SADC GENDER PROTOCOL 2021

BAROMETER

Voice + Choice

in the time of COVID-19

#VaccineGenderJustice

Southern Africa Gender Protocol Alliance

#VaccineGenderJustice

Colleen Lowe Morna,
Kubi Rama and
Shamiso Chigorimbo

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.

Gender Links coordinates the work of the Alliance.

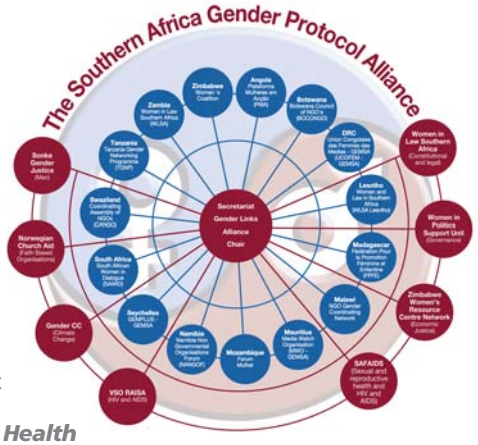
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#VoiceandChoice in the time of COVID-19
#VaccineGenderJustice Barometer 2021
ISBN

Gender Links
9 Derrick Avenue
Cyrildene, 2198
Johannesburg, South Africa
Phone: 27 (11) 029 0006
or 27 (11) 028 2410
Email: alliance@genderlinks.org.za
Websites: www.genderlinks.org.za
Twitter: @GenderProtocol
@GenderLinks
FaceBook: Gender Links
Instagram: GenderLinks

Editors: Colleen Lowe Morna,
Kubi Rama and Shamiso Chigorimbo

Design/Layout: Debi Lee

Sponsors: Amplify Change, Diakonia, Hivos and New Venture Fund



Alliance partners
Coordinator
Gender Links
Constitutional and legal rights
Women and Law Southern Africa (WLSA)
Governance
Women in Politics Support Unit (WIPSU)
Sexual and Reproductive Health and Rights
Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)
Climate Change
Gender CCSA
Economic Justice
Zimbabwe Women's Resource Centre Network (ZWRCN)
Angola
Plataforma Mulheres em Acção (PMA)
Botswana
Botswana Council of NGO (BOCONGO)
DRC
Union Congolaise des Femmes des Medias (UCOFEM)
Eswatini
Coordinating Assembly of Non-Governmental Organizations (CANGO)
Lesotho
Women and Law in Southern Africa (WLSA-Lesotho)
Madagascar
FPFE Federation Pour la Promotion Feminine et Enfantine
Malawi
NGO Gender Coordinating Network (NGOGCN)
Mauritius
Media Watch Organisation
Mozambique
Forum Mulher
Namibia
Namibia Association of Non-Governmental Organisations Trust
Seychelles
GEMPLUS
South Africa
South African Women in Dialogue SAWID
Tanzania
Tanzania Gender Network Programme
Zambia
Women and Law in Southern Africa – Zambia
Zimbabwe
Women's Coalition of Zimbabwe
Faith Based Organisations
ACT Ubumbano
Men's Groups
Sonke Gender Justice

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ACRONYMS

AfCFTA	Africa Continental Free Trade Agreement
AIDS	Acquired Immune Deficiency Syndrome
ALAT	Association of Local Authorities in Tanzania
AMCEN	African Ministerial Conference on the Environment
AMOG	Associação Moçambicana de Obstetras e Ginecologistas
ANC	African National Congress
ANC	Antenatal Care
ANDCH	Africa Nationally Determined Contributions Hub
ANEX	Activists networking against the exploitation of children
ARHI	Africa Health Research Institute
ARROW	Asian-Pacific Resource and Research Centre for Women
ART	Anti-Retroviral Treatment
ArtGlo	Art and Global Health Centre Africa
ARVs	Anti-Retroviral drug
ASCOBEF	Association Comorienne pour le Bien-Être Famille
ASIFF	Action for Integral Health of Women and Girls
ASRHR	Adolescent Sexual and Reproductive Health Rights
AU	African Union
AUC	African Union Commission
AWLF	African Women Leadership Fund
BCC	Botswana Council of Churches
BCP	Botswana Congress Party
BDF	Botswana Defence Force
BDP	Botswana Democratic Party
BDPA	Beijing Declaration and Platform for Action
BEAM	Basic Education Assistance Module
BIUST	Botswana International University of Science and Technology
BNF	Botswana National Front
BOCAIP	Botswana Christian AIDS Intervention Programme
BOCONGO	Botswana Council of Non-Governmental Organisations
BPC	Botswana Power Corporation
BPFA	Beijing Declaration and Platform for Action
CANGO	Coordinating Assembly of Non-Governmental Organisations
CAP	Capable Partners
CAT	Convention on Torture
CATS	Community Adolescent Treatment Supporters
CCA	Climate Change Adaptation
CCM	Charna cha Mapinduzi
CDC	Centre for Disease Control
CDM	Clean Development Mechanism
CE	Citizenship Education
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CEDEP	Centre for the Development of People
CEO	Chief Executive Officer
CeSHHAR	Centre for Sexual Health and HIV/AIDS Research
CGE	Commission for Gender Equality
CGPU	Child and Gender Protection Unit
CHESA	Community Health Education and Advocacy Services
COEs	Centres of Excellence
COMESA	Common Market for Eastern and Southern Africa
COP	Conference of the Parties
COP25	United Nations 25th Conference of the Parties
COPs	Conferences of the Parties
COPUA	Coalition for the Prevention of Unsafe Abortion
COVID-19	Corona Virus Disease
CPR	Contraceptive Prevalence Rate
CPS	Cash Paymaster Services
CRC	Convention on the Rights of the Child
CRD	UN Centre for Regional Development (SDGs)
CRPD	Convention on the Rights of Persons with Disabilities
CSA	Climate Smart Agriculture
CSC	Citizen Score Card
CSE	Comprehensive Sexual Education
CSE&I	Comprehensive Sex Education and Information
CSJ	Centre for Solutions Journalism
CSOs	Civil Society Organisations
CSTL	Care and Support for Teaching and Learning
CSW	Commission on the Status of Women
CTDO	Community Technology Development Organisation
CW	Commonwealth Secretariat
CWGL	Centre for Women's Global Leadership
DBE	Department of Basic Education
DCI's	Direction des Curricula et des Intrants'
DCS	Domestic Violence, Child Protection and Sexual Offenses
DFID	Department for International Development
DFJ	Dynamique des Femmes Juristes
DGRH	Directorate General for Fisheries Resources
DHA	Department of Home Affairs
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DIRCO	Department of International Relations and Cooperation
DPP	Democratic Progressive Party
DRC	Democratic Republic of the Congo
DREAMS	Determined, Resilient, Empowered, AIDS Free, Mentored and Safe
DSD	Differences of Sexual Development
DSW	Department of Social Welfare
EAC	East African Community
EAD	Department of Energy Affairs
ECA	Economic Commission for Africa
ECOWAS	Economic Commission for West Africa States
ECZ	Electoral Commission of Zambia
EIMC	Early Infant Medical Circumcision
EMBs	Election Management Bodies
EMIS	Education Management Information Systems

ERA	Employment Rights Act
ESA	East and Southern Africa
ESCOM	Electric Supply Company of Malawi
ESGM	Eswatini Sexual and Gender Minorities
EUC	European Union Commission
FAO	Food and Agriculture Organisation
FARDC	Armed Forces of the Democratic Republic of the Congo
FBI	Federal Bureau of Investigation
FGM	Female Genital Mutilation
FIAP	Feminist International Assistance Policy
FIB	Force Intervention Brigade
FODSWA	Federation Organization of the Disabled People in Swaziland
FPFE	Federation Pour La Promotion Feminine Et Enfantine
FPTP	First Past the Post
FRELIMO	Frente de Libeartacao de Mocambique Liberation Front
G-BEM	Botswana Girl/Boy Education Movement
G&C	Guidance and Counselling
GALZ	Gays and Lesbians of Zimbabwe
GAMAG	Global Alliance on Media and Gender
GAP	Gender Action Plan
GBI	Gender Budgeting Initiative
GBV	Gender Based Violence
GBVI	Gender-based Violence Initiative
GCF	Green Climate Fund
GDI	Gender and Development Index
GDP	Gross Domestic Product
GeAD	Gender Affairs Department
GEM	Gender Equitable Men
GEMI	Global Expanded Monitoring Initiative
GGCA	Global Gender and Climate Alliance
GHG	Greenhouse Gas
GIME	Gender in Media Education
GIZ	Deutsche Gesellschaft fu_r Internationale Zusammenarbeit
GL	Gender Links
GLM	Gender Links Mauritius
GMBS	Gender and Media Baseline Study
GMC	Gender and Media Connect
GMMP	Global Media Monitoring Project
GMPS	Gender and Media Progress Study
GNC	Gender Non-Conforming
GNI	Gross National Income
GNU	Government of National Unity
GPI	Global Peace Index
GPS	Gender Progress Score
GQA	Gala Queer Archives
GRA	Gender Responsiveness of constitutions and laws Assessment
GSIM	Gender-Sensitive Indicators for Media
GW	Gigawatt
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HPTN	HIV Prevention Trials Network
HPV	Human papilloma virus
HTQ	Harvard Trauma Questionnaire
IAAF	International Association of Athletics Federation
ICBT	Informal Cross Border Trade
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
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IDA	International Development Association
IDPs	Internally Displaced Persons
IEC	Information Education Communication
IEC	Independent Electoral Commission
IFASIC	Faculty Institute of Information and Communication Sciences
IFFs	Illicit Financial Flows
IIED	International Institute for Environment and Development
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
INDC	Intended Nationally Determined Contribution
INFP	Institut National de Formation Pédagogique
IPCC	Intergovernmental Panel on Climate Change
IPP	Independent Power Producer
IPPF	International Planned Parenthood Federation
IPU	Inter-Parliamentary Union
IPV	Intimate Partner Violence
IRP	Integrated Resource Plan
ISAD	International Safe Abortion Day
IT	Information Technology
IUDs	Intra-Uterine Devices
IWMF	International Women's Media Foundation
IWRM	Integrated Water Resources Management
JMP	Joint Monitoring Programme
JSC	Judicial Services Commission
KDI	Kolektif Drwa Imin
LAC	Legal Assistance Centre
LAD	Legal Aid Directorate
LEGABIBO	Lesbians, Gays & Bisexuals of Botswana
LePHIA	Lesotho Population Based HIV Impact Assessment
LGBTI	Lesbian, Gay, Bisexual, Transsexual and Intersexual
LHPP	Lesotho Highlands Power Project
LHRC	Legal and Human Rights Centre
LMPS	Lesotho Mobile Police Service
LSE	Life Skills Education
LSES	Lesotho Solar Energy Society
LUSLM	Lower Usuthu Sustainable Land management
LWPG	Lima Work Programme on Gender
M&E	Monitoring and Evaluation
MACR	Minimum Age of Criminal Responsibility
MBGE	Men and Boys for Gender Equality
MCP	Mexico City Policy
MDC	Movement for Democratic Change
MDC-T	Movement for Democratic Change Tsvangirai
MDGs	Millennium Development Goals
MEASURE	(Monitoring and Evaluation to ASsess and Use Results
MER	Monitoring, Evaluation and Reporting
MERF	Monitoring, Evaluation and Reporting Framework
MGYSR	Ministry of Gender and Youth, Sports and Recreation

