIDS in Southern Africa are in South Africa and its neighbouring countries

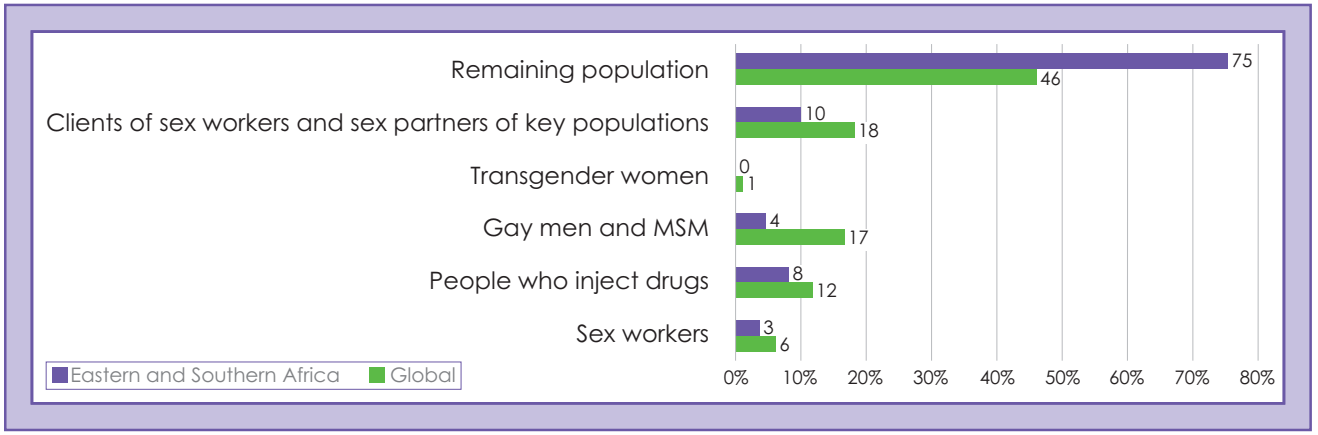
Southern Africa has a population of 277 million. Just over 16 million people are living with HIV and AIDS (7.5 million in South Africa), the highest in the world. However, as illustrated in figure 5.1, this varies considerably across the region. Four countries have a prevalence rate of 20% and above; four 10% and above and seven below 10%. Six SADC countries have a prevalence rate of less than 5%. Throughout this chapter it is important to note that Mauritius and Seychelles have quite small total populations (1.27 million and 98 000 respectively) and also very low HIV prevalence compared to other SADC member states. Thus, absolute numbers are often very low in these two nations and percentages not available.

The highest rates of HIV in Southern Africa are in South Africa and its neighbouring countries; the lowest in the three island countries (Mauritius, Madagascar and Seychelles) and the two countries furthest removed from South Africa (Angola and DRC). South Africa's history of race, gender and class inequality, as well as high levels of gender violence have been major contributory factors to the pandemic in Southern Africa's largest nation. South Africa is closely linked to its neighbouring countries through a long history of migrant labour to the mines, trade and trucking routes.

	Global	Eastern and Southern Africa
Sex workers	6%	3%
People who inject drugs	12%	8%
Gay men and MSM	17%	4%
Transgender women	1%	
Clients of sex workers and sex partners of key populations	18%	10%
Remaining population	46%	75%

Source: Gender Links.

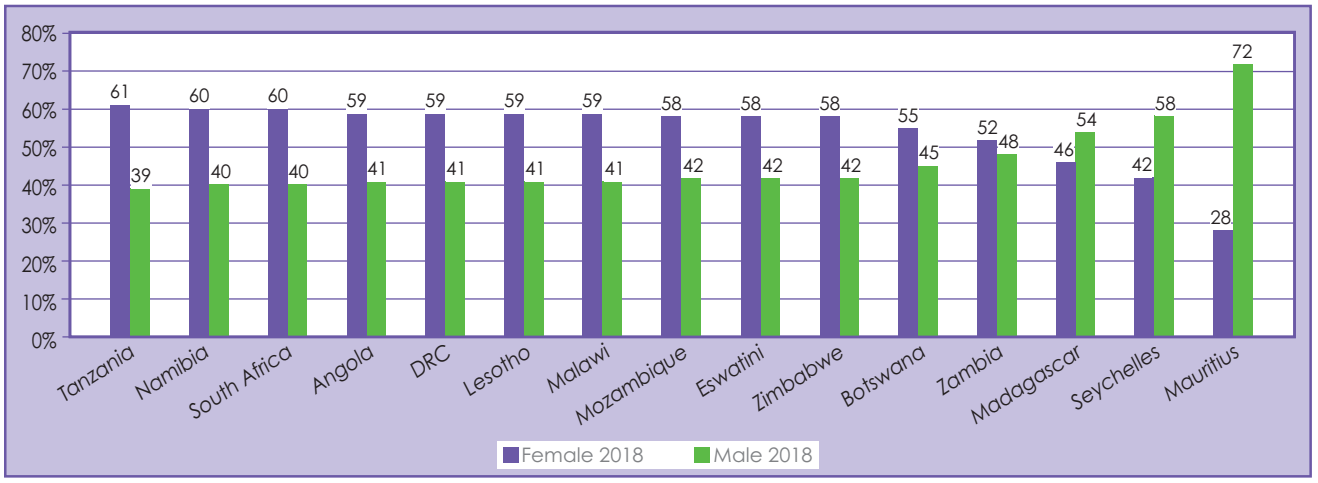
Figure 5.2: Distribution of new HIV infections - 15 to 49 years by population group



Source: Gender Links, with data from UNAIDS 2019.

As illustrated in Figure 5.2, globally "the pandemic is changing: in 2018, more than half of all new infections were among key populations - sex workers, people who use drugs, gay men, and men who have sex with men, transgender people and prisoners and their partners. New infections among young women (aged 15 to 24 years) were reduced by 25% between 2010 and 2018."[6] In Southern Africa, however, key populations account for only 25% of those living with HIV and AIDS, with "remaining population" accounting for 75%, in a region where HIV and AIDS is largely heterosexually driven.

Figure 5.3: Proportion of women and men living with HIV 2019

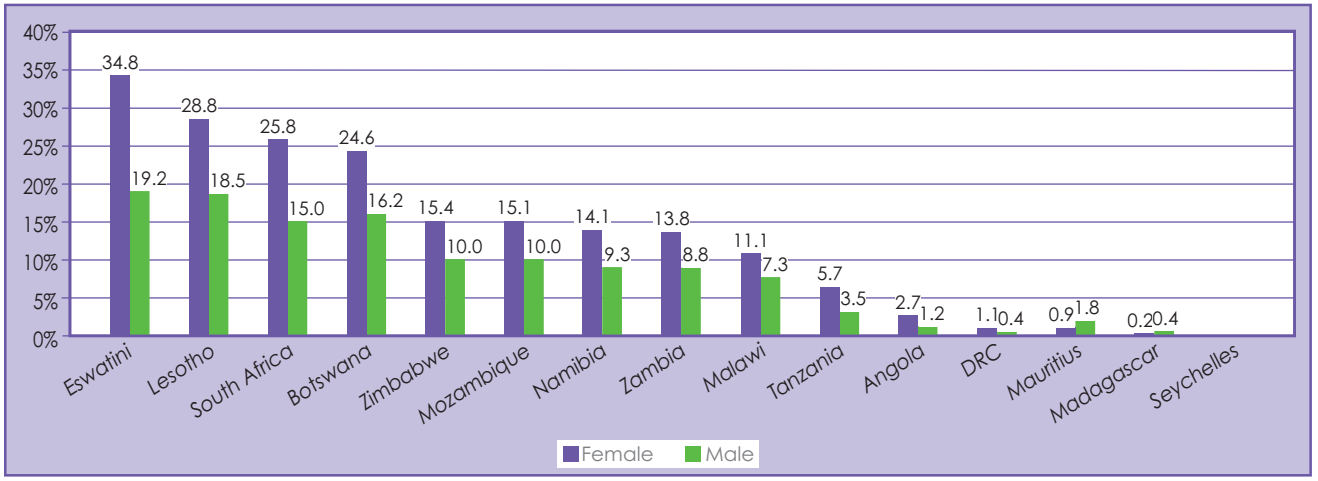


Source: UNAIDS Special analysis 2019.

As illustrated in Figure 5.3, with the exception of Madagascar, Seychelles and Mauritius where HIV is largely driven by drugs and the use of intravenous needles, there is a far higher proportion of women than men living with HIV in SADC. Globally, HIV infections among young women (age 15 to 24 are 60% higher than among men the same age.

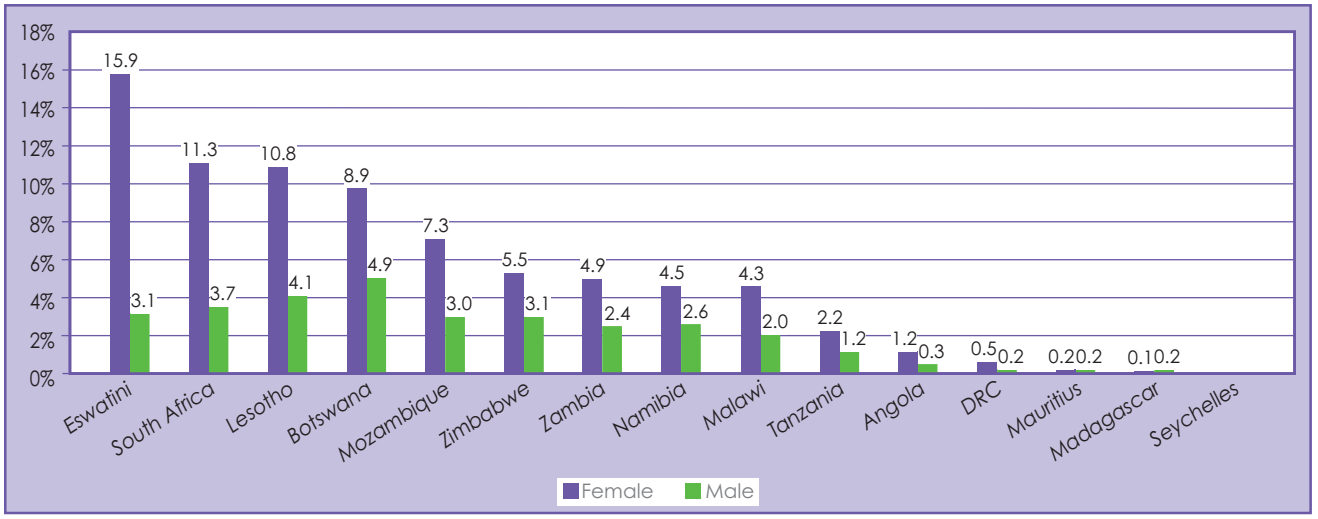
[6] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p2

Figure 5.4: HIV prevalence rates in women and men - 15 to 49



Source: UNAIDS Special analysis 2019.

Figure 5.5: HIV prevalence rates in women and men - 15 to 24



Source: UNAIDS Special analysis 2019.

Figure 5.4 and 5.5 shows prevalence rates among women and men 15 to 49 and 15 to 24 in 15 countries of the region. The graphs show that (with the exception of the islands) women constitute a higher proportion of those living with HIV than men, and this is especially pronounced among the youth. According to the UNAIDS 2019 report: "HIV and intimate partner violence share common risk factors: poverty, economic stress, gender inequality, social norm and rigid construction of masculinity and femininity (which often condone male sexual infidelity, heavy alcohol use and violence within relationships."[7]

[7] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p12.

Table 5.3: New HIV and AIDS infections in Southern Africa

Country	Women (15+)	% of total	Men (15+)	% of total	Young women (15-24)	% total	Young men (15-24)	% total	New infections all ages	Target 2020	Variance
Angola	14000	68%	6700	32%	6800	78%	1900	22%	28000	5000	-23000
Botswana	4500	55%	3700	45%	2000	67%	1000	33%	8500		-8500
DRC	8700	76%	2800	24%	4100	80%	1000	20%	19000	3000	-16000
Eswatini	4100	59%	2800	41%	2400	83%	500	17%	7000	3000	-4000
Lesotho	6600	62%	4000	38%	3200	71%	1300	29%	13000	5000	-8000
Madagascar	1700	30%	4000	70%	1000	38%	1600	62%	6100		-6100
Malawi	20000	57%	15000	43%	9900	70%	4200	30%	38000	11000	-27000
Mauritius	500	33%	1000	67%	100	50%	100	50%	1000		-1000
Mozambique	73000	57%	55000	43%	39000	66%	20000	34%	150000	30000	-120000
Namibia	3300	57%	2500	43%	1400	58%	1000	42%	6100	3000	-3100
Seychelles											0
South Africa	140000	62%	86000	38%	69000	73%	25000	27%	240000	88000	-152000
Tanzania	36000	57%	27000	43%	16000	68%	7600	32%	72000	14000	-58000
Zambia	25000	58%	18000	42%	13000	70%	5600	30%	48000	14000	-34000
Zimbabwe	19000	58%	14000	42%	9000	68%	4200	32%	38000	16000	-22000
TOTAL	**355900**	**60%**	**241500**	**40%**	**175800**	**71%**	**72400**	**29%**	**645700**	**192000**	**-453700**

Source: Gender Links with data from UNAIDS, 2019.

New infections are still three times greater than the 2020 target

Though most countries in SADC have experienced significant declines in the numbers of new infections, Table 5.3 shows that the rates are still very high. In countries with more mature heterosexual epidemics the gap between the rates of new infections in women and men is narrowing, while rates of new infections in children are decreasing significantly as PMTCT programmes bear results. Overall, new infections in women are 51% of the total, in men are 38% of the total and children 11%.

The total number of new infections in SADC in 2018 stood at 645,700 compared to a 2020 target of 192,000: more than three times higher than the desired target. Women over the age of 15 constitute 60% of the new infections. Young women (15 to 24) constitute 70% of the new infections. The new infections in all countries are still between 2 and 5 times as high as the target that has been set. There is thus huge need to focus on HIV prevention.

The **Zambia** PHIA report[8] released in 2019 presents discouraging evidence about HIV in adolescents. Among persons aged 15-24 years, nearly twice the proportion of males (17,1%) compared to females (9,5%) reported having sexual intercourse before the age of 15 years. Sexual debut before the age of 15 years among those aged 15-24 years was twice as high in rural areas (17,3%) as in urban (8,6%). Early sexual debut ranged from 7,4% in Copperbelt Province to 29,4% in North-Western Province. The percentage who reported early sexual debut was 17,9% among those with only primary education compared to 4,1% among those with more than a secondary education. HIV incidence among persons aged 15-24 years in Zambia was 0,57% (0,08% among males and 1,07% among females).

[8] Ministry of Health, Zambia. Zambia Population-based HIV Impact Assessment (ZAMPHIA) 2016: Final Report. Lusaka, Ministry of Health. February 2019. https://phia.icap.columbia.edu/wp-content/uploads/2019/03/ZAMPHIA-Final-Report__2.26.19.pdf accessed 5 June, 2019

Policies, laws and resources



Article 27.1: State Parties shall take every step necessary to adopt and implement gender sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance with, but not limited to, the Maseru Declaration on HIV and AIDS and the SADC Sponsored United Nations Commission on the Status of Women Resolution on Women, the Girl Child and HIV and AIDS and the Political Declaration on HIV and AIDS.

Article 27.2: State parties shall ensure that the policies and programmes referred to in sub- Article take account of the unequal status of women, the particular vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.

ICPD: 8.27 All countries, as a matter of some urgency, need to seek changes in high-risk sexual behaviour and devise strategies to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

SADC Sponsored UN Resolution on Women, the Girl Child and HIV and AIDS: In 2016 the CSW passed a SADC-sponsored resolution, put forward on behalf of SADC by Botswana: *The SADC Sponsored United Nations Commission on the Status of Women Resolution on Women, the Girl Child and HIV and AIDS*. Among others, the resolution calls on governments, the private sector and development partners to: give full attention to the high levels of new HIV infections among young women and adolescent girls and their root causes; attain gender equality and the empowerment of women and girls; eliminate all gender-based violence and discrimination against women and girls and harmful practices, such as child, early and forced marriage and female genital mutilation and trafficking in persons, and ensure the full engagement of men and boys to reduce women and girls' vulnerability to HIV.

Table 5.4: Countries with a stand-alone HIV and AIDS policy or strategy

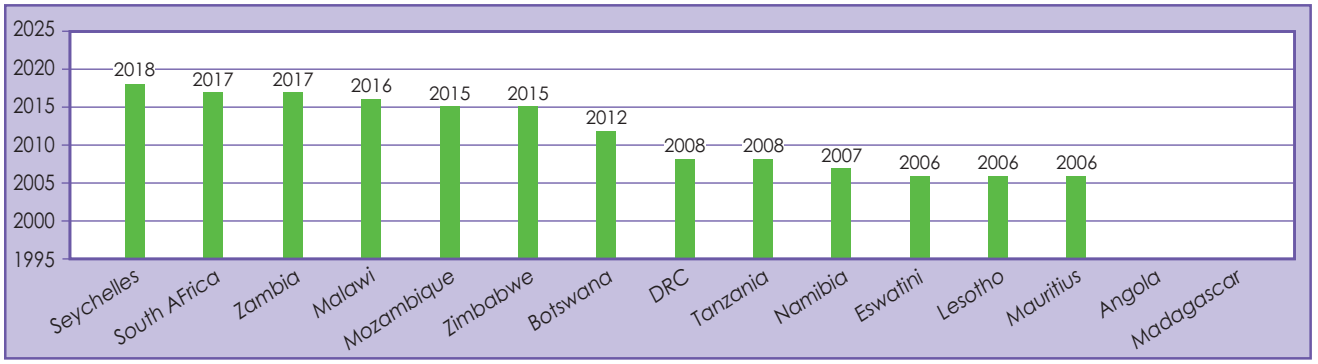
Country	Country has stand-alone HIV and AIDS policy or strategy	HIV and AIDS policy includes other STIs
Seychelles	Yes	Yes
Zambia	Yes	Yes
Malawi	Yes	Yes
Mozambique	Yes	Yes
Zimbabwe	Yes	Yes
Botswana	Yes	Yes
DRC	Yes	Yes
Tanzania	Yes	Yes
Namibia	Yes	Yes
Eswatini	Yes	Yes
Lesotho	Yes	Yes
Madagascar	Yes	Yes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

Source: Gender Links, with data from UNAIDS 2019.

Table 5.4 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. Stand-alone HIV policies are essential in a region where HIV overshadows so much other development. The HIV landscape is changing so rapidly that it is imperative that countries have up to date policies and strategic plans to guide them towards ending AIDS as a public health threat by 2030.

All SADC member states have a stand-alone HIV policy

Figure 5.6: When HIV and AIDS policies were adopted

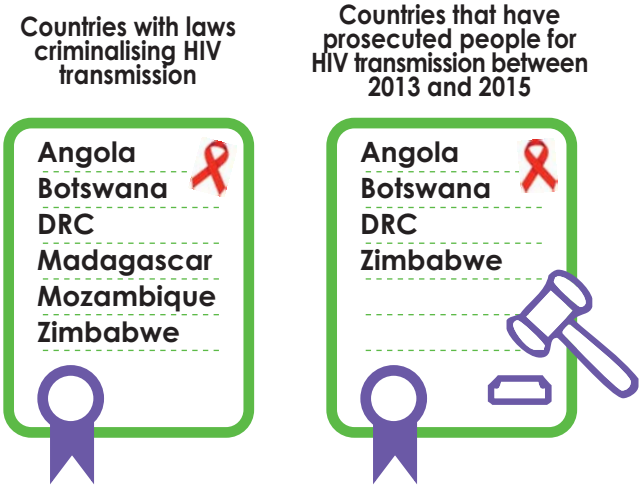


Source: GL Audit of SRHR Policies and Laws 2019.

Figure 5.6 shows that countries adopted stand-alone HIV and AIDS policies between 2000 and 2018. Seychelles (2018) is the latest country to adopt an HIV and AIDS policy. In at least seven Southern African countries for which data is available (DRC, Tanzania, Namibia, Eswatini, Lesotho, and Mauritius), HIV and AIDS policies are more than ten years old. Five countries (Seychelles, Botswana, the DRC, Namibia, and Angola) are currently updating their HIV and AIDS policies.

Figure 5.7 shows that six SADC countries (Angola, Botswana, DRC, Madagascar, Mozambique and Zimbabwe) currently criminalise HIV transmission and that four (Angola, Botswana, DRC and Zimbabwe) have prosecuted people for HIV transmission between 2013 and 2015.

Figure 5.7: Countries that criminalise/prosecute HIV transmission[9]



Source: HIV Justice Network.

[9] http://www.hivjustice.net/news/new-report-shows-hiv-criminalisation-is-growing-global-problem-but-advocates-are-fighting-back/

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 healthcare 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.[10]

Zimbabwe is set to decriminalise wilful transmission of HIV through the Marriages Bill which is now set to be tabled before Parliament for debate. Section 53 of the Marriages Bill will repeal Section 79 of the Criminal Law (Codification and Reform) Act which makes it an offence to transmit HIV to a partner. Justice Minister Ziyambi Ziyambi told Parliament that the global thinking was that the law stigmatised people living with HIV and Aids.[11] The thinking in Zimbabwe follows similar action in Malawi.

Per capita expenditure



Table 5.5: Spending on HIV and AIDS

Country	HIV	Health	HIV spending as proportion of health spending
Namibia	$90	$442	20%
Eswatini	$89	$265	34%
Botswana	$72	$389	19%
Lesotho	$51	$91	56%
Seychelles	$39	$490	8%
South Africa	$34	$510	7%
Zambia	$19	$69	28%
Zimbabwe	$19	$69	27%
Malawi	$13	$341	4%
Mozambique	$12	$28	43%
Tanzania	$7	$27	26%
Mauritius	$6	$367	2%
DRC	$3	$19	14%
Angola	$1	$122	1%
Madagascar	$1	$21	3%

Source: UNAIDS Special analysis 2019.

Table 5.5 shows that spending on HIV varies widely in the SADC region: from $90 per capita in Namibia to $1 per capita in Angola and Madagascar. This is to some extent driven by the extent of the pandemic in each SADC country (Angola and Madagascar have low prevalence rates), but also levels of poverty and health expenditure generally. HIV spending ranges from 56% of the health budget in Lesotho to just 1% of the health budget in Angola. The UNAIDS 2019 report comments that: "in Eastern and Southern Africa where expenditures per person living with HIV have reached the 2020 resource needs estimate, reductions in HIV infections and AIDS-related deaths are approaching the 2020 targets."[12]

[10] https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(18)30219-4/fulltext
[11] https://zoomzimbabwe.com/2019/07/22/government-to-decriminalise-wilful-transmission-of-hiv/, accessed on 31 July 2019.
[12] Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p9.



Malawi passes progressive HIV legislation[13]

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, 2018

[13] 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/

Prevention



Article 27. 3: State Parties shall:
a) Develop gender sensitive strategies to prevent new infections.
BPFA +20 Africa Declaration: (h) Scale up combined preventive HIV/AIDS measures for young women and girls and expand programmes to eliminate mother-to-child transmission;
SADC SRHR Strategy: HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
ICPD: 7.32 Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.
UNAIDS 90/90/90: TARGET 1: By 2020, 90% of all people living with HIV will know their HIV status (90% diagnosed)
The SADC-sponsored UN Resolution on women, girls, HIV and AIDS

- Achieve universal access to comprehensive HIV prevention, programmes, treatment, care and support to all women and girls and achieve universal health coverage.
- Enhance the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and reduce costs of lifelong chronic care,
- Eliminate mother-to-child transmission and keep mothers alive.
- Provide combination prevention for women and girls for the prevention of new infections, to reverse the spread of HIV and reduce maternal mortality.
- Avail comprehensive data disaggregated by age and sex to inform a targeted response to the gender dimensions of HIV and AIDS.
- Build up national competence and capacity to provide an assessment of the drivers and impact of the epidemic.
- Support action-oriented research on gender and HIV and AIDS, including on female-controlled prevention commodities.

It is impossible to reach the target of controlling HIV and ending AIDS by 2030 until the majority of those living with HIV know their status, access treatment and are virally supressed. Currently, the major gap in this process is testing so that all those living with HIV are aware of their status. The UNAIDS 2018 report, Knowledge is Power, details many barriers to testing including stigma, criminalization of key populations, distance and other physical barriers to accessing services, as well as costs (including loss of income) associated with accessing services. The report also details different approaches to ensuring that everyone

Renewed investment in testing is imperative to reach the first 90

is reached with testing. These include community testing, testing in places where men frequent (outside health centres) or at times that are convenient; self-testing, with or without support; following families of those that are known to be living with HIV (index case finding), and point of care testing for babies.

As progress to meeting prevention targets has not been fast enough, a Global Partnership on Prevention has developed the HIV Prevention 2020 road map.[14] Prevention is focused on 26 countries globally that are contributing the highest number of new infections, including ten countries in SADC - South Africa, Mozambique, Zambia, Tanzania, Zimbabwe, Malawi, Angola, Lesotho, Namibia and Eswatini.

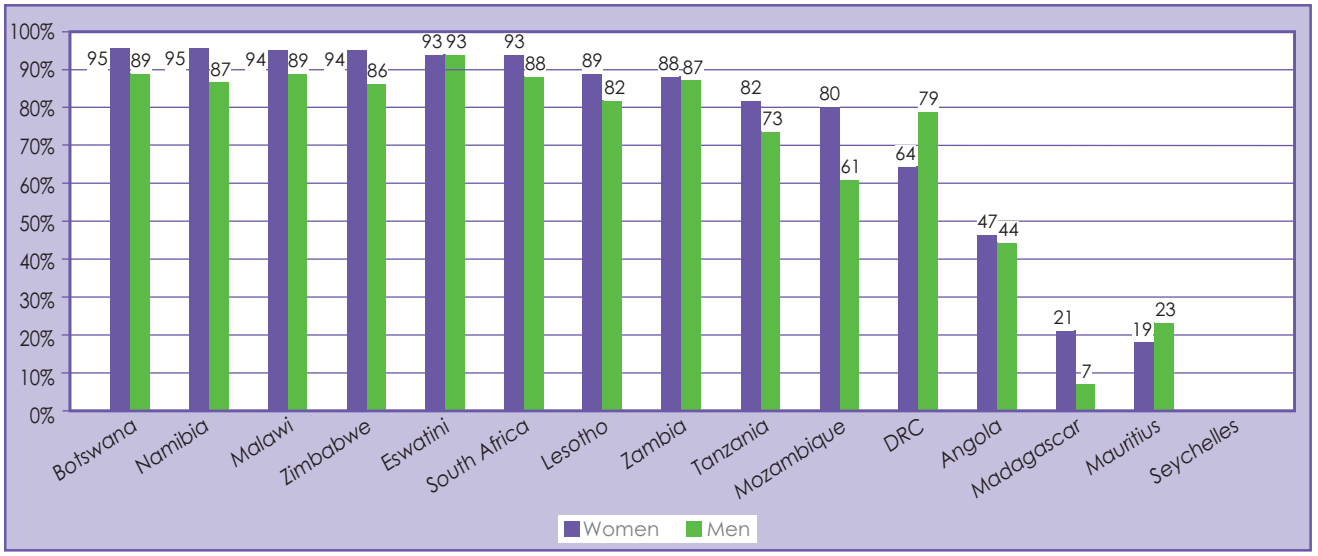
The plan calls for significantly increased political will and leadership; addressing policy gaps that would enable members of key populations (including sex workers, those in same sex relationships, injecting drug users, and prisoners) and young women and their partners to access prevention services; increasing funding for primary prevention and improving coordination for implementation. Leaders of the partnership met in 2018 to review progress.[15] Some of the issues highlighted in the meeting were: the need for bold action to scale up prevention programmes; national and sub national accountability for prevention; addressing stigma, discrimination and criminalization of key populations; and increased access to condoms for all that need them.



Still marching: World Aids Day in Mazenod, Lesotho. Photo: Ntolo Lekau

Knowledge of HIV status

Figure 5.8: People living with HIV 15+ who know their status



Source: Source: UNAIDS Special analysis 2019.

[14] UNAIDS, 2017. HIV Prevention Road Map. Geneva. UNAIDS. https://www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map
[15] https://www.unaids.org/en/resources/presscentre/featurestories/2018/july/global-hiv-prevention-coalition

Figure 5.7 shows that six SADC countries (Botswana, Namibia, Malawi, Zimbabwe, Eswatini, and South Africa) have succeeded in expanding coverage of testing to at least 90% of those that are living with HIV, with Zambia, Tanzania and Mozambique not too far behind. This is a particularly noteworthy achievement in South Africa, which has the largest population of people living with HIV of any country in the world. Low coverage of testing in the islands is understandable, due to low prevalence, but is a concern, as testing is one of the most powerful prevention tools.



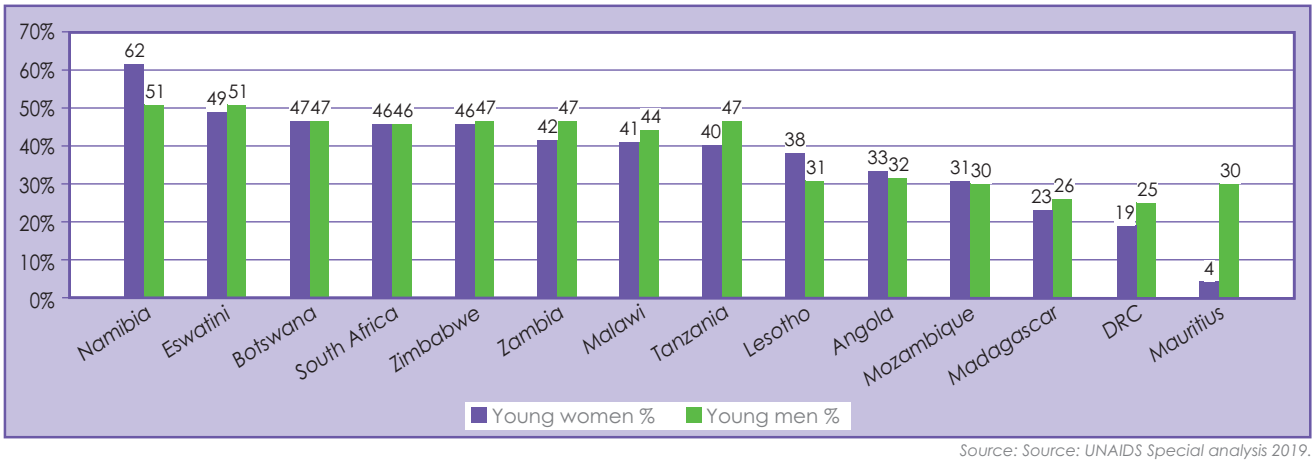
A self testing kit ready for operation in Mutare, Zimbabwe. Photo: Tapiwa Zvaraya

In all these countries (except Mauritius), knowledge of HIV status is higher among women than men. According to the UNAIDS 2019 report, globally uptake of the three 90s is much higher among women than men: "This is in line with numerous studies showing that men are less likely than women to take HIV tests and to initiate and adhere to HIV treatment, which results in poorer clinical outcomes and a greater likelihood that they will die of AIDS-related causes."[16]

Comprehensive, accurate knowledge of HIV and AIDS

In addition to knowledge of status, knowledge about the pandemic is essential to encourage safe sexual behaviour and promote HIV prevention. Available data suggests that knowledge is still low in both young women and men across SADC and therefore the target of reduction in new infections is unlikely to be reached.

Figure 5.9: Knowledge of HIV prevention 15 - 24



Source: Source: UNAIDS Special analysis 2019.

[16] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p85



Zimbabwe: Men's attitudes to health stalling SRHR progress[17]

Moses Chamunorwa aged 24 complains about burning sensations in his urethra and continuous fever but he refuses to go for HIV testing. In spite of having Sexually Transmitted Infection(s) symptoms, Chamunorwa prefers traditional healers to the clinic. "I am not employed and survive on vending. I cannot afford user-fees charged at polyclinics plus drug costs prescribed after consultation and examination," said Chamunorwa revealing his wife's medical records from an Opportunistic Infection (OI) Clinic.

"She is the one that goes to clinic. At least, my wife got treated when she delivered our son," he added. Realising that Chamunorwa cannot grasp what is written on the medical records of his partner, I interviewed Musindo separately. "My husband does not want to go to clinic, despite telling him that nurses say that I should come with him for treatment citing exorbitant costs."

Chamunorwa does not believe that he is HIV positive nor his wife and has never seen Musindo taking ARVs. "She only took some metro and other pills I can't remember when, perhaps when we had an STI in 2013 after her delivery," he said. When asked why he does not take advantage of free HIV counselling and testing outreach programmes common these days Chamunorwa said, "I am fit and I do not look ill, neither my son nor wife, so why should I go for HIV testing?" he questioned confidently.



Men in Zimbabwe shy away from treatment. Photo: Tapiwa Zvaraya

Chamunorwa revealed that the problem he and wife were currently facing were sore warts around the genital areas. "The warts are painful and we have tried to take some herbs but it is not helping," he said. According to the Harare City Council 2017 Annual Health Report the total number of new Sexually Transmitted Infections (STI) cases recorded in its health department clinics was 32 582. "This represents a 6% decrease compared to the previous year when 34 707 cases were recorded.

"Even though there was a decrease, there is still a need for health education in the community and stress on the importance of correct and consistent condom usage," reads part of the city's health report. Of concern to note is that adolescents aged 10-24 years accounted for 11 242 of the 32 582 STI cases recorded last year while children under the age of 9 years accounted for 1 094 STI cases.

It costs $5 for an adult consultation at local clinics in Harare excluding medication and examination tests, while maternal fees are $25. Amounts that very few people in Zimbabwe are able to raise in the face of 94 percent unemployment rate.

By: Thabani Dube, Gender Links News Service, 2019

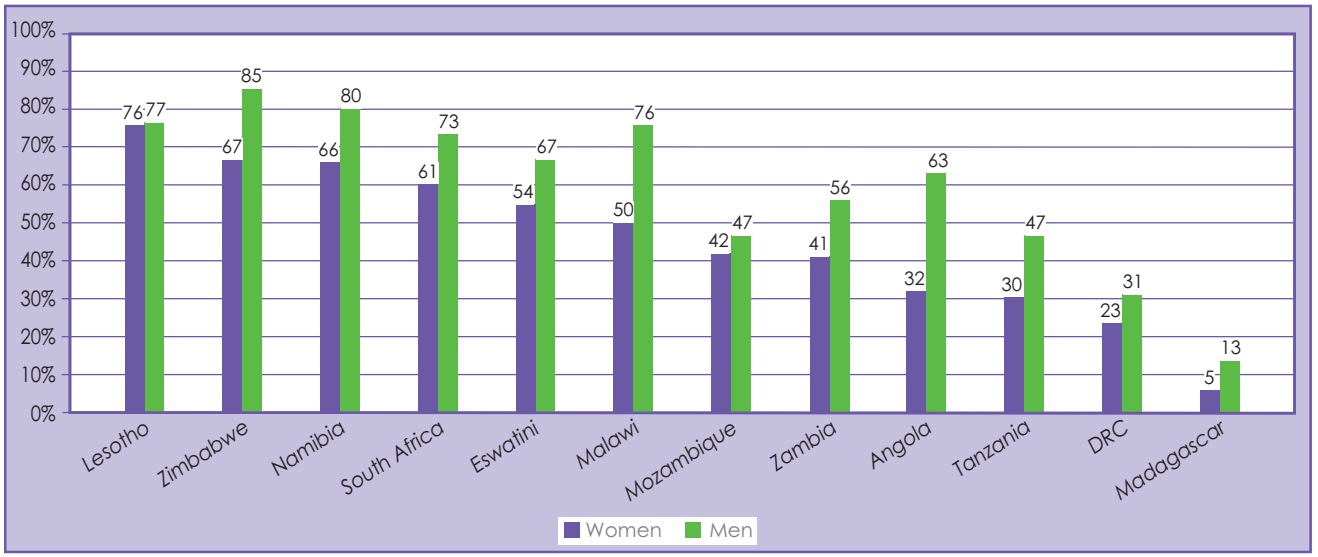
[17] Derived from http://genderlinks.org.za/news/zim-ignorance-stalling-srhr-progress/

Figures 5.9 shows that despite enormous effort the levels of knowledge of HIV are still generally low among young people. Knowledge about HIV is still less than 50% for both young women and young men in all but two countries (Eswatini and Namibia). Levels have not changed very much between 2008 and 2019. Poor knowledge is very likely to translate into low levels of risk awareness and poor prevention of HIV at a time when we need to redouble our efforts in prevention. With the exception of Namibia, knowledge is higher among young men than young women, despite the prevalence rate being much higher among young women than among young men.

The Malawi PHIA[18] report found that only 44.0% of females and 50.1% of males aged 15-24 years answered all five HIV knowledge questions correctly with a higher proportion of young men in urban areas (59.5%) responding correctly to all five questions, compared to those in rural areas (47.4%). Among those aged 15-24 years, 13.7% reported having sexual intercourse before the age of 15 years (19.0% among males and 8.8% among females). Sexual debut before the age of 15 years was especially high among those with no education. Among those aged 15-24 years living with HIV, 46% had not been diag-nosed, and among those diagnosed, 14% had not initiated ART. Among those on treatment, only 19% have not achieved viral load suppression.

Condom use at high risk sex

Figure 5.10: Condom use at high risk sex

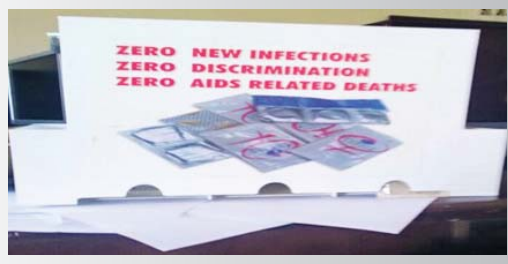


Source: Source: UNAIDS Special Analysis 2019.

Despite all the public education and awareness on condoms, the UNAIDS 2019 report notes that median condom use by men at last higher risk sex in 27 sub-Saharan countries stood at 58.6%.[19] Figure 5.8 shows that seven countries (Zimbabwe, Namibia, Lesotho, Malawi, South Africa, Eswatini and Angola) have condom at last high risk sex of over 50%. Other countries lag behind. The uptake among women in all countries is considerably lower than men.

[18] Ministry of Health, Malawi. Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final Report. Lilongwe, Ministry of Health. October 2018.
[19] http://phia.icap.columbia.edu accessed 26 April, 2019
Ibid p7

ECHO study on contraceptive options for women at risk of acquiring HIV[20]



The Evidence for Contraceptive Options and HIV Outcomes or ECHO Study in Eswatini, Kenya, South Africa and Zambia, which all have high HIV incidence, to test whether different methods of family planning may be related to increased risk of HIV acquisition. 7829 sexually active HIV-negative women aged 16 to 35 years who wanted to use a modern method of contraception were enrolled and randomly assigned to one of three contraceptive methods:

- DMPA - intramuscular (DMPA-IM), a three monthly, progestogen-only, reversible injectable contraceptive;
- Levonorgestrel implant, a progestogen-only implant inserted under the skin in the upper arm that can be used for up to five years;
- A copper-bearing IUD, a device inserted into the uterus that can be used for up to 10-12 years.All women received ongoing health services, including counselling on HIV prevention and care, screening and treatment for sexually transmitted infections.

The study found that all methods had high levels of safety and effectiveness in preventing pregnancy and were well-accepted by the women using them. 397 HIV infections occurred. 143 in women who used DMPA-IM, 116 in women who used a levonorgesterel implant and 138 in women who used an IUD. There was no statistical difference in the rate of acquisition of HIV among the different contraceptive methods. The study therefore supports continued access to all the methods studied by all women including those at high risk of HIV infection.

However, this was an incidence rate of 3.8% per year, which is alarming. Further, the rate of HIV infection was higher for women younger than 25 years irrespective of the method of contraception used. This reinforces the need to strengthen HIV prevention integration within contraceptive and other sexual and reproductive health services. These may include HIV testing and linkage to antiretroviral therapy for those testing HIV-positive, partner testing, condom promotion, and pre-exposure prophylaxis (PrEP). The reported HIV incidence is above the WHO suggested threshold for offering PrEP, which should be considered in countries where the incidence of HIV is above 3%.

WHO will issue updated recommendations concerning women's eligibility for using various contraceptive methods if they are at high risk of HIV by the end of August 2019.

Source: WHO, 2019

The rate of HIV infection was higher for women younger than 25 years irrespective of the method of contraception used

[20] Derived from https://www.who.int/news-room/detail/13-06-2019-new-study-finds-no-link-between-hiv-infection-and-contraceptive-methods accessed 20 June, 2019.

Voluntary Medical Male Circumcision (VMMC)

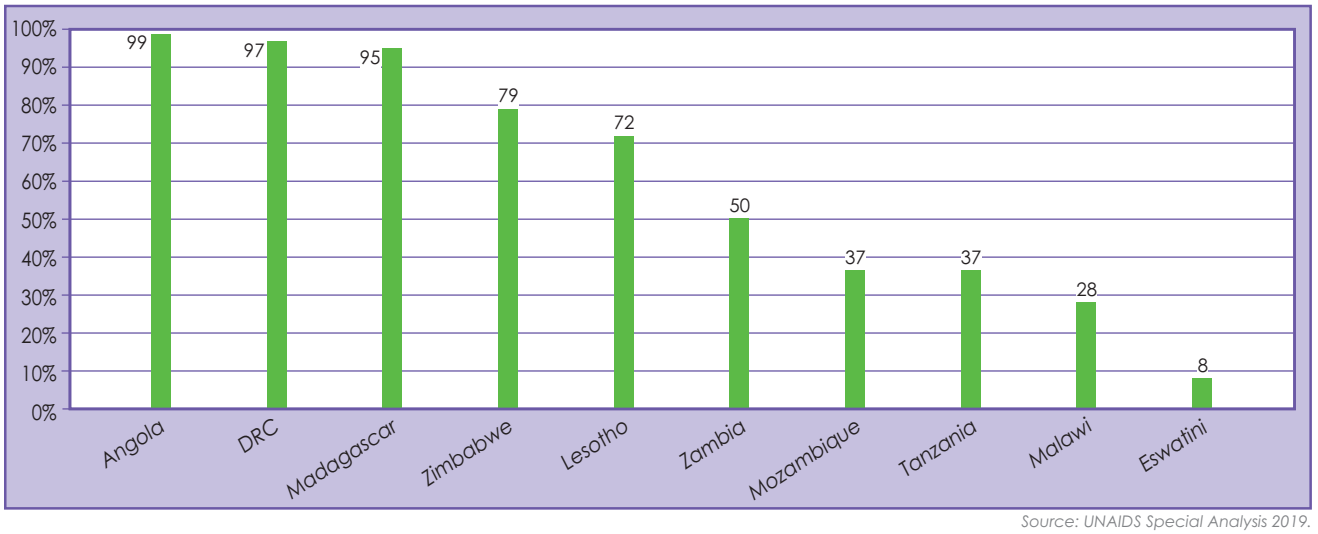


Voluntary male circumcision is taking off in Zambia.

Voluntary medical male circumcision (VMMC) is to date the only one-time intervention for reducing the risk of HIV infection. The procedure provides lifelong partial protection against female-to-male HIV transmission and should be used in combination with wider sexual and reproductive health service provision for boys and men. Together with condom promotion, STI management, pre-exposure prophylaxis, HIV testing and prompt initiation of antiretroviral therapy, VMMC can have a major impact on HIV epidemics in high-prevalence settings.

Ten of the 15 priority countries identified for intense effort to increase levels of VMMC are in SADC (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe). The Prevention Partnership goal is to increase the number of men that access VMMC by an additional 25 million by 2020.

Table 5.11: Proportion of men who are circumcised



Source: UNAIDS Special Analysis 2019.

Figure 5.11 shows that there are wide variations in the proportion of men circumcised in SADC: from 99% in Angola to 8% is Eswatini. Male circumcision is practiced traditionally among certain ethnic groups in east and Southern Africa but not in others.

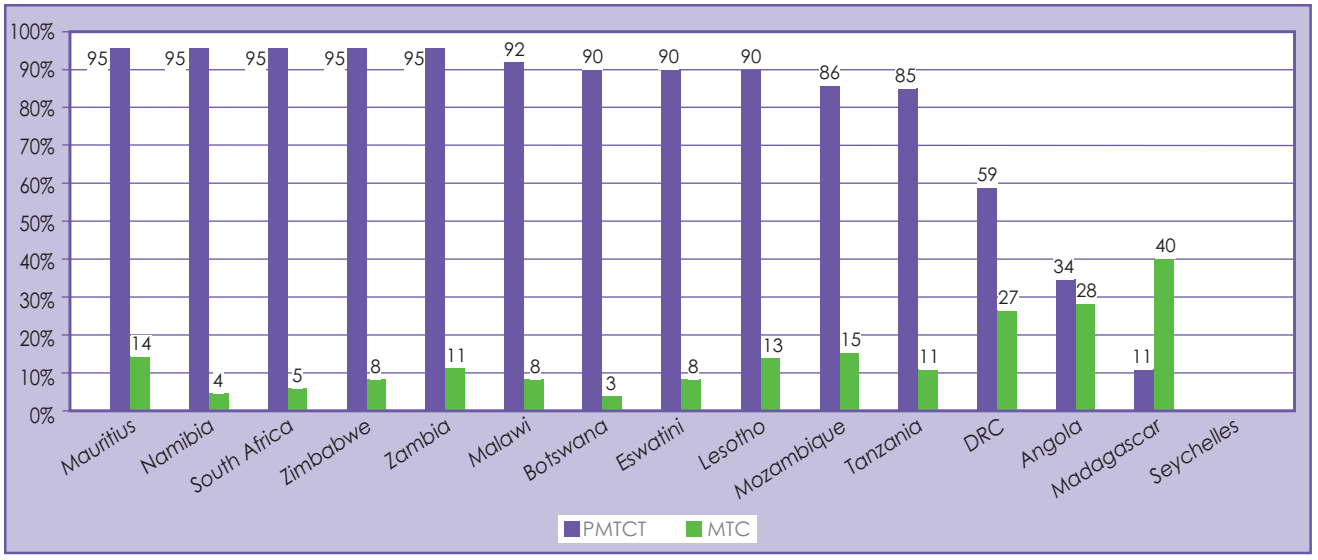
[21] https://www.unaids.org/en/resources/presscentre/featurestories/2019/may/20190529_VMMC_Malawi

In **Malawi**, more than 166,350 circumcisions were conducted in 2017, more than double the number conducted in 2014 and up from just 589 in 2008.[21] Among men ages 15-64 years, 9.2% reported undergoing medical circumcision and 16.1% reported having a non-medical circumcision. The percentage of males who reported being uncircumcised ranged from 65.8% among those ages 60-64 years to 73.2% among those ages 50-54 years. Among those who tested HIV positive in the survey, 8.8% reported having undergone medical circumcision, while 67.4% self-reported their status as uncircumcised. Of those who tested HIV negative, 71.7% self-reported not having undergone any form of circumcision, while 9.0% reported having undergone medical circumcision.

The proportion who reported medical circumcision was 10 times higher in men with more than secondary education (21.6%) than in men with no education (2.5%). Non-medical circumcision was approximately three times greater in men with no education (25.3%) than in men with more than secondary education (7.6%). The highest frequency of medical circumcision was reported among those in the highest wealth quintile (16.5%). The lowest frequency of uncircumcised men was among those who identified as Muslim (3%), with the majority (79.5%) having undergone non-medical circumcision.[22]

Preventing new HIV infections in children and keeping their mothers alive: The roll out of testing and enrolment on treatment for pregnant mothers is one of the success stories in the fight against HIV. The levels of access to ARVs by pregnant mothers have risen to excellent levels. But there are few countries that are near the target of eliminating all vertical transmission of HIV.

Figure 5.12: Coverage of ARVs in pregnant women and MTCT rates



Source: UNAIDS Special Analysis 2019.

Figure 5.12 compares coverage of ARVs among pregnant mothers to Mother to Child Transmission (MTC). Nine SADC countries (Mauritius, Namibia, South Africa, Zimbabwe, Zambia, Malawi, Botswana, Eswatini and Lesotho) have now achieved over 90% ARV coverage for pregnant women or Prevention of Mother to Child Transmission (PMTCT). These are the countries with the highest HIV prevalence. Countries lagging behind on PMTCT (DRC, Angola, Madagascar and Seychelles) also have the lower levels of HIV. Many SADC countries have considerably reduced MTC: at 2.5%, Botswana has the lowest MTC. However no country has eliminated vertical transmission altogether, and in Madagascar this stands at 39.8%.

[22] Ministry of Health, Malawi. Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final Report. Lilongwe, Ministry of Health. October 2018. http://phia.icap.columbia.edu

Even with high levels of access, few countries have eliminated all vertical transmission of HIV

The figures show that there are still high levels of transmission during breastfeeding and post-delivery. This calls for renewed efforts to ensure that all babies born to mothers that are HIV + are tested at least within two months of birth. Mothers need support to exclusively breastfeed and to continue taking their ART. With support from UNITAID and several other organizations, fifteen African countries (including DRC, Tanzania, Malawi, Zambia, Zimbabwe, Mozambique, Eswatini and Lesotho) are rolling out Point of Care infant diagnosis. Children who do not access treatment are likely to die before their second birthday. South African introduced testing at birth as early as 2015. Mozambique has recently also begun testing babies at birth, conducted by nurses. The results have found testing to be accurate and feasible.[23]

As more children are accessing treatment, the numbers that contracted HIV in utero, during delivery or through breast feeding that are now adolescents is increasing. In the Start Free, Stay Free, AIDS Free priority countries, almost two thirds of male adolescents aged 15 -19 that are living with HIV contracted it vertically, while almost two thirds of female adolescents living with HIV have contracted it through sexual transmission. Gender attitudes, such as those found through the Gender Links Attitude Survey contribute to high rates of sexual transmission in adolescent girls and young women as illustrated in figures 5.13 to 5.15.