MHD	Medium Human Development
MHM	Menstrual Hygiene Management
MIET	Media in Education Trust
MK	Mkhonto We Sizwe
MMD	Multi Month Dispensing
MMEWR	Ministry of Minerals, Energy and Water
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn Child Health
MOET	Ministry of Education and Training
MoH	Ministry of Health
MoU	Memorandum of Understanding
MP	Member of Parliament
MPAs	Marine Protected Areas
MPL	Members of the Provincial Legislature
MPLA	Movimento Popular de Libertacao de Angola - Popular Movement for the Liberation of Angola
MPSR	Malawi Public Services Regulations
MRG	Mediation Reference Group
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MVA	Manual Vacuum Aspiration
MWAGCD	Ministry of Women's Affairs Gender and Community Development
MWO GEMSA	Media Watch Organisation -Gender and Media Southern Africa
MWRCDFW	Ministry of Women's Rights, Child Development and Family Welfare
NAFCI	National Adolescent Friendly Clinic Initiative
NAMPA	Namibia Press Agency
NANGO	National Association of Non-Governmental Organisations
NANGOF	Namibian NGO Forum Trust
NAP	National Adaptation Plan
NAPAs	National Adaptation Plans of Action
NAPPA	Namibia Planned Parenthood Association
NAPs	National Action Plans
NATO	North Atlantic Treaty Organisation
NBS	National Bureau of Statistics
NCC	National Constitutional Conference (Zambia)
NCCC	National Climate Change Committee
NCCSAP	National Climate Change Policy and Strategy and Action Plan
NCOP	National Council of Provinces
NCRF	National Community Radio Forum
NDC/s	Nationally Determined Contribution/s
NDF	Namibia Defence Force
NDMC	Namibia Democratic Movement for Change
NDP	Nations Development Programme
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation
NGOGCN	NGO Gender Coordinating Network
NGP	National Gender Policy
NHI	National Health Insurance
NIAID	National Institute of Allergy and Infectious Diseases
NICTS	New Information and Communication Technologies
NIDS	National Income Dynamics Study
NIP	National Independent Party
NLD	National League for Democracy
NLFP	New Lesotho Freedom Party
NPCGBV	National Response to Combat Gender Based Violence
NPD	National Development Plan
NPP	National Progressive Party
NSOs	National Statistical Offices
NSP	National Strategy Plan
NUDO	National Unity Democratic Organisation of Namibia
OAU	Organisation for African Unity
OSHA	Occupational Health Safety Act
OST	Opioid Substitution Therapy
OVC	Orphans and Vulnerable Children
PAC	Post-Abortion Care
PANAGED	Gender and Development National Action Plan (Madagascar)
PAPCBP	Pan African Capacity Building Program
PCAR	Primary Curriculum Assessment Reform (Malawi)
PCC	Parent Child Communication
PCVs	Peace Corps Volunteers
PEI	Planet Earth Institute
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PERC	Partnership for Evidence-based Response to COVID-19
PGCDs	Police Gender and Children Desks
PIE	Promoting Inclusive Education
PISA	Participatory Initiative for Social Accountability
PLGHA	Protecting Life in Global Health Assistance
PLWHA	People Living with HIV and AIDS
PLWHIV	People Living with HIV
PMA	Platforma Mulhers Emaccao
PMTCT	Prevention of mother-to-child transmission
PNC	Post Natal Care
PPE	Personal Protective Equipment
PR	Proportional Representation
PrEP	Pre Exposure Prophylaxis
PSCE	Personal, Social and Citizenship Education
PSGR	People Serving Girls at Risk
PSI	Population Services International
PTSD	Post Traumatic Stress Disorder
PV	PhotoVoltaics
RC	Regional Commissioner
REIPPPP	Renewable Energy Independent Power Producer Procurement Programme
RESURJ	Realising Sexual and Reproductive Justice
RG	Registrar General
RISDP	Regional Indicative Strategic Development Plan
RNA	Radio National de Angola
RWPC	Regional Women's Parliamentary Caucus
SABC	South African Broadcasting Corporation
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SADC	Southern Africa Development Community
SADC-PF	Southern African Development Community Parliamentary Forum
SafAIDs	Southern Africa HIV and AIDS Information Dissemination Service
SALRC	South African Law Reform Commission
SANDF	South African National Defence Force
SAPMIL	SADC Preventive Mission in the Kingdom of Lesotho
SAPS	South African Police Services
SARPCCO	Southern African Regional Police Chiefs Cooperation Organisation
SARS-CoV-2	Novel Coronavirus
SASREG	Southern African Society of Reproductive Medicine and Gynaecological Endoscopy
SAT	SRHR Africa Trust
SAWID	South African Women in Dialogue

SBI	Subsidiary Body for Implementation
SBSTA	Subsidiary Body for Scientific and Technological Advice
SCA	Supreme Court of Appeal
SDGI	SADC Gender and Development Index
SDGs	Sustainable Development Goals
SEQUIP	Secondary Education Quality Improvement Project
SGP	SADC Protocol on Gender and Development
SIDA	Swedish International Development Cooperation Agency
SIGI	Social Institutions and Gender Index
SJS	Si Jeunesse Savait ("If Young Women Knew" in French)
SMEs	Small to Medium Enterprises
SODV	Sexual Offences and Domestic Act
SOGIE	Sexual Orientation or Gender Identity
SOGIESC	Sexual Orientation, Gender Identity and Expression and Sex Characteristics
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRHRR	Sexual Reproductive Health and Reproductive Rights
STEM	Science, Technology, Engineering and Mathematics
STIs	Sexually Transmitted Infections
SWAGGA	Swaziland Action Group against Abuse
SWAPO	South Western Africa's People Organisation
SWIFT	Sisters Working in Film and Television
TACRA	Tanzania Communications and Regulatory Authority
TAMWA	Tanzania Media Women's Association
TANU	Tanganyika African National Union
TAWLA	Tanzania Women's Lawyers Association
TB	Tuberculosis
TCCIA	Tanzania Chamber of Commerce Industry and Agriculture
TDF	Tanzania's Defence Force
TDHS	Tanzania Demographic Health Survey
TEVETA	Technical, Entrepreneurial and Vocational Education and Training Authority (Mauritius)
TGNP	Tanzania Gender Networking Program
THC	TB HIV Care
The Alliance	Southern Africa Gender Protocol Alliance
TIP	Trafficking in Persons
TPA	Televisão Publica de Angola
TPF Net	Tanzania Police Female Network
TSC	Teaching Service Commission
TSM	Temporary Special Measure
TVPA	Trafficking Victims Protection Act
UCOFEM	Union Congolaise des Femmes de Médias
UDF	United Democratic Front of Namibia
UHC	Universal Health Coverage
UKAID	United Kingdom's Department for International Development
UN	United Nations
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNPF	United Nations Population Fund
UNSCR	United Nations Security Council Resolution
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
URT	United Republic of Tanzania
USAID	United States for International Development
VAC	Violence against Children
VAM	Violence against Men
VAT	Value Added Tax
VAW	Violence against Women
VAWG	Violence against Women and Girls
VAWIE	Violence against Women in Elections
VCT	Voluntary Counselling and Testing
VFR	Victim Friendly Rooms
VMC	Voluntary Male Circumcision
VMMC	Voluntary Medical Male Circumcision
VSO-RAISA	Volunteer Service Overseas-Regional AIDS Initiative Southern Africa
WACC	World Association for Christian Communication
WANIFRA	World Association of Newspapers and News Publisher
WAR	Women Against Rape
WASH	Water, Sanitation and Hygiene
WCNOVAW	Western Cape Network on Violence Against Women
WCoZ	Women's Coalition of Zimbabwe
WEF	Water Energy Food
WGC	Women and Gender Constituency
WHO	World Health Organisation
WIDSAA	Women in Development Southern Africa Awareness
WILDAF	Women in Law and Development in Africa
WiLGF	Women in Local Government Forum
WIN	Women in News
WIPSU	Women in Politics Support Unit
WISETO	Women in Science, Engineering and Technology Organisation
WISPI	World Internal Security and Police Index
WLAC	Women's Legal Aid Centre
WLSA	Women and Law in Southern Africa
WomEng	Women in Engineering
WoMin	Women Building Power
WPS	Women, Peace and Security
WRO	Women's Rights Organisations
WSW	Women who have Sex with Women
WVL	Women's Voice and Leadership
WWF	World Wide Fund for Nature
YHC	Youth Health Centre (Seychelles)
YONECO	Youth Net and Counselling
YQA	Young Queer Alliance
ZAMEC	Zambia Media Council
ZANIS	Zambia News and Information Services
ZANU-PF	Zimbabwe African National Union-Patriotic Front
ZBC	Zimbabwe Broadcasting Corporation
ZCEA	Zambia Civic Education Association
ZDF	Zimbabwe Defence Forces
ZGC	Zimbabwe Gender Commission
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZWLA	Zimbabwe Women Lawyers Association
ZWRCN	Zimbabwe Women Resource Centre Network

CONTRIBUTORS

EDITORIAL TEAM



Colleen Lowe Morna (Zimbabwe/South Africa) is Special Advisor to Gender Links (GL). A South African born in Zimbabwe, Colleen began her career as a journalist specialising in economic and development reporting including as Africa Editor of the New Delhi-based Women's Feature Service. She joined the Commonwealth Secretariat as a senior researcher on the Africa desk in 1991, and later served as Chief Programme Officer of the Commonwealth Observer Mission to South Africa. Colleen subsequently served as founding CEO of the South African Commission on Gender Equality and then of Gender Links. A trainer, researcher and writer, Colleen has written extensively on gender issues in Southern Africa. She holds a BA degree in International Relations from Princeton University; Masters in Journalism from Columbia University and certificate in executive management from the London Business School. She has received awards from Princeton University; the Newswomen's Club of New York; South Africa's Mail and Guardian Newspaper, Media and CEO magazines. In 2013, the University of Johannesburg awarded Colleen honorary membership of the Golden Key Association that recognises excellence in academia and public service. Colleen has served as editor-in-chief of all twelve Barometers.



Kubi Rama (South Africa) is Executive Director of GL. She has 25 years' experience working in non-governmental organisations (NGOs) and institutions of higher learning. In that time her main focus has been on media, communication, education, research, training and gender. Rama has contributed to several Barometers as the author of the Education; Constitutional and Legal Rights; Sexual and Reproductive Health and Sexual Diversity chapters. Rama served as associate editor and author of the Sexual Diversity and Economic Justice chapters of this Barometer.

Danny Glenwright (Canada) is President and CEO of Save the Children Canada. He previously served as Executive Director of Action Against Hunger Canada, an international humanitarian and development organisation specialised in fighting hunger and its underlying causes. He is also the managing editor of *The Philanthropist*, an online journal for practitioners, academics, supporters, and others engaged in the non-profit sector in Canada. A journalist by training, Danny has more than 15 years of experience in the non-profit and media sectors in Canada and internationally - his work has taken him to more than 55 countries. This includes a stint as communications manager at Gender Links in Johannesburg, a role with the United Nations in Palestine, and media training experience in Sierra Leone, Namibia, and Rwanda. Danny holds a master's degree in international development from Italy's Pavia University. He has written extensively about gender issues, media literacy, and LGBT rights. Glenwright served as deputy editor of the #VoiceandChoice Barometer.





Shamiso F V Chigorimbo (Zimbabwe) is Policy and Movement Building Manager at GL. A development practitioner who is currently pursuing PHD research in Gender Based Violence and Migration studies with the University of Kwa Zulu Natal as a Health Economics & HIV & AIDS Research Division (HEARD) fellow. She holds a Masters' Degree in International Development from the University College of Dublin. Shamiso is a passionate African feminist interested in social justice and economic entrepreneurship innovation. Shamiso wrote the Adolescent Sexual Reproductive Health and Rights chapter of the #VoiceandChoice Barometer.

CHAPTER AUTHORS AND CONTRIBUTORS



Susan Tolmay (South Africa) is a feminist and human rights activist committed to social, economic and environmental justice, with 15 years' experience working in a regional and

international NGO environment. She returned to Gender Links as the Governance and Justice Manager after ten years working for international women and human rights organisations AWID and Amnesty International, where she managed women's rights programmes. She is currently GL's Gender and Governance associate. She has written on a range of global feminist and human rights issues, including women in political decision-making, refugee and migrant rights, gender-based violence, economic justice and resourcing for women's rights. She holds a BJuris and a Masters' degree in Governance and Political Transformation. Susan wrote the SRHR and Climate Change chapters of the #VoiceandChoice Barometer.



Kevin Chiramba (Zimbabwe) has worked with GL since 2012 coordinating the GBV household prevalence and attitudes surveys in Zimbabwe, Zambia, Seychelles, and Botswana. Kevin's experience includes working with civil society organisations, donors, gender ministries, national statistical offices, the police, courts, and government health departments across SADC, in drawing up gender mainstreaming programmes, GBV action planning, training as well as advocating for the analysis and utilisation of GBV data. He conducts rapid GBV and SRHR assessments and mapping exercises aimed at improving the prevention of GBV in the SADC region. Kevin holds a Masters in Population Studies and a BSc Psychology degree from the University of Zimbabwe. Kevin collated and analysed the SRHR data and authored the Gender Based Violence and the Harmful Traditional Practices Chapters of this #Voiceand Choice Barometer.



Lynette Mudekunye (Zimbabwe/ South Africa) is a public health professional who is an Advisor with Regional Psycho-social Support Initiative (REPSSI), providing psycho-social support for children and youth in 13 countries of East and Southern Africa. She has worked in the Health, HIV and AIDS sectors in Zimbabwe, South Africa and in the region. She wrote the HIV and AIDS as well as the Safe Abortion chapters of the SRHR Barometer under guidance from the Southern Africa AIDS Dissemination Service SAfAIDS, a regional non-profit organisation whose vision is to ensure that all people in Africa realise their sexual and reproductive health rights (SRHR) and are free from the burden of HIV, TB and other related developmental health issues. In recognition of the role that stigma and discrimination, gender inequality and related social structures and norms play in driving the epidemic and creating barriers to access to services in southern Africa, the organisation works to address gender equality and the rights of women, girls and key population groups, to access sexual reproductive health services and rights by confronting complex issues like culture, human rights and stigma.



Tarisai Nyamweda (Zimbabwe) is the Communication for Social Change Manager at GL. She became involved in gender and media monitoring through the Gender and Media Progress Study (GMPS) in 2010. She coordinated research teams on the recently completed GMPS 2020 study and the South Africa Global Media Monitoring Project (GMMP). She managed the writing of SRHR media stories and wrote the media chapter for the #Voice andChoice Barometer.

SAFAIDS
Knowledge for action: The power to make a difference!

SAFAIDS, which leads the SRHR cluster of the Alliance, pro-vided valuable input into, and peer reviewed the safe abortion as well as the HIV and AIDS chapters of the Barometer.



Fanuel Hadzizi (Zimbabwe) is the Monitoring and Evaluation Manager at GL. He holds an Honours Degree in Sociology from the University of Zimbabwe and has undertaken an M and E course at the University of Stellenbosch. He oversaw the data analysis and generation of graphs of the #VoiceandChoice Barometer.



Shau Mudekunye (South Africa) is a Digital Media Strategist with Gender Activism at heart. She holds a Bachelor of Political Science and an Honours degree in Sociology: Gender Studies both from the University of Pretoria. She began working with Gender Links in 2010 where she was responsible for the Beneficiary Analysis Research for the Gender Links publication *Giant Footprints*. After she left Gender Links she continues to consult on various monitoring and evaluation projects for GL. She currently works for a digital agency but continues her advocacy through blogging.

ACKNOWLEDGEMENTS

The Southern African Gender Protocol Alliance, chaired by Emma Kaliya (Malawi) brings together 15 national network partners who campaigned for the SADC Protocol on Gender and Development adopted in 2008. Gender Links (which has offices in ten SADC countries) serves as the Secretariat of the Alliance.

The following organisations and individuals gathered the data for the report:
Angola Plataforma Mulheres em Acçao (PMA), led by Executive Director- Veronica Sapalo;
Botswana Council of Non-Governmental Organisations (BOCONGO) under the guidance of GL Board Member and past chair of BOCONGO Chigedze Chinyepi with the support of the Young Women Alliance led by Bonang Modise and GL Botswana Senior Finance and programme officer Keletso Mesting;
DRC: Union Congolaise des Femmes des Medias (UCOFEM) under the leadership of outgoing director Anna M Ngemba;
Eswatini: Young Women's Alliance Eswatini Thembie Matsenjwa working with Thandokuhle Dlamini, GL Local Action for Gender Justice Eswatini Officer;
Lesotho: Women in Law Southern Africa Lesotho; Young Women Alliance leader Kelello Rakolobe; GL Lesotho Senior Programme Officer Ntolo Lekau and Local Action for Gender Justice Country Manager Mabetha Manteboheleng;
Madagascar Federation Pour la Promotion Feminine et Enfantine (FPFE) led by Gaby Razafindrakoto; Local Action for Gender Justice Madagascar facilitator Iafine Papisy and GL Madagascar Senior Finance and Programmes Officer Zotonantenaina Razanadratefa;
Malawi: NGO Gender Coordination Network (NGOGCN) guided and coordinated by Alliance Chair and GL Board Member Emma Kaliya;
Mauritius: Media Watch Organisation (MWO) working with GL Mauritius Local Action for Gender Justice Senior Finance and Programme Officer Sheistah Bundhoo and Local Action for Gender Justice Mauritius Manager Anushka Virahsawmy;
Mozambique Forum Mulher, led by Executive Director Nzira Deus;
Namibia Alliance focal person - Veronika Haimbili;
Seychelles Gender and Media Plus (GEMPLUS) led by Sharon Ernesta;
South Africa Women in Dialogue (SAWID) coordinated by Lindiwe Khoza working with local municipality partners in Cape Agulhas, Witzenberg, George, Bitou and Mossel Bay, assisted by GL South Africa Local Action for Gender Justice facilitator, Naledi Masipa;
Tanzania Gender Networking Programme (TGNP);
Zambia: Women and Law in Southern Africa Zambia working with GL Zambia Local Action for Gender Justice facilitator Albert Ngosa;
Zimbabwe: Women's Coalition of Zimbabwe; GL Zimbabwe Local Action for Gender Justice Coordinator Tapiwa Zvaraya and Local Action for Gender Justice Regional Manager Priscilla Maposa.

Sexual Reproductive Health and Rights (SRHR) cluster lead Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) provided technical inputs and support into the safe abortion, HIV and AIDS chapters.

Case studies for the Barometer are drawn from the #VoiceandChoice SADC Protocol@Work summits held from 2019 to 2021. Sincere appreciation to all members of the Alliance and the Centres of Excellence for Gender in Local Government (COE) who shared the inspirational work they do on the ground during these summits.

GL Executive Director Kubi Rama provided strategic oversight and wrote a chapter of the Barometer. Colleen Lowe Morna (Special Advisor, Gender Links) served as editor-in-chief of the Barometer with the support of guest editor Danny Glenwright. GL Policy and Movement Building Manager Shamiso Chigorimbo wrote a chapter and coordinated the project. Lynette Mudekunye, Susan Tolmay and Kevin Chiramba contributed key chapters (see details in the contributors section). Media workers trained by GL in covering SRHR contributed valuable reporting from their countries under the guidance of GL Communications for Social Change Manager Tarisai Nyamweda who also wrote a chapter for the Barometer.

GL data analyst Monica Bandeira and Systems Administrator Fanuel Hadzidzi contributed to data collation. Debi Lee designs laid out the Barometer. Simone Shall curated the Barometer on the GL and Alliance websites.

Sincere appreciation to Amplify Change for supporting the research and production of the SRHR chapters of this Barometer; HIVOS for supporting the rapid assessment of Adolescent SRHR; International Idea for supporting collection of data on Women's Political Participation, the New Venture Fund for supporting the #VoiceandChoice climate change chapter and Diakonia for supporting the work of the Alliance through to the end of 2020.

FOREWORD

2021 #VoiceandChoice SADC GENDER BAROMETER #VaccineGenderJustice



It is my honour to be asked by the Southern African Gender Protocol Alliance to write the foreword to the 2021 #VoiceandChoice Barometer in the year that the SADC Heads of States summit returns to Malawi. *Takulandirani!* Welcome!

In 1997, Heads of State signed the Southern African Development Community (SADC) Declaration on Gender and Development in Blantyre. This laid the ground for the SADC Protocol on Gender and Development in 2008, updated in 2016 in line with the Sustainable Development Goals (SDGs). In 2013 Heads of State met in Malawi as guests of the only woman ever to have served as president in SADC, Dr Joyce Banda. That year, we celebrated the tenth anniversary of the Maputo Protocol, an Africa-wide commitment to women's Voice and Choice.

The SADC Protocol on Gender and development is the only sub-regional instrument in the world to bring together all global and continental commitments to gender equality in one binding sub-regional instrument that has a Monitoring, Evaluation and Results Framework. This is complemented by the SADC Strategy on Sexual and Reproductive Health and Rights adopted by Health Ministers in 2018. Together, all these instruments provide powerful tools for measuring progress.

As a region we are proud of the role played by women's rights organisations in holding us to these commitments. Formed during the Beijing plus Ten review in 2005, the Alliance is a network of women's rights organisations in all the Sixteen SADC member states that campaigned for the SADC Protocol on Gender and Development, and now for its implementation. With the energy provided by national focal networks across the region such as the NGO Gender Coordinating Network (NGOGCN) in Malawi, the Alliance has faithfully produced an annual Barometer each year since 2009.



Emma Kaliya, Chair of the Southern Africa Gender Protocol Alliance, at the 2013 SADC Heads of State Summit. *Photo: Colleen Lowe Morna*

Now in its 13th edition, the Barometer remains true to its cause of monitoring change against established parameters, while raising the critical and topical issues of the day. In 2018, when the Barometer turned ten in the heat of the

#metoo era, this now prestigious gender monitor switched focus to women's bodily integrity, while still tracking #voice and #choice in politics and the media.

In 2020, as the COVID-19 pandemic struck, the Barometer pivoted to tracking the impact of the pandemic on sexual and reproductive health, GBV, economic justice, political participation and climate change. While the evidence of this impact is still being gathered and analysed, the 2021 barometer provides a wealth of anecdotal evidence (including from Malawi) showing the devastating impact that COVID-19 has had on lives and livelihoods.



Members of the Southern Africa Gender Protocol Alliance at the 2013 SADC Heads of State Summit. *Photo: Colleen Lowe Morna*

It is fitting, therefore, that in 2021, the Barometer foregrounds ***#VaccineGenderJustice***. As I speak only 2% of the 360 million people in SADC have been fully vaccinated against COVID-19 compared to half or more in most developing countries, and 14% across the globe. *Vaccine apartheid* is there for all to see! We still do not have sex disaggregated data on vaccine roll out. What we do know for sure is that if not the majority of those infected, women are the worst *affected* by this pandemic.

Women constitute 70% of frontline health workers in all our communities. They provide care to the sick and comfort to the bereaved. They support families on ever dwindling incomes as jobs and the informal sector are severely constrained under lockdown. In these circumstances, GBV, teenage pregnancies, child marriages and harmful practices are bound to soar. Unless a solution is found, the fragile gains we have made for gender equality will be frittered away. This is why I support the ***#Vaccine GenderJustice*** campaign being launched with this Barometer.

I would also like to commend the Alliance on launching the Gender Progress Score (GPS) report alongside the Barometer, rating gender attitudes in the region at 61%. While 60% of the 35,000 people surveyed believe that "a person should be treated the same whether they are male or female", 68% believe that a woman should obey her husband! This shows that we still have a long way to go in addressing the underlying attitudes that fuel inequality.

As our neighbours in Mozambique would say, *aluta continua*, the struggle continues! Let us all also join the Alliance in saying, 2030: ***Yes we can! Gender equality: yes we must!***

Hon. Dr Patricia Kaliati
Minister of Gender, Community Development and Social Welfare
Malawi, August 2021

This Barometer is dedicated to the memory of GL Eswatini Facilitator Ncane Maziya, who passed away on 21 June 2021. A tireless defender of women's rights, Maziya provided the inspiration for the Young Women's Alliance in Eswatini. May her soul rest in eternal peace.



EXECUTIVE SUMMARY



Ezulwini Mayors Walk and SRHR Campaign 2019, Eswatini. Photo: Thandokuhle Dhlamini

The 13th #VoiceandChoice Barometer reflects slow progress in advancing women's rights in the Southern African Development Community (SADC). The unrelenting COVID-19 pandemic has had devastating effects on women's voice and choice. The vaccine roll-out programme currently underway across the region is the best hope for consolidating the fragile gains made for women's rights in the last decade. Sex disaggregated data remains patchy but this and anecdotal evidence show that if not the most infected, women are the most affected by the pandemic. This underscores the #VaccineGenderJustice campaign being launched with this Barometer.

#VaccineGenderJustice

The #VoiceandChoice Barometer measures 100 indicators in seven thematic areas: sexual and reproductive health; adolescent Sexual and Reproductive Health and Rights (SRHR); safe abortion; Gender Based Violence (GBV); HIV and AIDS; harmful practices and sexual diversity. The 2021 Barometer adds chapters on Women's Political Participation and the media, key components of #VoiceandChoice, and clusters of the Southern African Gender Protocol Alliance. It also includes a chapter on climate justice, often referred to as the "twin pandemic", and one with similarly devastating consequences for the attainment of Sustainable Development Goal 5 - gender equality.

Since 2019, the #VoiceandChoice Barometer has measured progress against 100 SRHR indicators. This 13th edition continues to shadow the SADC SRHR strategy (2018-2030) adopted by Health Ministers in 2018. The strategy, seen as a progressive tool for measuring the progress of SRHR in the region, builds on several global, continental and regional frameworks to advance SRHR. The indicators used to measure the status of SRHR in SADC include 12 out of the 20 indicators in the SADC SRHR Scorecard that governments will be reporting against for which data could be obtained.

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 are included under the 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.

The real impact of COVID-19 will take some time to reflect in official data that is often a year or two behind. A survey by the United Nations Fund for Population (UNFPA)[2] that is quoted in several chapters of the 2021 Barometer reflects the incredible effort to sustain SRHR services following the first set of lockdowns, from March to May 2021. This is in no small measure thanks to the advocacy efforts of groups like the Southern Africa Gender Protocol Alliance, and the Centres of Excellence for Gender in Local Government working in nearly 400 municipalities across the SADC region to advance gender justice.

However, anecdotal evidence abounds in the Barometer of family planning services disrupted; Comprehensive Sexual Education (CSE) services curtailed as schools went into lockdown; teenage pregnancies and early child marriages on the rise; safe abortion even more difficult than usual to access; HIV and AIDS services disrupted; an increase in GBV; violence and stigma against the LGBTIQ community on the rise. Even the official statistics are beginning to reflect a roll back in fragile gains.