Prevention among key populations

Key populations are sex workers, men who have sex with men, people who inject drugs, trans-gender persons, and prisoners. Around the world, key populations face much higher rates of HIV and AIDS than the general population and are most at risk for contracting HIV.[24] They face many hurdles which stop them from accessing services such as punitive laws and policies, police harass-ment and stigma and discrimination within health settings.

Table 5.6: Sex Workers: HIV Prevalence and prevention

Country	Population size	HIV prevalence %	Condom use %
Lesotho	7 500	72	62
Eswatini	4 000	61	83
South Africa	240 000	58	86
Malawi	36 000	55	65
Zambia	18 000	49	79
Botswana	6 700	42	76
Namibia	8 100	41	
Zimbabwe	45 000	41	96
Mauritius	6 200	15	67
Tanzania	160 000	15	70
Angola	54 000	8	72
DRC	350 000	6	69
Madagascar	190 000	6	63
Seychelles	<1 000	5	16
Mozambique	27 000		

Source: UNAIDS Special Analysis 2019.

[23] UNAIDS. 2018. Knowledge is Power. Geneva.
[24] https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/key-populations

Table 5.6 shows much higher HIV prevalence rates in sex workers than in the general population, as well as very large populations of sex workers in DRC, Madagascar, Tanzania and South Africa. Prevalence ranges from 5% among sex workers in Seychelles, to 72% among sex workers in Lesotho. The table also shows much greater attention to issues of sex workers, as data on them is beginning to be collected. The data shows that use of condoms among sex workers in most countries is above 60% and goes as high as 96% in Zimbabwe. However, the table has many gaps, indicative that the data which is being collected is not sufficient. All countries need to take this issue much more seriously and to ensure that sex workers access testing, ARVs and are encouraged to adhere to ARVs.

Sex workers have much higher HIV prevalence than in the general population

Table 5.7: Provisions for sex work in SADC countries

Which statement best describes the provisions and their practice	Country
Sex work is outlawed and this is vigorously enforced	DRC, Madagascar, Malawi
Sex work is outlawed but this is not vigorously enforced	Botswana, Seychelles, Mozambique, Eswatini, Lesotho, Namibia, Mauritius, Tanzania, Zambia, Zimbabwe
Sex work is outlawed but recent court cases or other occurrences have opened the door to decriminalization	Angola, South Africa

Source: Audit of SRHR Laws and Policies in SADC.

Table 5.7 shows that all 15 SADC countries criminalise sex work but there are variations in the enforcement of the anti-sex work laws. The DRC, Madagascar, and Malawi vigorously enforce the law against sex work. Eight countries, (Botswana, Seychelles, Mozambique, Eswatini, Lesotho, Namibia, Mauritius, Tanzania, Zambia, and Zimbabwe) do not vigorously enforce the anti-sex work law. Court cases challenging the criminalisation of sex work may result in decriminalisation of sex work in Angola and South Africa. Criminalisation fuels stigma and discrimination and severely hampers access to all services. Thus, for those countries where there is information about sex workers, their knowledge of their HIV status is generally not good, except in Zimbabwe which has had NGO programmes targeting sex workers for a long time.



Sex workers at the Zimbabwe International Trade Fair. Photo: Google images

Supported by a network of peer educators, **the Sisters programme in Zimbabwe** provides female sex workers with free preventive and clinical services, including condoms and lubricants, management of STIs, contraceptive advice and options, HIV testing, and referral of anti- retroviral therapy. The programme, which began at five sites, has expanded to 36 clinics, most in urban areas or on transport routes. In 2017, the programme served 24,000 women and by 2018 had achieved 190,000 visits. A study of a representative sample showed that whereas only one third had tested for HIV in the past, almost all

those served by the programme have now gone for testing. Those living with HIV are receiving ARVs. Knowledge of HIV increased from 48% to 78%. Studies have found a decrease in police harassment as a result of the programme and general human rights awareness.[25]

Table 5.8: Men who have Sex with Men, Prevalence and Prevention

Country	Population size	HIV prevalence %	Condom use %
Lesotho	6 100	33	46
Zimbabwe	<1 000	31	
South Africa	300 000	18	98
Mauritius	5 500	17	53
Botswana	2 600	15	78
Madagascar	17 000	15	58
Eswatini	2 400	13	
Seychelles	<500	13	
Tanzania	50 000	8	14
Malawi	43 000	7	44
DRC	190 000	3	77
Angola	29 000	2	59
Mozambique	16 000		
Namibia	6 500		
Zambia	6 500		

Source: UNAIDS Special Analysis 2019.



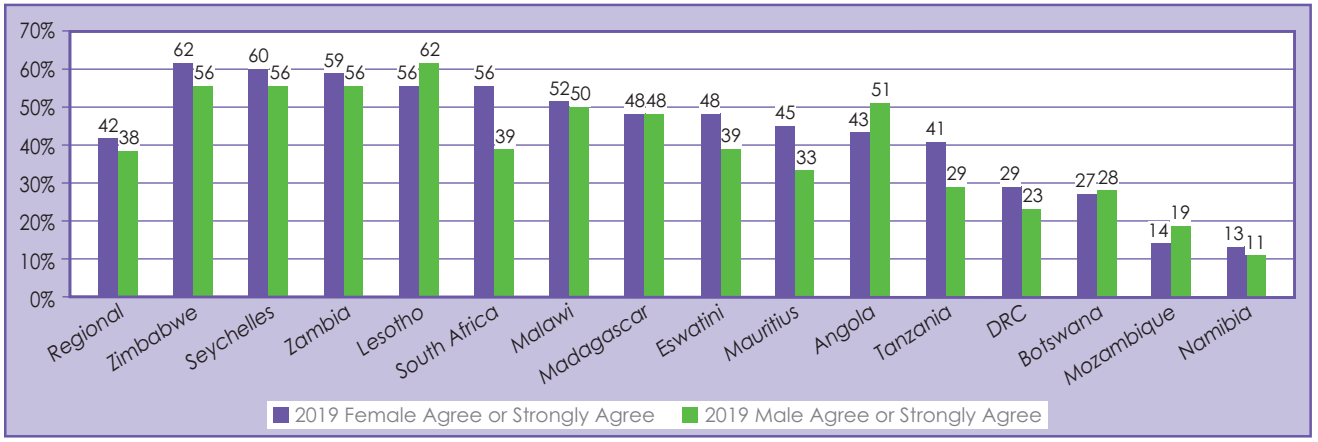
Table 5.8 shows that, as with sex workers, countries are beginning to collect data on men that have sex with men. Homosexual activity is still largely criminalised and highly stigmatised. Access to services is generally very poor, as shown by low levels of knowledge of HIV status. Where information is available it indicates much higher prevalence levels than in the general population and poor knowledge of HIV status in most countries. While condom use is encouraging in countries such as South Africa and Botswana, this is generally lower than what is needed to reach epidemic control. Table 5.8 also has many gaps which is indicative of the gaps in knowledge about men who have sex with men in SADC.

Attitudes

A critical test of HIV and AIDS prevention campaigns is the extent to which the attitudes that fuel this pandemic are changing. Each year Alliance partners administer the Gender Progress Score (GPS) that include several questions relevant to HIV and AIDS.

[25] Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p50-51.

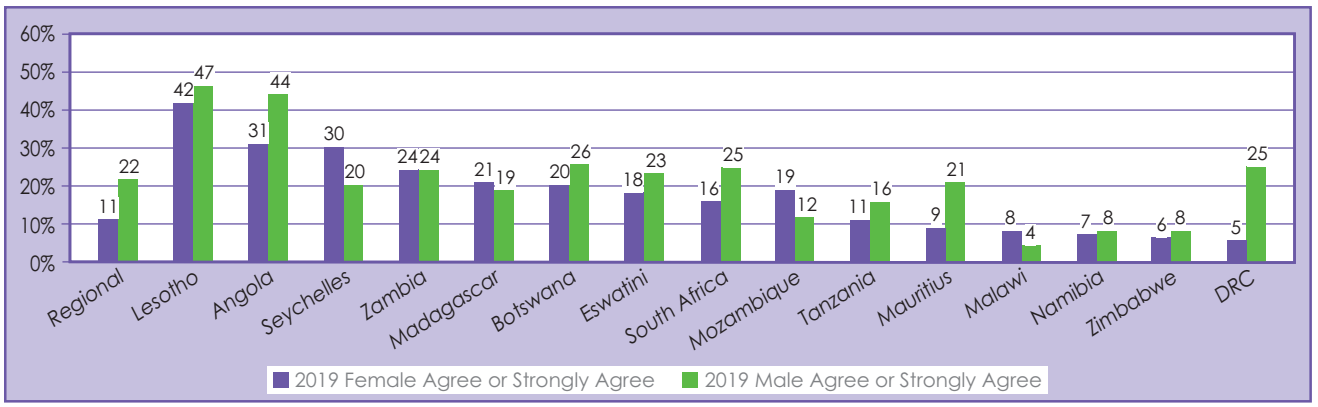
Figure 5.13: A woman can refuse to have sex with her husband



Source: Gender Links Attitude Survey, 2019.

The attitudes on whether a woman can refuse to have sex with her husband range quite widely with the highest rate of agreement to this statement of 62% of female respondents in Zimbabwe and the lowest rate of 11% of male respondents in Namibia. Overall male and female views are similar in every country. Over 50% of both females and males in Zimbabwe, Seychelles, Zambia, Lesotho and Malawi agree with the statement. South Africa and Angola have significant differences in attitudes between males and females with more females agreeing with the statement in South Africa and more males in Angola.

Figure 5.14: Nothing a woman can do if her husband wants to have girlfriends

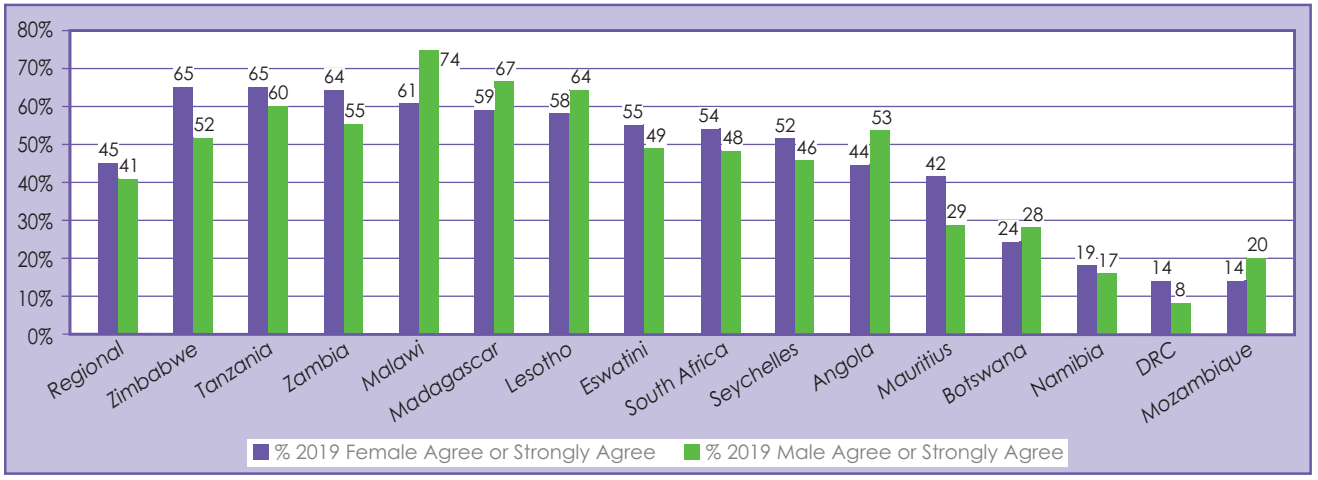


Source: Gender Links Attitude Survey, 2019.

Both males and females do not agree that there is nothing that a woman can do if her husband wants to have girlfriends. The highest rate of agreement in both females and males is in Lesotho (42% females and 47% males) and lowest for both is Zimbabwe (6% females and 8% males). Generally, the rates are quite similar for males and females in most countries, with higher rates for males in many countries.

Attitudes vary but do not yet promote HIV prevention

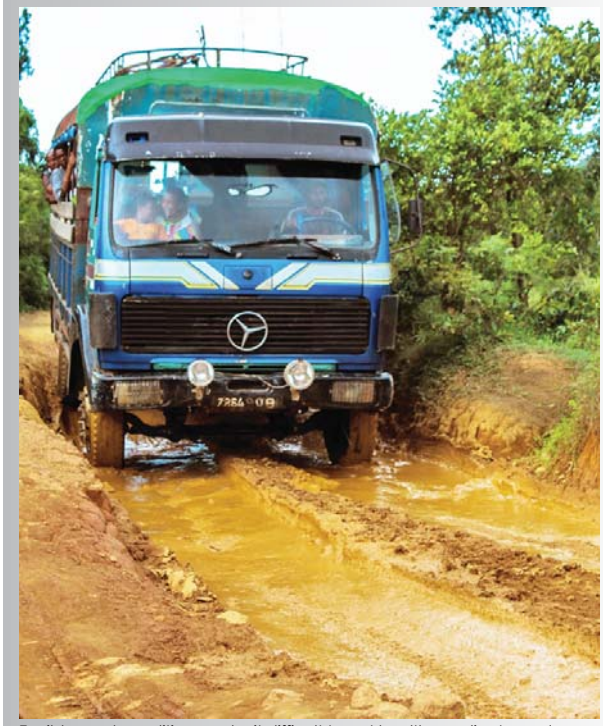
Figure 5.15: Women can insist and have right to insist on using a condom



Source: Gender Links Attitude Survey, 2019.

Over 50% of female respondents in Zimbabwe, Tanzania, Zambia, Malawi, Madagascar, Lesotho, Eswatini, South Africa and Seychelles believe that a woman can insist on using a condom. It is disturbing that rates of agreement drop to as low as 14% of female respondents in DRC and Mozambique. In some countries, such as Malawi, Angola and Mozambique more males than females agree that women have a right to insist on a man using condom. This reflects some change in attitude, especially at the local level.

Councils contribute to HIV prevention



Terrible road conditions make it difficult to get health supplies to rural communities in Madagascar. Photo: SEED Madagascar

In two very different settings, councils that have been part of the Gender Links programme have taken action to join schools and communities in fighting HIV and seeking to reduce the rate of new HIV infections.

The Urban Council of Mahajanga is located in the north-western part of **Madagascar**[26]: The population is estimated at 240 000 in an area of 53 square kilometres. Mahajanga is a tourist area and is classified as a red zone in terms of HIV prevalence, which means that prevalence in this area is higher than average.

The council sat with a range of stakeholders to develop an SRHR action plan which is funded by the council. One activity was SRHR training for key community members. After the training, the community members proceeded directly to the community sensitisation focusing on young people and reproductive health, HIV and AIDS, family planning and early pregnancy issues.

[26] https://genderlinks.org.za/casestudies/madagascar-mahajanga-fights-back-the-red-zone/

The programme was carried out in three public and private schools around the council by a team of the council staff, representatives of the health department and Population Services International (PSI) Madagascar during the 16 days of activism against Gender Based Violence in 2018.

Matzikama[27], is on the West Coast in the Western Cape Province of South Africa. Matzikama means "place of water" and boasts a wonderful destination where southern Namaqualand can be explored, with tourist attractions such as famous wines from the West Coast Winelands and beautiful flowers.

The council identified a number of problems, including HIV, poor use of condoms, commercial sex, CBOs facing funding challenges; patients not taking their medication correctly, or resorting to traditional medicines when they go to their rural homes and not adhering to their ARVs, failing to adhere over the weekends and turning to alcohol instead as well as the need for more support groups.

The municipality's main goal is a safe and healthy society. The municipality partnered with others such as local councillors, the police, department of Health, NGOs, home based care groups, local farmers, farm workers and mines. A committee was set up which is overseeing the programme. Monthly awareness and education sessions were instituted, which included awareness through the radio and social media. CBOs and Home Based Care organizations have been assisted to conduct door to door campaigns which has increased their visibility in communities. Each street now has an activist to monitor patients on their street and support them to adhere to their medication.

The committee also held a high profile awareness raising event in one area with high rates of substance abuse. This involved distribution of pamphlets and home visits. The campaign aims to change the mind set of people about HIV, GBV, substance abuse and address stigma. The campaign is also targeting TB which is very prevalent. The Municipality is planning a road show to every town to continue the awareness raising.

Source: Gender Links, 2019

PreExposure Prophylaxis (PrEP)

PreP is one of the five prevention pillars outlined in the Prevention Roadmap of the Global HIV Prevention Coalition. Prep means taking an ARV (currently Truvada - 1 pill per day) every day, before you have contracted HIV, to prevent HIV.

PrEP is recommended for discordant couples (where one is positive and the other negative), sex workers, or others at high risk of contracting HIV. If taken consistently and correctly the potential to prevent HIV is very high. Currently PrEp is not widely available but the prevention partnership aims to increase availability to 3 million by 2020.

Table 5.9: Number of people accessing PrEP

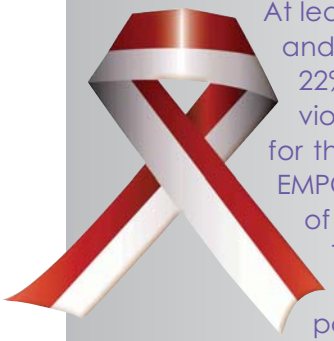
Country	Number of people that accessed PrEP in 2018
Angola	238
Botswana	7279
Mauritius	3
Namibia	190
Seychelles	4
South Africa	8184
Zambia	3823
Zimbabwe	4982

Source: UNAIDS Special Analysis 2019.

Table 5.9 indicates that PrEP is still in its infancy in Southern Africa. A total of 26,247 people accessed PrEP in 2018; the largest number in South Africa, Lesotho, Zimbabwe and Zambia. An important application of this prevention strategy is in cases of sexual violence.

[27] https://genderlinks.org.za/casestudies/south-africa-sexual-and-reproductive-health-hiv-aids/

GBV screening, counselling and PrEP



At least two studies have shown a clear link between intimate partner violence (IPV) and HIV. It is estimated from these studies that IPV accounts for between 12 and 22% of HIV. There are many pathways by which physical, sexual and emotional violence by a partner increases HIV risk for young women. One of the pathways for that linkage is in preventing a female partner from using HIV prevention. The EMPOWER study, conducted by Wits Reproductive Health Institute (RHI) at the University of the Witwatersrand in South Africa, in partnership with the Mwanza Intervention Trials Unit in Tanzania, the London School of Hygiene and Tropical Medicine in the UK, and the International Center for Research on Women, found that it is possible to deliver PrEP to Adolescent Girls and Young Women (AGYW) as part of a prevention package, within a framework of empowering them to manage and perhaps avoid unhealthy, controlling and violent relationships.[28]

The study found that integrating GBV screening into HIV counselling and testing for AGYW is acceptable and feasible when appropriate referral, staff debriefing and technical support are offered, and basic principles of empathetic listening and confidentiality are respected. It is essential that counselling for this group is adolescent-friendly and non-judgmental.[29] *Source: EMPOWER Study, 2018*

Treatment - access to ART

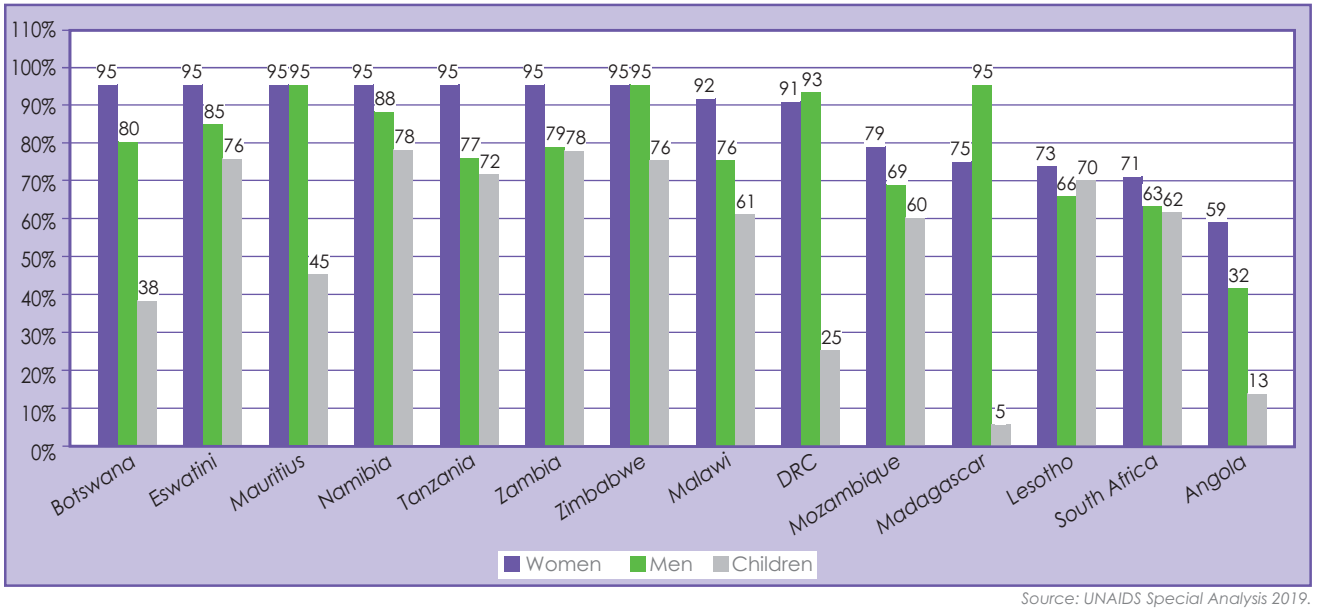
Article 27.3
b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and
UNAIDS 90/90/90: Target (2) By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

By 2018, all countries had significantly improved their treatment coverage for both women and men compared to 2008. All countries have adopted a test and treat approach, which means providing ARVs for all people living with HIV as soon as they are tested and found to be living with HIV, and many have increased coverage significantly despite limited infrastructure for health and heavy HIV burdens. The region has made great gains in treatment and the attainment of the 90-90-90 targets.

Great gains in the 90-90-90 targets

[28] http://www.ehpsa.org/all-documents/general/554-empower-eb/file accessed 5 June, 2019
[29] M.B. Colombini 1 , L. Ramskin2 , N. Khoza2 , A. Stangl 3 , F. Scorgie2 , S. Harvey4 , C. Manyamba2 , C. Watts4 , S. Kapiga5 , S. Delany-Moretlwe2 , Integrating gender-based violence screening and support into HIV counselling and testing for adolescent girls and young women accessing PrEP in South Africa and Tanzania - experiences from the EMPOWER study. IAC 2018 presentation. http://www.ehpsa.org/all-documents/aids2018/530-empowerment-columbini-1/file

Figure 5.16: People who know their HIV status on ARVs



Source: UNAIDS Special Analysis 2019.

Figure 5.16 shows that there are wide gender variations in access to ART, with women having higher levels of access than men. Namibia, Botswana, Eswatini, Namibia, Seychelles, Tanzania, Zambia, Zimbabwe, DRC and Mauritius have achieved at least 90% access to ART for women. Though South Africa and Mozambique have the largest absolute numbers of women on treatment (2, 782, 420 and 751, 577) this is only 66 and 63% of the number that is living with HIV respectively in the two countries. A total of 6,543,160 women living with HIV had access to ART in SADC in 2017.

The percentage of men living with HIV who accessed ART was much lower - with the highest rate of 76 per cent being in Eswatini and Zimbabwe. The only countries in which the percentage of men living with HIV that access ART is higher than the percentage of women living with HIV that access ART, are the DRC and Angola. The absolute number of men who access ART is generally approximately half of the absolute number of women in every country, except Madagascar. A total of 3,313, 340 men were on ART in SADC in 2017. In all countries the percentage of children living with HIV that were on treatment in 2017 was lower than that of women. In most, the percentage was lower than that of men as well.



Tanzania: Living positive, Living healthy[30]



"My first thought was how people would treat us. I was also afraid that if my husband and I were to die, our children would have no one to care for them. But, I thank God that seven years later, we're still surviving and we're a happy family". Asha Ramadhan is 42 years old and lives in the Tanzanian capital, Dar es Salaam. When she and her husband were diagnosed with HIV, their first thought was that they would die.

[30] Derived from http://genderlinks.org.za/news/tanzania-living-positive-living-healthy/

Her first husband died in a motorcycle accident in 2011 and she later remarried. However, she never went for HIV testing with her second husband until she fell pregnant. It was during her check-up at a local health center that both she and her husband were diagnosed with HIV. The doctor advised the mother of three that it was possible for their baby to be born without HIV as long as they followed the health instructions they received. The family began to follow the doctor's recommendations such as nutritional diets and medicine. In 2012, Ramadhan gave birth to a healthy baby.

She says, the child lives healthily and that as a family, they adhere to all the health principles administered by medical personnel. Asha says that being diagnosed with HIV is not the end of one's life. Their son, whom they named Akram, is now six years old and is a standard one student at a government school.

Ramadhan and her husband say that a lot has changed over the last seven years but they are glad to have survived. They now have a vision to do business in order to get plots for building houses.

"It is true that treatment has improved over time and has increased the life expectancy for those who access the medication. We appreciate the effort of the Tanzanian government, scientists and other stakeholders who play a big role to make sure that those living with HIV are under good supervision and care," She added.

She also said that health centers, dispensaries and hospitals, are playing a big role in educating women about preventing mother to child transmission of the disease.There is still a long way to go to ensure maximum sensitization in the country. More than 60% of women and 71% of men aged 15-49 know that HIV can be prevented by using condoms and by limiting sexual intercourse to one uninfected partner. Men are slightly more likely than women to know about the different HIV prevention methods and knowledge of HIV prevention methods is highest among women and men in urban areas and in the highest wealth quintile.

Rural areas need to be sensitized on issue of mother to child transmission. About 85% of women and 79% of men know that HIV can be transmitted by breastfeeding, only about two-thirds of women and men know that the risk of mother to child transmission of HIV can be reduced by the mother taking special drugs during pregnancy.

Even with so much HIV and AIDS information readily available, stigma and discrimination related to HIV are still widespread among Tanzanian adults. Although, the majority of women and men say they are willing to care for a family member with AIDS in their home, only 41% of women and 57% of men say that they would not want to keep secret that a family member has HIV. Another challenge, despite the availability of information, is the reluctance of some people living with HIV to take antiretroviral drugs.

During the opening ceremony of the National Aids Day International Conference for 2018, Antony Peter Mavunde, Deputy Minister for State in the Prime Minister's Office Responsible for Policy, Parliamentary Affairs, Labour, Employment, Youth and the Disabled said it was important that those diagnosed with HIV continue to take antiretroviral drugs. "This is important because they will be able to live a healthier life, they need to know that we need them to build our nation," he continued.

UNAIDS Country Director in United Republic of Tanzania, Dr.Leo Zekeng said Tanzania has taken a major step towards fighting AIDS since the 1980s and with access to treatment since 2010. "Tanzania can achieve the goal of removing AIDS as a health threat to the community by the year 2030 as part of Millennium goals and Tanzania vision of 2025. However, stigma and discrimination still continue to prevent people from getting an HIV testing to know their status."

Source: Godfrey Ismaely, Gender Links News Service, 2019

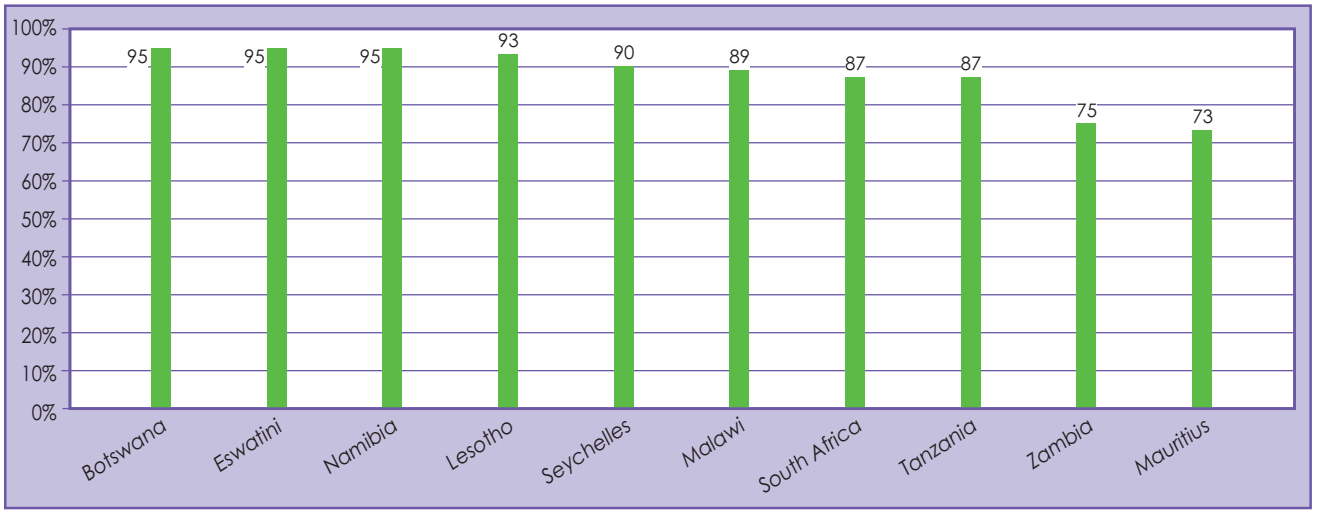
Drug resistance

Part of the Fifth South African National HIV Prevalence, Incidence and Behaviour Survey in 2017 was HIV drug resistance testing for the first time. The survey found that one in six people not on treatment already had drug-resistant HIV and more than half of those on treatment had resistance to at least one drug. The survey did not find any difference in the prevalence of drug resistance by age or sex.[31] The finding raises many concerns and researchers called for prioritisation of integrase inhibitors in first-line regimens and the stepping up of adherence support for people on antiretroviral treatment. Earlier switches from failing regimens are also needed to prevent the development of further drug resistance. South Africa plans to introduce dolutegravir-based first-line treatment during 2019. Dolutegravir (also known as DTG) has a higher barrier to resistance than other drugs but some South African clinicians think it should be preserved for use in third-line treatment.

Viral suppression

UNAIDS TARGET 3: 90% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.17: People on ART who achieve viral suppression



Source: UNAIDS Special Analysis 2019.

[31] Moyo S et al. HIV drug resistance in South Africa: results from a population-based household survey. Conference on Retroviruses and Opportunistic Infections, Seattle, abstract 152, 2019. http://www.aidsmap.com/page/3465700/

Figure 5.17 covering nine SADC countries has incomplete data, an indication that data on patients that have been retained in care or on viral suppression is not yet being routinely collected. It is anticipated that this data which will become more available in the coming years. Overall, the data which is available suggests that those that are being initiated on treatment are adhering. Thus, Botswana, Eswatini, Namibia, Lesotho and Seychelles are showing adherence levels of 90 per cent or higher. Malawi, South Africa and Tanzania show adherence levels between 80 and 90 per cent. However, there are differences, which are not seen in broad national data, between adherence in different sub groups of the population. This will need to be monitored closely and those on treatment will need continued encouragement to adhere to treatment.

Progress towards the third 90 is promising

The **Lesotho** PHIA study found that HIV prevalence in Lesotho peaks at 49,9% in women aged 35 - 39 and at 46,9% in men aged 40 to 44. At the age of 20 - 24 prevalence in females is 16,7% compared to prevalence in males of 4%. Viral load suppression (VLS) is highest at 45 to 59 years old at 80,3% for females and 81,4% for males. VLS in 20 to 24 years old is much lower - 50,9% in females and 46,1% in males.[32]

The **Namibia** PHIA study has shown that 86.0% of PLHIV aged 15-64 years were aware of their HIV status: 89.5% of HIV-positive females, and 79.6% of HIV-positive males. Among PLHIV aged 15-64 years who knew their HIV status, 96.4% were currently on ART: 97.1% of HIV-positive females and 94.9% of HIV-positive males. Among PLHIV aged 15-64 years who self-reported current use of ART and/or had a detectable ARV in their blood, 91.3% were virally suppressed: 92.2% of HIV-positive females and 89.5% of HIV-positive males.[33]

HIV and TB Coinfection



The World Health Organisation estimates that in 2017 there were about 10 million people (5·8 million men, 3·2 million women, and 1·0 million children) with TB, 9% of whom were coinfected with HIV. Of the 10 million, approximately 3.6 million, or 36%, are "missing", not diagnosed or properly treated. Among people living with HIV, the gap is 49%. People living with HIV with latent TB are 20 times more likely to develop active TB. Untreated TB is rapidly fatal among people living with HIV. TB is the leading infectious killer globally and the leading killer of people living with HIV, accounting for one in every three AIDS-related deaths. In 2017, 1.6 million people died of TB globally, including 300 000 people living with HIV.

The first ever United Nations High-Level Meeting on Tuberculosis held in September 2018, resulted in a "Political Declaration on Tuberculosis" to end the tuberculosis epidemic globally by 2030. The declaration included ambitious and bold targets for scale-up of tuberculosis care and prevention services, as well as commitments on research for new tools, principles of equity and human rights, and resource needs targets for both implementation and research. As current testing and treatment options are antiquated, achieving the end of TB will require at least double the current funding for both TB programming and research. This ambitious goal will also require action and accountability at all levels.

Seizing this opportunity would stop more than 6000 people dying every day from TB and HIV, prevent new infections and bring the world closer to achieving the Sustainable Development Goals.[34]

[32] Ministry of Health, Lesotho. 2018. Lesotho Population based HIV impact assessment. LePHIA 2016 -17. Summary sheet preliminary findings. http://phia.icap.columbia.edu
[33] MOHSS, Namibia. 2018. Namibia Population based HIV impact assessment. NamPHIA 2017. Summary sheet preliminary findings. http://phia.icap.columbia.edu.
[34] https://www.unaids.org/en/resources/presscentre/featurestories/2018/september/tb-and-hiv and Sahu, S, L. Ditiu & A. Zumla, " After the UNGA High Level Meeting on Tuberculosis - what next and how?", The Lancet Global Health, Vol 7, Issue 5. May 1, 2019.

Table 5.10: Aids related deaths

Country	AIDS related deaths	AIDS orphans (0-17)	Deaths averted due to ARVs
South Africa	71 000	1 200 000	330 000
Mozambique	54 000	1 100 000	73 000
Tanzania	24 000	850 000	57 000
Zimbabwe	22 000	630 000	51 000
Zambia	17 000	470 000	60 000
Angola	14 000	160 000	8 300
DRC	13 000	410 000	20 000
Malawi	13 000	500 000	37 000
Lesotho	6 100	110 000	16 000
Botswana	4 800	65 000	13 000
Namibia	2 700	37 000	8 000
Eswatini	2 400	45 000	7 700
Madagascar	1 700	24 000	500
Mauritius	1 000	3 600	500
Total	**246 700**	**5 604 600**	**682 000**

Source: UNAIDS Special Analysis 2019.

AIDS-related mortality in the SADC region declined by 54% between 2010 and 2018: from 540,000 to 246,700. The main reason for the decline in AIDS-related mortality in the region is the expansion of antiretroviral therapy[35] (ART) with 64 percent [58-72 per cent] of people living with HIV receiving ART, or about 10.4 million people. In 2018, ARVs averted 682,000 deaths, 330,000 of these in South Africa.

Care work

Article 27.3 a) Develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care givers, the majority of whom are women, the allocation of resources and the psychological support for care givers as well as support for care givers.

SDG 5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

SADC sponsored UN resolution on Women, Girls and HIV: Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognize, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure.

BPFA +20 Africa declaration: Reduce, recognize and redistribute unpaid care work, which falls disproportionately on women and girls, by investing in infrastructure and time-saving technology and emphasizing shared responsibilities between women and men, girls and boys.

[35] Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019–2030

In 2018, the International Labour Organization released a report, Care Work and Care Jobs for the Future of Decent Work[36]. Some of the findings of the report are:

- Most unpaid care work consists of household work (81.8%), direct personal care (13.0%) and volunteer work (5.2%).
- Across the world, women perform three-quarters of unpaid care work, or 76.2% of the total of hours invested. There is no country in the world in which men and women contribute an equal share of unpaid care work.
- Globally, unpaid care work is most intensive for girls and women living in middle-income countries, those married and of adult age, with lower educational achievement, resident in rural areas, and with children under school age.
- Most care workers are employed in education (123 million) and in health and social work (92 million). This total of 215 million workers (143 million women and 72 million men) represents 6.5% of total global employment in 2018. Domestic workers amount to at least 2.1% of total global employment: there are 70 million domestic workers employed by households across the world; of these, 49 million are women and 21 million are men.
- Care workers are mostly women who require a range of skills which are seldom recognized nor remunerated to engage with care recipients. They are not often well trained to provide these skills. Care workers often engage with clients in sustained care relationships; and often experience tensions between those they care for and the conditions in which they have to provide care. Care workers are not a homogenous group: there are differences and hierarchies among them, including in terms of pay, conditions and status.
- Community health workers are frequently undertrained, under- resourced and either underpaid or unpaid, and are often engaged to make up for a shortage of professional health workers.
- Poor job quality for care workers leads to poor quality care work. This is detrimental to the well-being of those who receive care, those who provide care, and also for unpaid carers who have fewer options available.
- It is in everyone's best interests to ensure good conditions for care delivery in both unpaid and paid forms. Transformative policies and decent care work are crucial to ensuring a future of work founded on social justice and promoting gender equality for all.
- We should aim to double investment in the care economy, leading to a total of 475 million jobs by 2030, or 269 million new jobs.

The role of community caregivers is continuing to be redefined as the AIDS epidemic progresses. It is generally accepted that we will not be able to care for all that need prevention services, testing, access to treatment, resupply of treatment and adherence support through the formal health system, especially in high burden countries such as in SADC. Thus, it is essential that formal services are supplemented by informal caregivers. The theory is that people living with HIV will receive differentiated care which takes account of different needs and realities. This may mean that fewer and fewer will be attended by professional care givers, with greater emphasis being on care provision by lay workers, who may be on a stipend or complete volunteers.



Lets Grow in Orange Far, Johannesburg provides peer education, care and support. Photo: Colleen Lowe Morna

[36] Addati, I, U. Cattaneo, V. Esquivel and I. Valarino. 2018. "Care Work and Care Jobs for the future of decent work, Summary," Geneva. ILO.

CHWs "provide the world's most promising health workforce resource for accelerating progress"

The African Union is calling for an additional two million community health workers (CHWs) to be recruited, trained and deployed. The case for these community health workers is[37]:

- In 2013, there were 17.4 million fewer health workers worldwide than were needed for essential primary health care services, with the most serious health workforce shortfall in Africa. Additionally, according to surveys, substantial percentages of doctors and nurses in Africa migrate to northern countries - 16.5% in South Africa, 17% in Nigeria and 43% in Zimbabwe. CHWs would help alleviate the impact of the loss of trained health personnel to other countries.
- Many health services can be effectively delivered through CHWs in community settings. Leveraging CHWs to serve as a bridge to sustainable health systems requires the rational sharing of clinical responsibilities among diverse cadres of health workers.
- A comprehensive review of available evidence found that CHWs "provide the world's most promising health workforce resource for accelerating progress".
- A major advantage of CHWs is that they take services directly to individuals and communities, at a time and place that is convenient for the client.
- Delivery of HIV testing services by CHWs offers an efficient and effective way to increase testing uptake as part of a "testing revolution" to achieve the first 90. This includes awareness raising for testing, making self-testing available and promoting community testing events.
- In the push to reach the second 90 by increasing the number of people receiving antiretroviral therapy from 18 million in June 2016 to 30 million by December 2020, CHWs can deliver medicines, monitor patients and support treatment adherence, achieving outcomes that exceed those reported for health facilities. Community-delivered models, with support from a range of CHWs, have achieved extremely high retention rates that are superior to those achieved in health facilities.
- In the face of seemingly insurmountable challenges, CHWs have proven to be innovators. For example, they pioneered community distribution of antiretroviral medicines, increasing treatment uptake while achieving very high rates of treatment adherence.
- Low rates of retention in HIV care led to the creation of peer-led adherence clubs, peer-based adherence assessments and other successful innovations. These community-generated innovations in the HIV treatment field, which were initially regarded as unorthodox but ultimately validated by rigorous evaluations, are now widely being adopted as standard national policy in high-burden countries.
- Studies indicate that supportive supervision of CHWs contributes both to the satisfaction of these workers and to the quality of the services they provide. A systematic review of available evidence found that community- and home-based approaches to the management of antiretroviral therapy generate clinical outcomes that are at least as good as those produced by facility-based care management, with patients receiving community support reporting higher levels of satisfaction.
- CHWs have made substantial contributions towards universal health coverage by ensuring meaningful service access for the hardest-to-reach, especially those that would not access health care as a result of stigma or negative attitudes. These include adolescents and young people, sex workers, men that have sex with men and injecting drug users.

[37] African Union. 2017. Two Million African community health workers: Harnessing the demographic dividend, ending AIDS and ensuring sustainable health for all in Africa. Addis Ababa. https://www.unaids.org/sites/default/files/media_asset/African2mCHW_en.pdf. Accessed 6 June, 2019.

- Studies have consistently found that services delivered by CHWs are highly cost effective.

Trained CHWs who are paid a living wage and valued by their community, are not likely to move, as they live in the communities they serve and are often elected to fill this role by their fellow community members.

The AU suggests 10 key action steps towards this massive new initiative:

1. Make development of a robust community health workforce a key political priority.
2. Reform policy frameworks to enable and accelerate mobilization of a community health workforce.
3. Develop a time-bound national scale-up plan for community health workers.
4. Empower communities to drive the recruitment of community health workers.
5. Use and adapt existing tools to train community health workers.
6. Provide fair compensation to community health workers.
7. Ensure proper supervision, access to mobile technology and performance monitoring of community health workers.
8. Train other health care workers to address and overcome potential professional resistance.
9. Ensure that community health workers have an organizational voice.
10. Mobilize sufficient financing for implementation of each national plan.

Next steps

- ***Continue to focus on cost effective mechanisms to increase prevention***, especially for adolescents and young people (both girls and their male partners). Prejudice, stigma and discrimination in relation to sex workers, men who have sex with men, prisoners, injecting drug users and other key populations will continue to fuel the epidemic and must be addressed.
- ***Put renewed emphasis on testing*** and ensuring that all know their status. It is not possible to begin the treatment cascade without testing. It is important that all are encouraged to be tested, including those that are older and those that are younger.
- ***Encourage mothers who are living with HIV adhere properly to their own medication and to ensure that their babies are tested early.*** The rates of transmission to babies will not reach elimination through only mothers accessing treatment during pregnancy. There is need for vigilance throughout breast feeding.
- ***Continue to focus on adolescents and young people:*** and especially encourage them to stay in school.
- ***Renew the focus on co- infections with TB*** and ensure that all that test positive for HIV are also screened for TB and that those need it receive TB medication.
- ***Support the AU calls for two million more community health workers*** and ensure that they receive training, psychosocial support, remuneration and materials which they require to conduct their work.



Candlelight vigil in Mauritius. Photo: Gender Links

Gender-Based Violence 6



A march against women and children abuse in South Africa's Orange Farm community in 2015.
Photo: Thandokuhle Dlamini

KEY POINTS

- Thirteen countries now have domestic violence and sexual assault legislation. But criminal justice system responses to GBV remain weak throughout SADC.
- Fifteen SADC countries now have legislation on sexual harassment.
- Six countries have valid National Action Plans (NAPs) on GBV, 10 have expired NAPS and only three have fully costed NAPs.
- All countries have laws on human trafficking, but many do not have the data to track victims.
- All countries offer some form of services to survivors of GBV, yet under-resourced NGOs continue to do most of the work.
- Stakeholders have called for a regional approach to meet the goal of eliminating GBV by 2030.
- Tanzania has approved a five-year budget of nearly 267 billion shillings (approximately US $115 million) to combat GBV.
- All SADC countries offer comprehensive treatment, including PEP, to survivors of violence.
- Out of the seven countries that have undertaken dedicated GBV Baseline Studies, only Botswana has approved a follow-up study.
- In Tanzania, nearly one in three girls and one out of seven boys experience some form of sexual violence before turning 18.
- A study on TV media in South Africa shows that this medium lacks diversity, balance and sensitivity in the coverage of gender violence. Only 16% of TV news stories on GBV mentioned where survivors can go for help.
- Attitudes seem to be shifting in the region. In one example, less than a quarter of respondents in all countries but one disagreed with the statement that "if a man beats a woman it shows he loves her."

This chapter focuses on Gender Based Violence (GBV): its extent, prevention, response and support across SADC. It tracks member state progress on GBV laws and policies, as well as interrogates how each respond to violence, and challenges linked to tackling it, by assessing countries against a number of normative frameworks. These include the SADC Protocol on Gender and Development, Beijing Platform for Action (BPFA) +20 Africa Declaration, Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Sustainable Development Goals (SDGs), the Maputo Protocol, International Conference on Population and Development (ICPD), and the Commission on the Status of Women (CSW) Resolution 60/2 on Women, the Girl Child and HIV. Due to the devastating effects of GBV, its linkage with the HIV and AIDS scourge, and its potential to inhibit women's reproductive health autonomy, this edition of the 2019 Barometer shines a spotlight on GBV as a key issue linked to SRHR.

Only seven countries have undertaken GBV Baseline Studies

Research carried out in the region over the past several years, including the GBV and Violence Against Women and Girls (VAWG) Baseline Studies conducted by Gender Links (GL) and partners in local government and civil society, points to alarming levels of GBV in Southern Africa.[1] In line with the 2030 Agenda for Sustainable Development, the European Union (EU) and the United Nations (UN) have invested more than US $500 million towards the Spotlight Initiative to eliminate violence against women and girls, with its mantra to "leave no one behind." In June 2019, the Government of Zimbabwe, the EU and the UN launched a US $34 million fund through the Spotlight Initiative to eliminate GBV and assist women and girls realise their potential. The UK government also contributed around £25 million (US $31 million) to What Works to Prevent Violence, an evidence-generating global programme that has been engaging global experts to produce rigorous evidence on the most effective interventions to reduce rates of VAWG. In June 2019, Canada announced the Equality Fund in which it pledged US $229 million for women's organisations that support gender equality.

At the regional level, some countries have made progress in addressing GBV by implementing multisectoral approaches that include legislative and criminal justice responses, measuring incidence and costing of GBV, awareness-raising, women's empowerment programmes, community-based social norm programmes, and health-based interventions.[2] In November 2018, the South African government, together with civil society, convened a two-day GBV and femicide summit in response to a request by thousands of women who marched on the Union Buildings in the #TotalShutDown protest against GBV in August 2018.

To date, only seven countries have undertaken VAWG and or GBV Baseline Studies (Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe). Botswana launched a more comprehensive follow-up study in May 2019. GL continues to collaborate with national statistical offices and gender ministries in the region to bolster efforts to collect, analyse and disseminate quality data on GBV.

[1] https://genderlinks.org.za/what-we-do/justice/research/violence-against-women-baseline-research/
[2] Lowe Morna, C. Dube S and Makamure, L (2017). SADC Gender Protocol Barometer 2017 Southern Africa. SADC Gender Protocol Alliance

Table 6.1: Key data: extent, response, support and prevention of GBV

INDICATORS	Region	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Proportion (%) of women and girls aged 15-49 who experienced intimate partner violence (IPV) in the previous 12 months (2016)[3]	All 15 countries	50	35	58	43	41	42	43	25	48	39	30	31	47	47	43
Proportion (%) of ever-partnered women aged 15-49 years experiencing intimate partner physical and/or sexual violence at least once in their lifetime (2013)[4]	Seven countries	N/A	N/A	64	N/A	N/A	N/A	31	N/A	33	N/A	N/A	26	43	49	42
Proportion (%) of women and girls aged 15 years and older subjected to physical and sexual violence by a partner in the previous 12 months (2013)[5]	Nine countries	32	N/A	4	N/A	N/A	N/A	14	N/A	7	6	N/A	10	12	9	18
Proportion (%) of women aged 15-49 years experiencing physical and/ sexual violence perpetrated by someone other than an intimate partner at least once in their lifetime (1995-2013)[6]	Five countries	N/A	N/A	3	N/A	N/A	N/A	2	N/A	N/A	N/A	N/A	N/A	3	3	1
Laws on domestic violence in 16 countries[7]	13 countries	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Laws on sexual assault in 16 countries[8]	13 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Human trafficking laws in 16 countries[9]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexual harassment laws in 16 countries[10]	15 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Integrated approaches: national action plans in 16 countries[11]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Accessible, affordable and specialised services, including legal aid, to survivors of GBV in 16 countries[12]	15 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Specialised facilities, including places of shelter and safety, in 16 countries[13]	14 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Comprehensive treatment, including post-exposure prophylaxis (PEP) in 16 countries[14]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
% who say if a woman works, she should give her money to her husband[15]	N/A	24	17	91	21	14	13	1	29	10	6	28	29	19	25	25
% who say if a wife does something wrong, her husband has the right to punish her	N/A	53	26	16	23	33	18	3	41	16	8	17	32	18	14	15
% who say if a man beats a woman, it shows that he loves her[16]	N/A	29	23	13	24	10	7	1	45	9	6	14	22	8	14	16
% who say if a woman wears a short skirt, she is asking to be raped[17]	N/A	44	29	8	26	22	20	2	44	18	5	21	26	26	19	19

Source: Gender Links, 2018.