[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.
[2] UNFPA COVID Impact: What we know 1 year into the pandemic, https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf

Table I: Overview of countries by indicators, 2021

SADC SRHR scorecard	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe	Green	Yellow	Red	No data
Maternal mortality, institutional (to be complemented with population-based estimates or survey data, where applicable). Global target is 70.	241	144	273	473	437	544	335	349	61	289	195	53	119	524	213	458	2	4	10	0
Neonatal mortality, institutional (to be complemented with population-based estimates or survey data, where applicable). Global target is 12 per 1000.	28	18	30	27	18	43	20	20	10	29	19	9	12	20	23	26	3	10	3	0
Adolescent birth rate, 10-19 years of age.	163	51	70	109	87	91	151	137	23	180	64	68	41	139	135	108	6	4	6	0
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation.	0	0	0	1	0	1	1	1	0	0	0	0	1	0	1	0	6	0	10	0
Unmet need for family planning (contraception).	27	8	19	21	10	11	15	13	8	19	10	n/d	11	16	15	8	5	7	3	1
Percentage reduction in new HIV infections, females 15-24.	1	8.8	0.1	0.4	12.2	9	0.1	3.7	0.3	3	5.1	n/d	10.4	2.2	6	5.9	8	3	4	1
Mother to child transmission of HIV.	18.6	1.9	n/d	27.8	3.7	6	39	6.3	13	13.5	3.8	n/d	3.9	11.1	13.4	8.7	7	5	2	2
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age.	32	n/d	28	23	54	76	5	50	n/d	42	66	n/d	61	30	35	67	1	7	5	3
Minimum legal age of consent to marriage, 18 years for all irrespective.	1	3	2	1	1	1	2	3	2	3	2	1	3	1	2	3	5	5	6	0
Legal status of abortion.	1	1	1	1	1	1	0	1	1	2	1	1	2	1	1	1	2	13	1	0
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.	50	35	40	58	43	41	42	43	25	48	39	30	31	47	18	43	2	4	10	0
Percentage of annual budgets allocated to health sector (Abuja Declaration recommends 15%).	5	8.8	8.6	11	16.5	13	10.1	16.7	10	8.8	13.8	9.7	14.2	12.3	11.3	8.4	2	9	5	0

Key:
- Existence of laws and policies that allow adolescents to access SRH services without third party authorisation: 1=Exists; 0=Not in place.
- Minimum legal age of consent to marriage, 18 years for all irrespective: 1=Below 18 for women and/or men; 2=18 for women and men, with exceptions; 3=18 for women and men, no exception.
- Legal status of abortion: 0=Abortion not available 1=Restricted abortion; 2=Abortion on demand.

Source: Gender Links SRHR indicators table computed from global data sources.

Table I applies the colour coding across 16 SADC countries for which data could be obtained. Table II summarises the findings per indicator, ranking these from best to least achieved.

Table II: Summary of performance by indicator

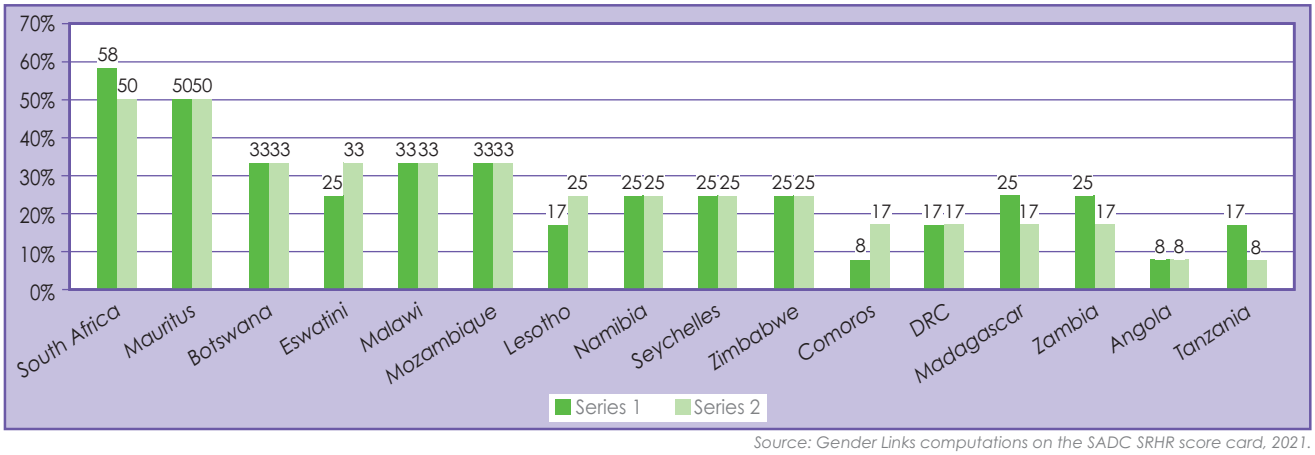
Indicators	Green	Yellow	Red	No data	% Green
Percentage reduction in new HIV infections, females 15 - 24.	8	3	4	1	50%
Mother to child transmission of HIV	7	5	2	2	44%
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation.	6	0	10	0	38%
Unmet need for family planning (contraception).	5	7	3	1	31%
Minimum legal age of consent to marriage, 18 years for all irrespective.	5	5	6	0	31%
Adolescent birth rate, 10-19 years of age.	6	4	6	0	38%
Neonatal mortality, institutional.	3	10	3	0	19%
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.	2	4	10	0	13%
Maternal mortality.	2	4	10	0	13%
Legal status of abortion.	2	13	1	0	13%
Percentage of annual budgets allocated to health sector.	2	9	5	0	13%
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age.	1	7	5	3	6%
Total #	***49***	***71***	***65***	***7***	
Total possible score	***192***	***192***	***192***	***192***	
Percentage of total	***26%***	***37%***	***34%***	***3%***	

Source: Gender Links SRHR indicators table computed from global data sources.

Table II shows that:

- Overall, only 26% of the 12 indicators that could be measured fall in the green category (compared to 27% last year); 37% in the yellow category (compared to 36% last year); 34% in the red category (the same as last year) and 3% in the no data category.
- The largest number of greens (50%) is percentage reduction in new HIV infections among females aged 15 - 24 followed by reduction in Mother to Child transmission of HIV (44%). Reducing HIV infections is still a priority for the region.
- Similar to last year, the lowest percentage of greens (6%) is percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age. 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 (13%); maternal mortality (13%); legal status of abortion (13%) and percentage of annual budgets allocated to the health sector (13%) also garner a low score.

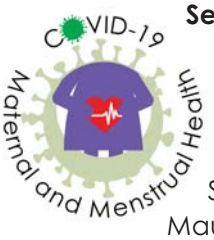
Figure I: Green SRHR scores 2020 and 2021



Source: Gender Links computations on the SADC SRHR score card, 2021.

Figure I summarises each country's performance on the basis of the 12 indicators. South Africa (50% green, compared to 58% last year) and Mauritius (50%) have the highest score followed by Malawi, Botswana, Eswatini and Mozambique (33%). Mozambique, Namibia, Seychelles, Zimbabwe and Lesotho (25% green) tie for fourth place. Fourteen SADC countries have achieved less than 50% of the targets. The lowest ranking countries on the green scores are Madagascar, Zambia, DRC, Comoros (17% each) followed by Angola (8%) and Tanzania (8%).

Four SADC countries (South Africa, Madagascar, Zambia and Tanzania) experienced a decline in their percentage green scores. Three countries went up: Comoros from 8% to 17%, Eswatini from 25% to 33% and Lesotho, from 17% to 25%. In other countries, the scores remained the same as last year. This shows that for the most part SADC countries either regressed or held the line on SRHR in the year past. Key factual highlights in each theme chapter of the Barometer include:



Sexual and reproductive health: While there has been good progress, maternal mortality remains unacceptably high in the region with just two of 16 SADC countries, Seychelles and Mauritius meeting SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100,000 live births, seven times higher than the SDG target. Neonatal deaths also remain high in the region with just three SADC countries (Seychelles, Mauritius and South Africa) having achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.

More countries in the region understand the importance of women's menstrual hygiene to their overall health and wellbeing. Seven SADC countries (Lesotho, Mauritius, Seychelles, South Africa, Zambia, Zimbabwe, and now *Namibia as well*) have removed VAT on menstrual products. Five countries (Botswana, Lesotho, Madagascar, Seychelles, and Zambia) now provide free sanitary pads in schools.

Local government plays a key role in providing access to SRHR services and should develop SRHR specific policies, including provisions on national health emergencies. Most pregnant women in the region have access to at least one antenatal visit, but women in rural areas have less access than those residing in urban areas. The COVID-19 pandemic has strained public health systems globally, interrupting and delaying many kinds of critical health care.

The World Health Organization (WHO) conducted two surveys on the continuity of essential health services during the COVID-19 pandemic. The first covers the period January-March 2020 in 105 countries and the second the period June-March included responses from 135 countries. In the second survey all SADC countries were included except Tanzania and Zimbabwe. The first survey found that family planning and contraception were among the most frequently disrupted health services, with 7 in 10 countries experiencing disruptions.[3]



Adolescent SRHR: Except for Tanzania (which never locked down), 15 of the region's member states adopted a phased approach to re-opening schools following COVID-19 pandemic lock-downs, with standard operating procedures to ensure the safety of learners and staff. So far the limited vaccines available have not been extended to anyone below 35 in the region; this is a major challenge in the coming period, as the deadly Delta variant of the virus is proving equally devastating among young people.

[3] Continuity of Essential Sexual and Reproductive Health Services During Covid-19 Pandemic in The WHO African Region, pp4.



Comprehensive Sex Education (CSE) refers to the provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relation-ships. In February 2020, Angola and Mozambique updated their CSE programmes to meet international standards. Members of the Zambia parliament shot down a regressive motion that sought to suspend the teaching of CSE in schools pending wider consultations by stakeholders with some members of civil society and teacher unions collaborating under the banner "Pro-CSE." These groups welcomed guidance provided by Vice President Inonge Wina on the floor of the National Assembly on 2 October 2020[4].

Gender Links (GL), the Southern African Gender Protocol Alliance partners, and youth leaders from the Centres of Excellence for Gender in local government conducted the Youth Rapid Assessment Study in eight out of 16 SADC countries between 2019 and 2021. The study found that nearly two fifths of young people who sought Sexual and Reproductive Health (SRHR) Services in eight Southern African countries were denied these services because they were not accompanied by a parent or family member. More than two thirds had to pay a fee for the health services they received. These services cost an average of $2, which is 9-20% of the daily income in the countries surveyed. But 81% of the those who accessed services said that health personnel treated them confidentiality.

Adolescent fertility rates remain exceptionally high: Mozambique is one of six countries in the world in which at least one in ten girls (14%) has had a child before they turn 15, and 57% before age 18. While the data is stil being collated, lock-downs have almost certainly increased the level of teenage pregnancies. The global pandemic shed light on some perennial challenges for teenage fathers, who faced heightened financial challenges during COVID-19 and pressures around their role as caregivers for their children. CSE gaps on the topic of teenage fatherhood point to a need for increased psychosocial support and education aimed specifically at young fathers.



Safe abortion: Africa has the highest rates of unintended pregnancies in the world at 91 per 1000 women aged 15 to 49, as compared to 35 per 1000 women in Europe and North America. This region has the highest pregnancy rate overall (218 per 1,000). Eight-nine percent of unintended pregnancies in Sub-Saharan Africa occur among women with unmet need for contraception: 11% result from failure of a modern method. The abortion rate in Africa has increased from 27 per 1000 women aged 15 to 49 to 33, representing a 24% increase since 1990.

Unsafe abortions affect mostly poorer, unmarried women and adolescents fuelling high maternal mortality rates in the region. US President Joe Biden rescinded the Global Gag Rule, enabling resumption of US government funding for the United Nations Fund for Population Activities (UNFPA). Disruptions resulting from the COVID-19 pandemic were not as dire as the UNFPA had initially predicted. But the pandemic led to increases in unwanted pregnancies and demand for safe abortion, while slowing down campaigns for safe abortion.

All SADC countries allow abortion if it is a risk to the woman's life. However, only two countries, South Africa and Mozambique permit abortion on demand. Abortion laws are most restrictive in Madagascar and Malawi where the only ground for abortion is risk to life. But in ruling on a case of statutory rape that led to the pregnancy of a 15 year old girl during lockdown who sought relief because she said this had threatened her life, the Malawi High Court has

[4] Shamiso Chigorimbo, Gender Links Opinion piece as part of a submission for the SADC Protocol @ Work Media articles October 2020. https://genderlinks.org.za/news/zambia-comprehensive-sexuality-education-must-be-continued/, accessed 10 August 2021.

injected new energy into the safe abortion campaign in Malawi.

Globally, there is debate on whether to advocate for decriminalisation of abortion or legislation for safe abortion, a medical procedure that should be available to all women. Canada is the only country in the world that has completely decriminalised abortion, making it a medical procedure available to women on demand at any time. Medication abortion is a safe and effective way self-managed procedure to end an early pregnancy that gained ground in Latin America and now across the globe. WHO recommends the combination of: mifepristone, which is more expensive, and used only to terminate a pregnancy, as it interferes with hormonal processes with misoprostol, which causes the cervix to dilate and the uterus to contract, is cheaper, used for other reasons, such as to treat ulcers, and thus more readily available.

SAfAids, the Alliance SRHR cluster lead, is spear-heading the My Choice, Our Choice campaign, through champions from all walks of life - MPs, traditional and religious leaders. SAfAids and the alliance will hold an expert meeting in 2021 to chart a way forward that will ensure women have #voice and #choice in matters concerning their reproductive health.



HIV and AIDS: SADC accounts for 46% of all people and 58% of the adolescents living with the human immunodeficiency virus (HIV). The COVID-19 pandemic has disrupted all health services in SADC including those for HIV. Adaptation and innovation are keeping the most critical services available. Much adaptation relies on community care givers. There is evidence that people living with HIV are at higher risk of serious illness and death as a result of COVID-19 than the general population.

Overall the world missed the UNAIDS 90- 90- 90 targets by 2020: 90% of all who are living with HIV knowing their status; 90% of those that know their HIV status on treatment and 90% of those on treatment are viral suppressed. But the achievement of 84% (31.6million) of PLHIV know their HIV status; 73% (27.4 million) accessing treatment and 66% virally suppressed is impressive.[5]

Of the 8 countries in the world that achieved the 90- 90- 90 targets four are in Africa (Eswatini, Botswana, Malawi in SADC and Uganda). A further 11 countries globally reached the overall 73% viral suppression target, including Zimbabwe, Lesotho, Namibia and Zambia in SADC and Kenya, Burundi in Africa, but did not achieve one of the three 90s. Eswatini has already achieved the 2025 target of 95- 95- 95. With the largest HIV burden in the world (7.8 million people living with HIV or 21% of the total in the world), South Africa's achievement of 92- 72- 66 is noteworthy[6].

World leaders have adopted a new Global Strategy to address inequalities and end AIDS by 2030 in June 2021[7]. SADC countries will need to redouble their efforts to achieve the 2020, and now the 2030 targets, which are of such great relevance to this region.



Gender-based violence: COVID-19 lockdowns remain a reality in SADC with pandemic-related challenges unrelenting in many countries, including increases in gender-based violence (GBV). The global "vaccine apartheid" is prolonging the agony of the pandemic, and correspondingly high levels of GBV.

South Africa amended key legislation to fight GBV and femicide during the pandemic. Law-makers in Lesotho drafted a domestic violence bill, which awaits cabinet approval.[8] A Common-

[5] Global HIV & AIDS statistics Fact sheet 2021, https://www.unaids.org/en/resources/fact-sheet accessed 10 August 2021.
[6] HIV & AIDS statistics South Africa, https://www.unaids.org/en/regionscountries/countries/southafrica, accessed: 10 August 2021.
[7] New global pledge to end all inequalities faced by communities and people affected by HIV towards ending AIDS, https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2021/june/20210608_hlm-opens, accessed 10 August 2021.
[8] SADC GBV Virtual Workshop, March 2021

wealth study shows domestic violence costs Lesotho $113 million annually.[9] To inform a comprehensive review of its Labour Act on sexual harassment at work, a Zimbabwe Parliamentary committee conducted public consultations across the country[10]. Namibia is the only country in Africa to achieve a Tier 1 ranking on eliminating human trafficking in 2020, joining 34 nations globally. The country fully meets the US State Department's minimum standards for the elimination of human trafficking.

The SADC Secretariat has bemoaned the lack of critical GBV data submissions by member countries. Data on intimate partner violence is outdated and incomplete. In March 2021, the SADC Gender Unit convened two virtual workshops on GBV prevention and coordination. One of the outcomes included selecting shared GBV indicators that the unit will review annually[11].



Harmful practices: The COVID-19 pandemic coupled with slow vaccination roll out programmes could further expose women and girls to harmful practices especially child marriages and Female Genital Mutilation (FGM). Vaccine hesitance is itself emerging as a harmful practise.

South Africa has the lowest percentage of women married by age 18 (4%) and Mozambique has the highest (53%).[12] Campaigns to end child marriages pivoted to cyber space while poverty drove many families to marry their young daughters off to older men. Giving rise to some optimism, in December 2020, the Mauritian government gazetted the Children's Act of 2020. The Act, which now awaits proclamation, seeks to address the issue of child marriages in the country and establishes the Children Coordinating Panel, a body to oversee the implementation of the Act. Activists hope that addressing this obstacle to Mauritius signing the SADC Gender Protocol will finally pave the way for Mauritius to sign. Mauritius is the only SADC country that has still not signed this unique sub-regional instrument.

The Zambian parliament is amending Article 47.2 of the of Constitutional Amendment Bill number 10 of 2019 to enhance the participation of women with disabilities in politics.[13] Zimbabwe launched a National Disability Policy which seeks to address the marginalization and discrimination of Persons with Disabilities (PWDs)[14]. Medical practitioners performed 52 million of the Female Genital Mutilation (FGM) procedures globally. Besides FGM and child marriages, women and girls in parts of Zimbabwe and South Africa could be experiencing other less common harmful practices like breast ironing.



Sexual diversity: Five (one-third) of Southern African countries (Angola, DRC, Mozambique, Seychelles, and South Africa) have decriminalised homosexual relationships. Botswana's High Court decriminalised same-sex relationships in June 2019, but promulgation of the law is pending following an appeal. COVID-19 has exacerbated vulnerabilities in LGBTI communities, especially those relating to health care and violence. Three countries (Mauritius, Namibia, and South Africa) allow LGBTI people to change their gender markers. Mauritius and South Africa ban conversion therapy, which causes extensive physical and psychological damage. Only one SADC country, Angola, has hate crimes legislation that explicitly protects LGBTI persons from violence and discrimination. The UN Human Rights Office calls on countries to outlaw sporting regulations that pressure female athletes to undergo "unnecessary" medical interventions. COVID-19 health strengthening strategies must include long-term

[9] Violence against women costs Lesotho economy $113 million annually, The Commonwealth, https://thecommonwealth.org/media/news/report-violence-against-women-costs-lesotho-economy, accessed: 1 June 2021.
[10] EWF engages the public service, labour and social welfare parliamentary portfolio committee on the amendment of the labour relations act.', http://emthonjeniwf.org/ewf-engages-the-public-service-labour-and-social-welfare-parliamentary-portfolio-committee-on-the-amendment-of-the-labour-relations-act/, accessed 10 August 2021.
[11] SADC GBV Virtual Workshop, March 2021
[12] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.
[13] Zambia Daily Mail, Women's movement nods support for Article 47.2 of Bill 10, http://www.daily-mail.co.zm/womens-movement-nods-support-for-article-47-2-of-bill-10/, accessed 28 June 2021.
[14] UNESCO (2021) Zimbabwe launches National Disability Policy, UNESCO, https://en.unesco.org/news/zimbabwe-launches-national-disability-policy, accessed 24 June 2021.

strategies towards the attainment of universal health care.



Governance: Women's political participation is a powerful measure of women's voice and choice in the public space. Women's representation in parliament (28% in lower chambers and 29% in upper chambers) in SADC has increased by just three percentage points over the last decade, from 25% in 2009 to 28% in 2021. Women's representation in parliament in SADC is three percentage points higher than the global average and Africa average of 25%[15].

Women's representation in parliament (both houses) ranges from 11% in Botswana to 46% in South Africa. Variation in women's representation ranges from an increase of 17 percentage points in Zimbabwe to a decrease of seven percentage points in Angola (from 37% in 2009 to 30% in 2021). Women's representation in local government decreased from 24% in 2009 to 20% in 2021. In Lesotho, women's representation in local government dropped from 58% in 2005 to 40% in 2017[16].

Data in the Barometer establishes the close correlation between the Proportional Representation (PR) system used in conjunction with some form of Temporary Special Measure (TSM) in increasing women's representation. The opposite is true of the First Past the Post System (FPTP) used by two thirds of the countries in the region.

Women are best represented in Electoral Management Bodies with 40% of leadership positions held by women. Women are least represented in top executive positions (President, Vice President, Prime Minister, Deputy Prime Minister) with just three of 33 (9%) positions being held by women. Women's representation in cabinet in the SADC region has increased by three percentage points from 23% in 2009 to 26% in 2021. South Africa has achieved and surpassed the target of 50% women in cabinet. Women are under-represented on national COVID-19 taskforces making up just 39% of members and 19% of leaders.



Media: The extent to which women's views and voices are reflected in the media is a powerful proxy indicator of women's voice and agency. The Gender and Media Progress Study (GMPS) remains the largest and longest longitudinal research study on gender equality in the news media in Southern Africa, stretching from 2003-2020. The 2020 GMPS monitored 18630 news items over an entire month.

The GMPS shows a paltry increase in women sources in the media, from 17% in the 2003 Gender and Media Baseline Study (GMBS) to 19% in 2010 GMPS, to 20% in the 2015 GMPS, and just 21% in the 2020 GMPS. This ranges from 16% in Democratic Republic of the Congo (DRC), Tanzania and Zambia, to 31% in Seychelles: all still well short of the 50% target[17].

At just 2%, topics on Sexual and Reproductive Health and Rights (SRHR) rank among the least covered. Gender Based Violence (GBV) accounts for half of SRHR coverage. At 2% each, sexual diversity, harmful practices, and menstrual health are the least covered SRHR topics. Regional media prioritises other topics, including economy (19%), social topics (15%) sports (12%), politics and government news (11%)[18].

Across all topics, women's voices dominate only in news about gender equality (52%). Spokespeople and experts continue to comprise the majority of sources in regional news. An analysis

[15] Women's Political Participation Africa Barometer 2021, https://www.idea.int/sites/default/files/publications/womens-political-participation-africa-barometer-2021.pdf, accessed 10 August 2021.
[16] Women's Political Participation Africa Barometer 2021, https://www.idea.int/sites/default/files/publications/womens-political-participation-africa-barometer-2021.pdf, accessed 10 August 2021.
[17] Gender Links. 2020. Gender and Media Progress Study. Preliminary findings. Gender Links. Johannesburg, https://datastudio.google.com/u/0/reporting/ee53fd80-a91a-46e0-9cc3-f8c7f352d484/page/eKwT?s=tim9YL3OEew , accessed on 16 July 2021.
[18] Gender Links. 2020. Gender and Media Progress Study. Preliminary findings. Gender Links. Johannesburg, https://datastudio.google.com/u/0/reporting/ee53fd80-a91a-46e0-9cc3-f8c7f352d484/page/eKwT?s=tim9YL3OEew , accessed on 16 July 2021.

of COVID-19 news coverage shows that women's voices accounted for 26% of those interviewed as sources. Online GBV increasingly hinders freedom of expression in online spaces, with women journalists disproportionately affected[19].



Climate justice: Gender equality, sexual and reproductive health and rights (SRHR), and climate change issues are inextricably linked. Climate change risks increasing social, including gender, inequalities. In addition, as global temperatures rise, extreme weather events like floods, droughts, and heatwaves particularly threaten the health and rights of girls and women. In turn, gender, sexuality, age, wealth, indigeneity, and race are all determining factors in the vulnerability to climate change.[20] Those that contributed least to the climate crisis are most severely affected by its impacts while also having most limited access to resources to adapt[21].

At the time the COVID-19 outbreak was declared a global pandemic, climate change was beginning to be at the forefront of political conversations and agendas. There is growing consensus that there is need to considered to take decisive action to protect the future of the planet. However, the world's spotlight moved away from climate change as the impact of the pandemic wore on. Now similarities are being drawn between the two crises with many of the same issues arising out of the crises.

COVID-19 is known to impact particularly the elderly and those with underlying health conditions, causing severe respiratory disease, and climate change affects air quality, drinking water, food supply and shelter - all factors that are associated with health. Climate change is expected to cause around 250,000 additional deaths annually between 2030 and 2050. COVID-19 has already claimed the lives of 2.3 million people worldwide since the start of the pandemic.[22] The twin pandemics of COVID-19 and climate change are without doubt the biggest challenge to achieving the SDGs, and especially SDG 5 (gender equality).