3 https://sdg-tracker.org/gender-equality [accessed 2 July 2019; (last updated 2016]
4 https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf [accessed 2 July 2019; (last updated 2013)]
5 IBID
6 https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf [accessed 2 July 2019 (last updated 2013]
7 GL Audit of SRHR Policies and Laws in SADC, 2019.
8 IBID
9 Department of State, USA. (2016). Trafficking in persons 2016 report. (0nline) available at https://www.state.gov/documents/organization/258876.pdf (accessed 14 July 2017).
10 GL Audit of SRHR Policies and Laws in SADC, 2019.
11 https://genderlinks.org.za/what-we-do/justice/policy-and-action-plans/ [accessed 28 May 2019].
12 Status of DHS Surveys in SADC countries.
13 IBID
14 https://aidsfree.usaid.gov/sites/default/files/2018.2.26_pep-xwalk-update.pdf [accessed 28 May 2019].
15 Gender Links administered SADC Gender Protocol Attitude Survey 2018-2019.
16 IBID
17 Gender Links administered SADC Gender Protocol Attitude Survey 2018-2019.

15 countries offer accessible, affordable and specialised services to GBV survivors

Table 6.1 shows that:

- Thirteen SADC countries (up from nine in 2009) have implemented domestic violence legislation and 13 have sexual assault legislation.
- Three countries (DRC, Lesotho and Tanzania) have yet to enact specific domestic violence laws.
- In 2009, just two countries had laws on sexual harassment and three had legislation on human trafficking. Now, 15 countries out of 16 (Comoros is now a 16th SADC member) have legislation on sexual harassment.
- All 15 SADC countries have human trafficking laws.
- Six countries have valid National Action Plans (NAPs) on GBV; 10 have expired NAPS or NAPS for which the status is unknown. Meanwhile, three have fully costed NAPs.
- There is no consistency in when researchers conduct studies across countries - this chapter has used the latest for each indicator. This presents a monitoring issue for those reviewing the SADC Strategy, which stakeholders should aim to address moving forward.

While most SADC countries have laws on domestic violence, many of these need an update because they date back as much as 15 years. Additionally, enforcement remains a challenge due to limited resources. Tanzania has budgeted 2.4% of its 5-year costed National Plan of Action to End Violence against Women and Children (NPA-VAWC 2017/18-2021/22) budget for implementation and enforcement of laws. In some settings, incongruence exists between civil and traditional law, especially Lesotho and Eswatini,[18] and these countries have not yet harmonised legislation.

Fifteen countries offer accessible, affordable and specialised services, including legal aid, to GBV survivors. Yet services remain unevenly distributed due to ineffective sectoral coordination, with rural areas largely disadvantaged given that under-resourced NGOs provide most services. The number of countries that offer places of safety for GBV survivors has risen from only two countries in 2009 to 15 in 2019.

In 2009, just two countries provided PEP to survivors of sexual violence under statutory obligation.[19] Today, all 16 countries offer comprehensive treatment, including PEP, to survivors of violence. As previous Barometers have highlighted, there is need to measure progress on the quality of services rendered and how it transforms the lives of ordinary people.



A focus on youth is key to ending GBV: Goshwe Junior School Students during the Sixteen Days of Activism. Photo: Keletso Metsing

[18] Musariri, L., Machisa M, T. Nyambo, V. and Chiramba, K. (2015) The Gender based violence Indicators Study: Lesotho. Gender Links available at http://genderlinks.org.za/programme-web-menu/publications/gender-based-violence-indicators-study-lesotho-2015-02-27/

[19] Lowe-Morna, C and Walter, D. (2009). SADC Gender Protocol Barometer, Gender Links website, available at http://genderlinks.org.za/shop/sadc-gender-protocol-baseline-barometer-2009/

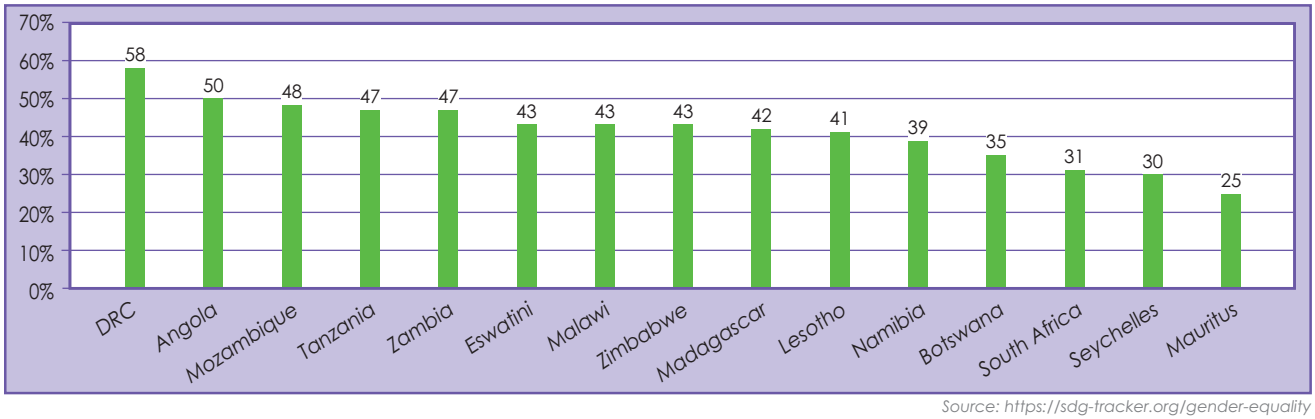
The extent of GBV

Over the years, global attention has slowly turned to GBV as a human rights violation of endemic proportions, but the issue remains sensitive and hidden in most societies and cultures. By spear-heading dedicated surveys and having led these in seven countries so far, GL is responding to the lack of reliable data on GBV in the region. The data challenge is compounded by serious under-reporting, inherently patriarchal institutional structures (such as police and health services[20]), significant cultural or religious barriers, weak sectorial infrastructure, a lack of fiscal and human resources and capacities, low statistical capacity, ineffective sectorial coordination in relevant government ministries, and a lack of universal indicators that hinder effective data collection. However, several stakeholders, including the UN Economic Commission for Africa and some gender ministries, have been making efforts to harmonise indicators and measure GBV in its various forms.



Women march for gender justice in the #TotalShutDown Women's March in South Africa in 2018.
Photo: Thandokuhle Dlamini

Figure 6.1: IPV in the last 12 months



Source: https://sdg-tracker.org/gender-equality

The SADC Gender Strategy score card proposes to use data from DHS surveys to measure the extent of GBV. As illustrated in the first four indicators in Table 6.1, this data is patchy across the SADC countries. The most complete data (Figure 6.1) is experience in the last twelve months of Intimate Partner Violence (IPV) for women aged 15 to 49 (2016 fugures). The data shows that IPV in the last twelve months for this age category ranged from 25% in Mauritius to 58% in Madagascar. In ten countries, the rate was 40% or higher. These figures support the frequently cited statistic that at least one on three women experience some form of GBV in Southern Africa.

[20] Lowe Morna, C. Dube S and Makamure, L (2017). SADC Gender Protocol Barometer 2017 Southern Africa. SADC Gender Protocol Alliance

Table 6.2: Difference between the DHS and GBV Baseline Studies

DHS	GBV Baseline Studies
Scope	
30 questions	More than 150 indicators that seek to measure the prevalence, effects and drivers of violence.
Source	
	Several standard, globally accepted and tested measurement tools, including the UN's Multi-country Study on Women's Health and Domestic Violence, Gender Equitable Men (GEM) scale and the Harvard Trauma Questionnaire (HTQ).
Measures	
Physical, emotional and sexual abuse in intimate relationships	Physical, sexual, psychological and economic intimate partner violence.
Physical abuse by stranger	The VAW/GBV Indicators only looked at physical abuse within intimate relationships, not by strangers. DHS has specific questions on physical abuse by non-partners.
Physical abuse in pregnancy	Physical, sexual, psychological and economic intimate partner violence in pregnancy.
Physical violence perpetration and alcohol	GBV violence perpetration and alcohol, child abuse, attitudes, and demographic factors.
Rape by non-partner	Rape by non-partner. Rape and sexual assault by a partner, stranger, acquaintance or family member, experienced by adults and in childhood.
Help-seeking behaviour	Help-seeking behaviour (medical, legal, police, shelter and family) and reporting and conviction patterns.
Witnessing domestic violence of parents	Witnessing domestic violence in the home and community.
	Sexual harassment in schools, workplace and public places.
	The study also has output indicators focusing on the response mechanisms and some prevention strategies, such as campaigns.
	Effects, including reproductive health (HIV, sexually transmitted infections) mental (post-traumatic stress disorder and Center for Epidemiological Studies Depression scales), physical and economic.

Source: GBV Indicators Questionnaire and DHS Domestic Violence Module.

In some countries, researchers have specifically designed dedicated surveys with a module to measure GBV in all its different forms. Table 6.2 illustrates that these tend to be more in depth than other Demographic and Health Survey (DHS) modules, which fall into existing larger surveys measuring various health indicators.[21] This includes the VAWG and or GBV Baseline Studies, which employed several standard, globally accepted and tested measurement tools to measure a number of indicators not in the DHS modules, such as sexual harassment and effects of GBV.

Prevalence of GBV and intimate partner violence (IPV) in seven countries

Of the seven countries where GL conducted GBV Baseline Studies, only Botswana and Seychelles have carried out a follow-up study that included a module on violence against men. The results show that GBV transcends boundaries and the abusers of women are people that they know and live with, in their homes.

[21] UN Expert Group (2007) available at http://www.un.org/womenwatch/daw/egm/IndicatorsVAW/IndicatorsVAW_EGM_report.pdf (accessed 10 June 2018)

Table 6.3: Proportions of women experiencing and men perpetrating GBV and IPV in lifetime

Country	Lifetime GBV (%)				Lifetime IPV (%)			
	Women experiencing	Men perpetrating	Men experiencing	Women perpetrating	Women experiencing	Men perpetrating	Men experiencing	Women perpetrating
Lesotho	86	41	-	-	62	37	-	-
Selected provinces Zambia	77	66	-	-	79	74	-	-
Zimbabwe	68	46	-	-	69	41	-	-
Seychelles	58	43	43	31	54	42	35	40
South Africa (four provinces)	50	39	-	-	49	40	-	-
Botswana	37	30	21	12	37	28	18	18
Mauritius	24	23	-	-	23	22	-	-

Source: GBV/VAW Baseline Studies, Gender Links.

Table 6.3 shows that lifetime experience of GBV among women ranges from a high of 86% in Lesotho to 24% in Mauritius. A higher proportion of women reported experiencing violence than the proportion of men who reported perpetrating violence in all seven countries. However, the extent to which men report such behaviour is high in all countries and is almost equal in Mauritius.

Findings by GL in the two countries (Botswana and Seychelles) that have included a violence against men module show that high numbers of men also reported experiencing both GBV and IPV: 43% of men in Seychelles and 21% in Botswana reported experiencing GBV. Additionally, 35% of men in Seychelles and 18% in Botswana reported experiencing IPV at least once in their lifetime. Many more (40%) women interviewed in Seychelles reported perpetrating IPV compared to 18% of women in Botswana.

Why VAM

Violence against men is generally hidden and not recognised in many countries. In order to effec-tively tackle it, policy makers require more and better quality information, to guide legislative and policy reforms; to ensure adequate provision of targeted and effective services.

Getting data on VAM poses challenges due to traditional gender roles in society and the stigma of the perceived weakness of any man who admits to falling victim to a woman. In most cases VAM is foreshadowed by actions that may not seem like domestic violence on the surface, but do, in fact, represent a series of abuses against the men.



Men's "I" Story workshop in Botsana. Photo: Keletso Metsing

Trafficking in persons (TIP)



SADC Gender Protocol Article 20.5: State parties shall:

(a) Enact and adopt specific legislative provisions to prevent trafficking in persons and provide holistic services to the victims, with the aim of re-integrating them into society;

(b) Put in place mechanisms by which all relevant law enforcement authorities and institutions should eradicate national, regional and international trafficking in persons' syndicates;

(c) Put in place harmonised data collection mechanisms to improve research and reporting on the types and modes of trafficking to ensure effective programming and monitoring;

(d) Establish bilateral and multilateral agreements to run joint actions against trafficking in persons among origin, transit and destination countries; and

(e) Ensure capacity-building, awareness-raising and sensitisation campaigns on trafficking in persons are put in place for law enforcement officials.

SDGs 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation; and 16.1 Significantly reduce all forms of violence and related death rates everywhere.

Despite the challenges in tracking and monitoring trafficking in persons, all SADC member states have enacted laws against it. Countries have also committed to the 10 Year SADC Strategic Plan of Action on Combating Trafficking in Persons Especially Women and Children (2009-2019), which SADC gender ministers adopted in Gaborone in June 2016.

Supporting local action to fight a global problem

A 2018 report by the United States Department of State emphasises the need to support local communities to fight human trafficking, otherwise known as "modern day slavery." The annual report prepares a global tracking report on human trafficking using information from various sources in all countries. In the report, the department places each country into one of four tiers, as mandated by the United States Congress Victims of Trafficking and Violence Protection Act of 2000 (TVPA), which stipulates that governments should make serious efforts to prohibit and eliminate various forms of trafficking in persons and punish acts of such trafficking. Therefore, it bases the analyses on the extent of governments' efforts to reach compliance with the TVPA's minimum standards for the elimination of human trafficking, consistent with the Palermo Protocol (Department of State, 2016).[22]

Human trafficking is also known as "modern day slavery."

[22] Department of State, USA. (2016). Trafficking in persons 2016 report. (0nline) available at https://www.state.gov/documents/organization/258876.pdf (accessed 14 July 2017).

Table 6.4: Compliance of SADC states with minimum standards for trafficking[23]

Tier	Characteristics	SADC countries 2015	SADC countries 2016	SADC countries 2017	SADC countries 2018	Notes
1	Countries whose governments fully comply with the TVPA minimum standards.	None	None	None	None	
2	Countries whose governments do not fully comply with the TVPA's minimum standards, but are making significant efforts to bring themselves into compliance with those standards.	Angola, Malawi, Mozambique, Seychelles, South Africa and Zambia	Angola, Botswana, Lesotho, Madagascar Malawi, Mauritius Namibia, South Africa and Zambia	Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Namibia, Seychelles, South Africa, and Tanzania	Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Tanzania and Zambia	Mozambique and Zambia upgraded from tier 2 watch list to tier 2
2 - Watch list	Countries whose governments do not fully comply with the TVPA's minimum standards, but are making significant efforts to bring themselves into compliance with those standards and: The absolute number of victims of severe forms of trafficking is very significant or is significantly increasing; There is a failure to provide evidence of increasing efforts to combat severe forms of trafficking in persons from the previous year; or the determination that a country is making significant effort to bring itself into compliance with minimum standards was based on commitments by the country to take additional future steps over the next year.	Botswana, DRC, Lesotho, Mauritius and Namibia	DRC, Mozambique, Seychelles, Eswatini and Tanzania	DRC, Mozambique, Eswatini, Zambia and Zimbabwe	Angola, Eswatini, Madagascar, Seychelles, South Africa, and Zimbabwe	Angola, Seychelles and South Africa downgraded from tier 2 to tier 2 watch list and Zimbabwe upgraded from tier 3 to tier 2 watch list
3	Countries whose governments do not fully comply with the minimum standards and are not making significant efforts to do so.	Zimbabwe	Zimbabwe		DRC[24] and Comoros	DRC downgraded from tier 2 watch list to tier 3

Source: Department of State, USA. Trafficking in persons 2018 Report.

Table 6.4 shows that, since 2015, no SADC country has ever sat in tier 1. Many countries have fluctuated, with tier 2 and tier 2 watch list seeing the most movement since 2016, when the tracking ranked nine countries in tier 2. In 2017, the number increased to 10 countries, before falling to eight in 2018. In 2018, the tracking tool upgraded Mozambique and Zambia to tier 2 from tier 2 watch list, whilst Angola, Seychelles and South Africa dropped from tier 2 to tier 2 watch list. There is a need for countries to cement gains in the fight against human trafficking if the region is to see less movement between tiers and improve work in this area to comply with TVPA minimum standards.

[23] Ibid
[24] https://www.state.gov/wp-content/uploads/2019/01/282798.pdf

Sexual harassment



SADC Gender Protocol Article 22.1: State parties shall enact legislative provisions and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres and provide deterrent sanctions for perpetrators of sexual harassment.

SADC Protocol Article 22.2: State parties shall ensure equal representation of women and men in adjudicating bodies hearing sexual harassment cases.

Fifteen countries now have sexual harassment legislation: Of these, only a few have stand-alone sexual harassment laws; in most countries this is covered in labour laws and penal codes.[25] Angola does not have a sexual assault/offences or sexual harassment law. Despite having far-reaching impacts on victims, SADC society has been slow to acknowledge it as a problem and victims rarely report it. Many groups in society continue to normalise and hide sexual harassment. In many settings, people in positions of power trivialise sexual harassment: sadly, this includes the victims themselves.[26] Thus, having legislation is only one step towards eradicating harassment. Activists and legislators must place more emphasis on raising the alarm around its abnormality.

In this digital age, a variant form of sexual harassment known as sextortion has gained traction in many countries in the absence of tough social media laws. Sextortion is defined as "a form of sexual exploitation that employs non-physical forms of coercion to extort sexual favours from the victim."[27] In Tanzania, the National Action Plan to end GBV 2017-2022 recognises sextortion as extorting sexual favours in return for rendering public services.[28] Sextortion is becoming more common in workplaces, especially those with a sole proprietor, as well as in primary and secondary schools, health centres and public service offices. In South Africa, the abuse is understood as a scam in which abusers doctor social media photos into porn images and videos, which they then use for blackmailing purposes. The blackmailer threatens to publish nude pictures in exchange for sexual favours or ransom from the victims. These are some of the emerging forms of violence that should be added and updated in GBV laws and policies.

Despite these ongoing challenges, since the publication of the 2018 Barometer, notable efforts to address GBV have occurred, both globally and across the region. Globally, GBV awareness raising campaigns such as the 16 Days of Activism and One Billion Rising continue to draw attention to the scourge. Simultaneously, the NGO sector, government, academia and international development partners continue to emphasise the need for evidence-based and theoretically-grounded interventions.

The case study from Zimbabwe underscores the need for governments to legislate deterrent sanctions against perpetrators of sexual harassment in line with Article 22.1 of the SADC Protocol.

[25] Lowe-Morna, C., Makamure, L., Dube, S. (2016) SADC Gender Protocol Barometer (online) available at http://genderlinks.org.za/shop/sadc-gender-protocol-barometer-2016/ (accessed 12 July 2017)
[26] Hinde, 2017. #MeToo: All Sexual Harassment Experiences Are Worth Reporting, But Don't Feel Pressured To ShareOpinion piece https://www.huffingtonpost.co.uk/entry/sexual-harassment-experiences-me-too-hashtag-pressure-to-share-stories_uk_59e5dbf1e4b0a2324d1d825e (accessed 1 June 2018).
[27] https://en.wikipedia.org/wiki/Sextortion
[28] Tanzania's National Action Plan to end GBV 2017/18-2021/2022



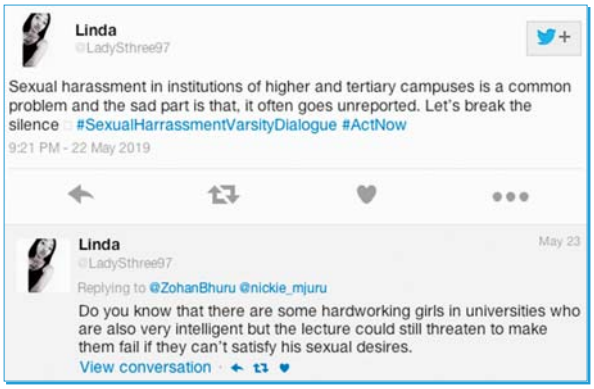
Zimbabwe students launch campaign against sexual harassment on campus[29]

The reality of sexual harassment in institutions of higher learning, also known as "sex for marks," continues to rear its ugly head across the SADC region. This affects the education of women and girls, whose enrolment in tertiary institutions remains lower than their male counterparts.

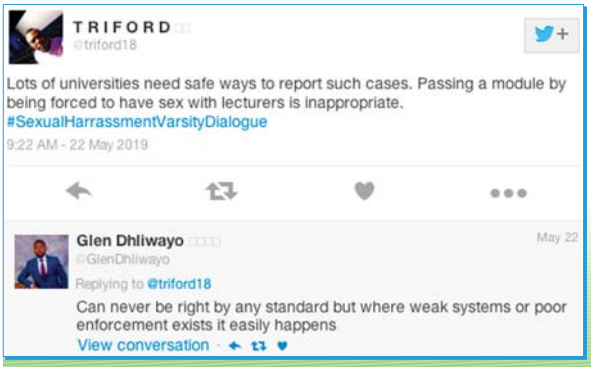
Following revelations by the Female Students Network Trust that male staffers have abused at least 74% of female students at universities across Zimbabwe, stakeholders in the Gender sector took to campaigning against the scourge by holding a dialogue dubbed *#SexualHarassment VarsityDialogue*. The event, with support from Sweden and UN entities in Zimbabwe, saw students sharing their personal stories ("I" Stories) about the challenges of sexual harassment and abuse on university campuses in Zimbabwe.

The extent that male lecturers play a role in the sexual abuse scandals that tend to ruin these students' futures remains a serious concern. This harassment exposes students to the risk of getting pregnant or contracting HIV and other sexually transmitted infections (STIs). When male lecturers perpetrate these crimes and abandon professional standards and their mandate to ensure good academic standards, they betray the next generation and the entire Zimbabwe education system, which has long been regarded as one of the best in the region.

Some Twitter comments show how participants engaged with the topic on the day of the event.









Source: Bishow Parajuli, UN Zimbabwe, 2019

[29] http://www.zw.one.un.org/newsroom/news/stepping-partnerships-end-sexual-exploitation-varsities

Hate crimes

Hate crime, also known as prejudice-motivated crime,[30] includes violence related to race, ethnicity, religion, gender or sexual orientation. Hate crimes also target property belonging to a community or group. News reports in the region show that regular violence against lesbian, gay, bisexual, transgender and intersex (LGBTI) is common. Nevertheless, many instances of violence against LGBTI individuals remain unreported owing to fear of secondary victimisation. This means many victims avoid or delay access to essential services like health, social, legal and psychosocial support. Apart from South Africa, which enacted the Prevention and Combating of Hate Crimes and Hate Speech Bill in 2018, no other SADC countries have yet created similar legislation to prevent hate crimes and speech.

The recent landmark rulings to decriminalise same sex relationships in Angola and Botswana pave the way for the LGBTI communities in these countries to access health, social, legal, and psychosocial services. This is in line with SDGs 3.7 and 5.6, to ensure universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings.

Online violence against women

Despite the great advances in internet technology as an information gateway, online violence against women has become endemic, further limiting the voice and choice of women and girls as these new forms of harassment often spill into the real world. Online violence includes death threats, online defamation, exposing nude pictures or texts, intimidation and disinformation campaigns.[31] Research shows that some form of online violence affects some 73% of women globally. Women in SADC have also been victim to online VAWG, and the scourge of online violence often goes unreported. Additionally, SADC countries have weak laws for dealing with online harassment. Legislators in Zimbabwe are currently mooting a bill to control the use of social media, but the scope of this bill is not yet clear.

Hate crime can include violence related to race, ethnicity, religion, gender or sexual orientation.

GBV in emergency situations

Responding to GBV in emergency settings can be a challenge. The devastating impact of Cyclone Idai and Cyclone Kenneth, which hit Zimbabwe, Mozambique, Malawi, Madagascar, Seychelles, Tanzania, Comoros, and Durban in South Africa, in early 2019, has not only exposed the lack of preparedness by countries to assist the displaced, but also increased the risk of women and girls' exposure to GBV. There have been reports in Mozambique men forcing women to barter sex for food to avert hunger.[32]

[30] http://hatecrime.osce.org/what-hate-crime (accessed 12 June 2019)
[31] https://www.ohchr.org/EN/HRBodies/HRC/Pages/NewsDetail.aspx?NewsID=23238&LangID=E (accessed 12 June 2019)
[32] https://africa.cgtn.com/2019/04/25/hrw-mozambique-cyclone-victims-force-to-trade-aid-for-sex/ (accessed 13 June 2019)



Investigating "sex for food" allegations in Mozambique[33]

Human Rights Watch recently reported on disturbing allegations that survivors of Cyclone Idai in Mozambique were being forced to have sex with community leaders in exchange for food. The next day, the United Nations pledged to investigate the allegations. It's a chance to protect women and girls in Mozambique and end exploitation of vulnerable cyclone victims.

On May 3, the UN humanitarian coordinator for Mozambique, Marcoluigi Corsi, reiterated the UN's "zero tolerance" policy on sexual exploitation and abuse, noting his team had trained hundreds of aid workers and volunteers on the prevention of sexual exploitation and abuse in Mozambique. He also admitted that despite their "best efforts" to prevent cases from occurring, the risk of sexual exploitation and abuse persists.

These are important steps towards ensuring other women and girls will not be forced to give sex for humanitarian aid. But the UN alone cannot help thousands of vulnerable women in areas where access to information is limited, and where UN survivor-support centres are non-existent.



Women carry food supplies they received at a farmhouse in Matarara, Mozambique on 4 April 2019. Photo: AP Photo/Tsvangirayi Mukwazhi

The Mozambican government and community leaders need to step up by investigating the allegations, holding those responsible to account, and sending clear messages across Mozambique that such abuse will not be tolerated.

Human Rights Watch is not aware of any actions yet taken by the Mozambican government to credibly investigate or punish those responsible, including in cases documented and reported on by Human Rights Watch and others.

Last month, Portugal's Jornal de Noticias reported on the case of a mother of three in Lamego, a village in Tica town, Sofala province, who was coerced into sex on three occasions by one of the neighbourhood secretaries, in exchange for bags of rice. The story was widely republished by the local Mozambican press, yet there is no public record of a government investigation, and authorities have not publicly reacted to the reports. A community official in Lamego told Human Rights Watch that the Tica town administrator called the secretary in for questioning, but no disciplinary action was taken against him.

The humanitarian coordinator said that the UN will engage with the government to ensure that any report of sexual exploitation "is addressed confidentially, promptly and comprehensively." Now the UN needs to follow through on its pledges. Real progress will only be possible if the Mozambican government and community leaders publicly commit to ending sexual exploitation and abuse of those needing humanitarian aid, and urgently investigate the Cyclone Idai cases that have been reported.

Source: Zenaida Machado, Human Rights Watch, 2019

[33] https://www.hrw.org/news/2019/05/08/investigating-sex-food-allegations-mozambique



Protesters march against GBV in South Africa's Orange Farm community in 2015. Photo: Thandokuhle Dlamini

Effects of GBV

Globally, studies have documented that GBV has devastating effects on the economic and social development of both women and men and society at large.[34] Studies show that the horrendous scourge often leaves permanent physical injury; indelible emotional wounds; serious health challenges, including negative sexual and reproductive outcomes; economic incapacity; and enormous mental health challenges, including depression and suicidal tendencies. In some circumstances, GBV leads to death. According to the World Bank and United Nations Population Fund (UNFPA), rape and physical violence caused more women's deaths compared to other deterministic factors such as cancer, motor vehicle accidents, war and malaria.[35] Abuse also affects the unborn child for those abused in pregnancy.

In sub-Saharan Africa, research has identified GBV as a major determinant of HIV and AIDS infections among women. This has seen several interventions focusing on the eradication of violence against women to fight the spread of the HIV. The GL GBV Baseline Studies and the "I" Stories gathered from the seven countries so far indicate traumatic experiences that are hard to imagine - worse when the abuse is committed by intimate partners.

"In 1995 he broke my leg again, while beating with a molamu (knobkerrie). I reported the incident to the police and a charge was laid against him. My husband begged me to have the charge dropped and even promised to take me to a private doctor for my leg and I gave in. However, nothing changed, he never took me to the doctor as promised and at present my leg is weak and because of that I am not able to do odd jobs to support my kids."

~ Gladys, 51 years.[36]

Measuring the cost of violence

Apart from health implications, GBV has cost implications to the economy of a country and to individuals. Several global studies have used a variety of methods to understand its economic impact. Two types of methodologies measure the cost of GBV: those that attempt to attach a monetary value to the effects of GBV, and those that concentrate on estimating its impacts on health, education, labour force participation and other outcomes of interest, without attaching a monetary value. The specific costs include:

- *Direct costs:* actual expenditures related to GBV. These include health care services, judicial services and social services.

[34] UNAIDS. Global Report Fact Sheet: Sub-Saharan Africa. Geneva: UNAIDS, 2010
[35] World Bank and UNFPA quoted in Mukanangana, F., Moyo, S., Zvoushe, A. and. Rusinga, O. (2014). Gender Based Violence and its Effects on Women's Reproductive Health: The Case of Hatcliffe, Harare, Zimbabwe. African Journal of Reproductive Health. 18[1]: 110-122
[36] I stories collected by GL available at https://www.dropbox.com/home/2015_I%20stories%20for%20Women/North%20East%20District/Physical%20violence?preview=Ariet+Matlhomola.docx

- *Indirect costs:* represent the value of lost productivity from both paid work and unpaid work, as well as the foregone value of lifetime earnings, revenue, and taxes for women who have died as a result of GBV.

Whilst stakeholders use the two methods to estimate the cost of GBV globally, there seems to be another cost that has been under-researched. This includes second generation costs of GBV: the cost of children witnessing and living with violence, such as increased juvenile and adult crime.

Studies on measuring the costs of GBV in SADC

There is an expanding body of research that is attempting to document GBV's economic impact on women and societies. Researchers have conducted three prominent studies in Southern Africa.

- **Seychelles** - The Commonwealth Secretariat has gone one extra step to measure the cost of GBV in Seychelles. Findings show that Seychelles loses more than US $65 million each year to VAWG. The report breaks new ground by capturing how direct costs of violence, such as loss of income, can lead to a much larger economic impact.[37] Researchers are now cascading the study to Lesotho and Trinidad and Tobago.
- **South Africa** - A 2014 study by KPMG on the cost of violence against women in South Africa revealed that GBV costs the South African government R28.4 to 42.4 billion (US $2-3 billion) per year.[38]
- **Zimbabwe** - A study commissioned by the Swedish International Development Agency (SIDA), revealed that the government was spending close to $2 billion annually on direct and indirect costs of GBV.[39]

Response

SADC Gender Protocol Article 20.1: States parties shall:
(a) Enact and enforce legislation prohibiting all forms of gender-based violence;
(b) Develop strategies to prevent and eliminate all harmful social and cultural practices, such as child marriage, forced marriage, teenage pregnancies, slavery and female genital mutilation; and
(c) Ensure that perpetrators of GBV, including domestic violence, rape, femicide, sexual harassment, female genital mutilation and all other forms of GBV are tried by a court of competent jurisdiction.

SADC Gender Protocol Article 20.3: States parties shall review, reform and strengthen their laws and procedures applicable to cases of sexual offences and GBV to:
(a) Eliminate gender bias; and
(b) Ensure justice and fairness are accorded to survivors of gender-based violence in a manner that ensures dignity, protection and respect.

SADC SRHR Strategy Outcome 10: Remove barriers - including policy, cultural, social and economic - that serve as an impediment to the realization of SRHR in the region (SDGs 5.1 and 5c).
Maputo Protocol 2(a): States parties shall take appropriate and effective measures to: Enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public.

[37] http://thecommonwealth.org/media/news/new-commonwealth-study-reveal-true-cost-violence-against-women-and-girls
[38] KPMG, 2014. Too costly to ignore the economic impact of gender based violence in South Africa available at https://assets.kpmg.com/content/dam/kpmg/za/pdf/2017/01/za-Too-costly-to-ignore.pdf
[39] https://www.pressreader.com/zimbabwe/sunday-news-zimbabwe/20160110/281754153311639

The region has made progress around legislation dealing with GBV, either through specific laws or penal codes. However, as noted in the 2018 Barometer, the lack of harmonisation between constitutional and customary law remains a challenge in the administration of justice across the region. Customary law remains relevant in the African context and, while it has managed to coexist with competing systems of domestic constitutional law, statutory law, common law and international human rights treaties, in some cases it creates a hindrance to the enforcement of the latter.[40] For instance, most countries have legislation criminalising rape, but countries like Botswana, DRC and Zambia do not address marital rape in their legislation. Even in settings where legislation exists, some men remain opposed to this concept as they believe that there can be no rape between spouses.[41]



Zimbabwe Gender Commission lobbies for tougher laws against GBV[42]

The Zimbabwe Gender Commission (ZGC) raised concerns last year about the spike in cases of sexual harassment in the workplace and called on government to enact laws that impose strict restrictions on GBV.



ZGC Chair Margaret Sangarwe-Mukahanana. Photo: New Zimbabwe

ZGC commemorated the 2018 16 Days of Activism campaign under the theme "Creating Zero Tolerance to Sexual Harassment in the Workplace" by conducting provincial campaigns at workplaces and universities, and sensitising citizens on sexual harassment at the workplace. "We call upon all stakeholders to speed up the enactment of a comprehensive legislative framework to deal with GBV and sexual harassment," ZGC Chair Margaret Sangarwe-Mukahanana told journalists. "The current legal framework has astonishing loopholes and such a situation cannot continue any longer."

In 2018, female legislators in Zimbabwe complained to the Speaker of the National Assembly, Jacob Mudenda, about sexual harassment in the House of Assembly.

Sangarwe-Mukahanana applauded milestones achieved on gender parity in the socio-economic and political spheres and on gender-sensitive legislation, including policies such as the Domestic Violence Act, but she said the nation still has a long way to go. "It is imperative to note that Zimbabwe has not yet reached where the country should be in terms of gender equality... The commission is calling upon all public and private institutions to put in place and maintain a comprehensive policy to deal with GBV. We are working with Parliament for a specific legislation that will protect women against sexual harassment."

Mukahanana said many victims of sexual harassment, particularly women, suffer in silence. She noted that her commission pleads with GBV survivors to report their cases to institutions that offer necessary support, including the Zimbabwe Republic Police.

Source: Tafadzwa Mutacha, Newsday, 2018

[40] Diala, A, (2018), "Legal integration of state laws and customary laws is inevitable" available at http://nai.uu.se/news/articles/2018/04/18/162652/index.xml (accessed 13 June 2019).
[41] Eswatini Joint Civil Society. (2017). Civil Society report on the Implementation of the Covenant on Civil and Political Rights 120th session of the Human Rights Committee.
[42] Tafadzwa Mutacha, https://www.newsday.co.zw/2018/11/commission-lobbies-for-tough-laws-against-gbv/.

GBV polices and laws audit

As there is no empirical way of assessing the gender responsiveness of constitutions and laws as laid out in Article 6 of the SADC Protocol on Gender and Development - which is crucial for the attainment of women's rights - GL used a peer review score card instead in order to gather data for the 2019 Barometer. Experts in each SADC country came together to score progress in eight areas.

In 2018, the SADC Gender Protocol Alliance members conducted consultation meetings that mapped the laws and policies which link to SRHR and GBV. Research has widely documented the latter as a public health threat, but women and young girls continue to endure the worst of this scourge, usually perpetrated by men. The existence of stand-alone GBV policies indicate a government's commitment to end GBV. But this is not enough. The allocation of resources towards the prevention of GBV truly shows bold government action to end the practice in the SADC region.

While 13 SADC countries adopted stand-alone GBV policies between 2000 and 2018, there is a need for many to update old GBV policies to better respond to global and regional protocols as well as capture emerging forms of violence. Namibia's latest NAP underscores the importance of an update in incorporating emerging trends and evidence-based programming for eliminating GBV.

13 SADC countries adopted stand-alone GBV policies between 2000 and 2018



Namibia National Action Plan on GBV, 2019-2023

Namibia adopted a new, progressive and modern National Action Plan on GBV 2019-2023. The plan is anchored on four action areas:

- *Survivors first:* Getting the response basics right
- *Safety nets and community care:* Primary prevention upgrade
- *Youth in the lead:* Transforming gender norms for long term prevention
- *Counting the cost:* Adequate data, adequate funding

Stakeholders have designed these action areas to be mutually supportive, implementable and suited to available resources. To achieve this, Namibia has identified priorities within each action area to provide the most impactful outcomes during the implementation of the plan.

The NAP has a corresponding "theory of change" with cause and effect linkages between action areas, strategies, intermediate outcomes, long term outcomes and desired impact. Above all, Namibia's NAP has an accompanying monitoring, evaluation and reporting plan: a tool that will guide the Ministry of Gender Equality and Child Welfare (MGECW) and members of the GBV and Human Rights Cluster to monitor the progress in implementing the NAP.

Source: Parliament of Namibia, 2018

[43] http://www.parliament.na/index.php?option=com_content&view=article&layout=edit&id=405

SADC Gender Protocol Article 20.6: State parties shall ensure that cases of gender-based violence are conducted in a gender sensitive environment.

SADC Gender Protocol Article 20.7: State parties shall establish special counselling services, legal and police units to provide dedicated and sensitive services to survivors of gender violence.

SADC Gender Protocol Article 23.2: State parties shall ensure accessible, effective and responsive police, prosecutorial, health, social welfare and other services to redress cases of gender-based violence.

Police and health care providers often serve as the first point of contact for victims of GBV, thus underscoring the need for specialised training for those working in both sectors. Police departments in all SADC countries have created specialised units that aim to address domestic violence cases in sensitive ways.

In Botswana, each police station has a police officer trained on GBV and other gender-related matters.



Botswana police marching against GBV. Photo: Keletso Metsing

Table 6.5: Police senior officers who received gender & GBV training in Botswana

Year	Number of trainings	Superintendent	Assistant Superintendent (ASP)	Total senior police officers
2014	3	33	31	64
2015	2	7	28	35
2016	1	14	6	20
Total	6	54	65	119

Source: Botswana Relationship Study, 2018.

Table 6.5 shows that, from 2014 to 2016, Botswana Police Service (BPS) conducted six gender training sessions for 119 police senior officers. This has enhanced implementation of GBV programmes and the collection of data on GBV. In response to community complaints about the way some police handle GBV cases, the BPS has invested in building the capacity of officers on handling GBV cases. Each police station and each district office now have a gender focal point. BPS trains the district gender focal officers to coordinate GBV work and collect statistics on GBV cases at district level. From 2014 to 2017, BPS trained 157 station commanders and their deputies (86 men and 71 women).[44]

[44] Botswana Relationship Study, 2018.

Mankweng Victim Support Centre helps GBV victims and changes community attitudes about GBV[45]

South Africa's Mankweng Victim Support Centre is a safe haven for GBV survivors, providing psychosocial assistance, counselling services, accommodation for GBV survivors, as well as training and protection.

The centre's objective is to reduce abuse and violence in the community and re-unite abused community members with their families. The centre also aims to provide a safe environment for those it shelters and protect community members against all violence and abuse.

The centre, which is situated at the Mankweng Police Services Station near the University of Limpopo and the Zion Christian Church, aims to address community challenges - including many incidences of abuse, namely sexual, economic, social and verbal.

Many abuses occur during the Zion Christian Church pilgrimage, on Good Fridays and in December, when many migrant workers return home. During these times, many university students report rape and physical abuse at the hands of local young men.



Photo: Increasing Services for Survivors of Sexual Assault (ISSSASA)

To deal with this issue, the departments of justice, education, social development and the South African Police Services came together to develop local strategies - the Mankweng Victim Support Centre represents one of these.

Since it opened, local women have been empowered to identify the various forms of abuse and report them to the Department of Safety and Security. But many remain afraid to report, which is why a number of local men have volunteered to take lead in preventing abuse against women, children and the disabled.

Additionally, some local men have changed their behaviour towards their partners, ensuring greater stability within families and in the community. There have been fewer cases of physical abuse reported to police, which seems to be an indication that the centre has had an impact.

Before it opened, many women reported abuse from intimate partners. This number has also dropped, which seems to point to an increased awareness in the community that this form of abuse it not acceptable. Police have also seen a reduction in the number of rape and physical abuse cases.

Members of the community still need more information on the different forms of abuse. The centre has thus adopted a strategy to issue pamphlets on forms of abuse, which seem more effective than verbal communication because community members can read them on their own to understand the various forms of abuse.

Source: Mankweng Victim Support Centre, SADC Protocol@work case study.

[45] https://genderlinks.org.za/casestudies/sa-gender-based-violence/

SADC Gender Protocol Article 25: State parties shall adopt integrated approaches including institutional cross-sector structures, with the aim of eliminating gender-based violence.

All SADC countries have created NAPs to end GBV, but most have expired, with only some marginal action accomplished due to resource constraints. In some instances, stakeholders did not formally adopt the draft NAPS until they expired. In the countries in which GL conducted GBV Baseline Studies, GL works with national and local governments to develop action plans to end GBV. Of the available NAPs, Tanzania has the most current, detailed (by eight thematic areas) and costed NAP, estimated at 267 billion shillings (approximately US $119 million) for the five-year period 2017-2022.

The Tanzanian government will finance its NPA-VAWC, with contributions from the private sector, international organisations and development partners.[46] Consistent with the goals of Agenda 2030 to end violence against women and children in all its forms - as part of an integrated agenda for investing in the protection and empowerment of women and children - Tanzania will now focus on building systems that both prevent violence against women and children in all its forms and respond to the needs of survivors.[47]



Table 6.6: Tanzania's costed NAP to end VAWC by thematic area 2017-2022

ANNUAL BUDGET DISTRIBUTION (USD)							
Thematic area	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**Total%**	**Total (USD)**
Household economic strengthening	5,764,011	5,583,110	5,419,396	4,781,022	4,649,438	22.8%	26,196,976
Norms and values	142,029	21,095,078	12,409,585	4,858,940	3,507,252	36.5%	42,012,883
Safe environment	164,003	238,736	269,765	182,165	179,327	0.9%	1,033,996
Parenting, family support and relationships	552,051	572,863	659,087	588,171	692,506	2.7%	3,064,679
Implementation and enforcement of laws	73,977	602,071	1,002,629	535,550	555,403	2.4%	2,769,631
Response and support services	2,308,393	2,200,463	2,545,908	2,454,008	2,269,624	10.2%	11,778,397
Safe schools and life skills	92,008	3,795,816	3,890,502	3,633,104	3,572,775	13.0%	14,984,207
Coordination, monitoring and evaluation	3,535,291	4,983,113	3,269,324	651,046	720,005	11.4%	13,158,780
GRAND TOTAL	**12,631,764**	**39,071,250**	**29,466,196**	**17,684,006**	**16,146,331**	**100.0%**	**114,999,548**

(*Shillings converted to dollars at the prevailing exchange rate on 10/07/2019). *Source: Gender Links.*

[46] http://www.mcdgc.go.tz/data/NPA_VAWC.pdf
[47] http://www.mcdgc.go.tz/data/NPA_VAWC.pdf

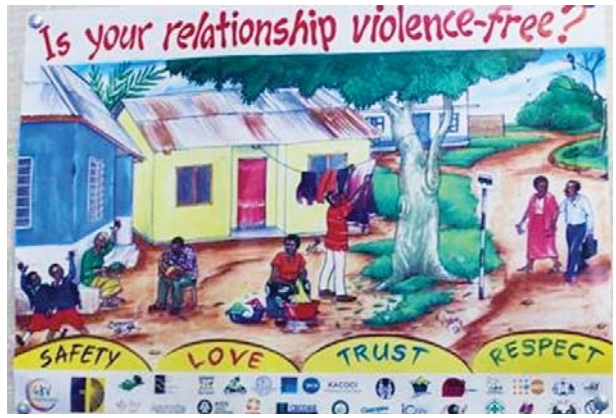
Table 6.6 shows the budgetary commitment by the government of Tanzania to end violence against women and children. In line with the SADC strategy, Tanzania has taken a bold step from rhetoric to financing. Perhaps most importantly, the government has anchored the budget on prevention, with a 36.5% allocation to changing norms and values and 22.8% for household economic strengthening, further buttressing GL's Sunrise Campaign message that economic independence is the panacea for women's development and leads to the lowering of GBV.[48] It will be critical to continue to evaluate Tanzania's progress in implementing its costed national action plan.

In **Botswana**, the successful launch of the Botswana Relation Study report should enable the government to be able to strengthen the local action plans using its comprehensive findings.

Tanzania has committed 267 billion shillings to fight GBV from 2017-2022

Besides costing, another challenge in implementation of NAPs links to the coordination of implementation and data management. Some countries have developed multi-sector structures with a mandate to track and evaluate implementation. Examples include the Mauritian Platform to end GBV, Zambia Anti-GBV National Committee and the Zimbabwean Anti-Domestic Violence Council. After hosting a 2018 National GBV summit, South Africa resolved to set up an interim structure with the eventual objective of establishing a national multi-stakeholder council. However, without adequate funding for operations, these structures may have limited impact.

Support



Artwork in Maun, Botswana in 2018 illustrates the importance of violence-free relationships. Photo: Gomolemo Rasesigo

Women victims of GBV often experience lifelong emotional distress, mental health problems and poor reproductive health, as well as being at higher risk of acquiring HIV and becoming intensive long-term users of health services.[49] This underscores the need for efficient support structures. Studies show that GBV survivors seek support from formal and informal sources (Coker, 2000). Informal resources include family, friends and faith-based communities where survivors seek support before approaching formal support sources. Formal resources include health professionals, the criminal justice system and police services,[50] and the social services sector. However, countries often lack capacity in providing adequate and well-coordinated essential services. The GBV Baseline Studies by Gender Links established that women prefer informal or traditional support to formal support.

The United Nations Essential Services Package for survivors of violence

Realising that many countries lack necessary services and proper coordination needed to support survivors of violence, the United Nations Joint Global Programme on Essential Services

[48] https://genderlinks.org.za/what-we-do/justice/advocacy/the-sunrise-campaign/
[49] Lowe-Morna, C., Makamure, L., Dube, S. (2016) SADC Gender Protocol Barometer (online) available at http://genderlinks.org.za/shop/sadc-gender-protocol-barometer-2016/ (accessed 12 July 2017)
[50] Musariri L., Nyambo, V., Machisa, M, T., Chiramba, K. (2015). The Gender Based Violence Indicators Study, Lesotho. Gender Links

for Women and Girls on Violence designed comprehensive guidelines to support countries as they work to design, implement and review services for all women and girl survivors of violence. The Essential Services Package is a practical tool for countries setting out a clear roadmap on how to ensure the provision and coordination of quality services in all sectors. The UN has designed it to ensure that the coordinated services of all sectors respond in a comprehensive, women-centred way and, where necessary, child-centred. The services must be accountable to victims and survivors and to each other. The guidelines identify the critical services to be provided by the health, social services, police and judicial services as the core elements of essential services in any context.

Lesotho, with support from the UNFPA, has begun piloting the Essential Services Package by including modules through its Husband Schools project, which will see the incorporation of men in gender equality education.

Following the GBV summit held in November 2018, the **South African** government has opened the Booysens Magistrate Court, which offers a range of services to support survivors of GBV. It will play a key role in alleviating the demand for services at the Johannesburg Magistrates' Court. Its services include:

- A fully-fledged sexual offences court;
- Family law services such as maintenance, domestic violence, harassment and children's court matters;
- Small claims court services; and
- Civil and criminal court services - regional and district.

SADC Gender Protocol Article 23.3: State parties shall provide accessible, affordable and specialised legal services, including legal aid, to survivors of gender-based violence.

All SADC countries now have accessible, affordable and specialised services for survivors of GBV. However, legal aid is still a challenge in most countries. The 2016 Global Study on Legal Aid by the United Nations Office on Drugs and Crime (UNODC) shows that one third of 153 countries have not yet enacted specific legislation on legal aid and only half offered legal aid to GBV survivors. The study covered five countries from the SADC region: Angola, DRC, Mauritius, Seychelles and South Africa.[51] The GBV Baseline Studies in the seven countries also showed that legal aid to survivors of violence remains limited. In most countries, NGOs provide these services, with many struggling due to inadequate funding.

Legal aid to survivors of violence remains limited

[51] UNODC Report (2016) available https://www.unodc.org/documents/justice-and-prison-reform/LegalAid/Global_Study_on_Legal_Aid_-_FINAL.pdf (cited in SADC Barometer 2017).

Survivors access legal aid thanks to WAR

Women against Rape (WAR) is based in Maun, in the northwest of Botswana. Started by a group of women in 1992 in response to the rape of local women by white hunters coming to the district, the NGO supports abused women and children and addresses the issues that contribute to their abuse, including rehabilitation for men who perpetrate the abuse. The organisation officially registered in 1995. With a strong activist and volunteer background, WAR continues to view its identity, management, and activities through this principle.



Women in Botswana take to the streets in 2017 to raise awareness about GBV as part of a series of "miniskirt protest marches." Photo: Right to Wear What I Want

WAR offers support to survivors of GBV, including legal and medical aid, through the following programmes:

- *Counselling (trauma counselling, couples counselling, parent and children counselling, suicidal and depression counselling):* WAR counsels survivors, their families and perpetrators of GBV to provide a holistic approach, complete healing and prevent further abuse.
- *Legal and medical aid:* After an incident of GBV, the victim must get proper treatment at a hospital, report what happened to the police, see a social worker and possibly go to court. WAR appoints an officer to accompany the client and provide support as they go to various offices seeking assistance. This ensures that the client receives the necessary assistance. WAR uses a referral system and it played a critical role in the GBV referral system pilot led by the Gender Affairs Department.
- *Psychosocial support:* WAR offers support to all GBV survivors by making follow up visits to survivors in respective homes.
- *Awareness-raising:* As a strategy to prevent GBV in the Ngamiland area, WAR conducts GBV awareness-raising campaigns targeting various stakeholders, including Safari Camps, schools and workplaces. They utilise the Start, Awareness, Support, Action (SASA) model in their interventions and have trained staff on it.[52] In recent years, WAR staff noticed a rise not only of violence in its area of operations, but also in severity.
- *Emergency accommodation:* WAR operates a safe house in Maun, which provides shelter, and a place for GBV survivors to rebuild their lives. They work with social workers, police and magistrate courts before placing the women in the shelter.

Source: Botswana Relationship Study 2018.

[52] http://raisingvoices.org/sasa/

SADC Gender Protocol Article 23.4: State parties shall provide specialised facilities including support mechanisms for survivors of gender-based violence.