[19] UNESCO (2020) Online violence Against Women Journalists: A Global Snapshot of Incidence and Impacts, available at: https://en.unesco.org/news/unescos-global-survey-online-violence-against-women-journalists, accessed 10 August 2021.
[20] Women Deliver, The link between climate change and sexual and reproductive health and rights: An evidence review, January 2021.
[21] International Planned Parenthood Federation (IPPF), Position paper: The climate crisis and sexual and reproductive health and rights, January 2021, pp 5
[22] https://www.news-medical.net/health/Climate-Change-and-COVID-19.aspx

Introduction 1



Defying the odds: SRHR campaign in Eswatini. Photo: Thandokuhle Dlamini

KEY POINTS

- The #VoiceandChoice Barometer is being launched virtually and in the wings of the Southern African Development Community (SADC) Heads of State Summit in Lilongwe, Malawi, in August 2021.
- The launch takes place under the shadow of the Corona Virus Disease- 2019 (COVID-19) pandemic and the glimmer of hope raised by the roll out of vaccines, albeit painfully slow.
- Vaccine apartheid has resulted in rich global north countries accumulating the majority of vaccine doses and prioritsing their citizens (high and low risk) over the global good.
- SADC countries have fully vaccinated two percent of their population. This ranges from 70% in Seychelles to less than one percent in DRC, Madagascar and Tanzania.
- Sex disaggregated data on COVID-19 tests, cases, deaths, hospitalisations, ICU admissions is sparse. Only five SADC countries (Eswatini, Malawi, Mozambique, South Africa and Zimbabwe) have collected some data on confirmed cases and deaths. Sex disaggregated data on vaccinations is non-existent.
- The Southern African Gender Protocol Alliance is presenting SADC Heads of State with a #VaccineGenderJustice petition demanding an escalation in vaccine roll out, and sex disaggregated data with which to monitor that vaccines are reaching those who need them most.
- The 2021 Barometer includes eight chapters on Sexual Reproductive Health and Rights (SRHR) as well as #VoiceandChoice chapters on women's political participation; the media and climate change - a pandemic potentially more devastating than COVID-19.
- Youth, especially young women are central to the #VoiceandChoice campaign. The SADC region consists of a largely youthful population who are demanding space to participate meaningfully in matters affecting their lives. This Barometer features a rapid assessment on Adolescent Sexual and Reproductive Health (ASRHR) conducted by youth in eight SADC countries. The Alliance co-leads Action Coalition Six - Feminist Leadership and Movement Building - of the UNWOMEN #GenerationEquality movement.



In 2021, the #VoiceandChoice Barometer enters its teens for the first time as it turns 13. Each year since the first Barometer in 2009, the Barometer has sought to reflect the pressing issues of the day. In the wake of the #MeToo, #TimesUp, #TotalShutdown and other regional and global campaigns the Barometer sharpened its focus on SRHR under the umbrella of the #Voiceand Choice campaign. Key themes included: maternal and menstrual health; adolescent SRHR; safe abortion; gender violence; HIV and AIDS; harmful practises and sexual diversity. The 2021 Barometer adds chapters on the media; climate change; gender and governance - all key components of #VoiceandChoice.

Produced in the midst of the COVID-19 pandemic that led to states of emergency or disaster in most SADC countries since March 2020, the Barometer analyses the gendered impacts of the pandemic across different chapters. Every pandemic and natural disaster preys on inequality. COVID-19 is no exception. Initially, women were less infected but more affected than men. As we go to press, data suggests women are now both the majority of those infected and affected by the deadly virus in at least one SADC country, South Africa which also accounts for nearly three quarters of all reported cases in the region.

The only solution on the horizon is to roll out vaccines to at least 70% of our populations in order to achieve "herd immunity" - the critical mass that will stop the pandemic in its tracks. Yet, at the time of writing, only 4% of SADC citizens had received one vaccination, and only 2% had been fully vaccinated, compared to 14% globally, and over half in most developed countries. Despite the commitment by SADC countries to gathering sex disaggregated data with which to monitor all endeavours, this is glaringly missing in COVID-19 statistics, and especially in vaccine roll out. This is at the heart of the #VacineGenderJustice campaign being launched with the #VoiceandChoice Barometer.

This chapter provides crucial background information on the pandemic; its impact on Southern Africa in general and gender equality in particular. It provides information on the global disparities in accessing vaccines (vaccine apartheid) as well as key gender considerations in vaccine roll out, our best hope for defending the fragile gains made for gender equality against the tide of rising poverty, unemployment, GBV, harmful practices, teenage pregnancies, child marriages, services and advocacy under threat. The chapter describes the instruments against which the progress towards gender equality is measured; the role played by the Southern African Gender Protocol Alliance; the methodology for gathering data in the Barometer, and the broader scope in 2021. The chapter ends with a summary of limitations in the research.

COVID-19 and SADC

COVID-19 is an infectious disease caused by a virus transmitted through droplets generated when an infected person coughs, sneezes, or exhales. Infection can also occur through breathing in the virus when in close proximity of someone who has COVID-19, or by touching a contaminated surface and then touching ones' eyes, nose or mouth.

Table 1.1: COVID-19 cases in SADC, August 2021

	# cases in SADC	% cases in SADC
South Africa	2 497 655	73,0%
Zambia	198 455	5,8%
Malawi	54 178	1,6%
Mozambique	126 391	3,7%
Namibia	119 984	3,5%
Zimbabwe	113 526	3,3%
Botswana	106 690	3,1%
DRC	50 529	1,5%
Angola	43 070	1,3%
Madagascar	42 194	1,2%
Eswatini	27 467	0,8%
Seychelles	17 747	0,5%
Lesotho	12 880	0,4%
Comoros	4 028	0,1%
Mauritius	4 393	0,1%
Tanzania	1 017	0,0%
SADC	**3 420 204**	**100,0%**

Source: GitHub[1] August 2021.

By 6 August 2021 SADC had confirmed cases nearly 3.5 million cases of COVID-19[2]. The table shows that South Africa accounts for 74% of confirmed cases, followed by Zambia with 6% of confirmed cases.

COVID-19 and Women's Rights



Sex-disaggregated data from testing through to vaccinations is critical to understanding the differential impact the virus is having on women, men and gender non-conforming people. Disaggregating data on who is being tested, confirmed cases, hospitalisation, ICU admissions, deaths and vaccinations will help to inform response. This information is, however, completely lacking in some countries.

According to the COVID-19 Sex disaggregated data tracker, which tracks sex disaggregated data across the globe, "very few countries are reporting this data in its entirety"[3] Of 198 countries only 139 disaggregate data on confirmed cases and only 107 on deaths. Only 16 countries disaggregate data on testing and 43 on vaccinations.[4]

Sex disaggregated data in SADC is scarce. Only five countries in the SADC region (Botswana, Eswatini, Malawi, Mozambique, South Africa and Zimbabwe) have at least some disaggregated data. *No SADC country provides sex disaggregated data on vaccines*.

1 https://github.com/owid/covid-19-data/tree/master/public/data accessed 6 August 2021
2 Tanzania has only recently started recording cases, following months of denial under the late President John Magufuli.
3 https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/ accessed 30 July 2021
4 Ibid

Table 1.2: Sex disaggregated data on COVID-19 in SADC

	Tests		% confirmed cases		% confirmed deaths	
	M	F	M	F	M	F
Botswana	No data		83%	17%	40%	60%
Eswatini	No data		48%	62%	52%	48%
Malawi	No data		59%	41%	76%	24%
Mozambique	No data		51%	49%	No data	
South Africa	46%	53%	43%	57%	49%	51%
Zimbabwe	No data		55%	45%	64%	38%

Source: Global Health 5050, the Covid-19 Sex Disaggregated Data Tracker. [5]

Similar to global trends, Botswana, Malawi, Mozambique and Zimbabwe record more confirmed cases in men. However, bucking these global trends, in Eswatini (62%) and South Africa (57%) women constitute more confirmed cases. Again similar to global trends, the death rate is higher for men in three countries (Eswatini, Malawi and Zimbabwe). However the death rate is higher for women than for men in two countries: Botswana and South Africa. In Botswana, men constitute 83% of confirmed cases, yet women constitute 60% of confirmed deaths. South Africa stands out in the global statistics as being one of the few countries in the world in which women constitute the majority of COVID-19 cases and deaths. These puzzling statistics show that at the very least, *comprehensive sex disaggregated data is required to understand how this pandemic is unfolding in SADC*.

Even where women may have a lower **infection** and mortality rate, they have been more **affected** because of the persistent gender inequalities that make them more vulnerable to violence, economic stress, lack of access to basic services including to primary health care.

Women comprise 70% of the global health workforce[6], being on the frontline of response they are more affected than the rest of the population. Women are also the majority of those performing unpaid care-work in the home, by caring for the sick and elderly and home-schooling children during the lockdowns, making them vulnerable to the virus.

Evidence shows that women have been most affected by the economic decline resulting from the pandemic. Women make up the majority of those in precarious work, including the informal sector, sex workers, domestic workers and migrant workers who lost their livelihoods because of hard lockdowns that restricted movement of people. Women are also the majority of those in the retail, food service, and hospitality, some of the industries facing the most widespread business closures.[7]



Nomnikelo Mbuthuma from Coastal Resources Centre talking about the importance of vaccination awareness with Gogo Nopasika Khalweni, Sirhasheni village in the Eastern Cape. Photo: Ayanda Khalweni

[5] https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/?explore=country accessed 30 July 2021, last updated 28 July 2021
[6] https://www.who.int/news/item/03-05-2021-expanding-reach-addressing-gender-barriers-in-covid-19-vaccine-rollout
[7] https://www.tandfonline.com/doi/full/10.1080/13545701.2021.1876906

Women **dominate in some of the sectors that have been hardest hit by the pandemic**, including the tourism and hospitality sectors. Women are also more likely to work in the informal sector, where many have lost their livelihoods because of not being able to conduct their business during lockdown restrictions. As a result hunger and poverty has increased, with half of all respondents (47%) in the NIDS rapid mobile survey, saying that their household ran out of money to buy food in April and one in five (22%) reporting that someone in their household went hungry in the last seven days.

Not factored anywhere into the statistics is the increased **burden of care work** that women are carrying as a result of the pandemic, including caring for or home-schooling children, for the sick and elderly. In some cases women are forced to drop out of the labour market completely. A poll conducted in 17 countries shows that both women and men are taking more responsibility for household chores and the care of children and family during the lockdown, but the majority of work continues to fall on women and girls, reflecting a pre-pandemic pattern.[8]

The rapid increase in COVID-19 cases is **overwhelming many health systems**. Many health facilities are closed or are only providing limited services. Essential health services and lifesaving interventions are being disrupted. People are unable or afraid to go to health-care facilities to seek services such as check-ups, vaccinations and even urgent medical care. This could reverse decades of improvements in health outcomes. In SADC, this will severely affect women's SRHR.

There is an **increased risk of maternal and child deaths**.[9] Many women and girls are choosing to skip important medical check-ups for fear of contracting the virus. In addition, global supply chain disruptions may lead to **shortages of contraceptives**. As a result, tens of millions of women may not be able to access contraceptive services, resulting in millions of unintended pregnancies. **Safe abortion**, unavailable at the best of times even in countries where it is legal (South Africa and Mozambique) is now even less accessible.

The lockdown restrictions have once again highlighted the crisis of **gender-based violence**, particularly intimate partner violence. The coronavirus pandemic lockdowns have confined many women and girls to their homes, sometimes with abusive partners, putting them at greater risk of domestic violence. Women are also more likely to have their phones monitored by abusive or controlling partners. In addition, because of service disruptions and closures, women experiencing violence have less access to support and may not be able to receive medical care, if needed.

All of these factors contribute to the increase in GBV, which UN Women has called the "shadow" pandemic. While there is no comprehensive global data, evidence shows an increase in domestic violence as a result of the pandemic, with many survivors confined in the household with their abusers. The lockdowns have also meant limited or no access to support services and countries diverting resources and efforts from GBV to COVID-19 relief.[10]

Although **harmful practices** are slowly declining, the COVID-19 pandemic has disrupted programmes aimed at ending child marriages and female genital mutilation in areas where it is practiced. Young girls who are normally at school are more vulnerable to harmful practices during the pandemic. COVID-19 has exacerbated vulnerabilities in **LGBTI communities**, especially those relating to health care and violence.

COVID-19 The **fifty-fifty campaign in SADC**, that has been a case of one step forwards, two steps backwards, now has the added challenge of making democracy more inclusive under states of emergency, crisis and threats - imagined and real. Civic space and advocacy work have

[8] United Nations, Sustainable Development Goals Report, July 2020
[9] World Health Organisation, July 2020 The effects of COVID-19 on maternal health
[10] https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19

been severely affected. Women politicians, especially in the First Past the Post system, have the cards stacked against them at the best of times, let alone under lockdown. While women comprise 70% of the global health workforce they only make up 25% of leadership positions.[11] This has been identified as a gap by the WHO, which says that apart from ensuring that women are involved in vaccine rollout plans, their equal and meaningful participation in leadership and decision-making is critical.[12]

The only glimmer of hope is that in SADC there is a strong correlation between post conflict and higher level of women's political representation and participation. This opens an opportunity to vision a new normal in which women and men stand side by side in political decision-making.

COVID-19 has dominated **media** reporting over the last year and a half. The Global Media Monitoring Project (GMMP) and the SADC Gender and Media Progress Study show that women's views and voices continue to be under-represented in the media, including in the COVID-19 topic category. The pandemic has seriously affected media practitioners who are at the frontline of reporting its devastating consequences.