Specialised units for survivors of violence, known as one-stop centres, are now widespread in the region. Every SADC country has at least one form of these, including one-stop centres, rape crisis centres, victim support units and sexual offences courts. One stop centres provide multi-sectoral case management for survivors, including health, welfare, counselling and legal services in one location. Most countries link them to the police through referral pathways, usually locating crisis centres in health facilities, including the emergency departments of hospitals, or as stand-alone facilities near a collaborating hospital.[53] Many countries have rape crisis centres, which NGOs usually run, providing support to victims (e.g., counselling, telephone helplines, etc.) and information about the legal system. Likewise, GL has opened a safe house in Mauritius to shelter young homeless girls aged 18 or older.



Safe Haven Halfway Home opens in Mauritius[54]

In September 2017, GL officially launched the first halfway house in Mauritius. The aim of the home, called Safe Haven Halfway Home (SHHH), is to shelter abused and homeless young women and their children. A grant provided by the National Corporate Social Responsi-bility Foundation allowed for the creation of SHHH, even though there has been an urgent need for this service in Mauritius for some time as no other shelters for homeless women exist.

Existing shelters serve women victims of violence but do not cater for homeless girls. As soon as young women in shelters reach the age of 18, they must leave. Homelessness is one of the main problems faced by these young girls since they usually have no relatives and nowhere to go. Some have spent their childhoods and their lives until the age of 18 in shelters. These children have low levels of education and are in low skilled, low paid jobs.

The halfway home provides the following services to the residents:

- Counselling and psychological support;
- Empowerment programmes on life skills; health and hygiene; art therapy, literacy and numeracy and gardening;
- Education programmes: alongside boosting the self-esteem of residents, the project is also geared towards educational training to help the young adults get a decent job;
- Economic empowerment programmes that include planning, keeping a budget, opening a bank account and saving money; and
- On the job training through different stakeholders so that residents can find a job and be autonomous when they leave the halfway home.

Source: Gender Links Mauritius, 2019

[53] End VAW Now website http://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html accessed 2 June 2018)
[54] https://genderlinks.org.za/casestudies/mauritius-gl-provides-a-safe-haven-for-girls-too-old-to-be-children/

Training of service providers

SADC Gender Protocol Article 24: State parties shall introduce, promote and provide:
(a) Gender education and training to service providers involved in gender-based violence, including the police, the judiciary, health and social workers;
(b) Community sensitisation programmes regarding available services and resources for survivors of gender-based violence; and
(c) Training of all service providers to enable them to offer services to people with special needs.
BPFA +20 Africa Declaration (4.1): Enact and strengthen the enforcement of laws addressing and punishing all forms of violence against women and girls through adequate resource allocation and targeted capacity-building of law enforcement agencies, including the judiciary.

The VAW Baseline Studies show that the attitudes of police officers toward GBV survivors discourage women from reporting violence. The establishment of victim support units within police stations is an attempt to mitigate this and it has resulted in increased training of police officers throughout the region.[55]



Zambian police help to sensitise communities about GBV[56]

The sensitisation of officers in Zambia on topics related to GBV - carried out with support from the Zambia Police Victim Support Unit - has gone a long way to improve how officers work with GBV survivors and their communities. The Victim Support Unit fights for the rights of the voiceless and GBV survivors by ensuring that they feel protected.

In short, this regional good practice motivates and empowers GBV survivors with information. The Unit also provides advice and guidance to the community so that they become aware of their rights on the issues of GBV in reference to when, why, where and what to report. By doing so it gives a warning to those who may engage in illegal activities.

Facilitators use sports, drama and poetry to easily disseminate information to the community. Door-to-door campaigns help to reach every household, and the formation of women's clubs enlightens members and the community on the steps and measures needed when they come across a GBV case.

One of the activities involves advocating for more women in decision-making positions to empower the community and local women. Until now, many Zambians had limited information about GBV and human rights. Another activity involves women forming clubs that help women vie for small loans from the government.

Source: Zambia police service, Gender Links case study

[55] Lowe-Morna, C., Makamure, L., Dube, S. (2017) SADC Gender Protocol Barometer (online) available at http://genderlinks.org.za/shop/sadc-gender-protocol-barometer-2017/
[56] https://genderlinks.org.za/casestudies/zambia-zambia-police/

Prevention

To meet the goal of eliminating all forms of GBV by 2030, there is a need for more collaborative, integrated and coordinated approaches that aim to both respond to, and prevent, GBV. These approaches should operate at all levels, including individual, relationship, community and societal.

Often there is a fine line between prevention and response. Each can enhance the effectiveness of the other. For example, strong laws and sanctions against GBV can have a preventive effect. Strong rehabilitation programmes for perpetrators of GBV can help to ensure that they do not become repeat offenders. Programmes of support for women that include economic empowerment can help to ensure that women do not become repeat victims.



Strong rehabilitation programmes for perpetrators of GBV help to ensure that they do not become repeat offenders

To date, stakeholders have mostly addressed GBV through reactive strategies. Prevention efforts, to the extent they have existed, have largely been driven by the women's movement. These have focused on changing social norms, building individual empowerment and addressing underlying structures that perpetuate VAW. The primary focus, however, has been at the level of response.[57] Response efforts focus on developing crisis services, law enforcement interventions, and judicial sanctions. In contrast, primary prevention focuses on education and includes efforts to change individual attitudes and social norms - what a community regards as acceptable behaviour from its citizens.[58]

Stakeholders can adopt three categories of prevention intervention,[59] namely:

- ***Primary prevention*** interventions aimed at addressing GBV before it occurs, to prevent initial perpetration or victimisation, targeted action aimed at behavioural issues and risk producing environments.
- ***Secondary prevention***, which happens immediately after the violence has occurred to deal with the short-term consequences, e.g. treatment and counselling.
- ***Tertiary prevention*** focuses on long term interventions after the violence has occurred to address lasting consequences, including perpetrator counselling interventions.

[57] Lowe Morna, C. Dube S and Makamure, L (2017). SADC Gender Protocol Barometer 2017 Southern Africa. SADC Gender Protocol Alliance
[58] Oregon Violence Against Women Prevention Plan; Oregon Department of Human Services; Office of Disease Prevention Epidemiology.
[59] Centres for Disease Control and Prevention. (2004). Sexual Violence Prevention: Beginning the Dialogue. Atlanta, GA p. 3

Sunrise Campaign heralds a new day for SADC women[60]

Lack of economic independence is one of the main reasons why women stay in abusive relationships. Economic justice starts with ensuring that resources and strategies adequately serve women's needs. This includes government use of gender sensitive budgeting, making education a key priority for girls, and employing research for evidence-based policies and laws. Institutions need to provide financing and support.[61] Civil society and business need to provide support and training for women entrepreneurs. It is this final element to which GL has developed a specific response.



GL's Sunrise Campaign won the 2016 Mail and Guardian Award for Investing in the Future in the category of Job Creation and Enterprise Development.
Photo courtesy of Mail & Guardian

During 2013, GL piloted a programme called *Empower Women: End Violence* which involved 1500 survivors in 10 countries in the SADC region. The programme demonstrated that GBV can be substantially reduced or eliminated by the financial empowerment of survivors. GL eventually renamed the programme the Sunrise Campaign. A sunrise symbolises a new day, the chance of a new beginning. It also symbolises strength: the power of women reclaiming their lives.

SUNRISE CAMPAIGN

The project provides women with the tools to make alternative long-term choices and it set out to increase women's agency and independence. Thereafter, the programme focused on supporting women to develop their businesses through providing access to finance, education and support. More than 100 Centres of Excellence for Gender in Local Government support the programme, which won a *Mail and Guardian* Award in 2016 (pictured).

In Zimbabwe, the Bulawayo City Council is part of the Sunrise Campaign and it runs skills training centres to mitigate and empower survivors of GBV. Some of these women have been trained in basket-making, mushroom-growing, handcrafts, dressmaking and catering.

"I continued depending on my husband for survival, but his abusive behaviour forced me to think otherwise," notes GBV survivor Sibongile in a GL "I" Story. "I started a sewing business in 2012 with the small amount of capital that I acquired from well-wishers. In time Fortune Faith Sewing Services developed into a fully established business entity.

"After I encountered Gender Links in 2014 and underwent entrepreneurship training, my business developed further. I engaged 60 people from my community whom I lectured on entrepreneurship. I taught them the basics of book-keeping and business management. I assisted them to start their own small businesses and they are all doing well."

Source: Gender Links, 2019

[60] https://genderlinks.org.za/what-we-do/justice/entrepreneurship/
[61] https://genderlinks.org.za/what-we-do/justice/advocacy/the-sunrise-campaign/#endingviolence

Political commitment

The GBV Baseline Studies measured political commitment at three levels:

- *Short term*, which looks at targeted messages made by the government officials;
- *Medium term*, including policy (re)formulation and (re)programming to mainstream GBV; and
- *Long term* commitments that include budget readjustment towards financial commitment for GBV policies and programming.



Botswana's first lady, Neo Masisi, marches during a 16 Days of Activism event in 2018. Photo: Gomolemo Rasesig

While it is easy to assess the targeted messages and policy-related progress, financial commitment is more difficult due to lack of explicit budgets ring-fenced for GBV programming. Bureaucratic barriers make it even harder to access information on budgets and expenditure related to GBV. For the sake of accountability, as well as for monitoring and evaluation, governments should make this information available.

Compared to the attention given to HIV awareness and resource allocation for its prevention, SADC member states have lacked real political will and financial commitment to end GBV, despite its significant impact on SRHR outcomes for women, girls, men and boys as well as the economy.

In 2019, and as part of the gender responsive assessment (GRA), GL analysed positive and negative changes to the political discourse on GBV. The results from the GRA, in line with the SADC strategy to harness social and political momentum around the agency of all, particularly women and girls,[62] show a positive trend to higher level commitment to end GBV among SADC political leadership. However, this needs adequate resource allocation to sustain it, as well as coordinated action to end GBV in the region.

SADC leaders begin to step up and speak out against GBV

President pledges to end GBV[63]

President Mokgweetsi Masisi made a personal commitment to end GBV in Botswana, which he says robs women and girls of the privilege to enjoy their rights and freedoms as enshrined in the Constitution.

"As a husband to a wife, a father to a daughter, a son to a mother, a brother to a sister, a nephew to an aunt, an uncle to a niece and male president to women, girls, men or boys,


Botswana President Mokgweetsi Masisi has committed to end GBV. Photo: The Argus Online

I, Mokgweetsi Eric Keabetswe Masisi will step up my commitment and actions on working hard and smart to end gender based violence," he said in a speech at the launch of the country's 2018 commemoration of 16 Days of Activism.

Masisi said that the weekly reports of GBV should challenge the nation to come up with strategies to eliminate violence at all levels. "As a nation

[62] See SADC 2018-2030 SRHR Strategy A.2
[63] https://www.facebook.com/argusonlineBW/photos/masisi-commits-to-end-gbv-i-too-want-to-make-a-pledge-as-a-husband-to-a-wife-a-f/320200261921669/

we can no longer ignore the fact that GBV has stretched its devastating ten- tacles across the country," he said. "GBV has undoubtedly affected our country socially and economically as women and girls contribute significantly to all spheres of life, including business, education, sport, agriculture amongst others."



South Africa hosts GBV summit[64]

To tame the scourge of GBV in the country, the South African government joined with civil society to convene a two-day GBV and femicide summit in November 2018. The summit responded to a request by thousands of women who marched against GBV in the #TotalShutDown march to the Union Buildings in August 2018. At the end of the summit, participants presented a national declaration of priority actions, setting the roadmap to a South Africa free from GBV and femicide.

Delegates endorsed President Cyril Ramaphosa's call for all South Africans to respond to GBV and made the following commitments:

- To set up of an interim structure with the eventual objective of establishing a national multi-stakeholder council;
- Reached consensus to develop a national strategy plan on GBV within six months of the Summit;
- Agreed to provide resourcing for the Thuthuzela Care Centres as well as sexual offences courts and shelters that assist victims of GBV, including people with disabilities and LGBTQI community; and
- To develop and implement a targeted social behaviour change programme to address patriarchal values and structural drivers of GBV.

Delegates also agreed to prioritise and strengthen current education policies regarding gender equality.



Malawi's first lady condemns GBV[65]

Speaking during an event linked to a recent campaign branded "Ending Violence Against Women and Girls," Malawi's first lady Gertrude Mutharika said it is sad that most girls and women suffer abuse from the very people who are supposed to protect them - their husbands and stepfathers. She described this as inhuman.



Malawi's first lady Gertrude Mutharika speaks to guests at the launch of a new campaign to tackle GBV in the country. Photo: Warm Heart News

Mutharika said that she had accepted to become the campaign's ambassador because she realized how GBV hinders national development by creating a social distance between males and females. "When women and girls are subjected to gender-based violence of various forms, they are affected both physically and emotionally, as such, they are unlikely to take part in development activities." This reduces the number of Malawians that could take part in development, Mutharika said, noting that it is common for both secondary and primary school girls in the district to drop out of school due to early pregnancies.

The Malawi government, through the Ministry of Gender, Children, Disability and Social Welfare and in conjunction with Oxfam, launched the campaign in 2018 to help reduce levels of violence against women, girls and children in the country.

Sources: The Argus Onine, 2018; Government of South, 2018; Majamanda, S., AllAfrica.com, 2018

[64] https://www.gov.za/nationalgendersummit
[65] https://allafrica.com/stories/201805110840.html

SADC Gender Protocol Article 21.2: State parties shall, in all sectors of society, introduce and support gender sensitisation and public awareness programmes aimed at changing behaviour and eradicating gender-based violence.

Community mobilisation and campaigns

To date, all SADC countries have implemented prevention strategies to raise awareness and advocate for GBV prevention. These include coordinated campaigns which, based on anecdotal evidence, remain the most common strategy across the region, especially during the 16 Days of Activism. While the 16 Days campaign has gained momentum across the region, many governments and civil society organisations want to turn it into a 365-day campaign. Zimbabwe has even tailored its GBV strategy to "Zero Tolerance 365: National Programme on GBV Prevention and Response 2016-2020." GL has worked with 10 countries to develop 365 Days NAPs to end GBV. It is hoped that the bold show of political commitment, as illustrated best by Botswana's president, will provide the impetus to ensure that political leaders deliver on these NAPs.

For 2019, most SADC countries have lined up several GBV and SRHR campaigns, including some punctuated by global and regional hashtags, while others tout home-grown anti-GBV campaigns.

Many stakeholders want to turn the 16 Days campaign into a 365-day campaign



Sixteen Days campaign in Mozambique. Photo: Gender Links

Botswana youth and police work together to reduce GBV[66]

Lobatse police and community members in Botswana have been working with youth to sensitise them on GBV prevalence by sharing information through educational empowerment and training tools. Stakeholders chose the strategy after it came to light that most young people do not have correct information about GBV, how it presents itself, or on ways of dealing with it, such as how to seek help.



The Botswana Family Welfare Association (BOFWA) Youth Action Movement teaches the public about GBV at a mall in 2019. Photo: Government of Botswana

The groups also educates perpetrators about the implications of their acts and attempts to persuade them to avoid future violent acts. The initiative is both proactive and reactive as it addresses the problem before it occurs and when it has already taken place in the hope of reducing the possibility of recurrence.

Police statistics in in Lobatse Council and policing area indicate that young people between age 18 and 35 are most affected by GBV, as both victims and perpetrators. This points to a need to inform, educate and empower young people and educate them about their rights and the implications of perpetrating GBV.

The approaches and activities of the programme include educational training as well as general SRHR discussions at informal settings such as tea parties and morning prayers. The Urban Rhythm Youth Centre provides focal points who spearhead "man up" sessions and host campaign activities. The Gender Links Botswana office has provided technical assistance where needed, attended marches and provided a platform to showcase the good work at the 2018 country summit, where the initiative took home a "Drivers of Change" award.

Police report that they have seen a reduction in GBV cases since the programme began, which is a clear indication that the message has not only been received but has been put to use.

Source: Onkometse Kwelagobe, Lobatse Council, SADC Protocol@Work case study, 2019

[66] https://genderlinks.org.za/driversofchange/botswana-okemetse-prudence-kwelagobe/

Table 6.7: Effectiveness of GBV campaigns

Questions from the survey	Botswana (2017)		Zimbabwe (2012)		Zambia (2014)		Lesotho (2013)		Mauritius (2009)		South Africa KZN		South Africa Western Cape		Seychelles	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
16 Days (%)	47	41	10.8	10.2	40.7	41.4	43.9	63.5	10	21	5.2	82.8	83.2	77.9	72	86
365 (%)	37	28	8.2	8.2	28.5	35.5	30.7	45.4			2.6	16	83.4	54.2	70	87
Prompted to act (%)	32	40	4.2	4.2	25.4	30.1	18.5	27.7			1.4	17.5	26.7	21.6	18	17

Source: GL VAWG surveys 2009-2017.

Table 6.7 shows that varying numbers of women and men in the region know about the 16 Days and the 365 Days campaigns to end GBV - ranging from a low of 2.6% of women in KwaZulu-Natal province in South Africa to a high of 87% of men in Seychelles. In Zambia, Lesotho, Mauritius, two provinces of South Africa and Seychelles, more men know about the 16 Days campaign than their female counterparts. In all the surveys, GL assessed whether the knowledge of the 16 Days and 365 Days campaigns resulted in women or men acting to end GBV in their communities. Again, results show that more men than women said they might be willing to take part in action to end GBV, such as participating in a campaign march or intervening in domestic violence dispute resolution.

The results raise questions as to the effectiveness of these annual campaigns; whom they are reaching and with what results. While the campaigns result in a high level of visibility, especially during the Sixteen Days of Activism, they appear to be missing their primary target, and do not seem to prompt the necessary action.

Role of the media

SADC Gender Protocol Article 29.7: State parties shall take appropriate measures to encourage the media to play a constructive role in the eradication of gender-based violence by adopting guidelines which ensure gender sensitive coverage.

The Protocol urges the media to ensure gender equality in and through the media and to challenge gender stereotypes. The Protocol also discourages media from promoting pornography and violence against all persons, especially women and children.[67]

It is hard to dispute the role of the media as potential opinion-shapers and agenda-setters in the fight against GBV.[68] The media does this by covering stories that promote awareness and prevention and also through counteracting myths and negative attitudes that may perpetuate violence.

[67] SADC Protocol on Gender and Development Article 29 (1-7).
[68] Chiramba, K. Musariri, L and Rasesigo G, (2018). Botswana Relationship Study. MNIGA.

New study reveals that old problems persist in South African media[69]



The Gender, Diversity and Gender Based Violence in South African Television study looked at almost 600 hours of TV and found that women's views and voices remain scarce. Photo: Gender Links

A 2019 study, *Gender, Diversity and Gender Based Violence in South African Television*, undertaken by GL in partnership with Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and UN Women in South Africa, revealed that there is urgent need to achieve greater diversity, balance and sensitivity in the coverage of gender violence in South African television.

This is the key finding of the first ever gender monitoring of the audio visual media to include entertainment and children's programming, in addition to the news, which has been the subject of much greater scrutiny over the years.[70] The study forms part of the GIZ and UN Partners for Prevention of VAW programme (P4P) in South Africa, Zambia and Lesotho. Overall, monitors around the country viewed and analysed 1462 news reports, children and adult TV episodes from 24 programmes on 13 channels from 25 November 2018 to 31 January 2019. This amounted to just less than 600 hours of TV.

The research found that:

- ***Women are still the missing voices in the news:*** Overall, women constitute 39% of TV news sources; an improvement on the 25% recorded in the 2015 Gender and Media Progress Study (GMPS) conducted by GL, but still 11 percentage points short of gender parity.
- ***These voices are scarcer after the 16 Days campaign and festive season:*** While the proportion of women characters remained constant across the three periods monitored in entertainment and children's programming, in the news the proportion of women dropped from 40% during the 16 Days to 33% following the festive season. Qualitative monitoring found that the most in-depth and direct reporting on GBV, including an extended interview with UN Women Executive Director Phumzile Mlambo-Ngcuka, took place during the 16 Days campaign. This type of reporting wanes in the new year.
- ***Women are better represented in entertainment and children's programming, but not as voice overs:*** At 48%, women are better represented as characters in entertainment. Girls and women comprise 61% of the characters in children's programming, but only 40% of the voiceovers.
- ***Black African sources and characters remain underrepresented, especially in entertainment:*** The 2011 census figures show black Africans at 76%, white South African at 9%, coloured at 9%, Asian at 3%, and Other/ Unspecified at 0.5% of South Africa's population.[71] At 71% for blacks, 13% for whites, and 11% for persons of mixed race, TV news comes close to reflecting the demographics of South Africa. But with only 47% blacks, 52% whites and 1% mixed race, entertainment does not yet reflect the true colours of the rainbow nation.
- ***Older women disappear, especially in the news:*** There is a marked decline in women's representation in TV as they grow older. In TV news, girls make up 65% of children and 52% of teenagers depicted. Women ages 20 to 35 comprise 66%, making this age group the most featured in the news. But women aged 35 to 50 dip to just 36% of the total, and those

[69] https://genderlinks.org.za/wp-content/uploads/2019/05/Gender-Diversity-GBV-in-TV.pdf
[70] https://genderlinks.org.za/news/sa-diversity-balance-sensitivity-still-missing-in-television-media/
[71] https://en.wikipedia.org/wiki/Ethnic_groups_in_South_Africa, accessed 4 April 2019

older than 50 comprise just 16%. This trend carries on in entertainment, where women from the age group of 35 to 50 and 50+ sit at 44% and 36% respectively.

- ***Entertainment and children's programmes portray women in a more diverse set of roles than the news:*** In children's programming, female characters predominate in all categories, and a 40:60 split occurs in most entertainment programming, or vice versa in almost every category. Yet in news, women sources are grossly underrepresented as experts (9%) and first-hand accounts; eyewitness and popular opinion categories (just 2% in each).
- ***Topics covered vary, with diversity as a topic low on the agenda:*** The mix of topics varies by genre, with economy, sports and politics dominating the news agenda more than in entertainment and children's programming. Crime and violence (21%) is higher in entertainment than in news (14%) and much higher than in in children's programming (4%). Of concern is that gender equality as a topic constitutes just 1% in news; 3% in entertainment and 1% in children's programming; GBV topics make up 2% of news, 4% in entertainment and 2% in children's programming. Further, sexual orientation as a topic only featured in entertainment (3%), and disability only in children's programming (2%).
- ***Women's views and voices remain scarce in mainstream topics:*** Men's views dominate in the categories of politics, economics and social topic on TV news. We only typically hear women's views in the gender equality category of coverage. In entertainment, women's views are scarce in any of the mainstream topic categories and comprise 37% of the gender equality category.
- ***Women are heard more than men on GBV in the news, but not entertainment:*** Women comprise 67% of sources in TV news on GBV, but only 34% of the voices on this subject in entertainment shows.
- ***Stories on where to get support remain sparse, except in children's programming:*** Only 16% of TV news stories on GBV mentioned where to go for help. On the other hand, 67% of children's stories on GBV did mention where to go for help. This reflects the reality that society remain much more concerned with help and support for children experiencing violence than women.
- ***There is very little focus on prevention:*** The breakdown of topic categories shows that prevention constitutes 5% of GBV topic coverage in the news and 29% in children's programming. This is a concern, especially considering the potential powerful role of TV in spearheading prevention campaigns.
- ***Strong elements of gender stereotyping remain, especially in entertainment:*** The study classified about one third or more of the items monitored as "gender aware" and the rest as "gender blind," "subtle stereotypes," or "blatant stereotypes." Although the latter appeared lowest (2% for news, 7% for children, and 16% for entertainment), it is still a concern.
- ***Men dominate content decision-making:*** With women making up 77% of programme creators but just 15% of directors in entertainment, content creation remains a "man's world."

Source: Gender Links, 2019

In many instances, regional media outlets miss opportunities in reporting on GBV. Yet media, especially television, has power to change attitudes on GBV and give voice and choice to survivors of violence.

Only 16% of TV news stories on GBV mentioned where to go for help

Missed opportunities across different channels[72]



The Gender, Diversity and Gender Based Violence in South African Television study looked at almost 600 hours of TV and found that women's views and voices remain scarce. Photo: Gender Links

The media sector often misses opportunities to increase women's voices when it omits the voices of women on stories where they should be providing their views.

One example is in a story aired on 14 January 2019 on the SABC 3 News at 9 bulletin. It ran under the title *"Police arrest serial killer and rapist."*

In the story, police note that they believe they have arrested a serial killer and rapist who had been terrorising residents of Embalenhle in Mpumalanga for the past four years.

In this story, only the police officer speaks to media, although the footage shows a woman standing with the police officers. But she does not get a chance to speak to the media.

The woman could have spoken about how a serial killer and rapist on the loose had an impact on her community. The footage also does not reveal her identity. The story also misses the opportunity to interview family members of those who had been raped and killed. By not including a diverse range of sources, the story misses an opportunity to show in-depth how this violence affected the community.

Source: SABC, Gender Links case study, 2019

Social media

The impact of social media as a campaign tool helps account for the significant strides made by stakeholders in the region in raising awareness around GBV laws and GBV in general. Twitter and Facebook represent the leading social media platforms and both are awash with country specific and global campaigns. The latest findings from Botswana show a notable increase in awareness of both GBV laws and campaigns from 2012 to 2018 thanks to social media.[73]

The immense recognition and intense debate generated through online platforms over the past year is perhaps the most notable recent advancement in this area. This has occurred in the form of campaigns such as *#MeToo, #TotalShutDown, #NotInMyName and #NotOur Leaders*, to name but a few. The momentum towards a change in thinking, from response to prevention, is intensifying as more voices speak out at various levels and platforms.

[72] http://genderlinks.org.za/barometer-newsletter/gender-based-violence/suspected-mpumalanga-serial-killer-nabbed/
[73] Chiramba, K, Musariri, L. and Rasesigo, G. (2018). Botswana Relationship Study, Gender Links.

Social media has come in handy to mobilise and boost anti-GBV campaigns. Organisers can also track the momentum of such campaigns across the globe. However, social media has also become a platform to abuse those women advocating for an end to GBV. Abusers can post negative or counter feedback. In some instances, anti-GBV campaigns trigger counter or reactionary campaigns. For example, the *#MenareTrash* campaign started in South Africa following a spate of femicides sparked a response by progressive men who coined the *#NotInMyName* campaign. Some organisations have devised innovative ways to use digital technology to protect women and girls at risk of GBV.



An app for women at risk of GBV in Lesotho[74]

Realising that Lesotho lacked both a private and public discourse on VAWG, GL Lesotho developed a GBV smart phone application called Nokaneng App. GL developed the app in partnership with the Ministry of Gender and Youth, Sports and Recreation, Vodacom Lesotho, Main Level consulting and Partners for Prevention of VAWG. The German Development Agency (GIZ), funded the project. The partners designed the app to teach women about their rights and point them to available GBV services available.



UN Tanzania Resident Coordinator Alvaro Rodriguez speaks about gender and news at the opening ceremony of the Gender and News Summit on 22 August 2018 at the Hyatt Regency in Dar es Salaam. Photo: Gender Links

The app:



- Creates awareness among women about what constitutes GBV;
- Informs women of their rights as well as locally available support services;
  Provides a safe virtual space for women to share stories and support each other; and
- Provides women with emergency systems to alert community members and peers in case of violence.

In addition to these features, Nokaneng has an instant rescue button. When pressed, it sends an alarm to alert authorities that someone is in trouble. Women can also activate it by shaking the phone several times. The alarm is meant to scare away perpetrators of violence. The app also has an emergency messaging service and women can set it to send messages to six people that form part of her "safe circle."

Source: Nokaneng App, Gender Links case study, 2019

[74] https://genderlinks.org.za/casestudies/lesotho-new-app-to-prevent-gbv/

Restorative justice

SADC Gender Protocol Article 20.4: State parties shall put in place mechanisms for the social and psychological rehabilitation of perpetrators of gender-based violence.
SADC Gender Protocol Article 23.5: State parties shall provide effective rehabilitation and re-integration programmes for perpetrators of gender-based violence.

Although not well documented, most countries provide some psychological rehabilitation to perpetrators of GBV. The departments of correctional services in most countries in the region also offer rehabilitation and re-integration services for perpetrators of GBV. Through its NAP 2014-2020, Malawi envisions that, by the end of 2020, it will see increased perpetrator accountability and rehabilitation. Malawi is one of 13 countries globally and eight African countries selected to receive grants from the Spotlight Initiative to improve the plight of women and girls. For the initiative to truly be transformative, Malawi needs to build strong alliances with all stakeholders, including working with men to eliminate VAWG.

South African restorative justice initiative tackles the root causes of intergenerational violence[75]



Juvenile felons and fathers (whose faces are disguised to protect their identity) come together monthly to learn from past mistakes and find strategies to make better choices in future. Photo: Gender Links

A new project in South Africa is focusing on male juvenile felons and fathers. The project, which works with men detained at Horizon Youth Centre, uses a monthly discussion with a neurologist to assess deep-rooted trauma and other issues. Additionally, facilitators conduct workshops and create individual development plans based on the specific needs of participants. The project aims to teach detained youth to be involved and effective fathers. It focuses on alleviating and eradicating behaviour that could result indomestic violence tendencies upon release.

The Horizon Youth Centre, together with the Department of Social Development for Sustainable Communities, identified the need to individualise the generational household violence epidemic to prevent recurrences of GBV. Research and rehabilitation programmes show that children exposed to domestic violence normally have a tendency to practice the

[75] https://genderlinks.org.za/casestudies/western-cape-restorative-justice-eradicate-generational-gbv/

learned destructive behaviour in their interpersonal relationships as adults. This project specifically targets abusive and destructive behaviour within personal relationships and focuses on youth who have been sentenced from the age of 18 years until 21.

The "circle of courage" is one aspect of the programme that provides evidence-based results through a proven format for reaching and teaching youth with severe emotional and behavioural disorders. This approach integrates research on positive youth development with the best of positive thought, professional wisdom, and educational practice. The circle of courage approach employs a strength-based perspective, which focuses not on the weakness and problems of the youth, but on their strength, protective factors and their desire to be better fathers and eradicate household violence. Activities focus on a sense of belonging, independence and generosity.

This project launched during child protection week. Alma Kritzinger, a gender focal point, has participated in the programme from inception, helping to ensure continuity and regularly reporting to the council on its progress.

Some of the young men have disclosed in-depth information on domestic violence experiences. The programme has encouraged them to become better fathers to their children. The young men can now describe and identity protective factors within their environment that will help them to make better choices for themselves and in their relationships.

Early exposure to domestic violence can cause deep-rooted emotional, psychological and physical damage to young people. Youth in the programme indicated that they resorted to bad behaviour and violence in order to fit in with deviant peers or gangs - all in the quest to belong, feel protected and understood. The neurological approach aids in reflection, and individuals learn from, and assess, their negative past behaviour, bringing about change and improvement that helps tackle the root causes of generational domestic violence.

Source: Horizon Project, SADC Potocol@work case study, 2019

Engaging men and boys in the fight against GBV

Stakeholders in the sector have begun to view the role of men, not only as aggressors, but also as potential allies, facilitators, and activists in the fight against GBV, as an indispensable element that requires specific policies and strategies.[76] There is an emerging recognition of the need to involve male traditional and religious leaders in the fight against GBV. For many women around the world, community-based, customary justice mechanisms remain the only available method of redress.

Most countries provide some psychological rehabilitation to perpetrators of GBV

[76] Aguayo, F., Kimelman, P., Saavedra, J., Kato-Wallace. (2016). Engaging Men in Public Policies for the Prevention of Violence Against Women and Girls. Santiago: EME/CulturaSalud. Washington, D.C.: Promundo-US. Panama City: UN Women and UNFPA.

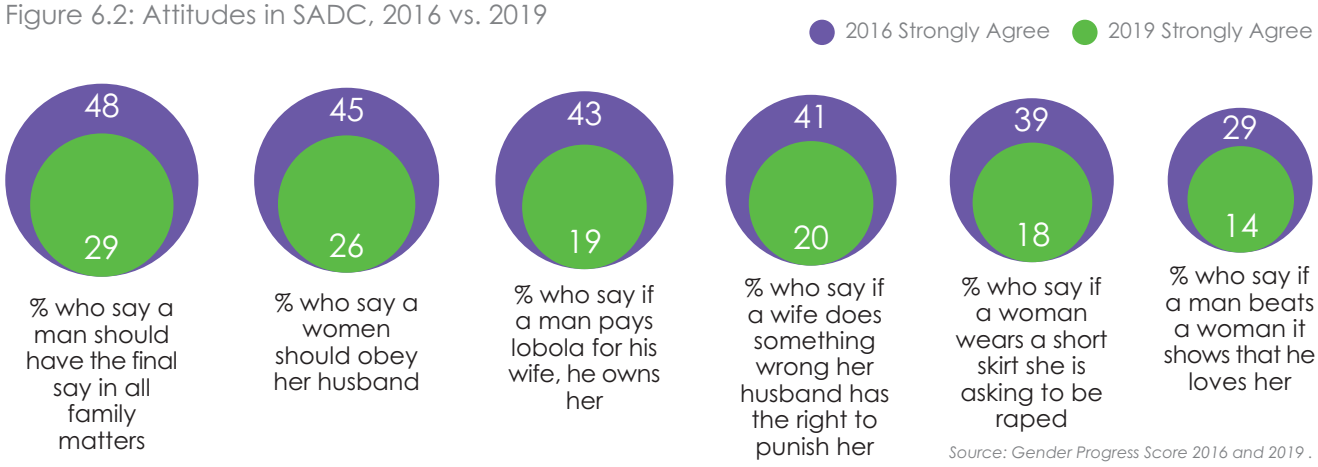
Additionally, the Seychelles National Baseline Study (2016) and the Botswana Relationship Study (2018) brought key issues to light about violence against men that previously had not received much attention, despite being critical in the fight against GBV.



Attitudes

Another crucial aspect of the GBV Baseline Studies and other research links to the attitudes of men and women in the region. Over the years, GL has asked survey participants for their attitudes on a number of provocative statements and questions. The answers point to both a stubborn entrenchment of patriarchal and sexist attitudes in some areas, but overall a significant shifting of views that should provide some hope to those advocating for change.

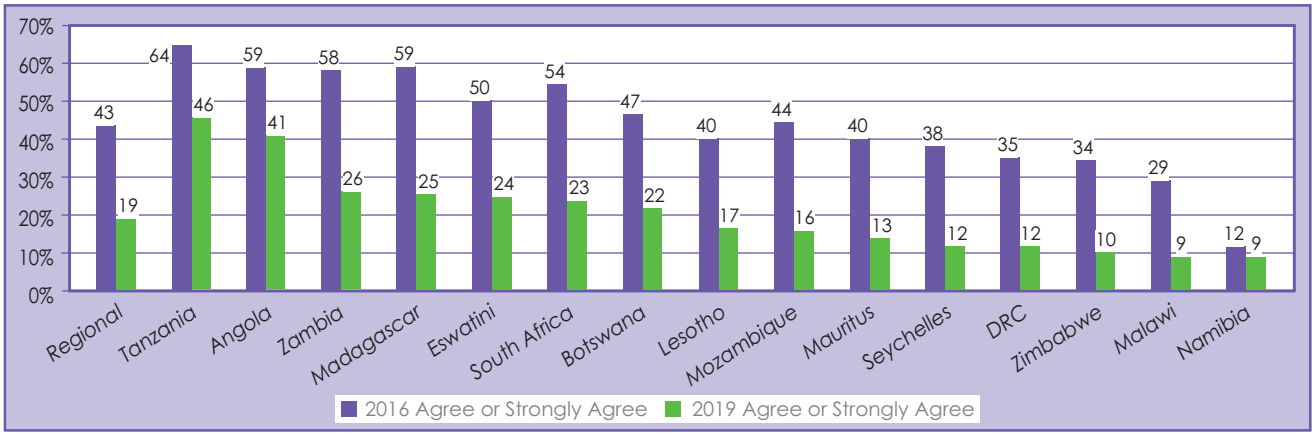
Figure 6.2: Attitudes in SADC, 2016 vs. 2019



Source: Gender Progress Score 2016 and 2019 .

Figure 6.2 illustrates a clear shift in attitudes in a short time. Between 2016 and 2019, the percentage point of those who strongly agree with the problematic statements ticked downward - in some cases substantially. For example, the number of respondents who said a man should have the final say in all family matters dropped from 48% in 2016 to 29% this year.

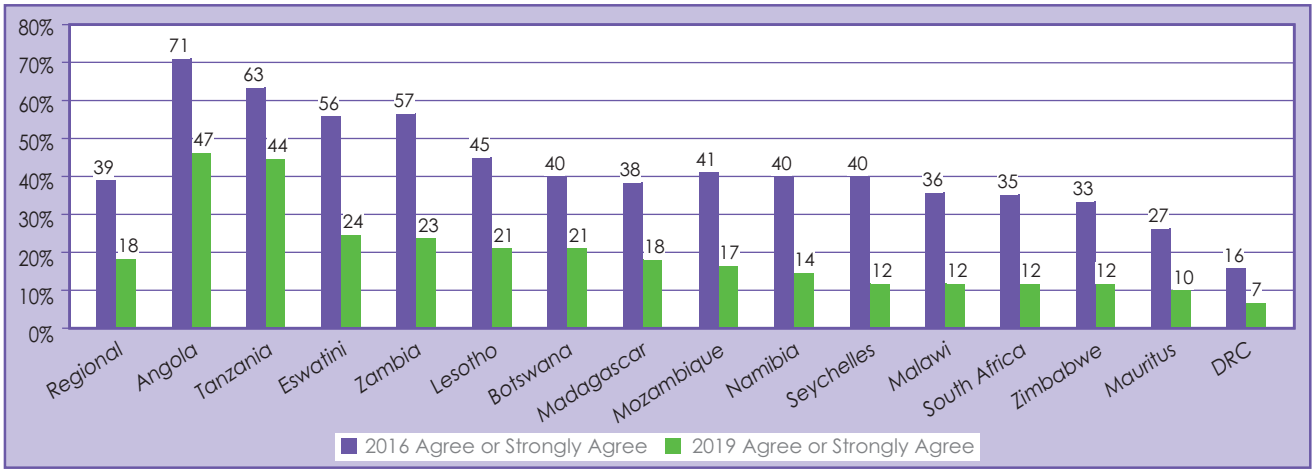
Figure 6.3: Gender attitudes - if a man pays lobola for his wife, he owns her



Source: Gender Progress Score 2016 and 2019.

Figure 6.3 shows a comparison of findings from the 2016 and 2019 gender progress scores. There is a sharp decline (from 43% to 19%) in the regional average in the previously entrenched view that if a man pays lobola he owns his wife. This is viewing women as property. The biggest drop on this view is in Madagascar (34 percentage points), followed by Zambia (from 58% to 26%), then South Africa, Mozambique and Mauritius. This could suggest a momentous change in gender attitudes across SADC. These findings also imply that, going forward, circumstances in which a man views a wife as property have begun to dwindle.

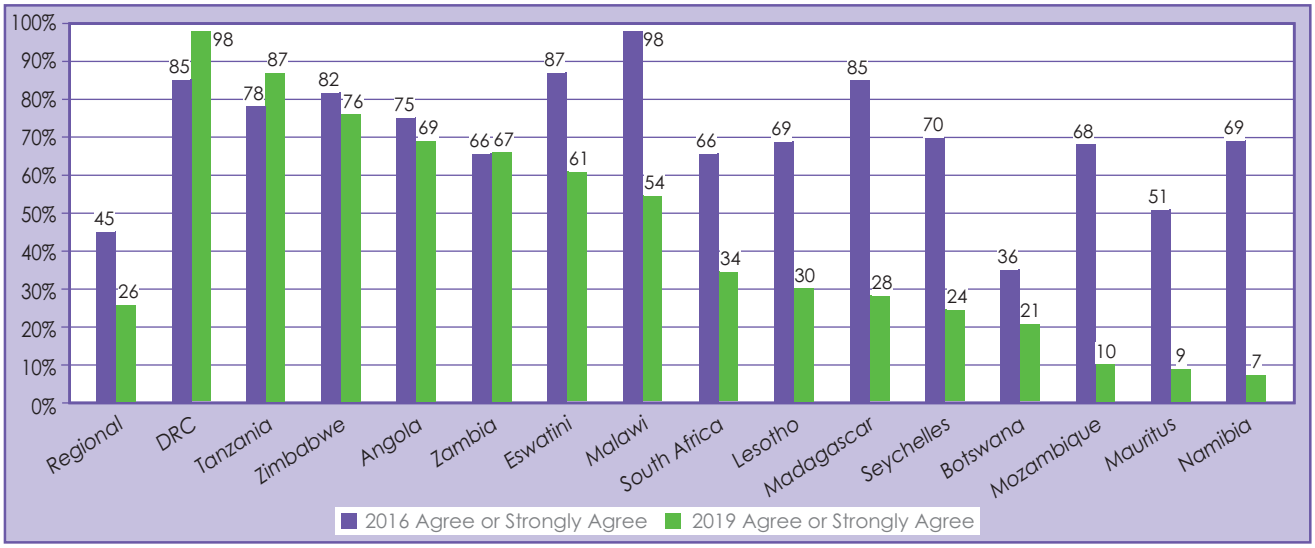
Figure 6.4: Gender attitudes - if a woman wears a short skirt, she is asking to be raped



Source: Gender Progress Score 2016 and 2019.

Figure 6.4 shows a shift in attitudes towards rape in the SADC region: 18% in 2019 compared to 39% of people in 2016 agreed or strongly agreed with the statement that "if a woman wears a short skirt she is asking to be raped." Even in countries like Angola or Tanzania, where most attitudes in 2016 seemed conservative and sexist, a sharp drop demonstrates a shift of mindsets. While there appears to be a true shift in attitudes, this has not yet translated to a change in behaviour. Evidence shows that reports of rape have not declined, with women and girls reporting rape on campuses and even on public transport.

Figure 6.5: Gender attitudes - a woman should obey her husband

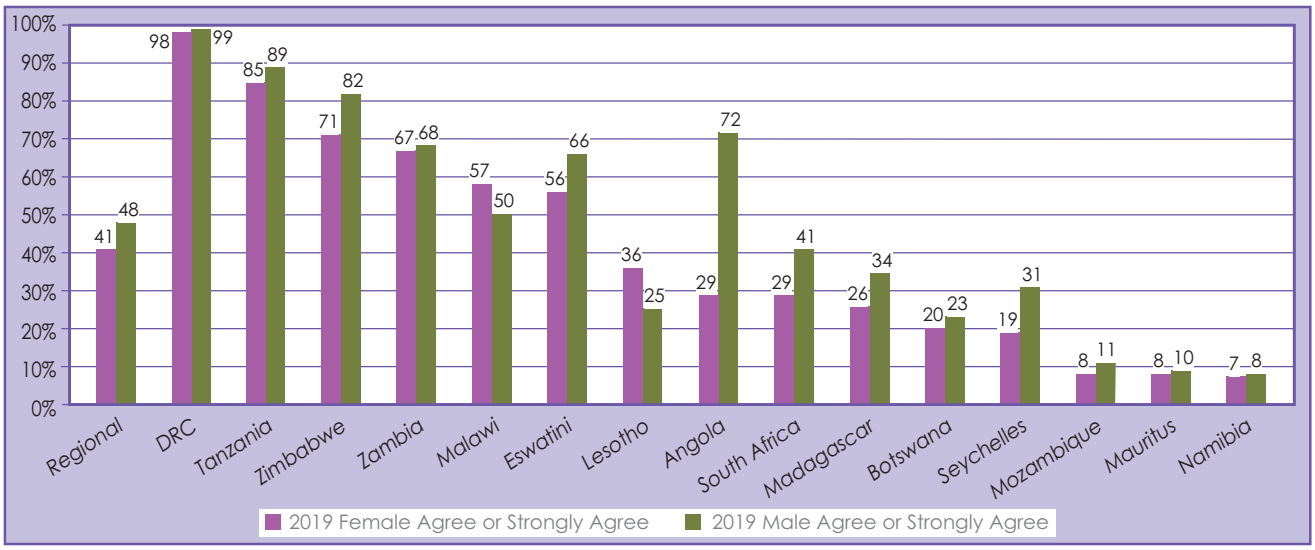


Source: Gender Progress Score 2016 and 2019.

Figure 6.5 illustrates a divide in SADC on the question of whether a woman should obey her husband, with some countries dropping substantially and others remaining almost the same or increasing. DRC and Tanzania fall into the latter category - both countries saw more citizens agree with this statement in 2019 than in 2016.

Meanwhile, Namibia logged a huge decrease in agreement with the statement, from 69% in 2016 to just 7% in 2019. The regional average shows a marked shift in attitudes, with the number of those agreeing with the statement dropping to 26% from 45% just three years ago.

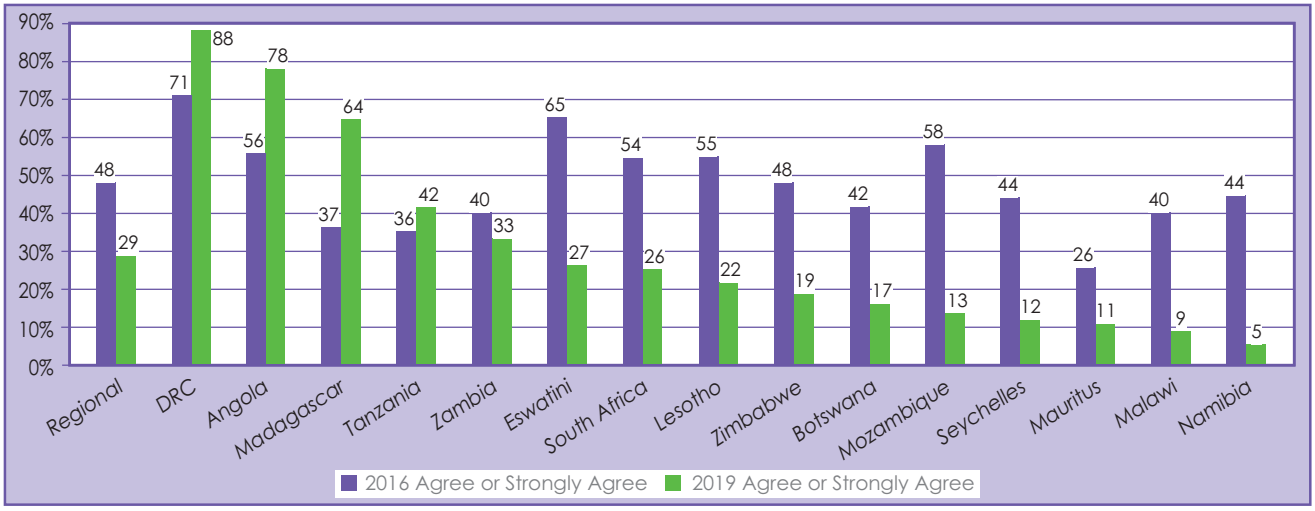
Figure 6.6: Gender attitudes - a woman should obey her husband, by sex



Source: Gender Progress Score 2016 and 2019.

Figure 6.6 disaggregates agreement about the statement that a woman should obey her husband by sex, showing that, in most cases, men and women in the region do not vary much in where they land. The only outlier is Angola, with a 43 percentage point difference between men (72%) and women (29%) agreeing or strongly agreeing with the statement. Regionally, more men agree with the statement (48%) than women (41%).

Figure 6.7: Gender attitudes - a man should have final say in all family matters

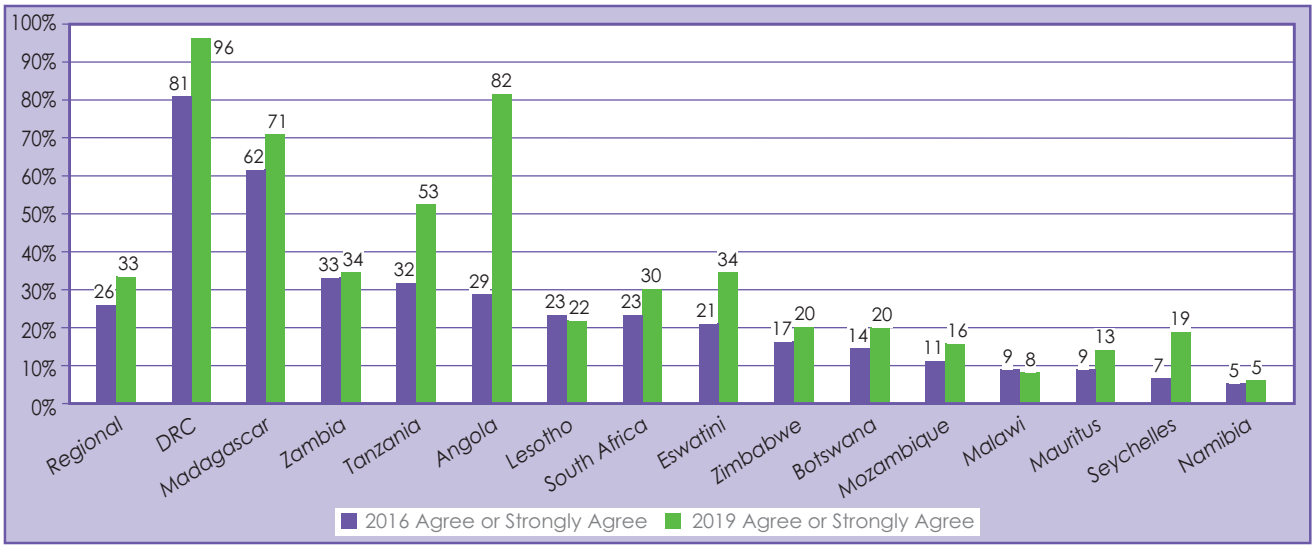


Source: Gender Progress Score 2016 and 2019.

Figure 6.7 illustrates another mixed result, with some countries seeing an increase in the number of people who believe a man should have final say in all family matters but most decreasing. Angola, DRC and Madagascar all increased, with 88% of those surveyed in the DRC saying the buck stops at men for all family matters. Elsewhere in the region, several countries saw substantial decreases in those who agree with this statement - including Mozambique, which saw the biggest drop, from 58% in 2016 to 13% in 2019. Overall, the region saw a 19 percentage point decrease on this indicator, from an average of 48% in 2016 to 29% in 2019.

Attitudes in the region have shifted, with many disagreeing with the statement that "a man should have final say in all family matters"

Figure 6.8: Gender attitudes - a man should have final say in all family matters, by sex

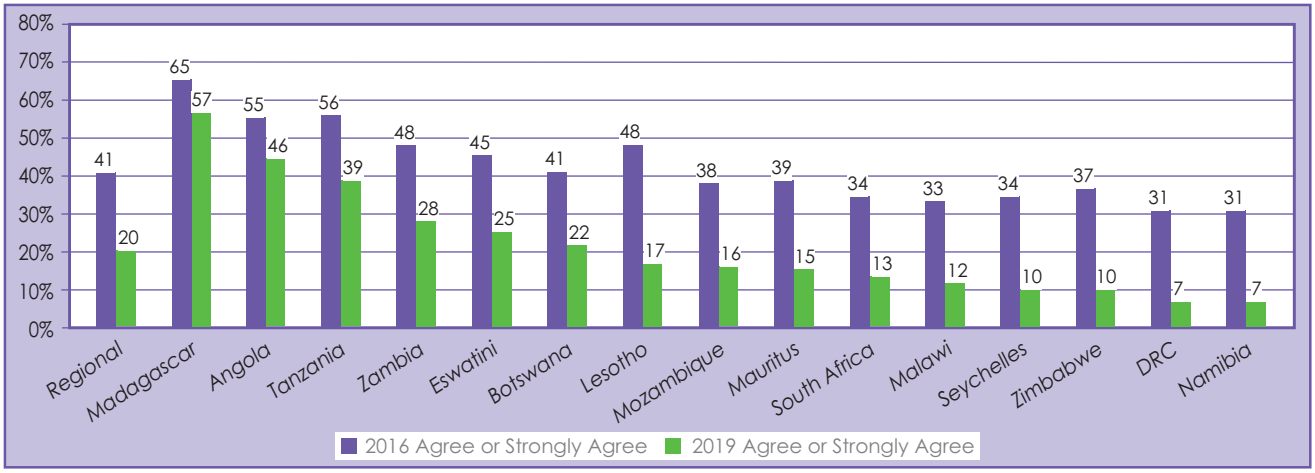


Source: Gender Progress Score 2016 and 2019.



Figure 6.8 shows that Angola is once again an outlier, with substantially more men (82%) agreeing with the statement that a man should have final say in all family matters than women (29%). Men and women in many other countries closely mirror each other, with both sexes in DRC and Madagascar agreeing in large numbers with the statement - notably 96% of men in DRC.

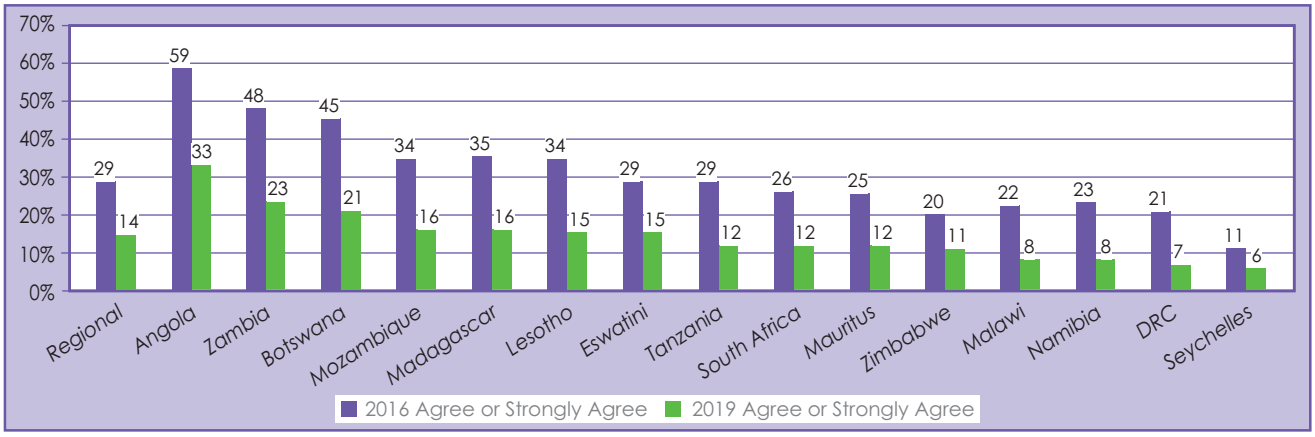
Figure 6.9: Gender attitudes - if a wife does something wrong, her husband has the right to punish her



Source: Gender Progress Score 2016 and 2019.

Figure 6.9 illustrates a positive shift in attitudes in every SADC country monitored, with fewer people agreeing with the statement that "if a wife does something wrong her husband has the right to punish her" in 2019 than in 2016. Many countries saw a marked drop, including Lesotho (from 48% in 2016 to 17% in 2019) and Zimbabwe (from 37% in 2016 to 10% in 2019). Overall, the regional average fell by 21 percentage points, from 41% in 2016 to 20% in 2019.

Figure 6.10: Gender attitudes - if a man beats a woman it shows he loves her



Source: Gender Progress Score 2016 and 2019.

Figure 6.10 shows another heartening shift in attitudes in relation to the statement "if a man beats a woman it shows he loves her." Respondents in all SADC countries monitored felt differently about this statement in 2019, three years after more than a quarter of people in 10 countries agreed or strongly agreed with it. Now, less than a quarter agree or strongly agree in all countries except Angola (33%), heralding a strong and compelling shift in attitudes that will hopefully translate to a reduction in GBV.

Next steps

- **Prioritise GBV data:** There is need for countries with scarce data on GBV, for example, the Comoros, to prioritise conducting dedicated GBV surveys. Additionally, those countries with data from earlier GBV Baseline Studies (Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe) should prioritise a follow-up study to measure progress. So far only Botswana has done so. Any new studies, which would help generate up to date evidence for GBV prevention programming, should expand to include the violence against men module.
- **Spotlight GBV:** With much of Southern Africa engulfed in election mode since 2018, and four countries still to have elections in 2019 (and the Comoros in January 2020), it is an opportune time to hold leaders seeking re-election to account on what they have done to prevent GBV in their jurisdictions. It is also the right time for those seeking political office to put GBV in the spotlight and show they have concrete plans and actions to end GBV in their constituencies.
- **Prevention:** Countries need to prioritise prevention of GBV and increase funding to address the factors that make individuals victims or perpetrators in both the private and public spheres, including GBV in emergency situations.
- **Legal:** The SADC audit of SRHR laws and policies shows different levels of comprehensiveness of existing GBV specific laws. There is need for an urgent updating of GBV specific laws and policies to keep in line with regional and international targets and capture the emerging forms of violence, such as those perpetrated online. Stakeholders should prioritise the creation of enabling legal environments for the use of technology[77] to help bring societies closer to ending GBV. Legislators should also approve funding for legal literacy campaigns to ensure women and girls know their rights in law, services available and remedies.
- **Support:** In addition to current efforts, SADC countries should embrace the Essential Services Package guidelines for supporting survivors of GBV. It is also important to consider including informal structures of support in these discussions, such as faith leaders and communities at large, to ensure they provide proper, human rights-based support.
- **Integrated approaches:** Ending all forms of GBV requires a strengthened multi-sectoral approach. This includes the justice and legal, security, health (including sexual and reproductive health), education, economic, social services, humanitarian, and development sectors. These approaches must work at the individual, family, community, local, national, and global levels.
- **Media coverage:** There is urgent need to achieve greater diversity, balance and sensitivity in the coverage of GBV in media, especially on television.

SADC countries should embrace the Essential Services Package guidelines for supporting survivors of GBV

[77] https://16days.thepixelproject.net/16-ideas-for-using-technology-to-prevent-and-stop-violence-against-women/ (accessed 12 June 2019)

Harmful Practices 7



Patriarchy is at the heart of harmful practices. Drama perfomance by Somnjalose High School during the eZulwini Municipality Mayors walk
Photo: Thandokuhle Dlamini

KEY POINTS

- The Constitutions of five SADC countries have claw back clauses. This means they provide for gender equality on one hand but make other guarantees that undermine that provision. Three Constitutions fail to address the contradictions between the constitution, customary laws and practices.
- The average regional score for the Gender Responsive Assessments of Constitutions and laws in SADC is 57%. The lowest rated area (average 49%) is access to justice.
- While all SADC countries meet the requirement of the minimum age of 18 for marriage for men, only three countries (Malawi, Mozambique and South Africa) stipulate 18 as the minimum age of marriage for women and men with no exceptions, i.e. are compliant with the SADC Protocol on Gender and Development.
- In eight SADC countries (Angola, DRC, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe) over one third of all young women are married by the age of 18.
- In Tanzania, the promulgation of a law prohibiting female genital mutilation in 1998 has not ended the practice.
- Widows in Southern Africa still face various forms of harmful cultural practices including forced widow inheritance, accusations of witchcraft including accusations of killing their deceased husbands, gender based violence, property grabbing and other forms of inhuman, humiliating and degrading treatment.
- In Swaziland widows are openly discriminated against by State institutions. Discriminatory practices include being barred from participating in politics and other public life/spaces, being barred from getting close to the King or the Queen mother or even obtaining mundane services like applying for a passport.

Introduction



Harmful cultural or traditional practices are a form of gender based violence in that they are mainly targeted at women and girls simply because they are women or girls. The practices are perpetrated by communities for so long, often for generations. As a result they are regarded by communities and in particular those who push or support the practices as part of the culture or way of doing things for those communities thus assuming an aura of morality within society.[1] Harmful cultural practices have a serious bearing on the sexual and reproductive health rights of women and girls. Examples of harmful cultural practices include early forced and child marriages, widow inheritance, property grabbing, female genital mutilation (FGM), and honour killings amongst others.

The SADC Protocol on Gender and Development states that "States Parties and policies must ensure that policies and programmes... take account of the unequal status of women, the particular vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS".[2] For example early or child marriage often results in early pregnancies and infection of the affected children with sexually transmitted diseases, including HIV. This in turn has long term effects on the health and wellbeing of the child, including potentially impacting the right to life as young girls often die in child birth or from HIV and AIDS related illnesses and complications. Female Genital Mutilation (FGM) may also expose women and girls to HIV infections, as does widow inheritance and virginity testing amongst other practices. Most of the harmful cultural practices that are perpetrated on women are executed in and around a culture of coercion, discrimination and violence, which increases women and girls' vulnerability and violation of their SRHR.

It is important to acknowledge that not all cultural practices are harmful and focus on the elimination of those that are. It is also important to analyse and decipher those practices that are regarded as positive, so that they are not used as a decoy to smuggle in, justify and hide harmful practices.

This chapter places significant focus on child marriage as a harmful practice. Child marriage is defined as "any marriage where at least one of the parties is less than 18 years of age".[3] A child marriage is also a form of forced marriage in that as a child or children, or both parties to the marriage could not have given their full, free and informed consent.

The practice has been a cause for concern the world over, including Southern Africa. The adoption of the *SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage* by the SADC Parliamentary Forum in 2016 marked a turning point in the region in acknowledging the scourge, and the need for governments to put in place measures to contain it.

[1] NHS Health Scotland, (2019), 'Harmful traditional practices' available at: http://www.healthscotland.scot/health-topics/gender-based-violence/harmful-traditional-practices (accessed 15 July 2019)
[2] Article 27 (2), SADC Protocol on Gender and Development
[3] United Nations Office of the High Commissioner on Human Rights (Undated), 'Child, early and forced marriage, including in humanitarian settings' available at: https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/ChildMarriage.aspx (accessed 16 July 2019)

Table 7.1: Key Indicators on Harmful Practices

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Constitution															
The Constitution has claw back clauses	No	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No	No	No	No	No
The Constitution addresses contradictions between the constitution, laws and practices	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gender Responsive Assessment of Constitutions and Laws (all Articles refer to the SADC Protocol on Gender and Development)															
Gender Responsive Assessment of Constitutions and Laws (GRA) overall %	50	43	39	30	50	49	73	54	32	68	73	62	67	58	74
Constitutional rights (Article 4) %	52	52	60	24	44	56	84	60	56	72	60	68	48	52	72
Laws and practise (Article 6) %	40	40	N/A	30	52	64	66	62	N/A	56	72	46	62	56	56
Access to justice (Article 7) %	48	30	42	6	42	24	56	48	34	68	78	64	56	62	76
Persons with disability (Article 9) %	80	40	40	60	40	80	60	N/A	80	80	60	100	100	80	100
Widows and widowers (Article 10) %	70	50	60	0	60	60	80	80	40	80	100	90	100	100	100
Marriage and family rights (Article 8) %	47	50	70	57	40	63	93	37	50	87	73	63	77	60	83
Early Child Marriages															
Minimum legal age of consent to marriage for women	15	21	15	16	16	18	18	18	18	18	15	18	15	21	18
Minimum legal age of consent to marriage for men	18	21	18	18	18	18	18	18	18	18	18	18	18	21	18
Exceptions for women	15	18	None	Possible no age	Possible no age	Possible no age	None	16	None	Possible no age	Possible no age	None	Legis-lation under appeal	16	None
Exceptions for men	16	18	None	Possible no age	Possible no age	Possible no age	None	16	None	Possible no age	Possible no age	None	Legis-lation under appeal	16	None
Percentage young women married by Age 18	30	n/d	37	5	17	41	42	n/d	48	7	n/d	6	31	31	32
Percentage young women married by Age 15	8	n/d	10	1	1	12	9	n/d	14	2	n/d	1	5	6	4

Source: Gender Links and Girls Not Brides.

Table 7.1 summarises key indicators on harmful practices. It shows that:

- The Constitutions of five SADC countries (Botswana, Eswatini, Lesotho, Malawi and Mauritius) have claw back clauses. This means they provide for gender equality on one hand but make other guarantees that undermine that provision.
- Three Constitutions (Botswana, Eswatini and Mauritius) fail to address the issue of contradictions between the constitution, customary laws and practices.
- The average regional score for the Gender Responsive Assessments of Constitutions and laws in SADC is 57%. The highest rated areas (average 71%) are disability and widowers rights. The lowest (average 49%) is access to justice.
- While all SADC countries meet the requirement of the minimum age of 18 for marriage for men, six countries (Angola, DRC, Eswatini, Lesotho, Seychelles and Tanzania) are in violation of this provision of the SADC Protocol on Gender and Development for women. Three countries (Angola, Mauritius and Zambia) allow exceptions to the 18 year rule. Botswana makes an exception to its 21 year age of marriage to the minimum requirement of 18. Five countries (Eswatini, Lesotho, Madagascar, Namibia and Seychelles) make exceptions without stipulating age. In Tanzania this is under review. Only three countries (Malawi, Mozambique and South Africa) stipulate 18 as the minimum age of marriage for women and men with no exceptions, i.e. are compliant with the SADC Protocol on Gender and Development.
- In eight SADC countries (Angola, DRC, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe) over one third of all young women are married by the age of 18.

Much work still needs to be done at national level to put in place laws, policies and other measures to eradicate child marriage and other harmful practices as espoused in the Model Law and the SADC Protocol on Gender and Development. Other focus areas in this chapter will include harmful cultural practices that impact on widows such as widow inheritance, witchcraft accusations, property grabbing, mourning rites and practices as well as other forms of violence and discrimination that are perpetrated against widows in the name of culture. The chapter will also cover FGM with a focus on Tanzania as the only country in Southern Africa with high levels of FGM.



Community drama in Bongatsara, Madagascar, challenges harmful practices. Photo: Colleen Lowe Morna

Constitutional and legislative provisions

Article 4:1: State parties shall enshrine gender equality and equity in their Constitutions and ensure that any provisions, laws or practices do not compromise these.

A key source of contradictory and discriminatory laws and practices emerges from parallel legal systems of statutory, customary and in some cases religious laws. Some Constitutions give customary law overriding authority over the constitutions (Claw back clauses). Examples include the Constitution of Botswana[4] and the Constitution of Lesotho.[5] This means that women cannot challenge any harmful or discriminatory customary practices as long as they are deemed to be part of customary law and the women are deemed to be subject to that customary law. The courts have however often come in to protect women by insisting that customary laws must comply with international human rights standards even in situations where the constitutions might not be compliant.[6]


Zambian Court of Appeal

The Courts are often a beacon of hope in shaping and condemning traditional or cultural practices that impair the rights and dignity of women. In some instances however, the courts may come short and fail to send a strong message about the evils of harmful cultural practice. In the recent Zambian case of *Try Hamenda vs The People*,[7] the Court of Appeal in Zambia upheld a High Court sentence of 30 years imprisonment for Try Hamenda after he was convicted of raping a 12 year old minor (the offence is also called defilement in Zambia).

The accused argued that the sentence was excessive and induced a sense of shock. Amongst the reasons advanced by the accused for a more lenient sentence was that he had acted in the manner he did in line with "Tonga tradition which is a notorious fact that one can abduct a woman and have sexual intercourse with her and later formalize the marriage." The Court of Appeal rejected the accused person's request to have the sentence reduced citing that the complainant was a minor and that she was tortured during the rape. But it failed to make any pronouncements regarding the harmful cultural practice of bride abduction.

Carmel Rickard has called this a "missed chance for judges to condemn 'barbaric' practice.'[8] Considering that this case was in the Court of Appeal in Zambia and that the Appeal Bench comprised three women judges, the court missed a critical opportunity to roundly condemn the practice, sending a strong message about the courts' intolerance of such actions. Courts are urged to take opportunities such as these to condemn harmful cultural practices. This in turn may lead to law reform and changed practices and attitudes within communities. *Source: Zambia Court of Appeal, 2019*

4 S 15 (4) (c) and (d) allow discrimination on the basis of personal law and customary law respectively
5 S 18 (4) (b) and (c) allow discrimination on the basis of personal law and customary law respectively
6 Mmusi and Others v Ramantele and Another 2012 2 BLR 590 HC
7 https://www.judiciaryzambia.com/2019/07/09/app-008-2018-try-hamenda-vs-the-people-june-2019-coram/
8 Rickard, C (2019), 'A Matter of Justice: Missed chance for judges to condemn barbaric practice' available at: https://legalbrief.co.za/diary/a-matter-of-justice/story/missed-chance-for-judges-to-condemn-barbaric-practice/ (accessed 19 July 2019)

Table 7.2: Key gender provisions of SADC Constitutions

Country/Constitution	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi
Provides for non- discrimination generally	Yes, Article 23	Yes, Section 15	Yes, Articles 11, 12 and 13	Yes, Section 20	Yes, Chapter II, Sections 1 and 18	Yes, Article 8	Yes, Section 20
Provides for non- discrimination based on sex specifically	Yes, Article 21	Yes, Section 3	Yes, Articles 14, 36 and 45	Yes, Section 20	Yes, Section 18	Yes	Yes, Article 20
Provides for non- discrimination on the basis of sex and others e.g. marital status, pregnancy	Yes, Article 21	Yes, Section 15	Yes, Articles 40	Yes, Section 20 (2)	Yes, Section 18	Yes, Article 8	Yes, Sections 13 and 20
Provides for the promotion of gender equality	Yes, Articles 21 and 35	No	Yes, Article 14	Yes, Section 28	Yes, Chapter III, Sections 26 and 30	Yes	Yes, Article 13
Has other provisions that relate to gender equality	Yes, Articles 36 and 77	No	Yes, Article 16	Yes, Section 28	Yes, Section 26	Yes, Article 17	Yes, Sections 19 and 18
Has claw back clauses	No	Yes, Section 15	No No	Yes, Section 20	Yes, Section 18	No	Yes, Section 26
Addresses contradictions between the constitution, laws and practices	Yes, Article 239	No		Yes, Section 2 and Article 20	Yes, Section 18	Yes,Article 160	Yes, Article 5

Table 7.2 provides an in-depth analysis of the gender provisions in SADC Constitutions. This shows that:

- All SADC Constitutions provide for non-discrimination generally, and for discrimination based on sex specifically, and other related indicators such as marital status and pregnancy.
- All constitutions except Botswana and Seychelles specifically provide for the promotion of gender equality.
- All constitutions except Botswana, Mauritius and DRC have other provisions that relate to gender equality.
- Five countries have claw back clauses, and three do not specifically address the contradictions between constitutional provisions and customary law.

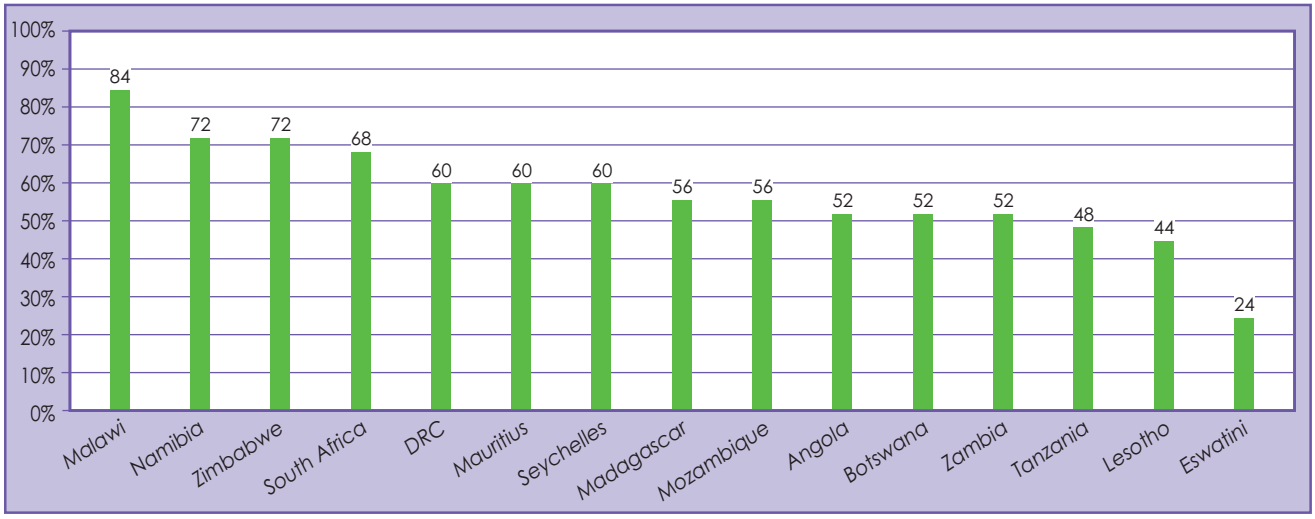
All SADC Constitutions provide for non-discrimination generally

Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Yes, Article 3	Yes, Article 35	Yes, Article 10	Yes, Article 27	Yes, Chapter 1	Yes, Article 13	Yes, Article 23	Equality and Non-Discrimination Section in the Declaration of Rights
Yes, Section 16	Yes, Article 36	Yes, Article 10	No	Yes, Chapter 2, Section 9	Yes, Article 9	Yes, Article 23	Section 23, Declaration of Rights
Yes, Section 16	Yes, Article 39	Yes, Article 14	Yes, Article 30	Yes, section 9	Yes, Article 16	Yes, Article 23	Section 23, Declaration of Rights
Yes, Article 16	Yes, Article 120	Yes, Article 95	No	Yes, Section 9	Yes, Article 66	Yes, 231	Gender equality a Founding Value and Principles; gender balance a National Objective
No	Yes, decriminalisation of homosexuality and termination of pregnancy	Yes, Article 8	No	Yes, Section 12	Yes, Article 13	Yes, Articles 45, 69 and 231	The Declaration of Rights in the new Constitution has been expanded to include equality and non-discrimination
Yes, Section 16	No	No	No	No	No	No	The new Constitution invalidates customary law and practices that infringe on women's rights
No	Yes, Article 143	Yes, Article 19	Yes, Article 5	Yes, Chapter 7, Sections 15 and 30	Yes, Article 30	Yes, Article1(1)	Lawmakers began a law review and reform process following the 2013 elections, but progress has been slow in achieving alignment

Source: Gender Links

The Gender Responsiveness of Constitutions and Laws Analysis (GRA) seeks to assess the level of legal and constitutional reforms in line with the provisions of the SADC Protocol on Gender and Development and other normative frameworks addressing gender equality and women's rights. In 2019, the assessment looked at whether Constitutions have been reviewed in line with the SADC Gender Protocol and other regional and international gender instruments; whether there are legislative measures/programmes involving policy makers, religious and traditional leadership to raise awareness and eliminate harmful practices; whether countries comply with the SADC Gender Protocol Provisions on 18 years as the minimum age for marriage. Additional indicators include whether there are campaigns on child marriages and the level of support to such campaigns by political leaders as well as evidence, both negative and positive in political discourse around the issues of child marriages.

Figure 7.1: GRA of Article 4 - constitutional rights



Source: Gender Links.

The outcome of this analysis in 2019 is reflected in Figure 7.1. Scores range from 24% in Eswatini to 84% in Malawi. It is interesting to note that countries with strong constitutional provisions for gender equality such as Namibia, Zimbabwe, South Africa and Mozambique did not necessarily score the highest. This is because the assessment covered provisions *and* practice. The overall average of 57% shows that SADC countries still have some way to go in ensuring the full realisation of women and girls' rights as provided by their Constitutions.

Discriminatory legislation

Article 6: State parties shall review, amend or repeal all discriminatory laws and specifically abolish the minority status of women.

Several countries in the SADC region still have discriminatory laws on their statute books. These include laws that provide differentiated inheritance rights between men and women, boys and girls (Lesotho), laws that have limitations on maternity leave (in South Africa, a woman can go on four months' maternity leave but her employer is not obliged to pay her during that period),[9] laws that discriminate against and criminalise the LGBTI community (all the SADC countries except DRC, Mozambique, Angola, Seychelles and South Africa) and claw back clauses in constitutions that effectively allow for discrimination on the grounds of gender (for example in Botswana, Eswatini and Lesotho).

[9] Even though the employer is not obliged to pay a woman during maternity leave, the woman can claim a maternity benefit from the Unemployment Insurance Fund (UIF) provided they she was contributing to the fund for at least four months before going on maternity leave. Whilst South Africa has a generous four months maternity leave, the non-compulsion for an employer to pay the woman whilst she is on maternity leave means that many women go without money at a time when they need it most.

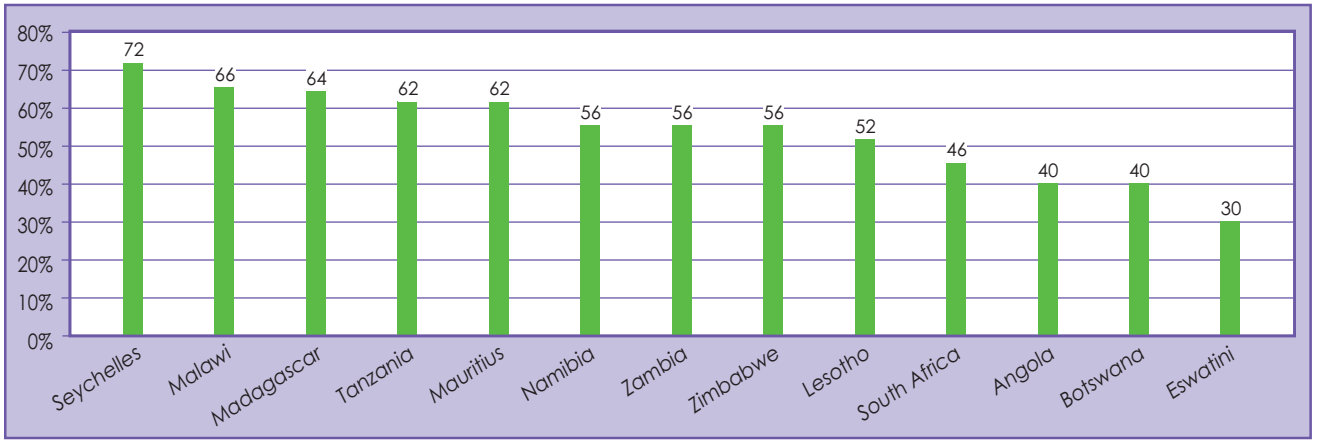
Discriminatory practices in SADC countries - frequently under harmful customary laws and practices - include:

- Child marriage;
- Age of consent frequently lower for girls than boys;
- Being "given away" in marriage;
- Forced marriage;
- Marital rape;
- Domestic violence;
- Not being allowed to divorce;
- No ability to travel without permission;
- Accusations of witchcraft;
- Not being deemed good enough to be guardian for children; and
- Economic disempowerment.



The GRA of Article 6 considered if countries had reviewed, amended and or repealed all laws that discriminate on the ground of sex or gender; guarantee the rights of marginalised groups (eg indigenous women, sex workers, sexual minorities); abolished the minority status of women; ensured that bride price (lobola) payment is not mandatory or abused to undermine the rights of women; that women can purchase land or immovable property without approval of their spouses, fathers or brothers; obtain birth certificates, identity documents, media interviews, photos, videos and passports without the consent of their spouses. A key consideration concerned enacting and enforcing legislative and other measures to eliminate gender based violence; integrated GBV services within an accessible distance; victim friendly services at police stations; health services equipped to address GBV; increase in reported cases of GBV and proportion of reported GBV cases successfully prosecuted.

Figure 7.2: GRA of Article 6 - laws and practise

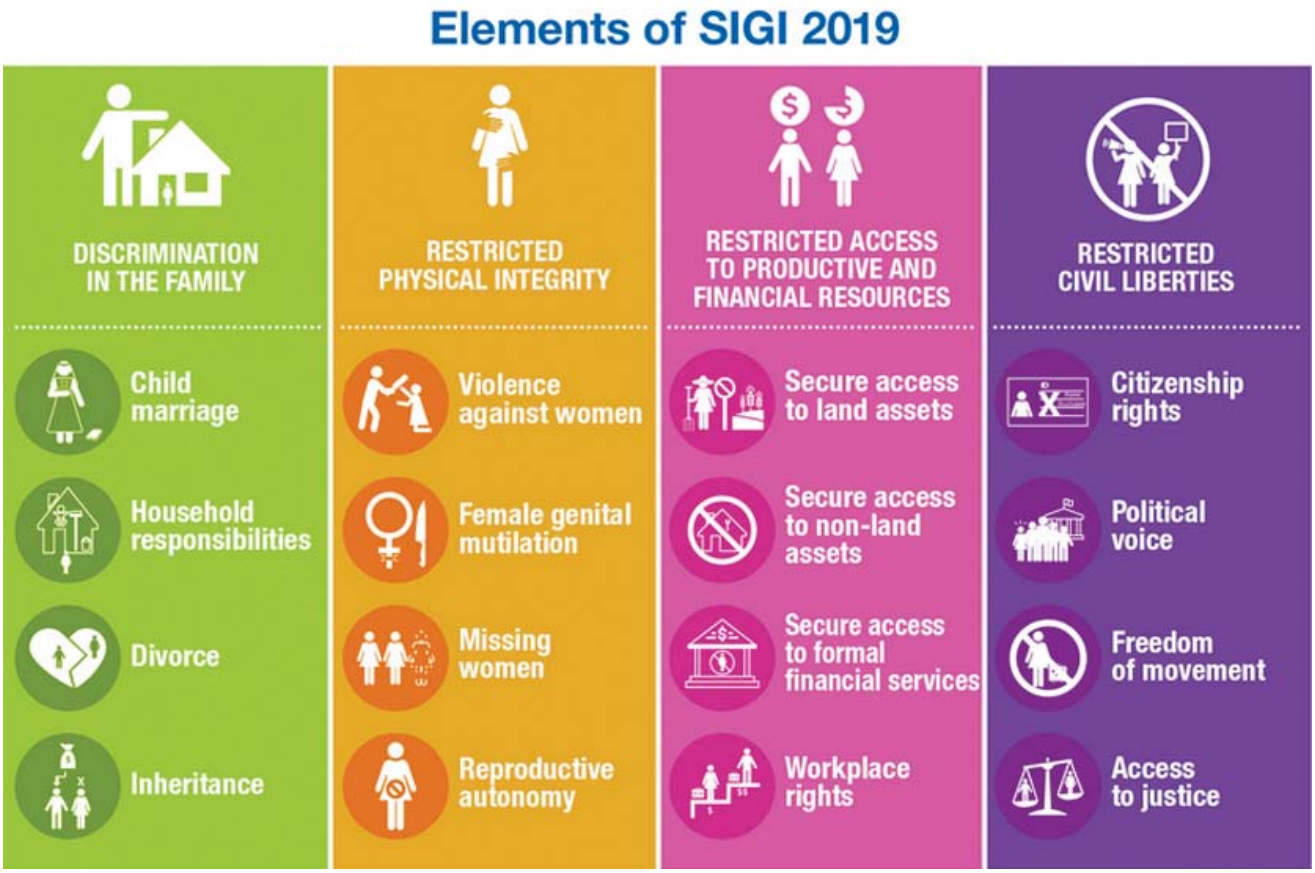


Source: Gender Links.

With a regional average of 47%, this set of questions had the lowest scores in the GRA. There is a strong perception that discriminatory laws and practices persist in SADC countries. At 72% Seychelles scored the highest. Eswatini (30%) scored the lowest. Despite 25 years of gender justice reforms post-apartheid South Africa scored 46%. These numbers reflect the gap between the rhetoric and the reality of gender equality.

The OECD Development Centre's Social Institutions and Gender Index (SIGI)[10] is a cross-country measure of discrimination against women in social institutions (formal and informal laws, social norms, and practices) across 160 countries inclu-ding SADC countries.[11] The SIGI 2019 covers four dimensions of discriminatory social institutions: discrimination in the family, restricted physical integrity, restricted access to productive and financial resources and restricted civil liberties.

[10] http://www.genderindex.org/ Accessed 3 June 2019
[11] www.genderindex.org , accessed 2 July 2016



Source: Social Institutions and Gender Index, 2019.

The SIGI's variables quantify discriminatory social institutions such as unequal inheritance rights, child marriage, household responsibilities, divorce, violence against women, female genital mutilation, missing women, reproductive autonomy, secure access to land rights, access to justice and political voice amongst others. Through its 160 country profiles, country classifications and unique database, the SIGI provides a strong evidence base to address the discriminatory social institutions that hold back progress on gender equality and women's empowerment.

SIGI Ratings:

Very low - Robust legal frameworks and measures that provide equal rights in the family code and in access to resources and assets and that promote women's civil liberties ((SIGI < 0.04).
Low - Strong laws providing equal rights for women and men in the family code, in access to resources and assets, and in civil liberties (0.04 < SIGI < 0.12).
Medium - Inconsistent or conflicting legal frameworks covering the family code, women's access to resources and assets, and civil liberties (0.12 < SIGI < 0.22).
High - Discrimination embedded in customary laws, social norms and practices and by inappropriate legal protections against gender discrimination in all dimensions of social institutions (0.22 < SIGI < 0.35).
Very high - High levels of discrimination in legal frameworks and customary practices; very poor implementation measures (0.35 > SIGI).

Table 7.3: SADC Countries rating on Social Institutions and Gender Index 2019

Country	SIGI rating				
	Very low	Low	Medium	High	Very high
Mozambique					
Namibia					
South Africa					
DRC					
Lesotho					
Zambia					
Zimbabwe					
Madagascar					
Malawi					
Tanzania					
Angola*					
Botswana*					
Comoros*					
Mauritius*					
Kingdom of Eswatini*					
Seychelles*					

*SIGI rating not applicable.

Source: Adapted from OECD Social Institutions and Gender Index (SIGI) study, 2019

Of the countries rated, some countries have improved; others have regressed, whilst others have remained constant since the last assessment in 2014. DRC and Zambia significantly improved from very high levels of discrimination to medium. Table 7.3 shows that South Africa and Namibia remained on low levels of discrimination; Zimbabwe maintained medium levels of discrimination and Tanzania maintained high levels of discrimination. Mozambique improved from medium to low, Malawi regressed from medium to high, Lesotho regressed from low to medium and Madagascar regressed drastically from low levels to high levels of discrimination.

Access to justice

Article 7: Equality in accessing justice

1. State parties shall put in place legislative and other measures which promote and ensure the practical realisation of equality for women. These measures shall ensure:

- Equality in the treatment of women in judicial and quasi-judicial proceedings, or similar proceedings, including customary and traditional courts and national reconciliation processes;
- Equal legal status and capacity in civil and customary law; including, amongst other things, full contractual rights, the right to acquire and hold rights in property, the right to equal inheritance and the right to secure credit;
- The encouragement of all public and private institutions to enable women to exercise their legal capacity;
- Positive and practical measures to ensure equality for women as complainants in the criminal justice system;

- The provision of educational programmes to address gender bias and stereotypes and promote equality for women in the legal systems;
- That women have equitable representation on, and participation in, all courts, including traditional courts, alternative dispute resolution mechanisms and local community courts; and
- Accessible and affordable legal services for women.

Access to justice is defined as "the ability of people to seek and obtain a remedy through formal or informal institutions of justice, and in conformity with human rights standards."[12] Across the region lack of resources, low levels of literacy and lack of information are emerging as the three main challenges women face when exercising their legal capacity. Men dominate traditional courts and it is highly unlikely that women will get a fair hearing in these courts. Numerous recent cases show that the justice on paper accorded to women by Constitutions and Protocols is not translating into reality. Religion and culture also plays a role in limiting access to justice.

Access to justice improves where there is investment of judicial personnel, public rights education and investment on facilities. Police and social workers also need to be trained on gender equality and how to handle cases of abuse, discrimination and harmful traditional practices. Women need to assume more leadership positions in the legal field.

Accessing justice in Southern Africa, especially for women, remains a struggle. In most situations, lack of resources, the complexity of the formal justice system and the failure of the traditional/customary justice systems to accord women their rights represent hindrances to accessing justice. Legal aid organisations have often stepped in to provide free legal assistance for women as a way of ensuring they can access justice. Such organisations include the Women and Law in Southern Africa Research and Educational Trust, various women lawyers' associations and various judges' associations.

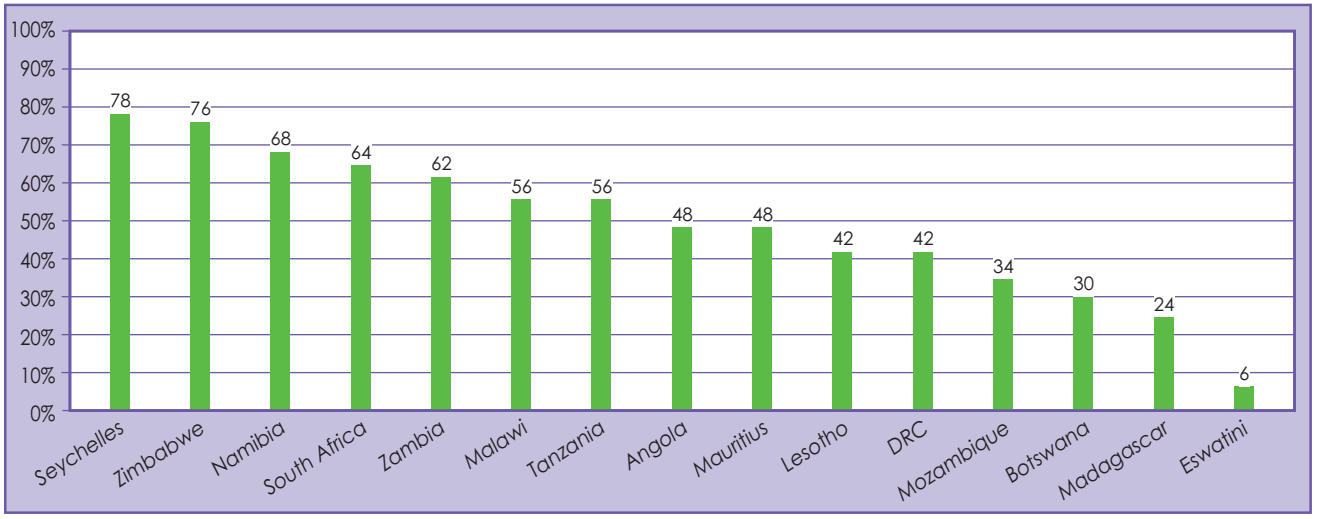
Governments also step in once in a while, although such efforts are often ad hoc and insufficient.

The GRA assessed whether countries have put in place legislative and other measures which promote and ensure the practical realisation of equality for women; ensured equality in the treatment of women in judicial and quasi-judicial proceedings or similar proceedings, including customary and traditional courts, and national reconciliation processes. It includes evidence of measures to promote equal treatment of women in judicial proceedings in civil, traditional and criminal courts, as well as national reconciliation processes. Other criteria are: equal legal status and capacity in civil and customary law, including, full contractual rights, the right to acquire and hold rights in property, the right to equal inheritance and the right to secure credit; awareness programmes on women's rights and the justice system; training of the judiciary on gender equality and women's rights and existence of state-supported free legal aid for women.

Legal aid organisations have often stepped in to provide free legal assistance...

[12] Maregere, T. P (2018), 'Justice in Transition and the Complexities of Access' available at: https://www.accord.org.za/conflict-trends/justice-transition-complexities-access/ (accessed 19 July 2019)

Figure 7.3: GRA of Article 7 - Access to justice



Source: Gender Links.

With an average GRA score of 49%, access to justice was another area of women's rights found to be weak in SADC. The scores range from 6% in Eswatini to 78% in Seychelles. There is no direct correlation between levels of development in the different countries and access to justice. For example, Botswana scored 30% despite being a middle income country. This shows that access to justice is first and foremost a matter of political will.

Marriage and family rights

Article 8: Marriage and family rights

1. State parties enact and adopt appropriate legislative, adminis-trative and other measures to ensure that women and men enjoy equal rights in marriage and are regarded as equal partners in marriage.
2. Legislation on marriage shall therefore ensure that:
(a) No person under the age of 18 shall marry;
(b) Every marriage takes place with free and full consent of both parties;
(c) Every marriage including civil, religious, traditional or customary, is registered in accordance with national laws; and
(d) During the subsistence of their marriage the parties shall have reciprocal rights and duties towards their children with the best interest of the children always being paramount.
3. State parties shall enact and adopt appropriate legislative and other measures to ensure that where spouses separate, divorce or have their marriage annulled:
(a) They shall have reciprocal rights and duties towards their children with the best interest of the children always being paramount; and

(b) They shall, subject to the choice of any marriage regime or marriage contract, have equitable share of property acquired during their relationship.

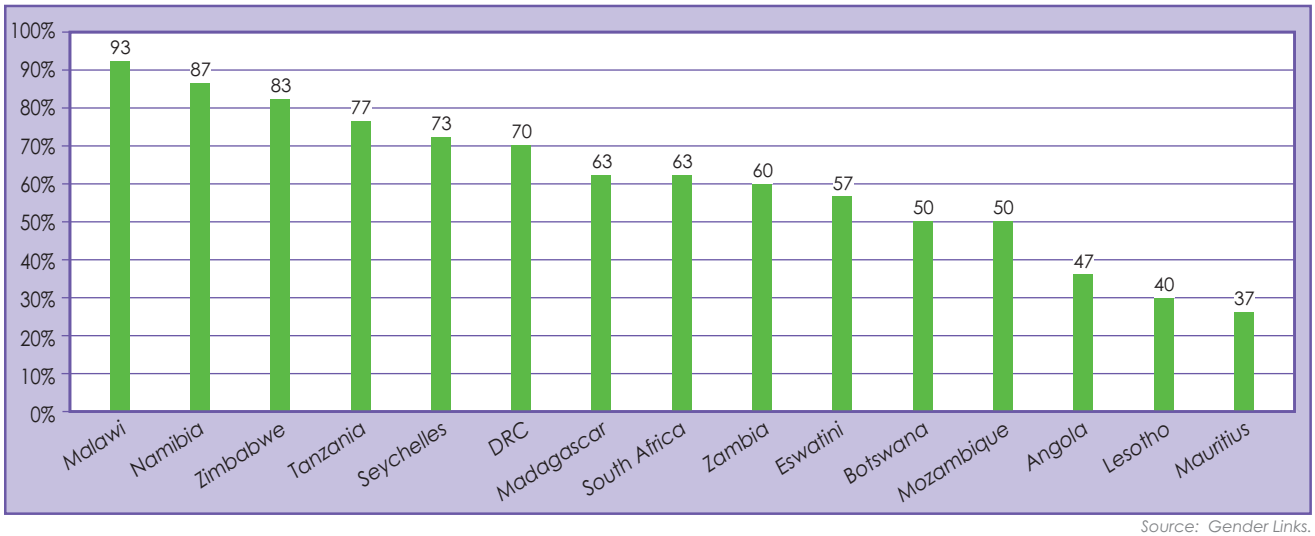
4. States parties shall put in place legislative and other measures to ensure that parents honour their duty of care towards their children, and maintenance orders are enforced.
5. States parties shall put in place legislative provisions which ensure that married women and men have the right to choose whether to retain their nationality or acquire their spouse's nationality.

The GRA Analysis on Marriage and Family Rights assesses the extent to which countries have enacted and adopted appropriate legislative, administrative and other measures to ensure that women and men enjoy equal rights in marriage and are regarded as equal partners in marriage. This includes whether married women can retain their maiden surname; if marital rape is criminalised; whether women can choose any contraception method without the consent of their partners. The score assesses the extent to which every marriage, including civil, religious, traditional or customary, is registered in accordance with national laws. It includes provisions for spouses to have equitable share of property acquired during their relationship and the outlawing of 'wife inheritance'.

With regard to age of marriage, the assessment covers:

- Whether legal age for marriage (for both women and men) is 18 and above.
- There are programmes in place to raise awareness against early and child marriages.
- Forced marriage is criminalised.
- Existence of campaigns against child marriages and their level of support by political leaders; and
- Evidence of changes in political discourse, whether positive or negative.

Figure 7.4: GRA of Article 8 - marriage and family Rights



Source: Gender Links.

The regional average GRA score for marriage and family rights, including child marriages is 63%. This ranges from 37% in Mauritius to 93% in Malawi. The latter reflects the frustration in Mauritius, the only country in SADC not to sign the SADC Gender Protocol, because of the insistence on 18 as the minimum age of marriage. The former reflects the more buoyant mood in Malawi, which has mounted a major campaign on child marriages over the last five years.

Child marriages

SDGs 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

CEDAW, Article 16(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;

Article 16(2) The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

ICPD 6.11 Countries should create a socio-economic environment conducive to the elimination of all child marriages and other unions as a matter of urgency, and should discourage early marriage.

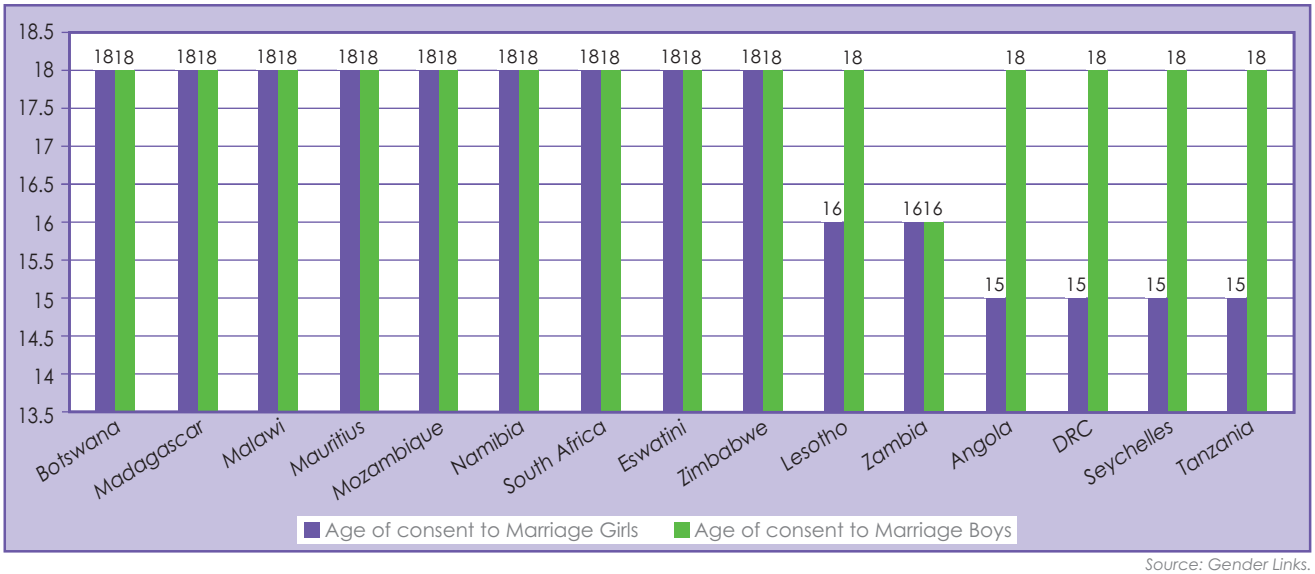
Maputo Protocol Article 6a) no marriage shall take place without the free and full consent of both parties; Article 6b) the minimum age of marriage for women shall be 18 years.

SADC Protocol Article 8.2a: No person under the age of 18 shall marry.

SADC UN CSW RESOLUTION calls upon all governments to enact and intensify the implementation of laws, policies and strategies to eliminate all forms of gender-based violence and discrimination against women and girls in the public and private spheres and harmful practices, such as child, early and forced marriage, female genital mutilation and trafficking in persons, and ensure the full engagement of men and boys in order to reduce the vulnerability of women and girls to HIV;

The SADC Model Law on Child Marriage defines "child marriage" as "a statutory or customary union in which one party is a child or both of the parties are children.[13] The same Model Law defines a child as any person under the age of 18 years in line with other international human rights instruments.[14]

Figure 7.5: Age of consent to marriage for girls and boys by country



Source: Gender Links.