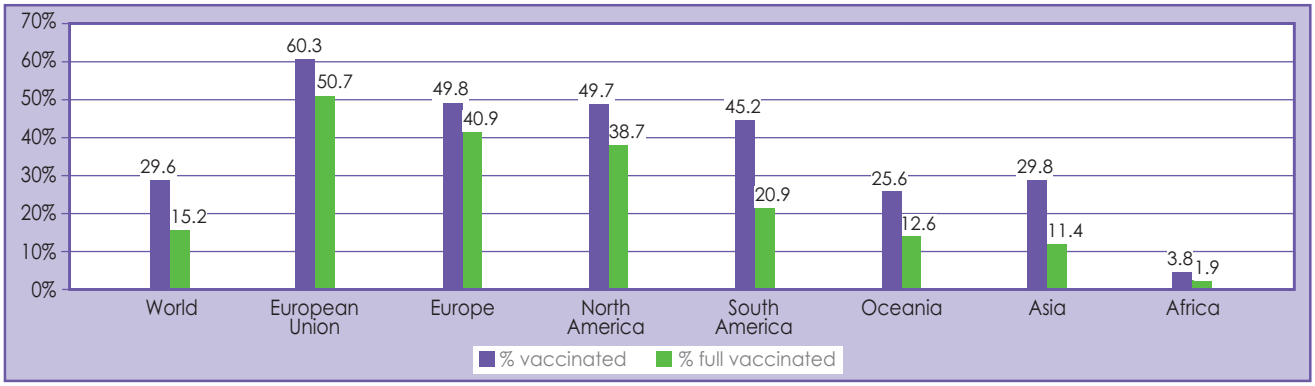
Climate change will make future disasters and epidemics, such as COVID-19 inevitable, pushing millions of women and girls even further into poverty. It will challenge the fragile **economic gains** made by women, unless the complete disruption of the economic and eco system can be used to create a "new normal" for gender equality.

Vaccine apartheid

The global vaccination roll out has laid bare the gross structural, systemic inequalities that exist within and between countries and the deep-ening divide between the global north and south. Oxfam reports that the covid vaccines have created nine new billionaires with a combined wealth greater than the cost of vaccinating the world's poorest countries.[13] The vaccine rollout is yet another example of how wealth is accumulated by the few at the expense of the masses, putting profit before people, even during an unprecedented global health crisis.

As of 6 August 2021, just over 15% of the world's population has been fully vaccinated[14]. This number increases to 51% for the European Union, 41% for Europe and 39% for North America. Conversely just two percent (1,9%) of Africa's population have been fully vaccinated.

Fig 1.1: COVID-19 "global apartheid"



Source: GitHub[15] August 2021.

[11] https://www.who.int/news/item/03-05-2021-expanding-reach-addressing-gender-barriers-in-covid-19-vaccine-rollout
[12] Ibid
[13] https://www.oxfam.org/en/press-releases/covid-vaccines-create-9-new-billionaires-combined-wealth-greater-cost-vaccinating accessed 30 May 2021
[14] https://github.com/owid/covid-19-data/tree/master/public/data, accessed 6 August 2021
[15] https://github.com/owid/covid-19-data/tree/master/public/data accessed 6 August 2021

Figure 1.1 illustrates discrepancies in vaccination rollout across the globe. Africa has the lowest rate of vaccination, followed by Asia, Oceania, and South America. The European leads the way with 51% partial and 60% full vaccinations.

This *vaccine apartheid* has two main causes: vaccine nationalism and the intellectual property rights regime. **Vaccine nationalism** has seen countries with big pharmaceutical companies hoarding vaccine pre-purchasing doses for up to six times the vaccinations they need for their populations. For example Canada ordered 188 million full vaccinations for its 32 million adults, an excess of 156 million.[16] Amnesty international reports that:

> "In August 2020, the UK was the world's highest per capita buyer, with an average of five doses per citizen. The USA led the total number of purchases worldwide, securing 800 million doses of at least six vaccine candidates, with an option to purchase around 1 billion more. The European Union, Japan, Canada and Australia followed suit, securing million of additional potential doses from several companies. By September 2020, Oxfam concluded that governments representing 13% of the global population had already secured over half of the promised doses of COVID-19 vaccine candidates."[17]

As these governments have bilateral agreements with the pharmaceutical companies they are buying vaccines at preferential rates. The European Union, for example, is paying $2.15 for each dose of the AstraZeneca vaccine, while South Africa is spending $5.25 for the same drug.[18]

The other barrier to vaccine equality and justice is pharmaceutical monopolies that are restricting supply. The result is that *non-vulnerable groups, such as young people, in the global north will receive a vaccine before more vulnerable groups in developing countries*. The International Monetary Fund (IMF) estimates that countries with large vaccine inventories could donate one billion doses in 2021 without undermining their domestic vaccination priorities.[19]

A global health and human rights issue

These practices are short sighted and counter-productive. Global experts have warned that uneven access to vaccines is fuelling risk of new variants emerging. The longer vaccines are not shared widely, there is a chance, as we have already seen, of the virus mutating, making vaccines less effective going forward.[20]

The right to health is enshrined in several international human rights treaties as well as conventions that spell out the right to benefit from scientific progress and its applications.

Article 25 of the Universal Declaration on Human Rights (UDHR, 1948), provides for the right of everyone to health and wellbeing including medical care, Article 12 (1) the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1976), reiterates "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Section 2 (c) specifically calling on states to take necessary steps for the prevention, treatment and control of epidemic, endemic, occupational and other diseases.

Most recently these rights are outlined in the Sustainable Development Goals (SDG). Goal 3 target 8 is to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. The World Health Organisations (WHO) Immunization Agenda (IA)

[16] https://theconversation.com/covid-vaccines-rich-countries-have-bought-more-than-they-need-heres-how-they-could-be-redistributed-153732
[17] Amnesty International (2020) A fair shot: Ensuring universal access to COVID-19 diagnostics, treatments and vaccines. Pp13
[18] https://www.thenation.com/article/world/coronavirus-vaccine-justice/
[19] Mohamed A El-Erian, Unbalanced, unfair and inefficient vaccine roll out could strike a blow to the global system, Dily Maverick, 30 May 2021 accessed 3 June 2021
[20] https://www.independent.co.uk/news/science/covid-vaccine-variants-mutation-latest-b1824057.html accessed 3 June 2021

2030 positions immunization as a "key contributor to people's fundamental right to the enjoyment of the highest attainable physical and mental health and also as an investment in the future, creating a healthier, safer, more prosperous world for all.[21]

Article 27 of the UDHR and Article 15 of the ICESCR establish the right to enjoy the benefits of scientific progress and its applications. In April 2020, the CESCR also highlighted that "pandemics are a crucial example of the need for scientific international cooperation to face transnational threats. Viruses and other pathogens do not respect borders…" and makes a number of recommendations for international cooperation and assistance "Such international assistance and cooperation include the sharing of research, medical equipment and supplies, and best practices in combating the virus; coordinated action to reduce the economic and social impacts of the crisis; and joint endeavours by all States to ensure an effective, equitable economic recovery. The needs of vulnerable and disadvantaged groups and fragile countries, including least developed countries, countries in conflict and post-conflict situations, should be at the centre of such international endeavours.[22]

SDG Target 3(b) provides for member states to "Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the Trade-Related aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all."[23]

Closer to home the SADC Health Protocol requires southern African governments to cooperate in addressing health problems and challenges facing them for "effective regional collaboration and mutual support" and to "coordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases".[24] Article 29 of the Protocol addressing pharmaceuticals provides that SADC states must "cooperate and assist one another" in the "production, procurement and distribution of affordable essential drugs". This obligation necessarily applies to the production and distribution of affordable Covid-19 vaccines and therapeutics.

To respect human rights, it is crucial that countries cooperate globally to ensure that safe and effective vaccines are developed in a timely manner, produced in sufficient doses at affordable prices, and distributed fairly across countries to achieve broad, non-discriminatory immunization coverage around the globe.[25]

The COVID-19 Vaccines Global Access (COVAX) is a worldwide initiative aimed at equitable access to COVID-19 vaccines directed by Gavi, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and the World

[21] WHO, Immunization Agenda 2030: A Global Strategy to Leave No One Behind, https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030 accessed 30 May 2021
[22] CESCR, "Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights", E/C.12/2020/1, 17 April 2020, pp4 http://docstore.ohchr.org/SelfServices/FilesHandlerashx?enc=4slQ6QSmlBEDzFEovLCuW1AVC1NkPsgUedPlF1vfPMKXidSV%2FGyVFSAvr6nizxSlX6zd%2Bu5KD26NraabiJKa WMnkFhhMb4MahybE5l%2FoU5sQSh6PCbcepqzl0iCYklyq accessed 30 May 2021
[23] https://sdgs.un.org/goals/goal3 accessed 30 May 2021
[24] https://www.sadc.int/documents-publications/show/804
[25] Amnesty International (2020) A fair shot: Ensuring universal access to COVID-19 diagnostics, treatments and vaccines. Pp 13

Health Organization (WHO). It is currently the global mechanism that is pooling COVID-19 vaccines for distribution to poor countries.

The COVAX facility seeks to use its collective purchasing power to negotiate pricing and speed up production of COVID-19 vaccines. As of November 2020, 178 countries had signed commitment agreements, submitted non-binding confirmations of intent to participate, or are eligible to participate in the COVAX Facility.[26]

In theory this mechanism should address vaccine inequality, but it is still unclear how this will be done. What has been happening is that "many of the higher-income economies have been purchasing additional batches of vaccine doses via bilateral agreements with companies. This has created a parallel procurement structure that allows rich countries to tap into global availability via multiple sources, compromising the effectiveness of COVAX as a mechanism to foster global access to COVID-19 vaccines."[27] And Canada, for example, is even actively undermining it by joining the initiative, thereby making whatever scarce doses it acquires through the program even scarcer.[28]

African civil society is critical of the COVAX facility because COVAX will reach 20% coverage at best and nine out of 10 people in most low and middle-income countries are set to miss out this year on vaccines. COVAX is overwhelmed and unable to meet its targets and is grossly underfunded. There are also questions about its transparency as it is an unelected body, which cannot be held to account for anything that they do and they have created a range of regulations and conditions in terms of vaccines. While COVAX is an absolutely critical and essential component of how to get vaccines to the community COVAX, according to civil society does not represent equitable access. More needs to be done get vaccines to all people everywhere.

WTO Director-General Nigeria's Ngozi Okonjo-Iweala (and the first woman to hold this post) has called disparities in vaccine roll out *"the moral and economic issue of our time"*

The Trade-Related aspects of Intellectual Property Rights TRIPS is the World Trade Organisation (WTO) comprehensive multilateral agreement on intellectual property. It sets out minimum standards for many forms of intellectual property that are pertinent to pharmaceutical companies, such as copyrights, trademarks, patents, undisclosed information (including trade secrets and test data) and anti-competitive practices.

On 2 October 2020, South Africa and India submitted a joint proposal to the WTO, to waive certain IP rights under the TRIPS agreement temporarily. If the waiver is granted, it would allow countries who are WTO members to choose to neither grant nor enforce patents and other intellectual property (IP) related to all COVID-19 drugs, vaccines, diagnostics, and other technologies. This will facilitate collaboration in research and development and manufacturing, scaling up and supplying COVID-19 tools.[29]

The waiver is supported by a significant number of lower- and middle-income countries but most high-income countries including the UK, Canada, Germany, Australia, Norway and Japan have been blocking the waiver. These countries together with pharmaceutical companies are trying to hide behind the COVAX facility to give small donations to poorer countries, rather removing the TRIPS so that these countries can manufacture at scale.

The waiver has been discussed at both the TRIPS Council the WTO General Council in and 2021, and will be again in early June, but it could still be weeks before an agreement is reached.[30] The first woman WTO Director-General, Ngozi

[26] Ibid Pp 14
[27] Ibid pp 15
[28] https://www.cbc.ca/news/politics/canada-stephen-lewis-covax-1.5930344
[29] Chrome extension://oemmndcbldboiebfnladdacbdfmadadm/https://msfaccess.org/sites/default/files/2020-10/COVID_Brief_ProposalWTOWaiver_ENG_2020.pdf
[30] Bloomberg, 'US vaccine patent surprise roil pharma as WTO debate heats up' 7 May 2021, accessed 30 May 2021

Okonjo-Iweala, has the opportunity to show what she is capable of by ensuring that the TRIPS waiver passes.

COVID-19 technology access pool (C-TAP) is another initiative launched by WHO in partnership with the government of Costa Rica and 40 other member states to ensure that the knowledge is shared to allow the manufacturing of vaccines to happen globally. It provides a platform for developers of COVID-19 therapeutics, diagnostics, vaccines and other health products to voluntarily share their intellectual property, knowledge, and data, with multiple quality-assured manufacturers. This enables manufacturers that currently have untapped capacity to produce COVID-19 health products by giving them the legal rights to manufacture and sell the products; the technological know-how required to develop high-quality products effectively and efficiently; and access to clinical data needed to obtain regulatory approval for their products.[31]

Table 1.3: Vaccine roll out in SADC August 2021

	# vaccinated (one dose)	% fully vaccinated
Seychelles	74,1%	69,7%
Mauritius	53,8%	43,6%
Comoros	13,9%	4,8%
Zimbabwe	11,7%	5,8%
South Africa	11,0%	5,6%
Botswana	10,1%	5,4%
Namibia	6,7%	2,0%
Eswatini	3,8%	2,8%
Angola	3,0%	2,2%
Malawi	2,4%	0,7%
Zambia	1,6%	0,9%
Lesotho	1,7%	1,7%
Mozambique	1,3%	1,0%
DRC	0,1%	0,0%
Madagascar	0,7%	0,0%
Tanzania	0,0%	0,0%
Region	4,0%	2,1%

Source: GitHub[33] August 2021.