[13] SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, s 2.
[14] Article 1 of the Convention on the Rights of the Child defines a child as every human being below the age of 18 years

Despite the numerous global, continental and regional instruments pronouncing 18 as the minimum age of marriage, including the SADC Model Law on Child Marriage adopted by the SADC Parliamentary Forum, laws at national level in many SADC countries directly contradict these commitments. Figure 7.5 shows that:

- In Zambia, young women and men are allowed to marry at 16.
- In four SADC countries (Angola, DRC, Seychelles and Tanzania) young women can marry at 15 (three years below the minimum age).
- In Lesotho, young women can marry at 16 (two years below the minimum age).

In some countries that set the general age of consent to marriage at 18, there are claw back clauses that allow children to be married either with the consent of the parents, a court or a government minister responsible for justice. The justification for allowing such derogation is that it might in the best interest of the child to be married. Mauritius is one example. Exceptions are made for both boys and girls to be married at 16, based on the argument that certain religions in the country permit this. However such derogations can be open to abuse, thereby defeating the whole purpose of eliminating child marriages. In essence child marriage must be outlawed, without exception.



Junior councilors in Norton, Zimbabwe, protest Child Marriages. Photo: Tapiwa Zvaraya

There are various push factors to child marriage. In many instances, parents encourage the marriage of their daughters while they are still children in hopes that the marriage will benefit the parents or families socially and financially. Some parents won't even send their girl children to school, perceiving it as a waste of money and resources. This is unfortunate, given that investing in girls' education is an important strategy in ending child marriages.[15]

Traditional or customary practices such as "*chigaramapfiwa*"[16] in **Zimbabwe** stoke child marriages despite legal and constitutional provisions to the contrary. Despite the Constitutional Court ruling[17] in 2016 declaring child marriage illegal and unconstitutional, child marriage through such practices as chigaramapfiwa remained a cause of concern in 2018.[18] Early pregnancy can lead to complications associated with child birth for children and young women.

Several factors hinder the reduction of child marriages in SADC including:

- Lack of effective and well streamlined birth registration systems making age determination difficult for purposes of enforcing a law on child marriage;[19]
- Lack of legal provisions for those who contravene the minimum age of marriage requirement conflicting with the criminal laws on sex with a minor;
- Slow reform in laws on marriage which may frustrate interventions on eradicating child marriage and preventing child marriage;[20]
- Cultural, religious and traditional practices that impede the advancement of women's rights and goes against State obligations under international human rights instruments[21]; and
- Lack of recognition of, and inadequate provision of sexual reproductive health services and rights (SRHSR) in the general legal framework.[22]

[15] Moses Maguranyanga (2018), 'Zimbabwe: Child marriages, a cause for concern', available at: http://genderlinks.org.za/news/zimbabwe-child-marriages-a-cause-for-concern/ (accessed 4 June 2019)
[16] This is a customary practice where a young girl is married off to her deceased sister or paternal aunt's widower.
[17] Mudzuru & Another v Ministry of Justice, Legal & Parliamentary Affairs (N.O.) & Others (Const. Application No. 79/14, CC 12-15) [2015]
[18] Moses Maguranyanga (2018), 'Zimbabwe: Child marriages, a cause for concern', available at: http://genderlinks.org.za/news/zimbabwe-child-marriages-a-cause-for-concern/ (accessed 4 June 2019)
[19] https://www.girlsnotbrides.org/wp-content/uploads/2016/10/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf
[20] https://www.girlsnotbrides.org/wp-content/uploads/2016/10/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf
[21] https://www.girlsnotbrides.org/wp-content/uploads/2016/10/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf
[22] https://www.girlsnotbrides.org/wp-content/uploads/2016/10/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf

Child brides are neither physically nor emotionally ready to become wives and mothers. Isolated and with limited freedom, married girls often feel disempowered. They are deprived of their fundamental rights to health, education and safety. They face more risks of experiencing dangerous complications in pregnancy and childbirth, contracting HIV/AIDS and suffering domestic violence. With little access to education and economic opportunities, they and their families are more likely to live in poverty.[23] The example that follows from Tanzania shows how child marriages affect the lives of young women:

Tanzania: Child marriages mar girls' future[24]



Despite her desire to complete her education, Neema Charles never made it to secondary school as she was forced to get married a year before she completed her primary education. The 16-year old girl from Tarime District in Mara Region of Tanzania dreamt of becoming a doctor but was barred from completing her primary education in 2016 and forced to get married to a 67 year-old man in her village.

"I was in standard six preparing to join standard seven in 2016, but my father told me to stop schooling because he had had talks with a man in the village who was to marry me," she says. The seriousness of the matter never dawned on her until her father ordered her to stop going to school and begin preparations for the marriage.

Neema's academic journey was cut short at the age of 14 and nothing save for a miracle was likely to turn tables in her favour as the father saw nothing wrong with cutting off her education. He was only interested in getting cows.

In her marriage, Charles suffered humiliation and violence. She fled from the village to Dar es Salaam. "The pain I endured was too much, I decided to flee to Dar es Salaam," she notes. In Dar es Salaam, she got married to another man, much younger than the old husband. The young woman with two-children is among the thousands of other young girls now serving as wives in many and poor households in Tanzania.

Tanzania has one of the highest child marriage prevalence rates in the world. On average, almost two out of five girls will be married before their 18th birthday. In 2010, about 37 percent of the women aged 20-24 were married/in union before age 18. Data shows a 10 percent decline since 2004. Experts argue that education is one of the most effective strategies to protect children against marriage. When girls are able to stay in school, an attitudinal change can also occur towards their opportunities within the community.

Source: Anne Robi, Gender Links News Service, 2018

[23] GirlsNotBrides (2019), 'What is the impact of child marriage?', available at: https://www.girlsnotbrides.org/what-is-the-impact/ (accessed 6 June 2019)
[24] https://genderlinks.org.za/news/tanzania-waging-war-against-dowry/ (accessed 6 June 2019)

Strengthening Laws and policies on Child Marriages in SADC

SADC states adopted the Model Law on Child Marriages in June 2016. The lack of prohibitive child marriage laws itself promotes gender inequality. Member states need to domesticate the provisions of the model law as a matter of urgency.

Table 7.4: Guide to implementing the SADC Model on Child Marriages[25]

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 materializes 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.
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.		

AREA OF GOVERNMENT	GOVERNMENT ACTOR	ROLES AND RESPONSIBILITIES
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 sensitize 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.		
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, immunization 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 Court System is responsible for interpreting the laws passed by the Legislative Branch and enforced by the Executive Branch. They are responsible for the administration of justice.
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.		

Source: UNFPA ESARO, 2018.

[25] https://esaro.unfpa.org/en/publications/guide-using-sadc-model-law-eradicating-child-marriage-and-protecting-children-already

Table 7.4 is a guide to the domestication on the Model Law. The challenge in the region is the existence of dual legal systems. Statutory legal provisions do not normally apply to customary laws. Laws on child marriages must regulate statutory and customary legal provisions on marriage.

To guard against the increased health risks and death of these children, the SADC Model Law obliges Member States to provide intervention programmes to support child brides/wives and their families by promoting earlier and more frequent use of family planning, HIV/AIDS and maternal health services.[26] Information must be made available to children already in marriage on services and facilities that they can access. In order to reach and provide information and services and facilities to such children, as well as monitor and evaluate the impact of their programs, governments equally need information on affected children. Required information include geographical prevalence and location as well as the most affected age groups. Such information must be obtained without compromising the child brides' rights to privacy.

Governments must put in place mitigation measures for the child already in marriage, especially for the girl wife/brides already in marriages. Married girls need educational and economic opportunities to help break the cycle of inequality, illiteracy, illness and poverty that frequently perpetuates child marriage.

SADC countries must also incorporate in their laws and constitutions rights and concepts that seek to protect children and promote their enjoyment of rights. These include:

- According specific rights in constitutions and laws;
- Defining "child" in law and constitutions;
- Laws to prohibit child marriage and the betrothal of girls and boys and allow for the voiding of child marriages under certain circumstances;
- Laws that specify the minimum age for marriage;
- Guaranteeing the right to registration at births and marriage;



Young married girls in Kalenga Maka Village, Zambia. Photo: Albert Ngosa

- Prohibition of discrimination against a child on any grounds;
- Equal treatment of children by national laws and according equal protection and rights regardless of whether they were born inside or outside marriage;
- Protection of children from abuse, neglect and harmful practices;
- Right to education; and
- Right to privacy and confidentiality of the child.

The Children's Law or Children's Act is one of the major legal instruments according children the above rights. Countries with a Children's Act in SADC are: Angola (Lei sobre a Protecção e Desenvolvimento Integral da Criança), Botswana (Children's Act) DRC (Loi n°09/001 Portant Protection de l'Enfant (2009), Lesotho (Children's Protection and Welfare Act), Malawi (Children and Young Persons Act), Mauritius (Child Protection Act), Mozambique (Lei n 7/2008: Lei de Promoção e Protecção dos Direitos da Criança), Namibia (Child Care and Protection Act), Seychelles (Children's Act), South Africa (Children's Act), Swaziland (Children Protection Act), Tanzania (Children's Act) and Zimbabwe (Children's Act).

In Comoros, Zambia and Madagascar, children's rights and protection issues are covered in different pieces of legislation such as the Penal Code, Trafficking in Persons Laws, and Laws against child labour. Whilst these laws are critical and important, a comprehensive Children's Act

[26] https://www.girlsnotbrides.org/wp-content/uploads/2016/10/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf

that is compliant with the provisions of the SADC Protocol on Gender and Development and other frameworks such as the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child remains critical in order to provide effective protection to children.

In most SADC countries, child marriages are criminalised through other legislation such as the law on Sexual Assault in the DRC, the Constitution in Malawi and the Marriage or Sexual Offences Acts in various countries. At present only one SADC country (Mozambique) has specific laws on child marriage.



Mozambique: Child marriages banned without exception[27]



Gender Links Mozambique in the parliament with other civil society organizations awaiting the law approval. Photo: Celso Gujamo

After almost two years of leg work, the Mozambican Parliament approved the "Law on Prevention and Combat of Premature Unions" (Child Marriages) on 19 July 2019. The new law prohibits marriage of children younger than 18 years old, without exception. An adult who marries a minor will be jailed for up to 12 years.[28] Mozambique has one of the highest rates of child marriage in the world, with almost half of girls marrying before 18, and 1 in 10 before their fifteenth birthday.

Although the age of marriage consent in Mozambique is 18, child marriage often prevails due to the parental consent loophole which results in girls dropping out of school, condemned to a life of poverty with few options and choices as child brides.

In 2016, Mozambique launched a National Strategy on Pr evention and Fight against Child Marriage. In addition to prohibiting child marriage, the new law assists in mitigating and penalising premature marriages, as well as establishing mechanisms to protect children already in those unions. In December 2018, Mozambique revoked a discriminatory 2003 decree that forced pregnant girls to take classes at night school. Education officials should now monitor schools to ensure that pregnant girls are going to school during the day.

Source: Agnes Odhiambo, Human Rights Watch, 2019

Like Mozambique, Malawi is among the 10 countries in the world with the highest rates of child marriage. In both countries over 50% of children were married before they reached 18 years of age.[29] In February 2015, Malawi adopted the Marriage, Divorce and Family Relations Act which set the minimum age of marriage at 18 for boys and girls. However, without amending the Constitution, the new law created a loophole that could be used to allow child marriages. In 2017, Parliament voted to amend the Constitution to make marriage before the age of 18 illegal, removing a provision that allowed children to marry at 15 with parental consent. Advocacy continues on implementation.

[27] https://www.bbc.com/news/topics/cjnwl8q4x1lt/mozambique
[28] https://www.bbc.com/news/topics/cjnwl8q4x1lt/mozambique
[29] SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, Article 1.0 (Rationale and Objectives)



Malawi: A Chief's fight against child marriages[30]


Senior Chief Kachindamoto.

Senior Chief Kachindamoto of Ntakataka Village in Dedza, Malawi has been recognised worldwide for fighting child marriage in Malawi. She has received death threats, been called names, challenged, received awards and international recognition, all because of her fight to end child marriages. She has managed to annul over 900 child marriages in her village within three years and banned sexual initiations of young girls. The chief believes that keeping girls in school is the single most important factor in breaking the cycle of rural poverty and preventing lifelong problems for women - a view supported by the United Nations (UN), the government and other global bodies.

"My opponents here say I am defying our tradition," she says. "But in my view we are redefining it." Her ultimate goal is not to terminate existing child marriages, but to prevent them in the first place. This has not gone down well with the people in her village including many sub-chiefs whom she manages. Many male elders argue that the chief is destroying their way of life, their culture. "Some have threatened me, saying things like, 'You are still quite young. Are you ready to die?' But I just tell them to go ahead and kill me, because it is the only way they will stop me from protecting our girls."

Bravery and boldness are in her DNA. In the Malawian Chichewa language, her family name *Kachindamoto* means "Don't mess with fire." After five years of political lobbying, Kachindamoto and other campaigners succeeded in getting Malawi's parliament to pass a bill in 2015 setting the minimum marriage age for both sexes at 18. "It is good that the law is on our side now, but enforcing it remains a big challenge," Kachindamoto says. "In many areas people still believe a girl is ready to have sex and babies when she reaches puberty. We have to eradicate these old ways of thinking."

She has experienced opposition and some have challenged her after she fired some naïve sub-chiefs. Regardless of this, many people are having their mind-set changed. Aside from annulling hundreds of child marriages, one of Kachindamoto's proudest achievements is how she is changing the archaic mind-set of the men under her rule despite resistance. "More and more male sub chiefs and village headmen are coming to me to say they realize the old ways are bad. They want to know how to improve the lives of girls."

One of the male sub chiefs she fired for breaking her ban six years ago, Pearson Chibanga, returned to her in 2016 to inform her that he had worked hard in an unofficial capacity to help his area eradicate all child marriages.

Source: Penelope Paliani-Kamanga, Gender Links News Service, 2019

Zimbabwe is set to domestic some of the provisions of the SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. The Country through the Marriage Bill 2017, which is not yet gazetted but was made public in May 2019 also seeks to harmonise marriage laws with the 2013 constitution. It sets the minimum age of marriage at 18 for both girls and boys, and extends this age provision to customary law marriages and civil unions. The

[30] Paliani-Kamanga P (2018), 'Malawi: A chief's fight against child marriages' available at: https://genderlinks.org.za/news/malawi-one-womans-fight-against-child-marriages/ (accessed 10 June 2019)

Bill outlaws the marrying, pledging or betrothal of children.[31] The good provisions in the Zimbabwean Marriage Bill have however been overshadowed by Section 40 of the bill which seeks to provide some form of protection for women in civil partnerships. This has been interpreted by many as legalising adultery and recognising "small houses."[32]

Mauritius is now the only SADC member state that has not signed the SADC Protocol on Gender and Development. During a closed meeting before the formal adoption of the Post 2015 SADC Gender Protocol, Ministers from other countries stood firm on 18 as the minimum age for marriage. Mauritius stated in the final plenary session of the Minister's meeting that it would not be able to sign the Protocol because of this amendment.[33] Ministers of Gender and Women's Affairs raised concerns at the June 2017 Gender Ministers meeting over Mauritius' reservations to the Post 2015 SADC Gender Protocol on grounds that it contravenes Mauritius Civil Law which allows children to marry at the age of 16 with parental consent.[34] This reservation implies that unless Mauritius reviews this law, there is no probability of it signing the Protocol. The Alliance is advocating for Mauritius to review its laws to set the age of marriage at 18 in line with the reviewed Protocol. The campaign was escalated to the Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW) review meeting in Geneva in 2018.



Mauritius: NGOs say No to Child Marriage at the CEDAW 71st session in Geneva[35]

Gender Links (GL) Mauritius and a senior advocate from Mauritius participated in the 71st session of the CEDAW committee held at the United Nations in October 2018. This was the first time that a Mauritian non-governmental organisation (NGO) presented a shadow report at the United Nations, CEDAW Committee. The shadow report consisted of the inputs from GL Mauritius, Media Watch Organisation (the Alliance focal network in Mauritius), SOS Femmes and the Young Queer Alliance. The shadow reported highlighted Child Marriage which is a major concern in Mauritius.

In their statement, the civil society organisations raised the following points on the issue of Muslim religious marriages and child marriages:

- The amendment of Section 16 (4) (c), which provides for an exception to the non-discrimination provision in cases of personal status matters;



Screenshot of Anushka Virahsawmy from the CEDAW 71st session in Geneva webpage. Photo: Google images

- To date, the legislature has not announced whether it plans to proceed with any constitutional reform, nor has the Muslim Family Council made any recommendation and/or assessment regarding this amendment; and that
- The Mauritian State has not codified a comprehensive personal status law, leaving Muslim women in religious marriages without legal recognition or rights.

[31] Zimbabwe, Marriage Bill, 2017s 3 and 4
[32] 'Small House' is a term used in Zimbabwe to describe an extra marital affair but often specifically refers to the woman in that relationship. Some of the relationships are long term and the partners would be typically behaving and relating like a husband and wife. Children are often born out of such relationship which at law do not have recognition as marriages.
[33] Record: Meeting of Ministers Responsible for Women's Affairs, June 2016. SADC Secretariat, p 3.
[34] Ibid
[35] https://genderlinks.org.za/casestudies/gl-mauritius-takes-child-marriages-to-cedaw/ (accessed 6 June 2019)

Religious marriages are not registered by any state authority. Registration is a basic protection. Requiring an authority to monitor marriages ensures that both spouses are not already married and enables the state to track and prevent child marriage. Registration also lays the foundation for substantive rights. Without registration, marriages are not recognised as existing. Religious marriages are not subject to civil marriage laws, and courts do not rule consistently on issues such as custody and survival rights. This legal ambiguity increases inequality and further subordinates Muslim women in Mauritius.

This scrutiny holds religious communities accountable to Mauritian values of non-discrimination and freedom to practice religion, and to the Shariah values of equality and justice. The Mauritian State must strive to codify a comprehensive personal status law to protect women in Muslim religious marriages.

There is no minimum age for religious marriages, leaving young girls vulnerable to child marriages. The most recent example came to light in June 2018, when a 13-year-old girl, who was married in a religious ceremony to a 19 year old man, died due to health complications while pregnant. Such tragedies cannot be permitted to continue.

The Civil Code allows children ages 16-18 to be married with consent of a parent or a judge. In 2014, there were 805 documented marriages of children aged 15-19 in Mauritius, the majority of who were girls. Girls suffer disproportionately from child marriage, risking their health and educational opportunities. A clear ban of child marriage for children under the age of 18 is a critical step in protecting children and reducing discrimination against girls in Mauritius.

Source: Anushka Virahsawmy, Gender Links Mauritius, Gender Links case Study, 2019

Persons with disabilities



Article 9: Persons with disabilities: State parties shall, in accordance with the SADC Protocol on Health and other regional and international instruments relating to the protection and welfare of people with disabilities to which Member States are party, adopt legislation and related measures to protect persons with disabilities that take into account their particular vulnerabilities.

Seven SDG targets specifically mention persons with disabilities (education, accessible schools, employment, accessible public spaces and transport, empowerment and inclusion, and data disaggregation).[36]

[36] United Nations Secretariat of The Convention on The Rights of Persons with Disabilities.

Women with disabilities are at risk of rape and domestic violence. In some cases the violence they experience directly exploits the nature of women's particular impairments. Abusers may purposefully lock wheelchairs away; or smash hearing aids or glasses, while family members and intimate male partners may assault or otherwise abuse women for their disability grants. Sexual harassment and other forms of sexual violence may be sparked by perverse curiosity about the sexuality of 'disabled' women (which is seen as different and strange). Women whose impairments limit their mobility may also be seen as easy targets for rape.

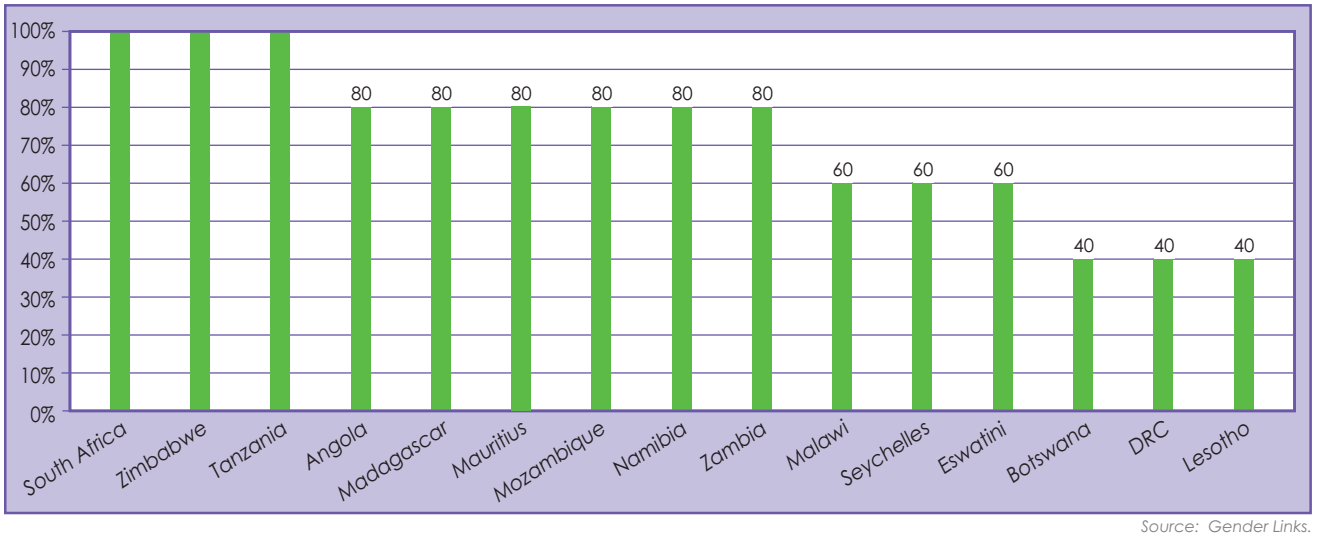
Violence also leads to disability. Spinal injuries incurred through stabbings may result in either quadriplegia or paraplegia, while injuries to the head may also lead to impairment of hearing and/or vision.

The disabling nature of the built environment further compounds the problems faced by this group of women and limits their access to help. Women with disabilities often need to negotiate precarious roads to access buildings, while ramps often serve cosmetic purposes only being either too steep or too narrow for safe use. Buses, taxis and trains may also be unsuited to wheelchairs. Few service providers are adequately trained to address the needs of women with intellectual impairments. Almost no information on violence against women is available in Braille and many organisations only start thinking about finding a sign language interpreter when presented with a deaf woman. Patronising and ill-informed attitudes on the part of service providers may also create difficulties for women with disabilities.

Women with disabilities are at risk of rape and domestic violence

The GRA on disability assessed whether there are special measure to promote participation of persons with disabilities in public and private life; if labour laws ensure equal rights and special facilities for persons with disabilities and whether persons with disabilities are protected by law.

Figure 7.6: GRA on Article 9 - Persons with disability



Source: Gender Links.

Figure 7.6 showed that South Africa, Zimbabwe and Tanzania scored themselves highly on the attainment of rights for persons with disability. Malawi, Seychelles, Eswatini, Botswana, DRC and Lesotho still have significant gaps in the attainment of these standards.

Widows and widowers rights

Article 10: Widows' and widowers' rights
1. State parties shall enact and enforce legislation to ensure that widows and widowers:
(a) Are not subjected to inhuman, humiliating or degrading treatment;
(b) Automatically become the guardians and custodians of their children when their husband/wife dies unless otherwise determined by a competent court of law;
(c) Have the right to an equitable share in the inheritance of the property of their spouses;
(d) Have the right to remarry any person of their choice; and
(e) Have protection against all forms of violence and discrimination based on their status.
CEDAW, Article 16(b) provides for widows, the same right freely to choose a spouse and to enter into marriage only with their free and full consent; among other protections that are given to widows.

Global and regional instruments protect widows and widowers from harmful cultural practices including widow inheritance *ukungena/kulowa kufa*, property grabbing and other forms of inhumane, humiliating and degrading treatment.

Data on women's status are often not disaggregated by marital status, so at every level of gender statistics, from national to global, widows are not visible. Yet we know that many elderly widows face multiple and intersecting forms of discrimination, based on their gender, age, rural location or disability. Many widows are still young when they lose their husbands, perhaps as a result of conflict or because they were married as children to a much older man. These women face a long lifetime of widowhood. Along with the shock of losing a spouse, the situation for widows is often compounded by stigma and social isolation. In many countries, widows are stripped off their rights to assets such as land, income and property. Without access to social protection, they face destitution.[37]

Like other parts of the world, widows in Southern Africa face similar or related challenges, even


Community meeting in Botswana debates harmful practices.
Photo: Keletso Serole

though various countries have put some legislative measures in place to protect widows and widowers' rights in areas such as property inheritance and the prohibition of property grabbing or forced widow inheritance.

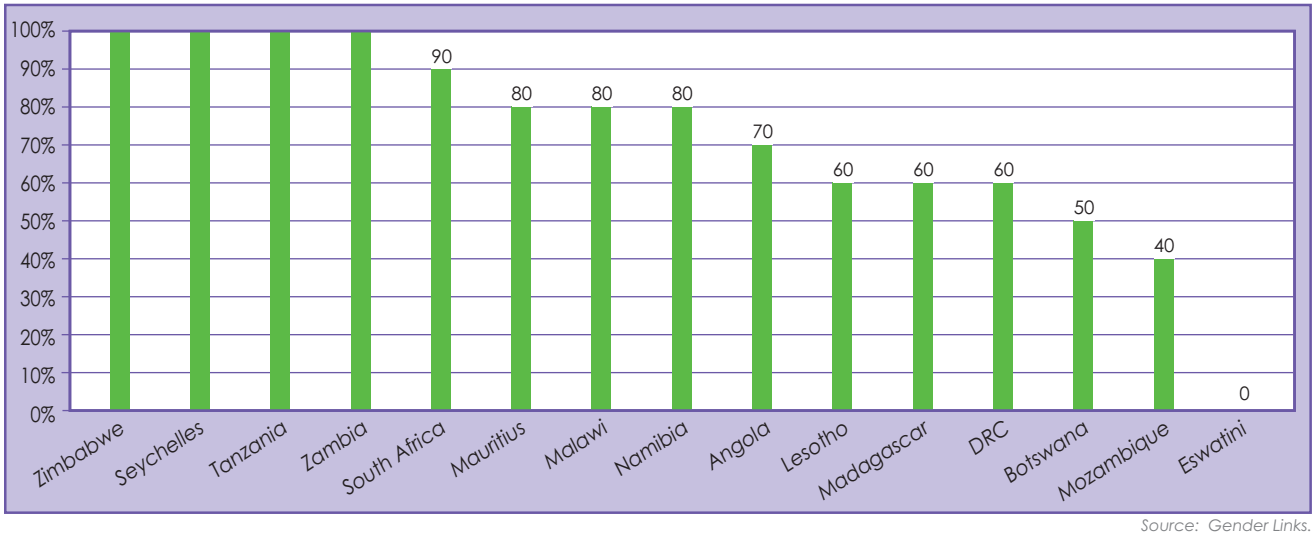
Legislative provisions are frequently undermined by practices and attitudes that compel widows and widowers to comply with otherwise harmful cultural practices. A 2017 report by Human Rights Watch shows that despite the various legal protections, women in Zimbabwe are often routinely dispossessed of their property, including land upon the death of a husband.[38]

[37] UN Women (2017), 'Statement: Widows' rights to independent life and livelihood after loss' available at: http://www.unwomen.org/en/news/stories/2017/6/statement-un-women-international-widows-day (accessed 12 July 2019)
[38] Human Rights Watch (2017), 'You will get nothing: Violations of Property and Inheritance Rights of Widows in Zimbabwe' available at: https://www.hrw.org/report/2017/01/24/you-will-get-nothing/violations-property-and-inheritance-rights-widows-zimbabwe (accessed 12 July 2019)

SADC countries need to urgently ensure that:

- Widows and widowers are not subjected to inhuman, humiliating or degrading treatment as espoused in Article 10 (1) (a) of the SADC Protocol on Gender and Development.[39] Widowhood rites and practices are often inhuman, degrading the humiliating. In Southern Africa such rites are 'meant to cleanse the widow of perceived defilement related to the death of her husband and to neutralise and/or counter the effects of ritual danger embedded in widowhood'.[40] Such treatment includes shaving of the head, wearing black clothes and headdress for prolonged periods of time, prohibition from leaving a home and stepping out of the road when a widow meets people whilst walking on the road,[41] amongst many practices.
- Widows and widowers have the right to an equitable share in the inheritance of the property of their spouses.[42]
- Widows and widowers have the right to remarry any person of their choice.[43] The practice of widow inheritance is often meant to deny widows this right, and is also closely linked to patriarchal attitudes that seek to control a widow's sexuality, inheritance and other fundamental rights and freedoms that a widow should otherwise be entitled to as a human being. Despite laws that outlaw such practices, (such as the Reform of Customary Law of Succession Act, 2010 in South Africa and the Deceased Estates Succession Act, Chapter 6:02 in Zimbabwe), retaining land and other property, or custody and guardianship rights over minor children by a widow is often tied to widow inheritance and marrying one of the deceased's brothers or relatives in lived reality. Marrying a person of their choice also often leads to widows being evicted from their land or homes or being stripped of property by the deceased husband's relatives.
- Widows and widowers have protection against all forms of violence and discrimination based on their status.[44] Violence against widows is often used a patriarchal control tool to ensure that women comply with demands and orders from (in particular) male members of the deceased husband's family. Perpetrators of violence against women are however also often female relatives of the deceased husband. In cases of property grabbing, violence is often used as a tool and physical and psychological/emotional violence is also used on women when they are accused of causing the deaths of their husbands. Discrimination against widows is also prevalent in Southern Africa.

Figure 7.7: GRA Article on Article 10 - Widows and widowers



Source: Gender Links.

[39] Article 20 (a) of the Maputo Protocol also enjoins state parties to ensure 'that widows are not subjected to inhuman, humiliating or degrading treatment'
[40] Manala, M (2015), 'African traditional widowhood rites and their benefits and/or detrimental effects on widows in a context of African Christianity' HTS Teologiese Studies/ Theological Studies 71(3), 1-9
[41] Manala, M (2015), 'African traditional widowhood rites and their benefits and/or detrimental effects on widows in a context of African Christianity' HTS Teologiese Studies/ Theological Studies 71(3), 1-9
[42] Article 10 (1) (c), SADC Protocol on Gender and Development, Article 21 (1), Maputo Protocol
[43] Article 10 (1) (d), SADC Protocol on Gender and Development, Article 20 (c), Maputo Protocol
[44] Article 10 (1) (e), SADC Protocol on Gender and Development

The GRA on Article 10 assessed the existence of national legislation protecting the rights of widows and widowers; whether custody court rulings consider widows and widowers as equal potential custodians of children after the death of a spouse; if widows and widowers are protected by law to receive full inheritance from their late spouse; whether wife inheritance is outlawed; if witchcraft killings/violence linked to widows and widowers is investigated and outlawed. Figure 7.7 reflects a wide range of scores, from top marks in Zimbabwe, Seychelles, Tanzania and Zambia to a score of zero in Eswatini, where the challenges for widows remain severe.

In **Eswatini** widows are not allowed to stand for election to public office until after a two year mourning period. The latest election in Eswatini was in 2018. For that election, Chief Gija Dlamini, the Chairperson of the Elections Management Board (EMB), the Elections and Boundaries Commission (ECB) of Eswatini confirmed that 'women who lost their husbands could register for elections only after the two-year mourning period and cleansing ceremony".[45] In the same year (February 2018) the President of the Eswatini Senate Gelane Zwane had to stop attending senate for a period of two years following the death of her husband. Zwane confirmed to The Times of Swaziland that she would be staying away from Parliament after the death of her husband despite her position as the leader of the Senate.[46]

... there is a belief that the enforcement of harmful cultural practices is confined to local remote and rural communities, or practiced in secrecy

Similarly on the 16th of February 2018, the Eswatini Minister of Labour and Social Security Winnie Magagula was stopped from attending the opening of Parliament following the death of her husband.[47] Often there is a belief that the enforcement of harmful cultural practices is confined to local remote and rural communities, or practiced in secrecy. However the developments in Eswatini as stated above indicate that all women, regardless of their status in society, class or levels of education can be subjected to such practices. This calls for holistic and all-inclusive approaches and strategies to ensure that widows and other women are protected from violence, discrimination and other harmful practices that humiliate degrade and strip them of their dignity.

Discriminatory practices continue to hinder women's access to many other public spaces. Widows in mourning remain in seclusion until the spouse is buried and a further month following the burial. This is followed by a period of two to three years of the wearing of mourning clothes, assuming a certain posture when walking, and observing restrictions in appearing in certain public and employment domains.[48]

Societal discrimination against widows is a problem in **Mozambique**, and the rights of widows are not directly addressed in the Family Law Act. For instance, there is a practice of accusing widows of witchcraft and then expelling them from their homes. This is reported to be more common in rural areas, although it can happen anywhere else. Julio Machele in his characterisation of profiles of victims of witchcraft accusations in Mozambique states that "Widows are also often in a precarious position in their family. They fall victim to these accusation when

[45] Rooney, R (2018), 'Widows still can't stand in election' available at: https://swazimedia.blogspot.com/2018/04/widows-still-cant-stand-in-election.html accessed 14 July 2019. (accessed 14 July 2019)
[46] allAfrica (2018), 'Swaziland: President 'Banned' From Swazi Senate' available at: https://allafrica.com/stories/201802210504.html (accessed 14 July 2019)
[47] allAfrica (2018), 'Swaziland: President 'Banned' From Swazi Senate' available at: https://allafrica.com/stories/201802210504.html (accessed 14 July 2019)
[48] CEDAW Report , 2012

they show a behaviour inconsistent with the models imposed by locally effective power relations".[49]

Closely linked to the practice of widow inheritance is the practice of *chigara mapfihwa/umthanyelo* in Zimbabwe, in which a young girl is forced to get married to the widower of her sister or paternal aunt. In most cases *chigara mapfihwa/umthanyelo* is also linked to early, child or forced marriage and the resultant challenges such as HIV and AIDS infection and early pregnancies and child birth. The 1999 Zimbabwe HIV and AIDS Policy acknowledged the negative role of this harmful cultural practice in the spread of HIV and AIDS.[50]

Other harmful practices



Zimbabwean Senator Hon Priscilla Misihairambwi-Mushonga has been instrumental in advocating for the elimination of harmful cultural practices, the promotion and protection of women's rights and gender equality in the country. Here she makes a contribution during the Quota or Total Equality Conference in Zimbabwe.

Photo: Tapiwa Zvaraya

In addition to the rampant occurrences of child marriages, women, young women and girls face violations of their bodily integrity and other women's rights through numerous other harmful traditional practices. These include practices such as sexual cleansing of widows, prohibition of family planning, elevation of boy children above girl children, widow dispossession/property grabbing, polygamous marriages, initiation rites, wearing of mourning clothes and other mourning rites, beating wives as a sign of love and abductions to force marriage. Specific practices include:

- *Kusasa fumbi/fisi* - A Malawian practice whereby a male has sexual intercourse with a female as an initiation requirement.
- *Kulowa Kufa* - A Malawian practice in which a male member of the community has sexual intercourse with a woman upon the death of her husband.
- Female genital mutilation (not prevalent throughout much of the SADC region, occurs in Tanzania).
- *Ukungena* - Widow inheritance (where a woman is made to marry her husband's brother if she is widowed).
- *Lobola* (bride price).
- *Kuhlanta* - A practice in Swaziland and Zimbabwe respectively where a woman is married off to her sister or aunt's husband.
- *Kulamuta, ukulamuza, chiramu* - A practice in Swaziland and Zimbabwe where a man has sex with a younger sister or paternal niece of his wife.
- Virginity testing - to ascertain the purity of a woman before marriage.
- *Chigaramapfihwa*- A practice in Zimbabwe where a girl/woman is married off to her sister or paternal aunt's widower.
- *Musengabere/Ukuthwalwa/Tjhobediso*/bride abduction - A practice in some countries in Southern Africa including South Africa, Zambia, Lesotho and Zimbabwe where a man abducts a girl or woman and has sex with her and then formalise the marriage later. It is still practiced in some of these countries but not very prevalent in others.

[49] Machele, J (2018), 'He then became a lion": witchcraft accusations in rural Mozambique', in Green MC, Gunn TJ & Hill M (eds), Religion, Law and Security in Africa. Stellenbosch, 283-296
[50] Government of Zimbabwe (1999), 'National HIV and AIDS Policy' http://nac.org.zw/wp-content/uploads/2019/01/National-HIV-and-AIDS-Policy-1999.pdf (accessed 16 July 2019)

Female genital mutilation

SDGs 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

Female Genital Mutilation (FGM) is a serious form of harmful cultural practice. The World Health Organisation (WHO) estimates that about 200 million girls and women between the ages of 15-49 have undergone FGM in the world.[51] In Tanzania, 10% of girls and women between the ages of 15-45 have undergone FGM. The law however does not protect FGM victims above the age of 18 years. Similarly Article 11 (1) (c) and Article 11 (2) of the SADC Protocol on Gender and Development seek to protect the girl and boy child from harmful cultural practices including FGM. This protection is not extended to adults.

FGM has serious short and long-term implications on the human rights and health of women and girls, including risks of getting the Human Immunodeficiency Virus (HIV). Other short-term challenges include severe pain, excessive bleeding, shock, genital tissue swelling, infections, urination problems, impaired wound healing, death and psychological trauma. Long term challenges and health risks include death, pain, infections, painful urination, menstrual problems, keloids, obstetric complications, obstetric fistula, perinatal risks and psychological consequences.[52] Despite these well-established challenges, FGM continues in Tanzania.

Tanzania is characterised as having "discrimination embedded in customary laws, social norms and practices and inadequate legal protections against gender discrimination in all dimensions of social institutions." While female genital mutilation (FGM) is on the decline in the country, the practice remains widespread in some rural areas. In Maasai communities such as Lingate in the northern Arusha region, dozens of women are turned away in marriage because they would have refused to be cut. Despite efforts to end the practice, some Maasai tribal elders embrace the tradition and want their daughters circumcised. Most women are still

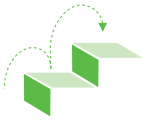
WHO estimates that about 200 million girls and women between the ages of 15-49 have undergone FGM in the world

[51] World Health Organisation (2013), 'Sexual and Reproductive Health: Female Genital Mutilation' available at: https://www.who.int/reproductivehealth/topics/fgm/prevalence/e (accessed 11 July 2019)
[52] World Health Organisation (2013), 'Sexual and Reproductive Health: Health Risks of Female Genital Mutilation: FGM' available at: https://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/ (accessed 12 July 2019)

being cut in several regions, including two regions just south of Arusha - Manyara, where 81% of women have undergone some form of genital mutilation, followed by Dodoma, where approximately 68% of women[53] have undergone the procedure. Statistics from UNICEF show Tanzania as the only country in Southern Africa where at 10% for women aged 15-49, FGM is practised on a large scale.

Even with the law protecting children from FGM, the practice is still common in some regions of Tanzania. The northern district of Ngorongoro in Tanzania is home to the Maasai people and a place where tradition and culture still reign supreme. Many live in fear of their ancestors and will often times attribute misfortunes as a punishment from ancestors. This is also the basis of female genital mutilation (FGM) practiced by some in the area.

Some people in the district secretly engage in Female Genital Mutilation in an attempt to 'appease' their ancestors and to avoid punishment from government. Although the act has serious health effects and sometimes leads to death, people still practice the tradition and believe that failure to do so leads to natural disasters such as drought. FGM is also widely practiced as a passage rite into adulthood. Those who do not go through the ceremony, risk facing discrimination and are regarded as people who bring misfortune into the community.[54]



Next steps

Harmful cultural practices are in many instances a reflection of the patriarchal nature of our societies in Southern Africa and a power and control instrument by men over women. As such there is likely to be resistance from the men who are the leaders at different levels in our countries towards the elimination of the practices. Resistance is often surreptitious, with leaders especially at government and national level publicly condemning the practices but stalling when it comes to the promulgation and implementation of the necessary reforms. The apparent eagerness with which the SADC Model Law on Child Marriages was received by regional leaders and the lethargy currently being experienced in adopting the Model Law at the national level is a clear example of this. Civil society organisations must therefore put in place accountability and follow-up mechanisms for leaders who support elimination of harmful cultural practices in public but make no tangible efforts to ensure action on the issues. National Women's Parliamentary Caucuses and the SADC/PF Women's Caucus can play an important role in this regard.

The SADC Parliamentary Forum Women's Caucus is a key institution in taking regional policy positions on harmful cultural practices to the national level for adoption and enactment in national legislation. Members of the regional women's caucus also often sit in the women's caucus in the national parliament and are therefore an important vehicle for regional-national coordination and cohesion. The Caucus should thus be engaged to play a leading role in the domestication of the SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. The regional Women's Caucus should also be linked with the national Women Parliamentary Caucuses to ensure effective flow of information from the regional to the national level and vice versa.

Key next steps include:

- Constitutional reviews to remove the duality/plurality of legal systems in all countries in Southern Africa (customary law, religious law and general law). All constitutions must provide for the supremacy of constitutions and human rights over customary law, cultural practices and other norms.

[53] Thomson Reuters Foundation, http://news.trust.org//item/20131216094140-k5c2x/
[54] Headman J (2018), 'Tanzania: Put an end to FGM' available at: https://genderlinks.org.za/news/tanzania-putting-an-end-to-fgm/ (accessed 11 July 2019)

- Courts must play a more pronounced role in challenging harmful practices that undermine constitutional provisions.
- Domestication of the SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage.
- Platforms for children to express themselves and highlight the issues that affect them such as Junior Parliament, Junior Council and Child President must be created in all countries, and such platforms must be allowed cross-sharing of ideas throughout the region and engagement with government at the regional level through the SADC Summit and related fora.
- Education and awareness raising amongst men and boys as well as traditional leaders on the rights of children, girls and women on eradication of harmful cultural practices must be encouraged.
- Education of women and girls about their rights and the harms associated with these practices. Older women, who are often the enforcers of the practices must be particularly targeted.
- Clear and unequivocal mandates for institutions that advance women's rights to address harmful practices. Often such institutions are hampered in their work by mixed messages from Governments which in many instances seek to appease their voters who might be in support of or follow/observe the harmful practices.



SADC Parliamentarians who attended the Alliance Regional Women's Parliamentary Caucus Training Workshop on Sexual Reproductive Health and Rights in Johannesburg.
Photo: Thato Phakela

Sexual Diversity 8



Participants in Eswatini's first pride parade in June 2018 in Mbabane. Photo: Thandokuhle Dlamini

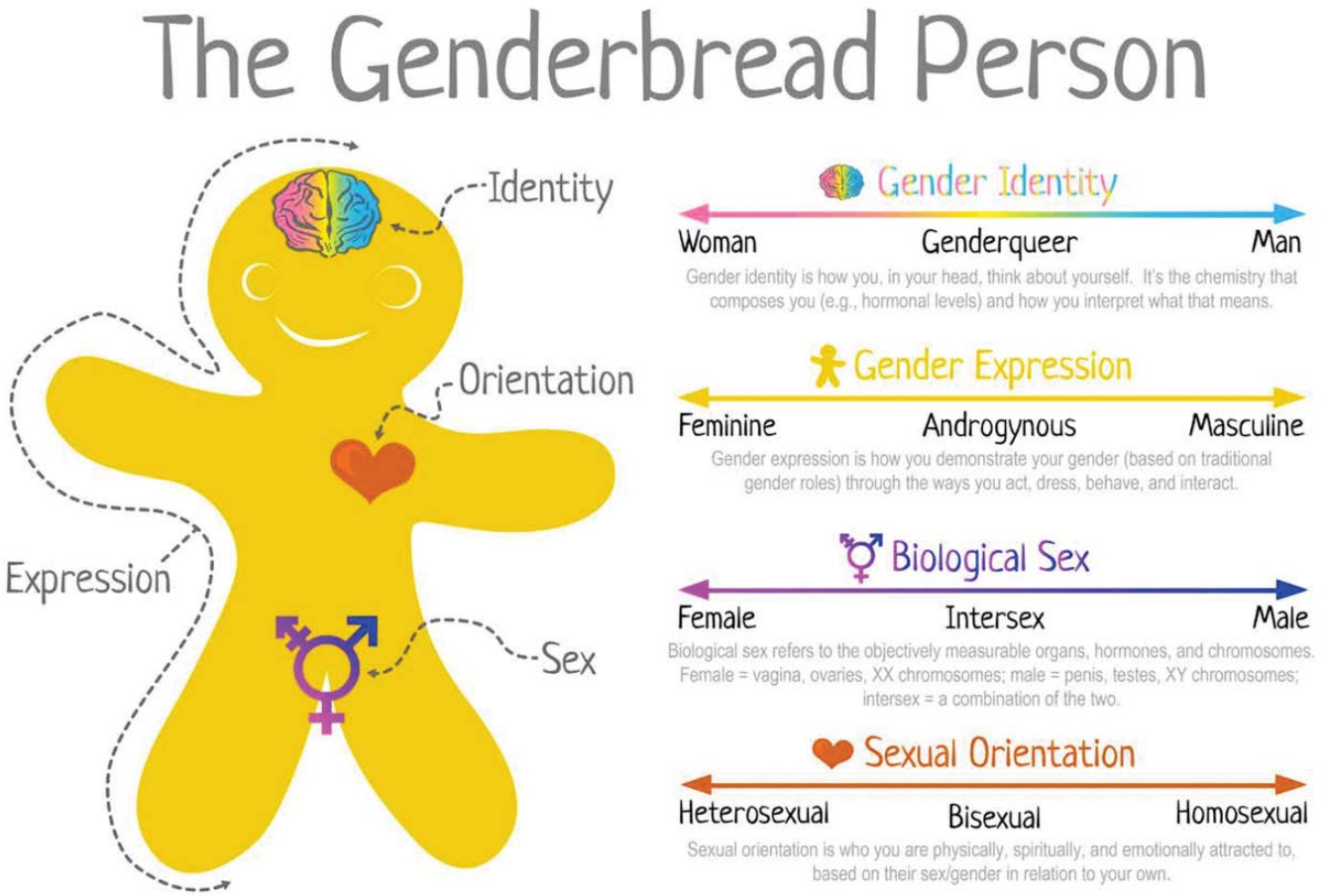
KEY POINTS

- Homosexuality is now legal in seven (about one third) of Southern African countries - South Africa, Seychelles, Angola, Mozambique, Lesotho, Madagascar and DRC.
- Botswana's High Court recently rejected sections of the country's penal code that criminalised same-sex relations. The Attorney General has signalled that he intends to appeal the High Court ruling.
- Only South Africa allows for same sex marriages and civil unions.
- Three countries (Mauritius, Namibia and South Africa) allow LGBTI persons to change their gender markers.
- Mauritius and South Africa ban conversion therapy, which is known to cause extensive physical and psychological damage.
- Only one SADC country, Angola, has hate crimes legislation that explicitly protects LGBTI persons from violence and discrimination.
- Only South Africa has laws in place for protection of intersex people.
- Gender Links and Southern African Gender Protocol Alliance are working with LGBTI organisations from five countries - Botswana, Malawi, Mauritius, Namibia and Eswatini - to lobby for the decriminalisation of LGBTI people and social protection for their communities.
- There is a lack of targeted SRHR services for LGBTI people and a dearth of data to guide informed strategies.

Introduction

In this inaugural edition of the SRHR **#VoiceandChoice** Barometer, this final chapter marks the first time the Barometer has included an extensive look at the regional situation for those in the Lesbian, Gay, Bisexual, Transsexual and Intersex (LGBTI) communities as part of its annual review.

Figure 8.1: The "Genderbread Person"



As reflected in Figure 8.1, **Gender identity** refers to a person's internal sense of being male, female or somewhere in the middle - i.e. gender non-conforming - and how they interpret what that means for them. Sometimes gender identity corresponds to biological sex. **Intersex** people are born with sex characteristics that do not fit typical binary notions of male or female bodies. Doctors or parents often decide for an infant which sex they think it should be. This choice could be wrong. Therefore, some intersex people advocate against doctors or parents making this choice for infants. A person who identifies as **transgender** has a gender identity that does not correspond to their biological sex.

Intersex people are born with sex characteristics that do not fit typical binary notions of male or female bodies

Gender expression relates to how a person chooses to communicate their gender identity to others through the ways they act, dress, behave and interact. This communication may be conscious or unconscious. While most people's understanding of gender expression relates to masculinity and femininity, countless combinations exist that may combine masculine and feminine expressions, or neither, through **androgynous** expressions.

Sexual orientation describes whom we are attracted to. A person's gender identity does not predetermine their sexual orientation. It is important to understand that these orientation and identity fall on a continuum and can be fluid.

In order to counter the gender norms that society assigns to "males" and "females," there is a movement to raise children in a "gender neutral" manner. This means not making distinctions between boys' and girls' clothes, toys and activities (for example, blue clothes for boys, pink for girls; cars for boys, dolls for girls; football for boys, playing house for girls).

It is also important for legislators in members states to recognise that their populations include people of diverse sexual orientations and gender identities and expressions. LGBTI refers to all people across the SOGIESC spectrum and all have a right to be treated with dignity, be safe, live freely and be equal.

In recent years, political discussions about LGBTI rights have expanded in the region alongside an unprecedented increase in the visibility of LGBTI people and organisations. The legal environment in Southern Africa varies from country to country and member states continue to criminalise LGBTI people in varying degrees.

In some cases, countries may appear to have progressive approaches or laws, but the reality is that LGBTI people may be able to take advantage of loopholes that exist due to the nature of legislation enacted before the advent of discussions about their rights. In other cases, new laws protect LGBTI people in countries where they remain criminalised in other ways. One example is Mauritius, where consensual same-sex acts remain criminalised, yet the country's Equal Opportunities Act protects LGBTI peoples' rights to equal access to employment. Because these protections are either not explicit or comprehensive, the LGBTI community views them as tenuous or as work in progress.

Southern African LGBTI communities face many types of prejudice and discrimination, including "corrective" rape and murder. These represent the more extreme forms of violence and discrimination perpetrated because of a person's Sexual Orientation, Gender Identity, Expression and Sex Characteristics (SOGIESC).

Many LGBTI people in SADC live in fear and in hiding

Figure 8.2: Advancements needed to fully realise LGBTI rights and freedoms



As illustrated in Figure 8.2, the advancements needed to fully realise LGBTI rights include:

- Repealing all discriminatory laws and policies against the LGBTI community;
- Ensuring laws and policies exist to protect LGBTI communities from all forms of violence and discrimination; and
- Implementing policies, laws and practices that promote and recognise the rights of LGBTI communities.

Table 8.1 shows that:

- Five out of the 16 SADC countries (or about one third of SADC countries) have decriminalised same sex consensual acts. These are South Africa, Seychelles, Angola, Mozambique and DRC. Botswana is pending an appeal on the High Court ruling.
- In four countries (Mauritius, Namibia, Tanzania and Zimbabwe) homosexuality is illegal for men only.
- Only South Africa has constitutional provisions for LGBTI persons.
- Five countries (Angola, Botswana, Mauritius, Mozambique, South Africa) have employment protection for LGBTI persons.
- Only Angola criminalises hate crimes and incitement to violence of LGBTI communities.
- Conversion therapy (the pseudoscientific practice of trying to change an individual's sexual orientation from homosexual or bisexual to heterosexual using psychological or spiritual intervention)[1] is only banned in South Africa.
- Only South Africa recognises same sex unions; civil unions; joint adoption of children and second parent adoption of children.

[1] https://en.wikipedia.org/wiki/Conversion_therapy, accessed 15 July 2019.

- Changing sex/gender markers[3] and name change is possible in four countries (Mauritius, Namibia, South Africa and Zamia); nominally and potentially in four countries (Angola, Botswana, Malawi and Mozambique) and not possible in the other seven.
- LGBTI organisations are able to register in ten countries (Angola, Botswana, Eswatini, Mauritius, Mozambique, Namibia Seychelles, South Africa, Tanzania and Zimbabwe) but only able to operate freely in the five countries in which homosexuality has been decriminalised, as well as Botswana and Mauritius.

A hostile environment in most SADC countries means LGBTI people face threats of violence, while living in fear and, in many cases, in hiding. A recent story (overleaf) about a Madagascar gospel star illustrates the prejudices that LGBTI communities face even though the country has decriminalised same sex consensual relations.

Table 8.1: Sexual diversity baseline indicators in 2019[3]

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Criminalisation of same sex consensual acts															
Consensual same-sex acts decriminalised	Yes	Pending	Yes	No	Yes	Yes	No	No	Yes	No	Yes	Yes	No	No	No
Gender/s		All genders		All genders			All genders	Male only		Male only			All genders	All genders	Male only
Years in prison/other		7		Undetermined			14	5		Undetermined			Life	Life	1
Protection															
Protection against discrimination															
Specific constitutional provisions	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Broad protections	Yes	No	No	No	No	No	No	Yes	No	No	No	Yes	No	No	No
Employment	Yes	Yes	No	No	No	No	No	Yes	Yes	No	No	Yes	No	No	No
Criminalisation of violence/discrimination against LGBTI communities															
Hate crimes/ aggravated circumstances	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Incitement to hatred/ violence	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Ban on conversion therapy															
CTs banned	No	No	No	No	No	No	No	Yes	No	No	No	Yes	No	No	No
Recognition of LGBTI+ rights															
Same sex marriages	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Civil unions	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Joint adoption of children	No	No	No	No	No	No	No	Yes	No	No	No	Yes	No	No	No
Second parent adoption of children	No	No	No	No	No	No	No	Yes	No	No	No	Yes	No	No	No
Changing identity															
Changing sex/gender markers	Nominally possible	Potentially possible	Not possible	Not possible	Not possible	Not possible	Nominally possible	Possible	Nominally possible	Possible	Not possible	Possible	Not possible	Possible	Not possible
Name change	Nominally possible	Possible	Possible	Possible	Possible	Possible	Nominally possible	Possible	Nominally possible	Possible	Possible	Possible	Not possible	Possible	Possible
LGBTI+ organisations															
Able to register	Yes	Yes	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No
Able to operate freely	Yes	Yes	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	No	No	No

[2] When state and government agencies change the gender identifier, sex marker, sex identifier on official documents such as a birth certificate or driver's license.
[3] https://ilga.org/state-sponsored-homophobia-report

Malagasy singer faces backlash after Facebook post with fiancé goes viral[4]



Malagasy gospel star faced vitriolic backlash when he got engaged to his male partner. Photo: D-Lain

D-Lain, a 31-year-old gospel singer, became known for his work in a popular Madagascar group called Tanà Gospel Choir before he left the country for Corsica after he won a Castel Live Opera competition in Abidjan in 2012. Since then, he has become even more popular at home - a figure of national pride and something of an icon.

Then, at the beginning of November 2018, some photos and a video of D-Lain kissing his fiancé, a man, at the announcement of their engagement appeared on someone else's Facebook page and the post went viral.

Social media users in Madagascar weighed in with a mixture of support and condemnation. The condemnation got so bad that the on arts group in Madagascar denounced the "hate speech" against the singer in a press release to raise awareness about LGBTI people.

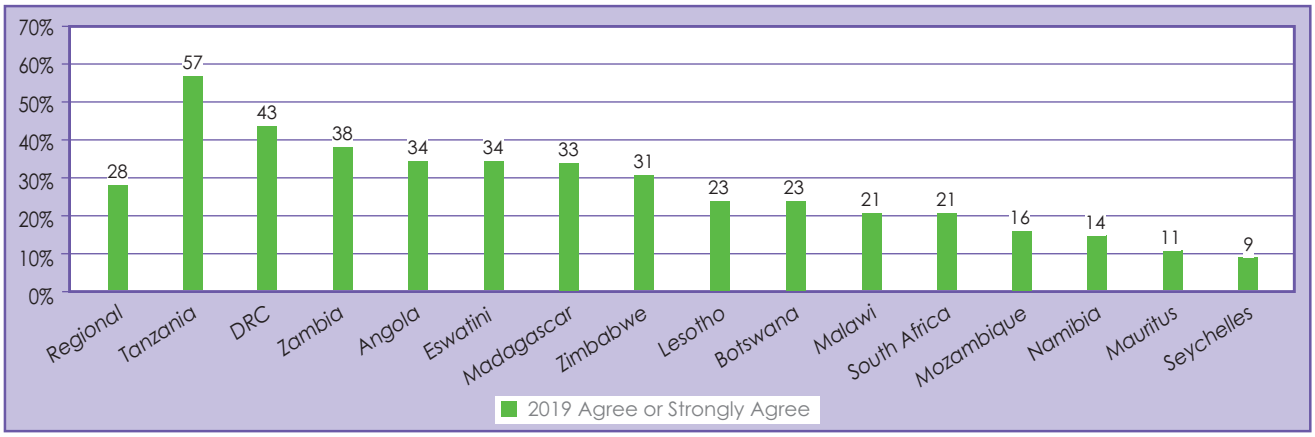
Comments included: "It's his life"... "If it's his way to find happiness, why not?"... "When you love someone, it doesn't matter," came the supportive voices of a few fans. Others wrote "Shame on you"... "It's unnatural"... "It's an abomination."

For LGBTI Malagasy, this latter kind of backlash is still far more common than responses showing respect or tolerance. Many sexual and gender minorities continue to face rejection, discrimination and even physical violence.

Source: Ratsara, D., City Press, 2018

Every year GL administers the Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey to citizens across 15 SADC countries. The survey measures attitudes and the prevailing levels of gender awareness in countries based on a series of 25 questions. For the 2019 SRHR Barometer, GL collected 11 068 responses from 5985 women and 5083 men.

Figure 8.3: Homosexuality is a psychological disease 2019



Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey.

[4] https://www.news24.com/Africa/News/madagascars-secret-society-20180204-2

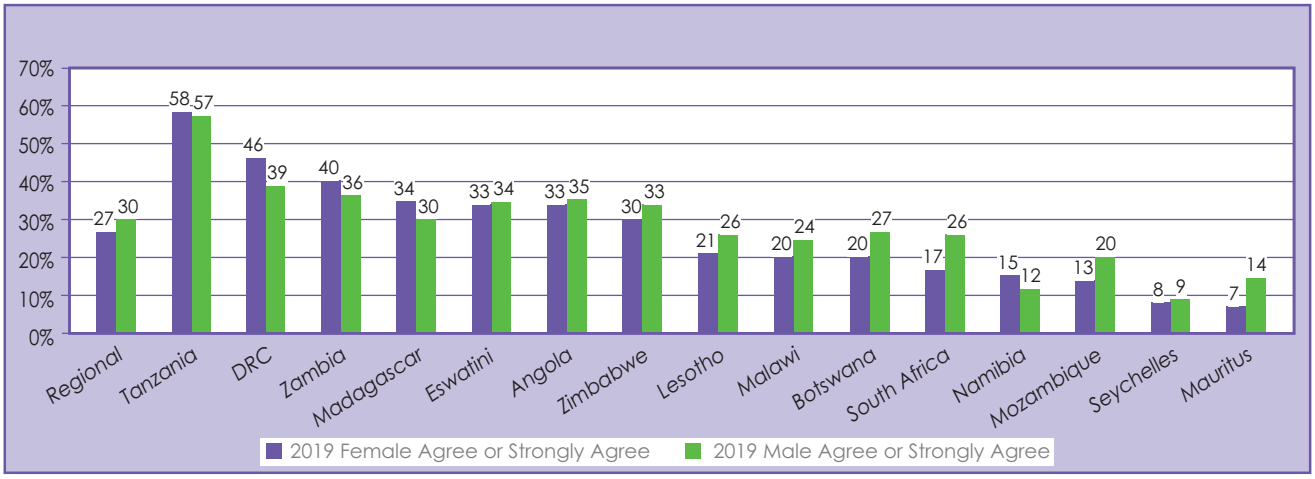
Figure 8.3 shows that 28% of respondents across the region agreed or strongly agreed in response to the statement "Homosexuality is a psychological disease." It may not be surprising, given the growing anti-LGBTI sentiment in Tanzania, stoked by lawmakers there, that the highest proportion of respondents in that country agreed or strongly agreed with the statement (57%).

It is concerning that between 33% and 43% of the respondents agreed or strongly agreed with the statement in three countries where governments have decriminalised same-sex consensual relations: Angola, DRC and Madagascar. This underscores the need to prioritise ongoing advocacy and awareness-raising campaigns.

Same sex consensual relations remain a crime in Namibia and Mauritius, but both display more progressive public perceptions and attitudes. Between 76% and 89% of respondents do not agree that homosexuality is a psychological disease. Given this finding, which points to high levels of acceptance, it is an opportune time to push for decriminalisation of same-sex consensual relations in these countries. Both have national elections at the end of 2019; the pre-election context is fertile ground for calls for legislative reform.

More than 50% women and men respondents from Tanzania agreed and strongly agreed that homosexuality is a psychological disease

Figure 8.4: Statement: "Homosexuality is a psychological disease," by sex, 2019



Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey.

Figure 8.4 illustrates that the most significant differences between women's and men's responses to the question appeared in Botswana, Mauritius, Mozambique and South Africa, with men agreeing with the statement more than women, between seven and nine percentage points more. Overall, women's attitudes appear less conservative.

Strategic litigation is an important way to challenge discriminatory laws and policies in countries that criminalise homosexuality.

However, stakeholders should accompany these initiatives with social protection strategies for LGBTI communities.

The mixed messages in Botswana and increasing government aggression in Tanzania show the fragility of gains made so far. There is a need for more monitoring and activism to hold states accountable for discriminatory laws and practices so they ensure that LGBTI citizens receive the same protections as all other citizens.

Media perpetuates negative views

The media remains one of the key drives of homophobia and transphobia in the region - both in its exclusion of stories about LGBTI people and in its sensationalism of issues related to the community when it does produce stories about it. Research conducted by the Gay and Lesbian Memory in Action (GALA) and Community Media for Development (CMFD) found that media around the world presents an unfair reflection of LGBTI people.[5] It noted that media highlights sexuality in stories where it is not relevant, creating a sense of "otherness." This also perpetuates stereotypes that construct the LGBTI community as hyper-sexed. In extreme situations, media reports have crossed serious ethical lines, calling for the arrest and murder of LGBT people.

In an environment of abundant state-led media, controlled by governments that have institutionalised homophobia, discrimination towards LGBTI people in SADC extends itself into the media, creating newsrooms that strategically misrepresent or underrepresent this community.

A well-known example is the 2010 *Rolling Stone* article in Uganda, which called for lawmakers to hang the country's "top" homosexuals. The story, like many articles published in Uganda, claimed activists had launched a gay campaign to recruit schoolchildren. It included the names of suspected "homosexuals" and gay rights activists. Shortly after the story appeared, police found Ugandan gay rights activist David Kato bludgeoned to death in his home.



A 2010 article in Uganda called for lawmakers to hang the country's "top" homosexuals. Photo: Daily Maverick

Another challenge is the sin of omission. The ground-breaking 2015 *Gender and Media Progress Study* (GMPS), the first comprehensive study on media coverage and portrayal of LGBTI issues, provided baseline data on this topic. It found that just 0.1% of all stories in SADC discuss LGBTI issues. Additionally, the GMPS research noted that most stories on the topic concern discrimination (55%), affirming the reality on the ground.

The research noted that stories often lack the voices of LGBTI people; fail to address stereotypes about LGBTI people; lack analysis, context, history or research; and use moralising or stereotypical language. This symbolic annihilation points to the ways in which poor media treatment can contribute to social disempowerment and in which symbolic absence in the media can erase groups and individuals from public consciousness.[6]

According to Klein and Shiffman (2009), this exclusion contributes to keeping sexual minorities invisible and without power. They further argue that when society does not value certain groups, the media tend not to include them in their storylines, in the process, casting them aside, and disenfranchising them further by not showing them. The absence of a particular group in the media instructs people, albeit tacitly, about how one should or should not act, and about what one should or should not look like.

Source: The Guardian, 2010; Gender and Media Progress Study (GMPS), Gender Links, 2015

5 http://www.mdda.org.za/OutInTheMediaFinalReport%20(2).pdf
6 http://www.blackwellreference.com/public/tocnode?id=g9781405131995_chunk_g978140513199524_ss12-1
7 Klein H and Shiffman , S.H (2009) Underrepresentation and Symbolic Annihilation of Socially DisenfranchisedGroups ("Out Groups") in Animated Cartoons . The Howard Journal of Communications
http://www.academia.edu/3046269/Underrepresentation_and_symbolic_annihilation_of_socially_disenfranchised_groups_out_groups_in_animated_cartoons (Accessed 29/05/2016)

Legal and policy and framework

This section covers the global, continental and regional instruments that promote the rights of LGBTI communities. It begins with an overview of seminal international declarations. These overarching frameworks provide entry points for lobbying and advocacy at national level.

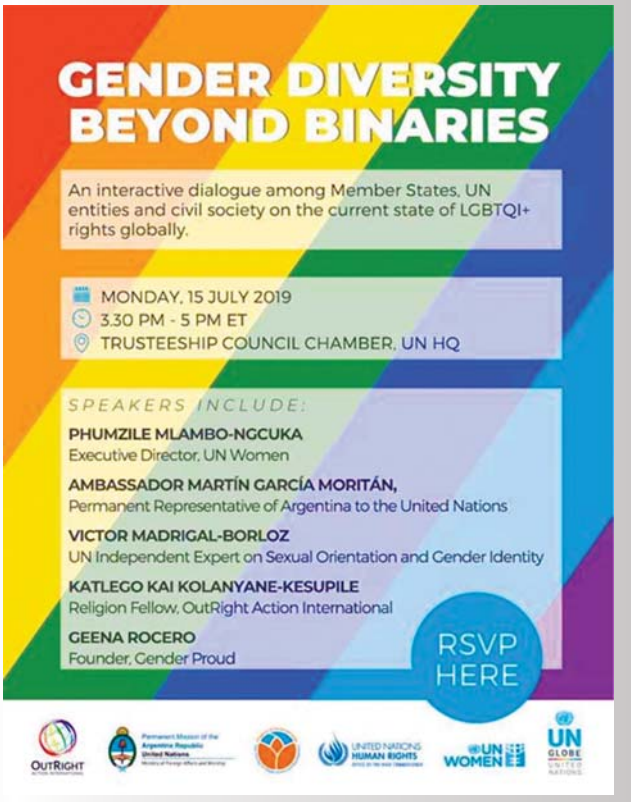
The Sustainable Development Goals do not include any specific references to LGBTI

Global instruments

The UN is the sum of its member states, many of whom do not tolerate LGBTI rights. As such the Sustainable Development Goals (SDGs) do not include any specific references to LGBTI. But to ensure that the global development agenda does not leave LGBTI communities behind, the UNDP developed the LGBTI Inclusion Index to inform evidence-based development strategies to advance their inclusion. Following extensive multi-sectoral and civil society consultations the five priority dimensions for measurement in the LGBTI Inclusion Index are: political and civic participation, economic well-being, personal security and violence, health and education.[8]

UN Women highlights importance of LGBTI rights[8]

In July 2019, Phumzile Mlambo-Ngcuka executive director of UN Women former Deputy President of South Africa convened an unprecedented discussion called "Gender Diversity Beyond Binaries," at the UN headquarters. Panellists included ambassador Martin Garcia Moritán, permanent representative of Argentina to the UN; Victor Madrigal-Borloz, the UN's independent expert on sexual orientation and gender identity; Katlego Kai Kolanyane-Kesupile, a Botswana LGBTI activist and fellow at OutRight Action International; and Geena Rocero, the founder of Gender Proud. This unprecedented gathering marked the start of a more bold approach by the UN in engaging member states on their attitudes towards LGBTI. *Source: UN Women*



[8] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf
[9] https://www.unwomen.org/en/news/stories/2019/7/news-event-gender-diversity-and-non-binary-identities

To bring greater clarity and coherence to states' human rights obligations, the International Commission of Jurists and the International Service for Human Rights, on behalf of a coalition of human rights organisations, developed a set of international legal principles on the application of international law to human rights violations based on sexual orientation and gender identity.[10] Although stakeholders first adopted the Yogyakarta Declaration, as it is called, in 2007 and updated it in 2017, it remains non-binding. However, it provides comprehensive guidance to states on guiding principles, these include:

- *Rights to universal enjoyment of human rights, non-discrimination and recognition before the law:* Principles 1 through 3 establish the universality of human rights and their application to all without discrimination. All people have a right to recognition as a person before the law, regardless of their sexual orientation or gender identity. Forced medical procedures, like sterilisation or sex reassignment surgery, cannot be required for legal recognition.
- *Rights to human and personal security:* Principles 4 through 11 address fundamental rights to life, freedom from violence and torture, privacy, access to justice and freedom from arbitrary detention and human trafficking.
- *Economic, social and cultural rights:* Principles 12 through 18 elaborate on non-discrimination in the enjoyment of economic, social and cultural rights. This covers the rights to employment, housing accommodations, social security and education, as well as sexual and reproductive health rights that include the right to informed consent and sex reassignment therapy.
- *Rights to expression, opinion and association:* Principles 19 through 21 set forth the freedom to express oneself, one's identity and one's sexuality based on sexual orientation or gender identity, without state interference. Along with this right to free expression, everyone also has the right to freely participate in peaceful assemblies and associate.
- *Freedom of movement and asylum:* Principles 22 and 23 highlight the rights of persons to seek asylum from persecution based on sexual orientation or gender identity.
- *Rights of participation in cultural and family life:* Principles 24 to 26 address the rights of people to have family life and to participate in public affairs and the cultural life of their communities without discrimination based on sexual orientation or gender identity.
- *Rights of human rights defenders:* Principle 27 establishes the right to defend and promote human rights without discrimination based on sexual orientation and gender identity, as well as the obligation of states to ensure the protection of human rights defenders working in these areas.
- *Rights of redress and accountability:* Principles 28 and 29 elaborate on holding rights violators accountable and ensuring appropriate redress for those who face rights violations.
- *Additional recommendations:* The principles establish 16 additional recommendations to national human rights institutions, professional bodies, funders, NGOs, the High Commissioner for Human Rights, United Nations agencies, treaty bodies, special procedures and others.[11]

Although stakeholders first adopted the Yogyakarta Declaration, as it is called, in 2007 and updated it in 2017, it remains non-binding

The UN has rolled out several instruments that enshrine these rights, and SADC countries have signed on to many of them.

[10] http://yogyakartaprinciples.org/introduction/
[11] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf

Table 8.2: Overview of key UN instruments and SADC commitments[12]

Country	International Convention on Civil and Political Rights (ICCPR)	International Covenant on Economic, Social, and Cultural rights (ICESRC)	Convention on Torture (CAT)	Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)	Convention on the Rights of the Child (CRC)	UN Centre for Regional Development (SDGs) (CRD)	International Convention on the Elimination of all forms of Racial Discrimination (ICERD)
Angola	SP	SP	S	SP	SP	SP	S
Botswana	N	N	N	SP	SP	S	S
DRC	SP	SP	SP	SP	SP	SP	SP
Eswatini	SP	SP	SP	SP	SP	SP	SP
Lesotho	SP	SP	SP	SP	SP	SP	SP
Madagascar	SP	SP	SP	SP	SP	SP	SP
Malawi	SP	SP	SP	SP	SP	SP	SP
Mauritius	SP	SP	SP	SP	SP	SP	SP
Mozambique	SP	N	SP	SP	SP	SP	SP
Namibia	SP	SP	SP	SP	SP	SP	SP
Seychelles	SP	SP	SP	SP	SP	SP	SP
South Africa	SP	SP	SP	SP	SP	SP	SP
Tanzania	SP	SP	N	SP	SP	SP	SP
Zambia	SP	SP	SP	SP	SP	SP	SP
Zimbabwe	SP	SP	N	SP	SP	SP	SP

Source: ILGA, 2019.

Table 8.2 provides an overview of the relevant UN instruments and the status of SADC members state commitments. All instruments promote equality, non-discrimination for all citizens and protection from hate crimes. It classifies the status of commitments in three ways:

- None means a state has not committed to the instrument, indicated with an "N."
- Signatory means a state has signed in agreement but has not ratified at national level indicated with a "S."
- State party means a state has ratified the instrument at national level, which means it must be domesticated, indicated with an "SP."

Ten SADC countries have committed to implementing all seven instruments in country: DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Namibia, Seychelles, South Africa and Zambia. It is a concern that Tanzania and Zimbabwe have not signed the Convention on Torture, particularly in Tanzania, where the regional governor of Dar es Salaam threatened in late 2018 to set up a task force to round up and arrest people suspected of being gay.

Angola has not ratified the CAT and ICERD, while Botswana lags in several areas as it has not committed to the ICCPR, ICESRC and CAT and it has only signed up to, but not domesticated, the CRD and ICERD.

[12] https://ilga.org/downloads/Treaty_Bodies_SOGIESC_references_2016_ILGA.pdf

Mauritius commits to LGBTI rights agenda following UN review[13]

As part of its Universal Periodic Review (UPR), which involves a review of its human rights record, Mauritius received 14 recommendations from 13 countries, four advanced questions and three comments in favour of LGBTI rights as human rights.

This included concerns that the government has not yet taken any policy decision to repeal section 250 of its Criminal Code regarding consensual homosexual activity; concerns about hate speech and violence, including death threats, against LGBT people; and a note that "non-heterosexuals experienced harassment by neighbours, forced marriages following kidnapping and sequestrations by the family, physical violence and blackmail."[14]



Lawmakers in Mauritius committed to continue to advance the rigths of LGBTI people at the 40th Regular Session of the Human Rights Council.
Photo: Gender Links

Following the UPR, the government committed to do better to advance the rights of its LGBTI community. "Please rest assured that Mauritius will take initiatives for the recognition of the rights of the LGBT community," said Maneesh Gobin, attorney general and minister of justice, human rights and institutional reforms, at the 40th Regular Session of the Human Rights Council.

The UPR is a unique state-driven process under the auspices of the Human Rights Council, which provides the opportunity for each state to declare what actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations.

As one of the main features of the Council, UN stakeholders designed the UPR to ensure equal treatment for every country in assessments of human rights. The ultimate aim of this mechanism is to improve the human rights situation in all countries and address human rights violations wherever they occur. Currently, no other universal mechanism of this kind exists.

The UPR holds states accountable to conventions and treaties that its lawmakers have ratified and have a moral obligation to implement. Advocacy on the UPR enabled peer-to-peer dialogue and brought pressure from development partners and other states to encourage Mauritius to guarantee the equal rights of LGBTI persons.

Source: Gender Links case study, 2019

[13] https://genderlinks.org.za/casestudies/mauritius-lgbt-youth-led-advocacy-paving-the-way-for-lgbt-rights/
[14] https://ilga.org/downloads/31ST_UPR_WORKING_GROUP_SESSIONS_SOGIESC_RECOMMENDATIONS.pdf

Continental instruments

Two binding treaties that apply at the regional level strengthen the fight to curb violence against persons based on their real or imputed sexual orientation or gender identity. The principal treaty is the African Charter on Human and Peoples' Rights (also known as the Banjul Charter), which guarantees the principles of non-discrimination and equality before the law; the rights to life, dignity and physical integrity; the guarantee against cruel, degrading or inhuman treatment or punishment; and the right to a fair hearing before competent national courts. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), in addition, requires state parties to take specific measures to combat violence against woman regardless of their sexual orientation or gender identity.[15]

In 2014, the African Commission on Human and Peoples' Rights adopted Resolution 275: Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity. It provides clarity on the import of the clauses in the African Charter for LGBTI communities. Resolution 275 calls on members states to:

- Ensure that human rights defenders work in an enabling environment that is free of stigma, reprisals or criminal prosecution as a result of their human rights protection activities, including the rights of sexual minorities; and
- End all acts of violence and abuse, whether committed by state or non-state actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence, including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.[16]

The first clause in resolution 275 commits member states to allowing LGBTI organisations to operate freely. This is currently only possible in Botswana, Lesotho, Mauritius, Namibia, Seychelles and South Africa. Nine SADC countries actively restrict the functioning of these organisations.

Clause two commits members states to creating a legal environment that criminalises violence against LGBTI persons in all its forms and ensures prosecution of perpetrators of such violence.

At the moment, Angola, is the only country in SADC that has hate crimes legislation that protects LGBTI persons from violence and discrimination. Ensuring other countries bring in similar legislation is an urgent priority across the region.

Regional instruments

No SADC instruments currently exist specifically to address LGBTI rights. This is indicative of the resistance amongst legislators in most SADC states to address the needs of these communities. South Africa is the exception, with some of the most progressive laws, policies and practices in the world. Given the policy-rich global and continental environment, there is a need to lobby and advocate for a regional Protocol on the Rights of LGTBI Persons - one that includes these global and continental provisions within a SADC context.

No SADC instruments currently exist specifically to address LGBTI rights

[15] http://cfnhri.org/uploads/files/resolution_275_eng.pdf
[16] http://www.achpr.org/sessions/55th/resolutions/275/

One important area of concern involves the provision of high quality sexual and reproductive health services to LGBTI communities. The right to health is fundamental to every citizen's wellbeing.

The Lancet and Guttmacher new SRHR definition include people's right to freely define their own sexuality, including sexual orientation and gender identity and expression. This ground-breaking new definition will help LGBTI people access sexual and reproductive health information and services. The Lancet and Guttmacher report stresses the importance of people being able to have access to the information, resources, services and support necessary to achieve this without discrimination, coercion, exploitation or violence.

It also acknowledges that people with diverse sexual orientations, gender identities and expressions, and sex characteristics, including LGBTI people, have been neglected in efforts to advance sexual and reproductive health and this has held back progress among wider populations. Exclusion has been due, in part, to pervasive stigma and discrimination of LGBTI people, including among health workers.[17]

Three SADC instruments speak to improving SRHR in member states:

- Strategy for Sexual and Reproductive Health and Rights in the SADC region, 2019-2030;
- SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights among key populations; and
- Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region.

The SADC SRHR strategy includes LGBTI people in its list of beneficiaries. It is intended to meet the SRHR needs of all people in the SADC region, including: adolescent girls and young women; women of a reproductive age; men and boys; and key populations including sex workers, people who inject and use drugs, prisoners, MSM and LGBTI, migrants, refugees, mobile populations, people living with disabilities and victims of sexual exploitation.[18] There is no other specific reference to the needs of LGBTI people in the SRHR strategy.



Malawian authorities arrested Steven Monjeza (left) and Tiwonge Chimbalanga in 2009 when they attempted to get married. Photo: Google Images

Additionally, the SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights among key populations does not include LGBTI persons at all. However, it does identify men having sex with men (MSM) and transgender persons as key populations. All key populations named in this strategy face elevated levels of stigma and discrimination, which impedes their access to health services, including HIV and SRH services. They also face stigma and discrimination in health care settings, the workplace, families, and within communities.[19]

The Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region takes a similar approach by referencing LGBTI persons as a key population. It calls on states to:

- Review and revise or develop new policies that support access to integrated SRH and HIV services for key populations, especially adolescents, youth, migrant populations, LGBTI persons and people with disabilities.

[17] https://www.outrightinternational.org/content/sexual-and-reproductive-health-and-rights-all
[18] https://genderlinks.org.za/wp-content/uploads/2018/11/1-Final-signed-SADC-SRHR-Strategy-2019-2030.pdf
[19] https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf

- Put systems in place, including the necessary facility and community service provision modifications and infrastructure, to facilitate access to SRH and HIV services by key populations, especially adolescents, youth, LGBTI persons and people with disabilities.[20]

While the various strategies do not include comprehensive provisions to address the SRHR needs and rights of LGBTI persons, they do provide entry points for engagements with governments and other key stakeholders. The global, continental and regional instruments commit SADC members states to ensure that they fully recognise LGBTI persons as equal citizens. It is important to hold governments accountable for the commitments they make and ensure that they implement them.

Status of same-sex consensual relations in SADC

People engaged in same-sex consensual relations face stigma and discrimination across SADC. Even in countries where legislators have decriminalised same-sex consensual relations, most governments stop at decriminalisation without putting further requisite rights in place. Political will remains a major challenge but examples of positive reforms do exist. For example, Mozambique decriminalised same-sex consensual relations in 2015 after a review of its 1886 Penal Code.

In 2018, GL compiled a case study on Mozambique's Penal Code review process. It comprised interviews with different stakeholders, including government. Isaque Chande, Mozambique ombudsman and former minister of justice, said that he believed Mozambican society is not ready to accept LGBTI communities. "Mozambique society will not accept marriage between same sex couples," he said, noting that the country needs to take its time and ensure everyone is ready before putting laws and policies in place to fully integrate LGBTI communities.

Chande's intervention raises several fundamental questions. Why are LGBTI communities viewed as separate from "society?" Who defines society? Why are LGBTI persons lesser citizens? Who decides when society is ready? Does society have to be ready for equality, fairness and dignity?

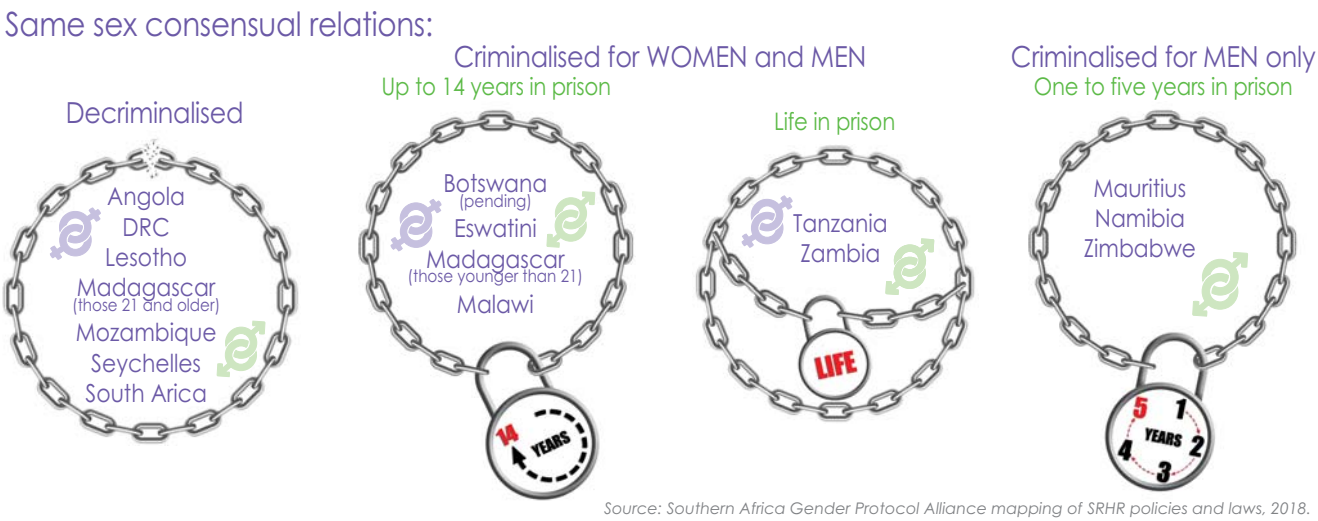
While Chande's strategy is one approach, the approach in other parts of the world has been one where government guarantees and facilitates the realisation of citizens' rights instead of dispensing them out as privileges when leaders believe a majority in the rest of "society" approves of it.



Pride march in Eswatini, 2018. Photo: Gender Links

[20] http://www.integrainitiative.org/wp/wp-content/uploads/2015/12/tmp-11285-SADC-Min-Stds-Eng-final-1158402048.pdf

Figure 8.5: Legal status of same-sex relationships in SADC



Source: Southern Africa Gender Protocol Alliance mapping of SRHR policies and laws, 2018.

Figure 8.5 shows that seven countries (Angola, DRC, Lesotho, Madagascar, Mozambique, Seychelles and South Africa) have decriminalised homosexuality. Meanwhile, nine countries have laws in place criminalising same-sex consensual relations. In Madagascar, homosexuality remains a crime for people younger than 21. In January 2019, Angola's High Court decriminalised homosexual relationships following the parliament's adoption of a new penal code. The country's courts went further, making it a criminal act to discriminate against another person because of their sexual orientation, with the possibility of imprisonment of up to two years.[21]

Nine countries have gender distinctions around the criminalisation of consensual same-sex relations. Six of the nine - Botswana, Eswatini, Madagascar, Malawi, Tanzania and Zambia - criminalise same-sex consensual relations for both women and men. But Mauritius, Namibia and Zimbabwe only criminalise same sex consensual relations between men.

These conditions create legal uncertainty and ambiguity. The latter three countries cannot charge lesbians for same-sex relations, and the reason for this anomaly is not clear. It could be gender blindness; an implicit acknowledgement that legislators believe gay relationships to somehow be more serious and/or threatening. The different ways that laws treat gay and lesbian relations point to a serious violation of the principles of equality and fairness. Decriminalising all same-sex consensual relations will remove any legal questions linked to this.

Mauritius, Namibia and Zimbabwe only prosecute men for same-sex consensual relations

In Tanzania and Zambia, the sentence for same-sex consensual relations is life imprisonment for both women and men.



Chanda says he tried three times to kill himself before he learned to accept himself. Photo: Prudence Phiri and Global Press Journal Zambia

[21] https://www.iol.co.za/news/africa/angola-lifts-ban-on-homosexuality-18965269

Landmark ruling in Botswana throws out law that criminalised same-sex relations[22]

LGBTI activists in Botswana celebrated on 11 June 2019 following a unanimous ruling by the Botswana High Court that cast aside sections of the country's penal code that criminalised same-sex relations.

University student Letsweletse Modshidiemang brought the case before the court, challenging the constitutionality of sections 164(a), 164(c) and 167 of the Botswana Penal Code.

These provisions criminalise same-sex sexual conduct between consenting adults in Botswana and impose a maximum sentence of seven years' imprisonment. Modshidiemang and the group Lesbians, Gays and Bisexuals of Botswana (LEGBIBO) argued that the penal code provisions were unconstitutional, and that the government should do away with them to reflect a changed society in which same-sex relations have become more widely accepted.

However, following the ruling, Botswana Attorney General Abraham M. Keetshabe said the government would appeal the decision, noting that he felt the judges made a mistake.

Keetshabe's statement confused LGBTI activists and pointed to government confusion on the matter because it contradicted an earlier statement from Botswana President Mokgweetsi Masisi, made in December 2018 during the 16 Days campaign. At that time, Masisi said: "There are also many people of same-sex relationships in this country, who have been violated and have also suffered in silence for fear of being discriminated [against]... Just like other citizens, they deserve to have their rights protected."



Activists in Botswana struggle for legal recognition of same-sex relations outside the High Court in 2019. Photo: Gender Links

In a June press release, the Southern African Gender Protocol Alliance noted that it welcomes the bold move by Botswana's high court to decriminalise homosexuality. Emma Kaliya, the group's Chair, said "Botswana has shown that they are progressive on human rights. We hope that other SADC member states will do the same."

It is important that civil society organisations and LGBTI advocates within government monitor the situation and continue to keep up the pressure and make strategic interventions to ensure that the government's appeal does not succeed. *Source: BBC News, 2019*

Chanda, a gay man in Zambia, spoke about the impact of the extremely harsh law in an interview with Public Radio International. "It's a jungle we live in. We are always hunted," he said. "If I had a choice, why would I choose such a hostile life?" The 34-year-old, who asked to remain anonymous for fear of being arrested, said he had attempted suicide three times because he could not cope with the rejection and harassment he endured from his family and community.

Many in Zambia's LGBTI community, who face potential imprisonment, say it's a struggle to cope with the emotional trauma that comes with living in a place where one's most personal practices or identity is regularly attacked. Suicide is common in the community, so is alcohol and drug abuse.[23]

Meanwhile, the Tanzania Penal Code 1945, Section 154 on Unnatural Offences, criminalises "carnal knowledge... against the order of

[22] https://www.bbc.com/news/world-africa-48594162
[23] https://www.pri.org/stories/2018-08-18/gay-men-zambia-where-homosexuality-banned-suicide-common-end

nature," which is punishable with a maximum penalty of life imprisonment.[24] The Tanzania government has implemented especially harsh measures against the LGBTI community. Alongside draconian laws, legislators have authorised special police units to arrest and imprison LGBTI persons for lengthy periods.

In November 2018, police arrested ten men for allegedly conducting a same-sex marriage ceremony on the Tanzanian island of Zanzibar. The men endured a forced anal examination under the pretext of "gathering evidence."

The UN Committee against Torture has said such examinations "have no medical justification" and violate international law.

The number of arrests increased following a call from lawmaker Paul Makonda, regional commissioner for Dar es Salaam, for citizens to begin reporting homosexuals for round-ups. Makonda said he had put together a team of officials and police that would target gay people, who could face lengthy prison sentences.[25]

Protections for LGBTI communities



Activists protest GBV and homophobia in South Africa's Orange Farm community in 2015. Photo: Thandokuhle Dlamini

LGBTI+ persons face high levels of violence, discrimination and stigma because of their sexual orientation, gender identity and expression, and sex characteristics. In addition to removing discriminatory laws and policies governments must provide protections in existing and new laws and policies. This section covers protection against discrimination, criminalisation of violence and discrimination against LGBTI+ persons and banning conversion therapy.

Constitutional provisions

Only South Africa has specific provisions in its constitution recognising the rights of LGBTI people. Chapter two, the Bill of Rights of the South African constitution, states under sub section nine: "The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth... No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection... National legislation must be enacted to prevent or prohibit unfair discrimination... Discrimination on one or more of the grounds listed in subsection 3 is unfair unless it is established that the discrimination is fair."

It is important to include protections for gender and sexual orientation in country constitutions. This guarantees long term protection of LGBTI people. Fourteen SADC countries include equality and non-discrimination clauses in their constitutions, but do not include sexual orientation.

GL works with groups of experts in countries across the region to conduct an audit on government responsiveness to gender. The Gender Responsive Assessment (GRA) includes a question on whether the constitution provides for non-discrimination based on different criteria. Experts scored their countries out of a total of two points.

Experts in seven out of 14 countries scored their countries a maximum of two points. These

[24] Tanzania Penal Code 1945, Section 154 Unnatural Offences
[25] https://www.theguardian.com/world/2018/nov/08/tanzania-men-arrested-for-gay-marriage-face-anal-examinations

included countries such as Malawi, Tanzania and Zimbabwe that have highly repressive LGBTI laws and policies. In contrast, Mauritius has several progressive laws and policies on equality, but experts there scored it at zero. In June 2018, Mauritius held a pride event. However, organisers cancelled its scheduled pride parade following threats from protestors who called the march "immoral and anti-Islamic."[26] The prevailing negative context with this and issues such as growing levels of child marriages could account for Mauritius's low score. Overall, the differences in rankings highlights a disparity in views and perceptions across the region, once again underscoring the need for more and better information on this topic as well as advocacy aimed at citizens and activists, not only political leaders.



Candidates give short shrift to sexual diversity during Malawi elections[27]

It is an exception rather than a rule when Malawi's political leaders mention LGBTI rights, even during elections when citizens pay closer attention, hoping to get a clear sense of which leaders may bring in progressive changes. But it was politics as usual in 2019 as the country went to the polls on 21 May following a campaign once again marked by almost no mention of the rights of LGBTI Malawians, who continue to be criminalised.

One of many litmus tests for any elected government is how they handle sensitive and divisive issues such as LGBTI rights, said activists in Malawi. "The winners of the 2019 elections are obligated to respect and protect the rights of LGBTI+ persons. The government must repeal 'bad laws' that impinge on LGBTI+ persons' rights and freedoms," said LGBTI activist, Eston Mwala.



UK-based activists call on Malawi lawmakers to release Tiwonge Chimbalanga and Steven Monjeza in a 2010 protest in London. Photo: MC Modern Ghana

"This is both a constitutional and a human rights obligation. The government must repeal the sodomy laws and put in place deliberate policies to protect the rights of LGBTI+ persons because, as we have seen, such laws fuel homophobic violence."

In 2009, Malawi's authorities arrested Tiwonge Chimbalanga and Steven Monjeza, and charged them with unnatural practices between males and gross public indecency after they were married in front of friends and family. The case attracted international attention and generated interest in Malawi, where homosexuality carries a maximum 14-year jail sentence.

Section 153 of Malawi's penal code criminalizes "carnal knowledge of any person against the order of nature." Same sex partners face discrimination as far as access to health services is concerned.

Following this year's election, a 33-year-old transgender woman who refused to be named for security reasons said, "The reality is that we are here and we deserve to enjoy the human rights like everyone else, and we must not be hunted down like animals but we should be given the rights to enjoy living in Malawi just like everyone else."

Source: Penelope Paliani-Kamanga, Gender Links News Service, 2019

[26] https://www.mambaonline.com/2018/06/08/mauritians-celebrate-pride-despite-backlash-and-threats-in-pictures/
[27] https://genderlinks.org.za/news/malawi-elections-and-sexual-diversity/

Broad protections

Only Angola, Mauritius and South Africa provide broad protections for the LGBTI community. As mentioned earlier, Angola passed legislation in January 2019 making it a criminal act to discriminate against another person based on sexual orientation, with punishment of up to two years' imprisonment.[28] This law accompanies the decriminalisation of same-sex consensual relations.

Mozambique decriminalised same-sex consensual relations in 2015. At that time, lawmakers in the country had an opportunity to broaden the provisions on discrimination. Article 243 of the 2015 Mozambique Penal Code covers discrimination against different people and sites.

Only Angola, Mauritius and South Africa provide broad protections for the LGBTI community

Table 8.3: Discrimination clauses in the 2015 Mozambique Penal code

Key provisions	Sentences
• Anyone who discriminates on the basis of race or colour, religion, sex, age, disease, social status, ethnicity or nationality and offends the victim's honour and consideration.	Up to one year.
• If the discrimination is based on the restriction or refusal of access to a commercial establishment, of teaching, of lodging or places of entertainment or leisure, beaches, sports venues, venues or public goods, elevators, public transport, in a bar or restaurant, to meet or receive customers, to buy or sell.	Penalty is imprisonment.
• If the discrimination is aimed at preventing or hindering access to someone duly qualified, to any position or employment public or private, or hinder their professional development.	Two to eight years.
• Anyone who manufactured, marketed, distributed, any propagandistic material containing elements based on racial prejudice or colour, sex, age, partisan affiliation, marital status, religion, ethnicity and family situation.	Two to eight years.
• If any of the offences referred to in this Article are committed in a humiliating, public or publicised manner.	Penalty is accompanied by a fine of between ten to 20 times the national minimum wage.

Source: 2015 Mozambique Penal Code.

Table 8.3 shows that Mozambique has extensive clauses on discrimination, most punishable with prison sentences. While the Mozambique Penal Code decriminalised homosexuality, the provisions on discrimination do not specifically reference LGBTI+ communities, which is a lost opportunity.

Employment

Five SADC countries protect LGBTI peoples' rights to equal access to employment: Angola, Botswana, Mauritius, Mozambique and South Africa.

[28] https://www.iol.co.za/news/africa/angola-lifts-ban-on-homosexuality-18965269



The Mauritius Equal Opportunities Act[29]

Mauritius passed an Equal Opportunities Act in 2008. The following clauses in Part III - Employment Activities - protect all potential and existing employees.



Thanks to the Mauritius Equal Opportunities Act, its military cannot exclude LGBTI persons from employment. Photo: Wikimedia

10. Employment of persons

No employer or prospective employer shall discriminate against another person -

(a) in the advertisement of a job;
(b) in the arrangements he/she makes for the purpose of determining who should be offered employment;
(c) in determining who should be offered employment;
(d) in the terms or conditions on which employment is offered; or
(e) by refusing or deliberately omitting to offer employment to that person.

11. Persons in employment

No employer shall discriminate against an employee -

(a) in the terms or conditions of employment that the employer affords that employee;
(b) in conditions of work or occupational safety and health measures;
(c) in the provision of facilities related to or connected with employment;
(d) by denying the employee access, or limiting access, to opportunities for advancement, promotion, transfer or training, or to any other benefit, facility or service associated with employment;
(e) by terminating the employment of the employee; or
(f) by placing the employee at a disadvantage in any other manner.

The legislation provides for an equal opportunities commission to monitor its implementation.

Source: Equal Opportunities Commission, Mauritius, 2019

Mozambique protects the rights of LGBTI people to employment. However, according to Danilo da Silva, executive director of Mozambican Association for the Defence of Sexual Minorities (LAMBDA), only one in ten LGBTI people in Mozambique have secondary level education. While the organisation has welcomed decriminalisation of same-sex relations, da Silva says the country still has a long way to go. He notes that, in many cases, members of the LGBTI community leave school because of stigma and discrimination. Sometimes families kick them out when they find out about their status.



LAMBDA welcomed the decriminalisation of same sex consensual relations, but it says government needs to do more to protect sexual minorities. Photo: Afrika News

[29] http://eoc.govmu.org/English/Pages/default.aspx

This lack of education severely affects a person's ability to find decent work. LAMBDA has called for stakeholders to focus on protecting young LGBTI people and enforce their right to equal opportunities to education and training.

Other SADC countries also need to develop policies and legislation to guarantee LGBTI access to employment and fair and equitable treatment while in employment.



Zimbabwe: LGBTI people not protected in the workplace[30]

Asked by CNN's Richard Quest about whether his new government would remove the country's ban on same-sex marriage and campaign for the rights of LGBTI people President Emmerson Mnangagwa responded: "Those who want it are the people who should canvass for it, but it is not my duty to campaign for this. In our constitution, it is banned and it is my duty to obey my constitution."

With this kind of attitude at leadership level, many organisations and companies refuse to take a progressive stand on LGBTI rights. Activists in the country say this is true even of those business leaders who know they employ people from the LGBTI community.

It is a divisive issue. In September 2018, a teacher from St Johns College came out to his students. In a perhaps surprising move, the school supported him, saying it provides "a safe environment for all persons regardless of gender, sexual orientation, abilities or disabilities or any other real or perceived differences." However, after parents threatened to pull their children out of the school, the teacher resigned.

spared," says Harare-based freelancer Chiedza*, who said the president's response to CNN worried her and raised many questions and fears. "His response to Richard Quest summed up my fears, new wine in old bottles." Chiedza, who pretends to be heterosexual to avoid retribution in the office, including worries that editors would not publish her stories, said "it's hard enough being a woman in a highly patriarchal working environment, being a lesbian makes it even more difficult."

** Chiedza is not her real name.*

Source: Shamiso Chigonde, Gender Links News Service, 2018



Protesting for rights in Zimbabwe. Photo: SADCNews.org.za

[30] https://genderlinks.org.za/news/zim-newsrooms-a-safe-haven-for-the-lgbti/

Criminalisation of violence and discrimination against LGBTI persons

As this chapter has set out, LGBTI people face high levels of discrimination and violence across the region. In some instances, such as in Tanzania, it is state-driven. In other countries, the lack of progressive legislation creates unsafe environments for these communities. Where enabling environments do exist, such as in South Africa, ongoing advocacy remains necessary to ensure that public values and attitudes align with the legal and constitutional environment.

> Only five SADC countries protect LGBTI peoples' rights to equal access to employment

At its worst, violence and discrimination manifest in hate crimes and mob violence. Bullying and public humiliation are other common forms.

Hate crimes and aggravating circumstances/ Incitement to hatred and violence

Hate crime is defined as crime, typically involving violence, that is motivated by prejudice on the basis of race, religion, sexual orientation, or other grounds.[31] In criminal law, incitement is the encouragement of another person to commit a crime.[32] Currently only Angola has laws on hate crimes and protections against incitement to hatred and violence included in the January 2019 Penal Code.

It provides extensive protection of LGBTI people. Articles 71, 172, 215, 216, 225, 382 and 384 outlaw incitement to hatred, hate speech, defamation and hate crimes motivated by sexual orientation with varying degrees of punishment. For instance, article 172 bans threats against someone or a group of people on account of their sexual orientation, among others, with one-year imprisonment and a fine of up to 120 days. In the case of a death threat, punishment doubles. Article 384 lists persecution based on sexual orientation as a crime against humanity, on par with slavery, wilful manslaughter, genocide, rape, forced mutilation and others.[33]

South Africa has a draft Hates Crimes Bill that has been in play at the political level since 2009. The highly contested Prevention and Combating of Hate Crimes and Hate Speech Bill, which is currently before the Department of Justice and Constitutional Development, has generated plenty of debate.



Mauritius gay pride event in June 2018. Photo: Herb Klein

[31] Dictionary.com
[32] IBID
[33] Angola Penal Code January 2019.

Originally intended to solely address the offence of hate crimes, legislators decided to include hate speech in 2015, spurred on partly by the public outrage following the infamous Penny Sparrow incident (in which the former KwaZulu-Natal estate agent wrote a Facebook post likening black people to monkeys).

A range of interested parties have submitted input on the Bill, from conservative religious groups not wanting to be denied the right to speak out against homosexuality, to human rights groups defending the constitutionally-entrenched right of freedom to expression, to politicians and journalists concerned that the Bill may be used as a tool to silence critics of government.[34]

In its election manifesto ahead of the May 2019 South African election, the ruling African National Congress (ANC) party committed to passing the Hate Crimes Bill as a matter of priority.



"Corrective" rape on the rise in DRC[35]

The hate crime known as "corrective" rape is on the rise in the SADC country already saddled with the moniker of the world capital of rape.

Between July 2016 and July 2017, a local organisation documented ten cases of "corrective" rape in Goma and East DRC.[36]

"Corrective" rape has been described as a "hate crime in which an individual is raped because of their perceived sexual or gender orientation, with the intended consequence of the rape being to 'correct' the individual's orientation or make them 'act' more like their gender."[37]

Navi Pillay, former UN High Commissioner for Human Rights has stated that "corrective" rape commonly combines "a fundamental lack of respect for women, often amounting to misogyny, with deeply-entrenched homophobia."[38]

Lydia,* a lesbian sex worker from Bukavu, in DRC, affirms that trans men have become targets of sexual violence because of their gender expression. She notes that people perceive them to be lesbians and sometimes rape them, which the offenders perceive to be a "corrective" measure."



Congolese women walk past a sign advocating against sexual violence in December 2008. The DRC has long been described as "the rape capital of the world." Photo: BBC

Celeste,* a female journalist, declared that "almost every day in the city, people look at you, insult you and stigmatise you. One day, in 2007, I was surrounded by a group of men, they threatened they were going to rape me, to give me the taste of men, that whatever I did I was still a woman. They beat me and raped me, but I was able to defend myself and run."[39]

A transgender man, Antoine,* was raped by four young men from his neighbourhood the night of 24 June 2017. In his own words: "it started with

[34] https://genderjustice.org.za/article/hate-crimes-hate-speech-bill-good-bad-unspeakable
[35] https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/COD/INT_CCPR_CSS_COD_29078_E.pdf
[36] 3 L'OBS, RDC: la vie des homosexuels entre ombre et lumière, 5/16/2014. http://tempsreel.nouvelobs.com/societe/20140516.AFP7367/rdc-lavie-des-homosexuels-entre-ombre-et-lumiere.html.
[37] Keren Lehavot and Tracy L. Simpson, Incorporating Lesbian and Bisexual Women into Women Veterans' Health Priorities, June 27, 2013
[38] Pillay, Navi "The shocking reality of homophobic rape" in The Asian Age, June 20, 2011
[39] L'OBS, RDC: la vie des homosexuels entre ombre et lumière, 5/16/2014. http://tempsreel.nouvelobs.com/societe/20140516.AFP7367/rdc-lavie-des-homosexuels-entre-ombre-et-lumiere.html.

insults every time I walked by. They had already attacked twice in the past, trying to rape me. They told me all the time: we are going to rape you and you are going to become a normal man." That night, Antoine said he saw four people behind him, "they threw themselves on me, while hitting me. They had knives, they said they would kill me if I cried. They ripped my pants and the four of them raped me. When they finished, they told me we just turned you into a normal man."[40]

"Corrective" rape is an extreme crime that can cause irreparable physical and psychological harm. DRC does not adequately protect victims against these extreme violations and does not hold perpetrators accountable.

** Not their real names*

Source: Human Rights Violations Against Lesbian, Gay, Bisexual and Transgender (LGBT) People in the Democratic Republic of the Congo (DRC), Submitted for consideration at the 121st Session of the Human Rights Committee, 2017[41]

Conversion therapy

So-called "conversion therapy," sometimes known as "reparative therapy," is a range of dangerous and discredited practices that falsely claim to change a person's sexual orientation or gender identity or expression. Every mainstream medical and mental health organisation has rejected such practices for decades, but due to continuing discrimination and societal bias against LGBTI people, some practitioners continue to conduct conversion therapy. Minors are especially vulnerable, and conversion therapy can lead to depression, anxiety, drug use, homelessness and suicide.[42]

Mauritius and South Africa both ban conversion therapy. In other countries, such as Zambia, religious leaders like evangelical reverend Pukuta Mwanza, executive director of the Evangelical Fellowship of Zambia, endorse prayers and counselling as way to "cure" homosexuality. Mwanza asks LGBTI people to seek "spiritual help and prayers" from the church. In his view, the church is the hospital for African gays - if they accept to be "cured."[43]

This view of LGBTI people as having an ill that needs curing is dangerous. It spreads the false ideology that LGBTI people yearn to "fix" themselves. Homophobic churches in Southern Africa have tended to see human rights as secular and anti-Christian. To overcome this, it is important for citizens in SADC to understand that no conflict of substance exists between the foundational Christian belief that all human beings are created in the image of God and the equally foundational human rights principle of the inherent dignity and equality of all human beings.[44]

Recognition of LGBTI rights

Recognition of LGBTI human rights is an integral part of the process to ensure that this community enjoys the same rights and freedoms as all other citizens. These include, amongst others, the right to marriage, adopt children and have free expression.

Same sex marriages and civil unions

Only South Africa provides for same sex marriages and civil unions in its legal frameworks. The other SADC countries define marriage as a union between a woman and a man. This fundamentally affects a same sex couple's human rights, which is evident in the case of Johann Potgieter, a Namibian, and his South African husband, Daniel Digashu, versus the Namibian government.

[40] IBID
[41] https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/COD/INT_CCPR_CSS_COD_29078_E.pdf
[42] https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy
[43] https://www.politicalresearch.org/2014/10/06/conversion-therapy-a-bigger-threat-to-africa-than-scott-lively/
[44] http://theotherfoundation.org/wp-content/uploads/2017/01/Silent-No-Longer.pdf



Gay couple sue Namibian government for same-sex marriage and family rights[45]

Namibian Johann Potgieter married his South African husband Daniel Digashu in South Africa in August 2015 and the couple are now adopting a young boy. However, Namibia recognises neither their relationship nor family, a reality that has affected Digashu's and the boy's right to live in the country.



Johann Potgieter and Daniel Digashu.
Photo: Google Images

The men recently filed an urgent application in the Windhoek High Court against the government, the minister of home affairs and immigration, the attorney general, the Immigration Selection Board, the Immigration Tribunal, and the country's ombudsperson.

They are asking the court to order the government to issue a certificate of identity to Digashu as Potgieter's spouse, to recognise their marriage and family, and to recognise an order of the High Court of South Africa that gave them guardianship of their son. The couple have been raising the eight-year-old boy since his mother, Digashu's aunt, died in 2014. A South African court granted them permission to take the boy to Namibia while the adoption process is underway.

Since moving to Windhoek, the family have faced numerous hurdles and instances of discrimination from officials at the ministry of home affairs and immigration. Authorities have forced Digashu to go in and out of the country on various visas. In one case, a senior official reportedly said to the men: "I have never met people like you in my life. I don't know anyone of your kind. Who is the husband and who is the wife in the relationship?"

Digashu noted in court papers that the incident was "extremely demeaning, humiliating and degrading" adding, that "we were ridiculed and at the same time powerless to do anything. It was one of the worst feelings we have ever felt."

Friedel Dausab, director of Out-Right Namibia (ORN), an LGBTI rights organisation, said, "The case forces our hand to deal with issues on marriage equality and same-sex adoptions and parental recognition. We would like to support the couple and work towards a win for the sake of all LGBTI+ folks in Namibia."

Source: Mambaonline, 2017

Joint adoption of children/second parent adoption of children

South Africa is the only country in the region that allows same sex couples to adopt children. It is possible for a partner in a same-sex relationship to adopt the other partner's biological or adopted child regardless of the legal status their relationship in South Africa and Mauritius. The inability to adopt children is a violation of an LGBTI person's rights.

[45] https://www.mambaonline.com/2017/12/15/namibia-gay-couple-sue-govt-sex-marriage-rights/



Seychelles: Same sex couples seek right to adopt children[46]

As a country that has signed on to multiple human rights conventions, Seychelles is missing one important human right law: it does not allow same sex couples to adopt children. The current adoption law, enacted in 1982, does not make any provision for it.



LGBTI activist Fabianna Bonne.
Photo: Twitter

According to Marie-Agnes Ally, a social worker, the country's social service assesses applicants on their capacity as potential parents if they are childless, and as parents (for those who already have children).

She says that social services consider all other factors related to "the best interest of the child" and not the best interest or want of the foster parent. "Bearing in mind that the issue of LGBTI is sensitive and our society is coming to terms with the moral implication of the right of a person to his/her sexual orientation. As much as the government or system will not interfere with their sexual orientation, social services having the mandate to ensure the well-being and protection of children has an obligation to ensure protection of children. Hence, we need to be mindful of arising/interrelated issues such as how a child residing with same-sex couple, will be accepted/related to, for instance in a school environment and wider community."

Ally notes that the ministry is considering certain amendments of the Children's Act, but adoption by same-sex couples is not a priority. "The society needs to be prepared to affront this drastic change. It goes beyond only the Children Act but other legislations concerning family issues such as the Civil Code and even the Constitution," she said.

National Council for Children Chief Executive Officer Jean-Claude Matombe said that it will not be easy for the people of Seychelles to accept the idea of same sex couples adopting children. "We all know that it is coming because Seychelles has signed the human rights convention. Our constitution gives the same chance and opportunity to all, we speak of equality for everyone, meaning that these people need to be treated as equal," he said. "But in practice it's totally different. I just thought of an example, a couple of years ago there was a same-sex wedding in Seychelles, but it was held at the British High Commissioner's residence. There was an uproar, people were against it, the churches and everyone disagreed with that. This shows that there is a lot of work to be done to educate the population to advocate for these people to be able to enjoy the same rights."

Fabianna Bonne, chairperson of a local LGBTI association, says that couples in the community have been told that they cannot adopt children as a couple but can do it as a single parent as long as they are not in a relationship.

Bonne believes it is time for chage, noting that the real victims of the current rules have refrained from speaking out due to fear of discrimination.

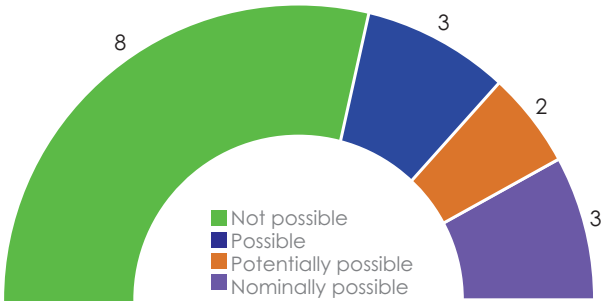
Source: Julliete Dine, Gender Links News Service, 2019

[46] https://www.betrue2me.org/resources/be-true-2-me-guideline-legal-gender-marker-and-forename-change/

Changing sex designation, name or gender marker

The ability to change a gender marker or name is a critical right for trans and diverse people. Experts refer to this as "legal gender recognition." In countries where it is not possible to change gender markers, the ability to change names is stopgap measure. Research conducted by the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) suggests that, even where it is possible to change names and gender markers, the process remains inordinately difficult.

Figure 8.6: Ability to change sex and gender markers



Source: ILGA, 2019.

Figure 8.6 shows that only three SADC countries allow for changing gender markers unconditionally. These are Namibia, South Africa and Zambia. Changing a gender marker is potentially possible in Botswana and is nominally possible in Angola, Malawi and Mozambique. It is not possible to change gender markers in the DRC, Eswatini, Lesotho, Madagascar, Mauritius, Seychelles, Tanzania and Zimbabwe. At a practical level, the inability to change gender markers affects trans people in several ways:[47]

- Certain institutions, both private and public, may require a legal gender identity on official documents, this includes health care services;
- If a person is presenting in a gender opposite to their gender marker it makes it difficult to engage in everyday activities, everything from opening a bank account to applying for a job or driver's licence, to boarding a plane;
- Most countries around the world still use a binary gender system of male and female. This also applies to Visa applications, which often need to be filled out in person;
- Correctional services, also known as imprisonment/prison/incarceration or gaol. Gender markers will determine where prison officials house an individual during imprisonment.

For these reasons and more, it is critical for all SADC countries to enact and implement laws and policies to facilitate the process of changing gender markers.

Only three SADC countries allow for changing gender markers: Namibia, South Africa and Zambia

[47] https://www.betrue2me.org/resources/be-true-2-me-guideline-legal-gender-marker-and-forename-change/

Table 8.4: Conditions under which gender markers may be changed[48]

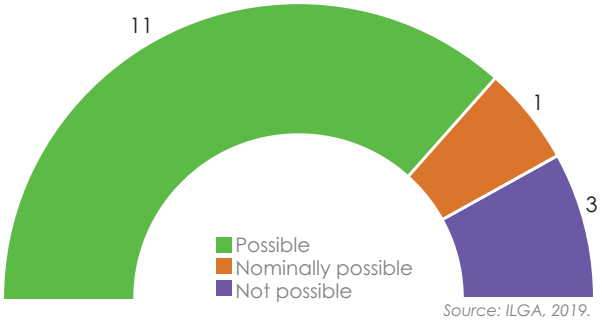
Country	Relevant law	Conditions	Issue
Angola	Código do Registo Civil 2015, Section 87	Although s. 78 of the Code does not allow alterations of details entered in the registration of records of the Civil Registrar, s.87 permits changes, including change of name where there is a change of facts which alter the legal identity or status of the person.	Unclear, no specific reference to trans and diverse gender identities.
Botswana	National Registration Act 26 of 1986, s.16	Section 16. Material change. (1) Where the registrar is of the opinion that any change in the particulars relating to a registered person materially affects his registration, he shall record the change and notify the Registrar of National Registration of the circumstances and recommend that the person concerned should be issued with a new identity card. […] (3) The particulars relating to the new identity card and its holder shall be recorded in the national register and the register of the area in which that person is registered.	At the discretion of the registrar not an unconditional right.
Malawi	National Registration Act 13 of 2010 (not trans specific).	Section 20(1) provides that where a change in particulars of a registered person materially affect his registration, the district registrar shall record the change and notify the Director of the circumstances and recommend that the person be issued with a new identity card. Section 21(1) provides that every registered person may, when he is satisfied that his appearance has changed so as to make it likely that his identity may be questioned, apply to the district registrar for the issue of a new card with a more recent photograph	Unclear, no specific reference to trans and diverse gender identities.
Mozambique	Código do Registo Civil 2004	Section 85(1) gives the Civil Registrar general authority to make changes when there is a change of facts which alter the legal identity or status of the person registered.	Unclear, no specific reference to trans and diverse gender identities.
Namibia	Births, Marriages and Deaths Registration Act 81 of 1963; Identification Act 2 of 1996	The Secretary may on the recommendation of the Secretary of Health, alter in the birth register of any person who has undergone a change of sex, the description of the sex of such person and may for this purpose call for such medical reports and institute such investigations as he may deem necessary. The Act does not define "change of sex". Applications in terms of s.7B are done on a case-by-case basis- as long as a person can provide medical reports of their "change of sex". Once the application is granted, a trans person can apply for a new identity document and passport. Namibia does not provide gender affirming healthcare in the public health system, making the Act largely inaccessible. A transgender person who has not had a "change of sex" could use s.12(1)(a) of the Identification Act 2 of 1996. It states that "if an identity document does not reflect correctly the particulars of the person to whom it was issued, or contains a photograph which is no longer a recognizable image of that person", the person shall hand over the identity document to the Minister. Section 12(3) states that the Minister shall cancel it and replace it with an improved identity document. The majority of trans people who have made applications to update their photographs have not been successful.	Comprehensive legislation, barrier in the public health system.
South Africa	Alteration of Sex Status and Sex Descriptor Act, No.49 of 2003	(2) Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register. There are no directives from the National Department of Home Affairs (DHA) on how to interpret the Act, and in practice this causes arbitrary obstacles such as requiring proof of gender reassignment surgery, long waiting periods for applications to be processed (averaging 1-7 years), what forms to use and what documents and applicant must bring.	Comprehensive legislation, barrier in the Home Affairs.
Zambia	National Registration Act 19 of 1964	Section 9(2): In any case where a national registration card issued to a registered person ceases in any material particular to accurately represent his identity, such person shall, without undue delay, produce his national registration card and give such particulars as shall be necessary for the issue of a new national registration card to a registrar who… shall issue to such person a new national registration card	
Not possible currently, law or policy needed in DRC, Eswatini, Lesotho, Madagascar, Mauritius, Seychelles, Tanzania, Zimbabwe			

Source: ILGA, 2017.

[48] https://ilga.org/downloads/ILGA_Trans_Legal_Mapping_Report_2017_ENG.pdf

Name change

Figure 8.7: Changing names

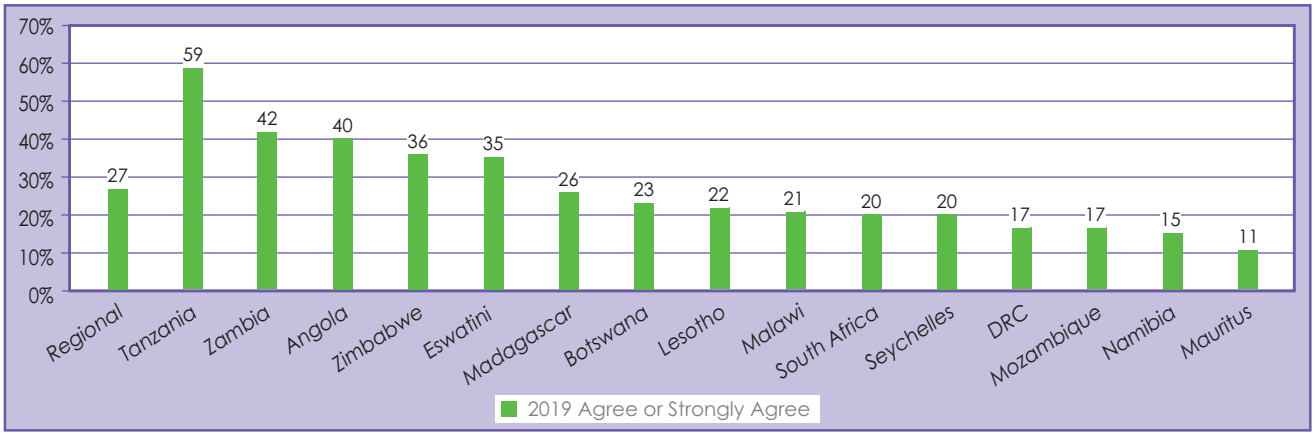


Source: ILGA, 2019.

Figure 8.7 illustrates that changing names in SADC countries is less challenging than changing gender markers. It is possible to change names in 11 SADC countries: Botswana, DRC, Eswatini, Lesotho, Madagascar, Mauritius, Namibia, Seychelles, South Africa, Zambia and Zimbabwe.

It is nominally possible to change names in Angola, Mozambique and Malawi. It is not possible to change names in Tanzania. While not ideal, trans and gender diverse people may use this option until countries allow

Figure 8.8: "It bothers me when a girl acts like a boy," 2019



Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey, 2019.

Scores point to relatively high levels of intolerance of trans and gender diverse people

In response to the statement "It bothers me when a girl acts like a boy," between 40% to 59% of respondents to the Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey in Angola, Tanzania and Zambia agreed or strongly agreed. The scores in other SADC countries range from a low of 11% in Mauritius to 36% in Zimbabwe. These scores point to relatively high levels of intolerance of trans and gender diverse people.

Figure 8.9: "It bothers me when a girl acts like a boy," male vs. female, 2019[49]

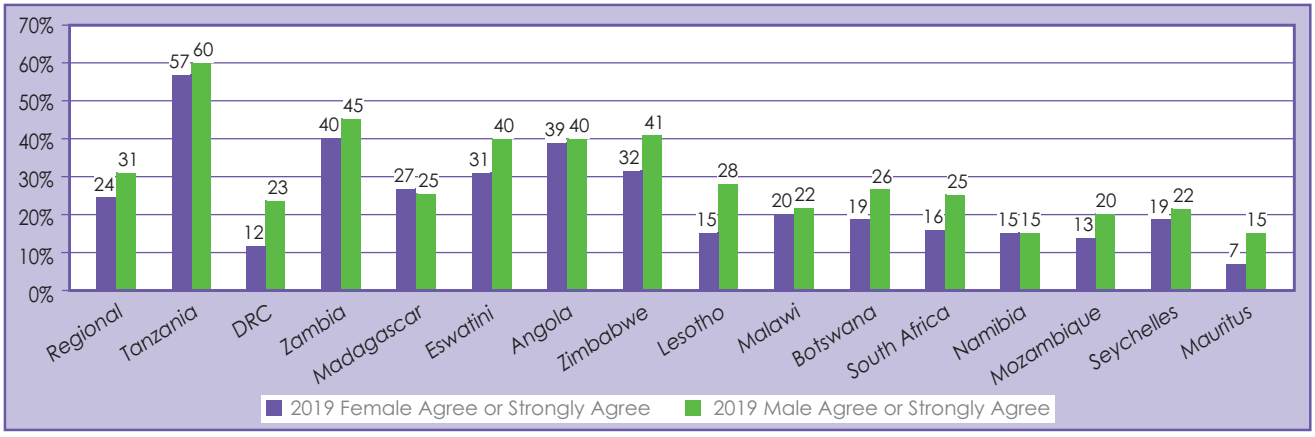
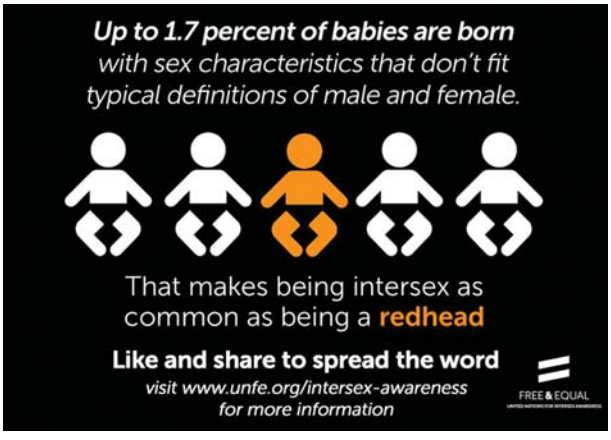


Figure 8.9 shows that women and men in many countries hold similar views about this statement. But in the DRC, Lesotho, Mauritius, Mozambique, South Africa, Swaziland and Zimbabwe, substantially fewer women agreed or strongly agreed with the statement.

Intersex

Intersex is an umbrella term to describe people born with natural sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.



Unlike sexual orientation or gender identity, intersex relates to natural biological sex characteristics

Intersex people have been referred to as "hermaphrodites" or persons with "disorders of sexual development." Describing something as a "disorder," however, infers that it is something that society needs to correct. Variations of intersex traits may be visible at birth, while others only manifest during puberty. The UN's Free & Equal campaign tell us that up to 1.7% of the world's population identify as intersex.[50] Up to two million babies come into the world every year with intersex traits.

Unlike sexual orientation or gender identity, intersex relates to natural biological sex characteristics and is unrelated to sexual orientation or gender identity.[51] Researchers did not include indicators relating to intersex and gender non-conforming persons in the overall set of queries guiding this chapter. There is a dearth of data on intersex individuals across the region, except in South Africa, which was the first country in the world to explicitly include intersex people within the definition of "sex" in its anti-discrimination laws.[52]

[49] Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey, 2019.
[50] https://www.unfe.org/perfect-just-as-they-are/
[51] https://www.chr.up.ac.za/images/researchunits/sogie/documents/Intersex_Fact_Sheet.pdf
[52] http://www.justice.gov.za/vg/lgbti/2018-NationalIntersexMeetingReport.pdf



South Africa: Caught in the intersex no-person's land[53]

The ruling by the International Association of Athletics Federations (IAAF) that track star Caster Semenya must moderate her testosterone levels if she wants to compete in certain races has sparked furious debate about gender and sex.

But while society expects people to conform to being either male or female, being intersex and fitting somewhere between the two is more complex and common than you might think. Dimakatso Sebidi was born 34 years ago at Baragwanath Hospital on April Fools' Day with ambiguous genitalia. Her father, Abraham Sebidi, says it was a day he will never forget.



Dimakatso Sebidi wants to change how society sees intersex people. Photo: Daily Maverick

"When I arrived at the hospital, my wife told me we were going to change our baby's name to Dimakatso," he reminisces. "I asked her why and she said because Dimakatso means something surprising. She is a surprise.

"As we had bought clothes for a baby girl as we were expecting a girl we decided to go ahead and have the operations done to turn our baby into a girl."

It meant six long years in hospital for little Sebidi.

"I used to get pass-outs only for my birthday and family events and I would cry when I had to return to the ward," remembers Sebidi. On those visits home, she recalls that some family members saw her as a curiosity. "My aunts and family friends would go with me to the bathroom and ask me to pull down my pants. They would look and point and laugh and then go out. I never understood what it was all about. What was so different?"

As Sebidi reached puberty, she found herself attracted to girls and wrestled with herself over these "lesbian tendencies," wondering why she felt that way. "In the townships there was a lot of stigma and I remember this one boy used to wait for me when I was coming home from school." She recalls him threatening her, telling her that she is a girl and he is going to change her. Terrified and knowing that many lesbian women in her community have been raped to "fix" them, she tried to evade him and started using different routes home.

It was only when she turned 21 that her parents finally sat her down and broke the news. "The doctors had told us not to say anything, just to accept it," says Abraham, "but we had to tell her."

In the past, with children born with ambiguous genitalia like Sebidi, doctors pressured parents to operate to assign a gender immediately. "Doing a surgery at three means that you are committing a child of three to genital penetrations and dilations on an ongoing basis till they are a teenager," says David Segal, a paediatric endocrinologist, "And I am not sure that's the right thing to be doing to a three-year-old."

Sebidi is still emotional when she speaks about the impact the operation has had on her life. "I am angry at the doctors, I am angry at my parents for agreeing to take my penis," she cries, tears streaming down her face, "Let your child grow until they can make the decision. Until they say they want to keep them both or remove a penis or vagina. They have a right - don't take that right away from them."

[53] https://www.dailymaverick.co.za/article/2019-05-22-caught-in-the-intersex-no-persons-land/

Not all intersex individuals are born obviously intersex at birth. Sharon Rose Khumalo only discovered her condition at age 21.



Sharon Rose Khumalo is an activist for the intersex community.
Photo: Daily Maverick

"I grew up a normal little girl by all appearances. I wore pink, I grew my hair and it was only when I reached my late teens and I did not get my period that we realized there might be something was amiss," she says.

Khumalo says her mother, who was a nurse, attributed this to her being very thin at first but by the time she turned 21 they decided to seek advice from a gynaecologist. "I just thought he would give me some pills, or they would need to do a small operation or something," recounts Khumalo.

But the doctor did a sonar and told her that he could not see a uterus and ovaries. He explained that this fell into a range of intersex conditions. For Khumalo, it was all surreal. "As a biotechnology student, I understood what it meant but I never thought I would be a case study." She says her family were incredibly supportive as she grappled with her new identity.

After one of her friends made a cruel comment in conversation about intersex, she realised it was time to speak up. "I wrote three blog posts and I posted on Instagram." She was amazed at the number of people who reached out to her. It was an awakening.

"For such a long time you think that there is something wrong with you and something broken. Our diversity is what makes us unique and special."

Source: Bernadette Maguire, Daily Maverick, 2019

In 2013, the third International Intersex Forum issued the Malta Declaration,[54] which sets out key demands to end discrimination against intersex people and ensure the right of bodily integrity, physical autonomy and self-determination. The demands include:

- End mutilating and "normalising" practices such as genital surgeries, psychological and other medical treatments through legislative and other means. Intersex people must be empowered to make their own decisions affecting own bodily integrity, physical autonomy and self-determination;
- End pre-implantation genetic diagnosis, prenatal screening and treatment, and selective abortion of intersex foetuses;
- End infanticide and killings of intersex people;
- End non-consensual sterilisation of intersex people;
- Depathologise variations in sex characteristics in medical guidelines, protocols and classifications, such as the World Health Organisation's International Classification of Diseases;
- Register intersex children as females or males, with the awareness that, like all people, they may grow up to identify with a different sex or gender;
- Ensure that sex or gender classifications are amendable through a simple administrative procedure at the request of the individuals concerned. All adults and capable minors should be able to choose between female (F), male (M), non-binary or multiple options. In the future, as with race or religion, sex or gender should not be a category on birth certificates or identification documents for anybody;
- Raise awareness around intersex issues and the rights of intersex people in society at large;

[54] https://oiieurope.org/malta-declaration/

- Create and facilitate supportive, safe and celebratory environments for intersex people, their families and surroundings;
- Ensure that intersex people have the right to full information and access to their own medical records and history;
- Ensure that all professionals and healthcare providers that have a specific role to play in intersex people's wellbeing are adequately trained to provide quality services;
- Provide adequate acknowledgement of the suffering and injustice caused to intersex people in the past, and provide adequate redress, reparation, access to justice and the right to truth;
- Build intersex anti-discrimination legislation in addition to other grounds, and to ensure protection against intersectional discrimination;
- Ensure the provision of all human rights and citizenship rights to intersex people, including the right to marry and form a family;
- Ensure that intersex people are able to participate in competitive sport, at all levels, in accordance with their legal sex. Intersex athletes who have been humiliated or stripped of their titles should receive reparation and reinstatement;
- Recognition that medicalisation and stigmatisation of intersex people result in significant trauma and mental health concerns; and
- In view of ensuring the bodily integrity and well-being of intersex people, autonomous non-pathologising psycho-social and peer support be available to intersex people throughout their life (as self-required), as well as to parents and/or care providers.

The stories from South Africa highlight the urgent need for SADC states to recognise the needs and rights of intersex persons. The Malta Declaration of 2013 is an important departure point for this engagement.

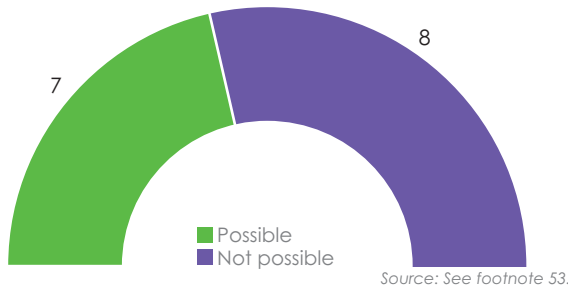
LGBTI organisations able to register and operate freely

The ability to organise and operate freely is a vital right for LGBTI organisations advocating for change. As well as organising events and promoting LGBTI rights, these groups often provide a safe space and shelter for LGBTI youth, who are often kicked out of the family home, to talk about their own sexuality or gender identity.

In countries where registration of an LGBTI organisation is impossible, LGBTI activists often register using generic umbrella names, such as women's groups or human rights groups. Inability to formally register and operate freely also impedes fundraising, which limits a group's ability to collect research for advocacy purposes. In some cases, it also means organisations cannot receive tax exemptions.

A 2018 report by LGBTI rights group OutRight Action International found that only 56% of the 194 countries analysed allow LGBTI groups to legally register and organise safely. It found that gay organisations exist in many countries, but states deny them official authorisation. Other countries ban these groups outright.

Figure 8.10: Registration of LGBTI+ organisations[55]



Source: See footnote 53.

Figure 8.10 illustrates that it is currently possible to register LGBTI organisations in eight countries:

[55] Angola, Botswana, Eswatini, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Zambia, Zimbabwe - Canaries in the Coalmine, The Other Foundation, 2016. DRC - Human Rights Violations Against Lesbian, Gay, Bisexual and Transgender (LGBT) People in the Democratic Republic of the Congo (DRC) Submitted for consideration at the 121st Session of the Human Rights Committee 2017, Madagascar - News24 2018, Seychelles - MambaOnline 2017, South Africa - Constitution of South Africa 1996, Tanzania - Human Dignity Trust 2018.

Angola, Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles and South Africa. Organisations operate freely in all these countries except Mozambique, where the government has spent years blocking the formal registration of LAMBDA, Mozambique's only organisation for LGBTI rights.

A 2015 Penal Code change in Mozambique removed a provision that had been used to prosecute the community in the past. After the change, LAMBDA went to the Constitutional Council to challenge the government's refusal to allow its registration. The government had cited a legal clause which declared that organisations can only operate if they benefit "the moral, social and economic order of the country and not offend the rights of third parties or the public good."

LAMBDA and other civil society organisations took the issue to the Constitutional Council and requested that it declare the clause unconstitutional as it illegitimately restricted the right to freedom of association. In November 2017, LAMBDA won its case, yet it remains unregistered because officials at the Ministry of Justice, the body in charge of registering associations, have ignored repeated registration requests.

Human Rights Watch has said that the treatment of LAMBDA is "discriminatory" and that "The failure to register LAMBDA in this arbitrary manner is a clear violation of their right to association, guaranteed under Mozambique's constitution and in international law."[56]

The other eight SADC countries that do not allow LGBTI organisations to register and operate freely must urgently remove policies and laws that prevent people in these groups from exercising their right of free association. These countries include the DRC, Eswatini, Madagascar, Malawi, Tanzania, Zambia and Zimbabwe.

Eight SADC countries do not allow LGBTI organisations to register and operate freely

LGBTI Sexual and Reproductive Health Rights

LGBTI communities face high levels of discrimination and social exclusion, including access to SRHR services. For example, health centres throughout the region will turn trans and intersex people away because they do not resemble their photographs in their identity documents.

The lack of, or disparities in, healthcare available to LGBTI persons represents a denial of their civil and human rights and is an example of societal stigma and discrimination. While much anecdotal evidence for this exclusion exists, there is limited data on LGBTI communities' access to SRH services. Additionally, SADC countries do not have specific health programming for lesbians and women who have sex with women (WSW).

Moreover, existing provisions on transgender people and men who have sex with men (MSM) in the national strategic plans and frameworks of many countries in the region unfortunately remained unimplemented. A lack of clear guidelines on healthcare provision to LGBTI persons means healthcare workers face a major roadblock in their quest to ensure universal access to health services for all citizens.[57]

[56] http://www.mambaonline.com/2017/11/09/mozambique-major-constitutional-victory-lgbtq-community/
[57] http://catalogue.safaids.net/sites/default/files/publications/LGBTI%20Southern%20Africa%202014.pdf



Healthcare workers in Zimbabwe "afraid to touch" LGBTI patients[58]

A 2017 study from Zimbabwe - one of very few studies of healthcare access beyond HIV for key populations in Africa - examined the experiences of LGBTI people, MSM and sex workers regarding access to, and experiences of, healthcare in the country.



Zimbabwe's LGBTI community has long struggled for recognition, protection and health care support. Photo: Twitter

It found that discrimination towards key populations "discourages early diagnosis, limits access to healthcare/treatment and increases risk of transmission of infectious diseases." Additionally, it noted that key populations experience unnecessary suffering from untreated conditions, exclusion from healthcare and extreme psychological distress.

Jennifer Hunt, Katherine Bristowe, Sybille Chidyamatare and Richard Harding conducted the in-depth qualitative study, called *"They will be afraid to touch you": LGBTI people and sex workers' experiences of accessing healthcare in Zimbabwe*, amongst 60 respondents in Zimbabwe.

Three distinct main themes emerged from the data: (1) Populations think that healthcare workers believe their illnesses have been caused by "bad behaviour" and that they deserve blame, discouraging key populations from seeking health support: these workers perceive key populations to have brought illnesses on themselves through sexual behaviour; (2) Equal access to healthcare is conditional on conforming to sexual norms: to receive the same access to health and palliative care services as the general population, key populations believed they must pretend, deny or lie about their sexual identity/behaviour; and (3) Perceptions that healthcare workers are ill-informed about needs of key populations, and personal attitudes impacted on their care delivery: the lack of understanding of, and disrespect for, key populations by health workers resulted in experiences of poor support and provision of care during chronic illness, significantly increasing morbidity and mortality.

The main findings included:

- Participants experienced widespread stigma and discrimination irrespective of their symptoms and illnesses. They described healthcare workers blaming them for their illness because of their identity or profession. The discrimination for sexual minorities extended to accusations of witchcraft to explain their condition, bringing a curse on the family or suggestions of divine retribution against their sexual identity.
- Participants reported humiliating responses and inadequate care from health workers when they disclosed sexual orientation or sex worker status, often resulting in unwillingness to pursue treatment. Participants described assessing the level of discrimination of the health worker from their manner and language, which often discouraged disclosure. Fears regarding potential reactions from healthcare professionals resulted in failure to attend the hospital for diagnosis. Such delays in attending clinics had significant impacts on the health and well-being of these individuals.

[58] https://gh.bmj.com/content/2/2/e000168

- Participants living with a diagnosis of an advanced sexually transmitted infection, HIV diagnosis or any other chronic illness described not receiving anything other than basic history taking and simple treatments. Lack of knowledge and experience of working with key populations seems to be a key driver of stigma. Health workers appeared unwilling to examine key populations for fear of possible contamination or sexual predation.
- Participants described care being driven by the personal attitudes of health workers, often based on religious beliefs. Participants perceived that health workers abused their professional role by promoting personal religious views and that they often framed prejudice against sexual minorities in moral and religious (Christian) terms.[59]

Source: Hunt, J., Bristowe, K., Chidyamatare, S. and Harding, K., 2017

Any strategies to mitigate the healthcare challenges faced by members of the LGBTI community must include health worker training and sensitisation as well as incorporation of health services that respond to the community's specific needs.

Don't get angry - get smart!

In an effort to highlight the importance of LGBTI equality and align the struggle for it with the struggle for gender equality and SRHR, the Southern African Gender Protocol Alliance secretariat and GL convened a regional meeting in April 2019 in Johannesburg.

The meeting brought together five regional LGBTI organisations: Centre for the development of people (CEDEP) from Malawi; Namibia Diverse Women's Association (NDWA); Eswatini's Rock of Hope group; Young Queer Alliance from Mauritius and Lesbians, Gays & Bisexuals of Botswana (LEGABIBO). The group sought to identify institutional areas that require capacity building and advocacy strengthening or training in SRHR-specific thematic expertise.

Other objectives centred on:

- Identifying country specific campaigns for the decriminalisation of homosexuality and for social protections for LGTBI communities in five SADC countries.
- Strengthening the Alliance LGBTI sub-group as a new cluster of the SADC Gender Protocol Alliance.
- Building the institutional capacity of LGBTI organisations in all five countries.
- Creating linkages between LGBTI organisations and the media to increase media coverage of the key LGBTI issues.

The SADC Gender Protocol Alliance has renewed its efforts around LGBTI rights as part of its focus on gender justice issues including menstrual health, safe abortion, maternal health, GBV, HIV and AIDS, and sexual diversity.

A core component of the second phase of work involves strengthening the Alliance SRHR LGBTI network by setting up country chapters of the SRHR and LGBTI networks that work closely together in national campaigns. These autonomous networks will conduct their own fundraising and campaigns.



Participants in an April 2019 workshop in Johannesburg to promote LGBTI work linked to SRHR in the SADC region. Photo: Colleen Lowe Morna

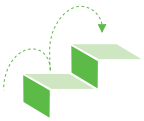
[59] https://gh.bmj.com/content/2/2/e000168

The meeting brought together key decision-making managers and chief executive officers from strategically chosen organisations. These included members of Rock of Hope, which, in 2018, helped organise Eswatini's first ever LGBTI Pride, which the group saw as a success.

The Young Queer Alliance in Mauritius is currently working on SRHR peer education and outreach campaigns that include training of public healthcare providers to reduce stigma and discrimination against LGBTI community members when they seek treatment.

The most recently established network is NWDA, which has been raising awareness in Namibia about gaps in SRHR policy.

As one workshop participant noted, "We need strategies [to work together] so we do not end up in a worse off situation."



Next steps

The lack of recognition of LGBTI rights is a fundamental violation of human rights and requires urgent action in all SADC countries. Strategies must include:

- A concerted region-wide push for LGBTI protections against discrimination and the enshrining of LGBTI rights within member state constitutions to ensure that these cannot be easily changed or repealed. This includes pressuring Eswatini, Malawi, Mauritius, Namibia, Tanzania, Zambia and Zimbabwe to decriminalise same-sex consensual relations and ensure that Botswana upholds the recent decision to decriminalise same-sex consensual relations.
- Lobbying governments to repeal laws criminalising gender variant identity. Countries must commit to human rights conventions and emulate the good practices demonstrated by those countries that protect and include LGBTI people.
- Civil society organisations must develop mechanisms to hold governments accountable for the commitments they sign up to and push for their implementation.
- Lobbying SADC member states to develop laws and policies that recognise the rights of LGBTI people and protect them.
- Engage with faith-based organisations (FBOs) on the rights of LGBTI people as human rights and encourage them to play a role in tackling stigma and discrimination.
- Advocate for stakeholders to enforce LGBTI rights legislation in all sectors and social services, including institutions of education, law enforcement, the justice system, healthcare, government departments and in all workplaces.
- Create partnerships between media and civil society to foster a better understanding of LGBTI issues and improve media coverage of them.
- Develop regional and national strategies to tackle stigma and discrimination, ensuring that states equally implement them to ensure no one is excluded.
- Continue to align the struggle for LGBTI equality with other struggles such as gender, racial and economic equality. This includes continuing to grow relationships between regional LGBTI organisations and the SADC Gender Protocol Alliance and other key gender stakeholders in the region.
- Work with governments and civil society organisations to extend the ambit of existing SRHR strategies to address the needs of LGBTI persons across the region.

ANNEX A
TECHNICAL NOTE: METHODOLOGY FOR SCORING THE SADC SRHR SCORE CARD

In November 2018, SADC member states approved the SADC Regional Strategy and Scorecard for Sexual and Reproductive Health and Rights (SRHR) 2019-2030. The SRHR Scorecard is an important monitoring and evaluating tool that set targets as articulated in the Sustainable development Goals (SDGs), descriptions, outcomes and frequency.

The Score card consists of 20 key indicators that covers sexual and reproductive health; comprehensive sexuality education; HIV and AIDS; gender-based violence; child marriage and safe abortion.

The indicators will be divided into two groups. One those that have global or regional target and those that do not. The indicators will be measured using a 'Traffic light' approach:

- GREEN = Member State has achieved the target;
- YELLOW = Progress made but more efforts required to achieve the targets;
- RED = Urgent action required if targets are to be met.

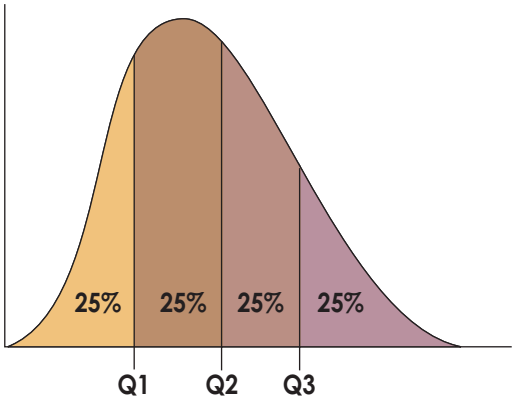
Where global target exists, data from the 16 SADC member states will be used as the initial regional baseline and progress measured year on year. The dataset is sorted in ascending or descending order depending on the nature of the indicator.

Where targets do not exist, the data is divided into three parts. The dataset will be divided into three sections using the interquartile range:

- 1st quartile will consist of the GREEN color - best performers.
- Values in between the 1st and 3rd quartile will fall under the YELLOW color.
- Those below the 3rd quartile will fall under the RED color - worst performers.

The diagram provides the method for calculating the four quartiles.

Determination of Cut-off points



- Sort scores low to high or vice versa.
- Calculate Q1 by dividing the sum of country scores by 4.
- Calculate Q2 by multiplying Q1 by 2.
- Calculate Q3 by multiplying Q1 by 3.
- Calculate Q4 by multiplying Q1 by 4.
- Add the firs score to the second and second to the third and so on.
- Compare the recalculated scores to the Q1 to Q4 scores to determine the colour allocation.

Indicator	Means of verification	Sources of data
1. Maternal mortality, institutional (to be complemented with population-based estimates or survey data, where available).	Comparison against global target 70 per 100 000	The World Health Organisation (WHO)
2. Neonatal mortality, institutional (to be complemented with population-based estimates or survey data, where available).	Comparison against global target 12 per 100	The World Health Organisation (WHO)
3. Percentage of obstetric and gynecological admissions due to abortion, b) Facility records for the treatment of abortion complications.	Health facilities admission data	Quantifying data is difficult, health facilities record admissions as obstetric or gynaecological complications
4. Adolescent birth rate, 10-19 years of age.	Country health data	The World Health Organisation (WHO)
5. Proportion of population accessing integrated SRH services (total population).	Country health data	Definition of integrated SRHR services unclear; data is not recorded in health facilities
6. Existence of laws and policies that allow adolescents to access SRH services without third party authorization.	Laws exist or not	National laws and policies
7. Percentage of primary and secondary schools that provided life skills-based HIV and sexuality education in the previous academic year.	Country education data	This data is currently not measured annually
8. Unmet need for family planning (contraception).	Country health data	The World Health Organisation (WHO)
9. Percentage reduction in new HIV infections, females 15 - 24.	National HIV and AIDS data	UNAIDS
10. Mother to child transmission of HIV	National HIV and AIDS data	UNAIDS
11. Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age.	National HIV and AIDS data	UNAIDS
12. Sexually transmitted infections (STIs) incidence rate, using the overall rate of syphilis, given the impact of syphilis on sexual and reproductive health outcomes.	Country health data	Country level data on STIs is not consistently gathered or available in central repository
13. Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (age).	Country health data	The HPV is not widely available in health facilities
14. Minimum legal age of consent to marriage, 18 years for all irrespective.	Age of marriage legal provisions	National laws and policies
15. Legal status of abortion	Abortion available on demand or not	National laws and policies
16. Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months.	Country GBV prevalence data	Demographic Health Surveys (DHS); not done annually or at regular intervals
17. Non-partner sexual violence prevalence	Country GBV prevalence data	Demographic Health Surveys (DHS); not done annually or at regular intervals
18. Percentage of annual budgets allocated to health sector	Abuja Declaration recommends 15%	National budgets
19. Health worker density and distribution for SRMNAH	Statistics from health facilities	Departments of Health, health workers provide a broad of services and it is not disaggregated by area of work
20. Proportion of services within the essential package of SRHR services covered by public health system	SRHR services offered at health facilities	Departments of Health, health workers provide a broad of services and it is not disaggregated by area of work

Key issues on scoring

- ***Data gaps and anomalies:*** On certain indicators data is not being collected in a manner that will enable its measurement. In some instances, data does not exist. Some indicators require annual measurement but the data is gathered over a different time period.
- ***When global or regional targets exist:*** If targets are met it is green however how yellow and red be determined. What are the cut off scores that determine where the result should be located? There should guidance on for the different indicators.
- ***Measuring policy or legislation:*** A policy or legislation exists or does not. Does that imply that the result is a green or a red? Or, for example, abortion legislation, does it refer to abortion on demand?
- ***Measuring numerical indicators that are not standard:*** For example, the age of marriage. While countries stipulate that 18 is the age of marriage they provide for exceptions. Guidance is needed on how to interpret the data.
- ***Calculating scores where no target exists:*** The scores are calculated using a quartile system. This means that scores are calculating using a four-part measurement system. The calculations are made using the countries performance scores and working out where countries are by comparing country to country without establishing what the optimum target is. Working out what a good or bad performance is, is relative to other countries. In this regard, a fixed target might be a better option.
- ***Colour coding ranges where no target exist:*** Green in this instance are the best performers and red the worst. The challenge is in the yellow classification. Yellow includes quartiles two and three. This creates vastly varying set of scores that are grouped together. The lower end of quartile three is often closer to the red zone. Splitting the two quartiles will provide a more accurate representation of the score.

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The SADC Protocol on Gender and Development

Encompasses

commitments made in all regional, global and continental instruments for achieving gender equality.

Enhances

these instruments through a Monitoring, Evaluation and Reporting Framework.

Advances

gender equality by ensuring accountability by all SADC Member States, as well as providing a form for the sharing of best practices, peer support and review.



Southern Africa Gender Protocol Alliance

Scoring another goal for gender equality, the 2019 SADC Gender Protocol Barometer breaks with past tradition in focusing solely on Sexual and Reproductive Health and Rights. Measuring 100 indicators across seven themes, the Barometer is the first civil society shadow report on SADC's new SRHR Strategy Score Card, ranking countries based on their performance, while offering detailed analysis and insights into what is changing and still needs to change. The no-hold-barred #VoiceandChoice Barometer features the first stand-along chapters on Adolescent Sexual and Reproductive Health and Rights, Safe Abortion, and Sexual Diversity. It provides the data that underpins 40 national campaigns led the focal networks of the Southern African Gender Protocol Alliance, and 174 local campaigns led by the Centres of Excellence for Gender in Local Government. A must read for all those committed to *Action and Results for Agenda 2030* in the SADC region.

Yes we can and yes we must!



Community peer educators from Let us Grow in Orange Farm champion the Sunrise Campaign - End Violence, Empower Women.
Photo: Thatho Phakela

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