As of December 2020, no company had joined C-TAP. While nearly 40 states had expressed support for C-TAP, countries with strong pharmaceutical industries remained silent, including France, Germany, Switzerland, the UK and the USA.[32] Only 40 of the 200 WHO Member States have so far endorsed C-TAP. The only SADC States to have endorsed are Mozambique, South Africa and Zimbabwe.

In August 2021, only 2.1% of SADC citizens had been fully vaccinated, and 4% partially vaccinated. In seven countries less than 2% of the population has been fully vaccinated. In DRC, Madagascar and Tanzania, less than 1% of their populations have been vaccinated.



Seychelles (70%) and Mauritius (44%) had the highest rate of vaccine roll out. With a population of 98,340 heavily reliant on tourism, Seychelles had registered 11,145 cases by 3 June 2021 (11.3% of the population). This gave Seychelles the highest rate of infection, prompting the island to move expeditiously on vaccinations. The small population facilitated rapid vaccination roll out.



Madagascar only announced its decision to join the COVAX initiative on 1 April 2021. Until mid-March 2021, President Rajoline and his government had advised the use of the herbal "Covid-Organics" drink as an effective cure against COVID-19, despite the lack of scientific evidence. Citizens have been left in the dark. The absence of transparent and reliable health data prevents the assessment of the magnitude of the pandemic in the country. During the symposium on equitable vaccine access in Southern Africa the government had to acknowledge the need for a vaccine.[34] Less than 1% of the population has been vaccinated.

The denial of the existence of the pandemic in **Tanzania** by former President Magufuli has put Tanzania far behind in terms vaccination roll out. President Suluhu Hassan who assumed office in March has taken a different approach setting up a health task force to review the status of COVID-19 and advise her on how to tackle the

[31] https://www.who.int/initiatives/covid-19-technology-access-pool/what-is-c-tap
[32] Amnesty International (2020) A fair shot: Ensuring universal access to COVID-19 diagnostics, treatments and vaccines. Pp19
[33] https://github.com/owid/covid-19-data/tree/master/public/data accessed 6 August 2021
[34] International Commission of Jurists, The Unvaccinated: Equality not charity in Southern Africa, a briefing paper, May 2021, pp 39

virus. The task force has already made several recommendations to fight the pandemic. President Suhulu Hassan will look to obtaining vaccines from COVAX, the global vaccine-sharing facility for low-income countries and contrary to her predecessor she has encouraged Tanzanians to wear masks, practice social distancing and has implemented travel restrictions. She is also expected to roll out COVID-19 data on Tanzania, which has not been reported on since April 2020 which will go a long way in the fight against the pandemic in the East African region and beyond.[35]

Vaccine allocation - *Fair, equitable and timely*

The African Union and African Centre for Disease control and Prevention (CDC) have developed a *Framework for fair, equitable and timely allocation of COVID-19 vaccinations in Africa*, which outlines Africa's approach to vaccine rollout to ensure it does not exacerbate already existing inequalities in societies.

This acknowledges that: "The indigenous value system emphasizes social solidarity and equitable distribution of resources among all members of the society. *It however is exclusionary on the basis of gender.*" The framework declares that "all persons, irrespective of their gender, religion, sexual orientation and political affiliation should have access to the vaccine. In the context of access to vaccines, the culture of the African society would translate to decision-making towards the greater good for all while protecting vulnerable individuals and groups from exploitation and other forms of harm and wrong."[36]

The Africa COVID-19 Vaccine Development and Access Strategy aims to accelerate African involvement in the clinical development of a vaccine; ensure African countries can access a sufficient share of the global vaccine supply; and remove barriers to widespread delivery and uptake of effective vaccines across Africa through work on streamlined regulatory approvals, preparations for the delivery of the vaccine, and community engagement and communication campaigns to ensure uptake.[37] The Framework for fair, equitable and timely and allocation of COVID-19 vaccinations in Africa outlines some criteria for vaccination selection criteria. These include: whether the country supply chain logistics can support the requirements; trade-offs between cost of vaccine and timely access to available vaccines; use of vaccines that are less efficacious than others, but available early or can be stored at better conditions.[38]

Table 1.4: Comparison of vaccines in use in SADC

	Doses	Storage temp degrees Celcius	Price	Efficacy	Efficacy against variants
Pfizer-BioNTech	2	-70	$20 per dose	About 95%. Apparently 100% at preventing hospitalisation and death.	Data suggest "quite effective" against the UK variant as well as the South African and Latin American variants.
Moderna	2	-20	$33 per dose	About 95%. Apparently 100% at preventing hospitalisation and death	Lab data suggest "quite effective" against the UK variant as well as the South African and Latin American variants.

[35] Rasana Warah, After a year of denial, Tanzania responds to COVID-19 under new female leadership, ONE, 1 July 2021, https://www.one.org/africa/blog/tanzania-president-samia-suluhu-hassan/ accessed 25 July 2021
[36] Africa Centres for Disease Control and Prevention (Africa CDC), African Union, Framework for fair, equitable and timely and allocation of COVID-19 vaccinations in Africa (January 2021)
[37] Ibid
[38] Ibid

	Doses	Storage temp degrees Celcius	Price	Efficacy	Efficacy against variants
AstraZeneca	2	Regular fridge temp	$2.15 in the EU; $3-4 in the UK and U.S.; $5.25 in South Africa	62 - 90 %	At least one study finds it has little effect against the South African variant, but appears effective against UK and Brazilian variants.
Johnson & Johnson	1	Between 2°C and 8°C	$10 per dose	66% efficacy at preventing symptomatic COVID-19 infections. In the U.S. it was slightly higher, 72%. Appears to be 100% effective at preventing hospitalisations and death	Based on clinical studies in Africa, UK and Latin America, there is evidence the vaccine is effective against the variants, although less so against the South African and Latin American strains.
Sputnik V	2	Regular fridge temp	$10 per dose	91,4%	Unknown. Clinical trial data was largely conducted in Russia prior to the emergence of major variants.
Sinovac Biotech	2	Between 2°C and 8°C	$60 per dose in China ($29.75 per dose)	50.38% to 91.25%, depending on the clinical trial	Unknown, although a study in Brazil demonstrated 50.4% efficacy at preventing symptomatic infections.
Sinopharm	2	Between 2°C and 8°C	$19-36	79% efficacy against hospitalisation	This vaccine has not yet been evaluated in the context of circulation of widespread variants of concern.

Sources: Biospace and BBC News.[39]

Table 1.4 provides a comparison of the vaccines most widely used across the globe and within SADC in particular. It compares by number of doses, storage temperature, cost and efficacy, which are all key consideration in the choice of a vaccine.

Given cost and logistics considerations most SADC countries are using Astra Zeneca (AZ). This was also the vaccine available through the COVAX facility, which is the means by which most countries have received their vaccines. While AZ appears to be effective against the UK and Brazil variants, the efficacy of AZ against the South African variant is low. Eight countries are using the more expensive Sinopharm and/or Sinovac vaccines, which may be because they are more readily available.

Table 1.5: Vaccines in use in SADC

Country	Vaccinations being used
Angola	Astra Zeneca (AZ) Sinopharm
Botswana	AZ, Sinovac
Comoros	AZ, Sinopharm
DRC	AZ
Eswatini	AZ
Lesotho	AZ
Madagascar	AZ
Malawi	AZ
Mauritius	AZ, Sputnik V ,Covaxin
Mozambique	AZ, Sinopharm
Namibia	AZ, Sinopharm
Seychelles	AZ, Sinopharm, Sputnik V
South Africa	Pfizer BioNTech J&J
Tanzania	-
Zambia	AZ, Sinopharm
Zimbabwe	Sinopharm Sputnik V Sinovac Covaxin

Source: Africa CDC.[40]

[39] https://www.biospace.com/article/comparing-covid-19-vaccines-pfizer-biontech-moderna-astrazeneca-oxford-j-and-j-russia-s-sputnik-v/ accessed 6 June 2021, and https://www.bbc.com/news/world-asia-china-55212787 accessed 6 June 2021

[40] https://africacdc.org/covid-19-vaccination/ accessed 3 June 2021

In February 2021, the South African government announced that it would halt Astra Zeneca vaccine rollouts after a study showed that it was less effective against the B1.135 variant, which had already spread considerably across Southern Africa. While some Southern African countries, such as Eswatini and the DRC followed suit, others have moved ahead often without any explanation to the public of their decision to maintain the AZ vaccine.[41] South Africa is now using Pfizer BioNTech and J&J, which differ both in price and storage requirements.



Questions have however been raised about the efficacy of the vaccines in Seychelles, which had by 3 June 2021 already fully vaccinated 62% of its population. The island has the highest per-capita vaccinations in the world. 57% of those vaccinated received the Sinopharm vaccine, and 43% AstraZeneca. Worryingly, however, despite being the *most vaccinated nation in the world*, the country has seen a rise in COVID-19 cases. Between 3 June and 22 July confirmed cases increased from 11,145 to 17,745. With 70% of the population fully vaccinated, Seychelles should have reached herd immunity. Theoretically new cases should have dropped. The country has also recorded deaths of six fully vaccinated people.[42] About two-thirds of those who tested positive largely had mild or no symptoms. Of those who needed admission to hospital, 80% were people who hadn't been vaccinated, and a majority of these also had other health conditions.[43] Other possible explanations include:

- Herd immunity is unreachable due to inadequate efficacy of the vaccines being used;
- Variants that escape vaccine protection are dominant in Seychelles;
- The B1617 variant which appears to be more infectious than other variants is spreading;
- Mass failures of the cold-chain logistics needed for transport and storage, which may have rendered some of the vaccines ineffective.[44]

This is a situation that should be closely followed in the region so that lessons can be shared across the region, regarding efficacy of the vaccines, especially protection against new and more transmissible variants.

What is still unknown is how often vaccines will need to be administered as this will affect both cost and access. If rich countries in the global north continue to hoard vaccines, with current levels of vaccine inequality it is unlikely people in the global south will have get the required booster shots when needed.

Civil society response



The People's Vaccine Alliance (PVA) is a coalition of organisations and activists united under the common aim of campaigning for *A People's Vaccine*. Currently 44 organisations from all over the world have signed up as official members of the Alliance. The African Alliance, which is currently coordinating the work of The People's Vaccine Alliance in Africa.

[41] International Commission of Jurists, The Unvaccinated: Equality not charity in Southern Africa, a briefing paper, May 2021, pp 34
[42] Pharmaceutical Technology - https://www.pharmaceutical-technology.com/special-focus/covid-19/international-update-post-vaccination-covid-fatalities-in-seychelles/ accessed 30 July 2021
[43] BBC News, Covid: Why has Seychelles seen rising case numbers? 21 May, https://www.bbc.com/news/57148348, accessed 30 July 2021
[44] https://theconversation.com/covid-is-surging-in-the-worlds-most-vaccinated-country-why-160869

The PVA is calling for a free of charge vaccine for everyone everywhere, distributed according to needs, with no exceptions. The goal is to openly share the vaccine science technology and know-how, through the WHO C-TAP, to be able to scale up manufacturing of vaccines globally. The PVA is trying to influence rich country governments who could push pharmaceutical companies to share the science and technology.

Another area of focus for the PVA is the TRIPS Waiver, focusing advocacy efforts on countries opposed to the waiver, including UK, Canada, Germany, Australia, Norway an. There was a strong lobby in the US, which contributed to the Biden-Harris administration agreeing to the waiver.

African Vaccine Delivery Alliance (AVDA), a member of the Alliance, aims to ensure that vaccines get to communities as soon as possible and they have procured and distributed across the continent working with African Centre for Disease Control (CDC), which falls under the African Union (AU). AVDA works across three pillars:

- African involvement in clinical development.
- Ensuring access to sufficient vaccine supply.
- Regulation and logistics.

Women's rights and vaccine roll-out



The disproportionate effects of the pandemic, if not addressed, will affect the vaccine roll-out process, further exacerbating gender inequalities. The Association for Women's Rights in Development (AWID) held a Vaccine Justice Teach in May to explore the ways transnational corporations, philanthrocapitalism and vaccine nationalism are interfering with public decision-making to prioritise corporate interests over public interests and why this is a feminist issue.

All of the speakers underscored how corporates have captured the health market, how privatisation of healthcare has further limited women's access and how states are reneging on their duty to provide health care, as a human right. "Public health provision is a cornerstone of a fairer social organization of care and thus a central intersectional feminist demand."[45]

Sibongile Tshabalala from the Treatment Action Campaign in South Africa who spoke about the struggle of the HIV and AIDS movement in getting equal and affordable access to HIV and AIDS treatments. She reminded us that "No one is safe until everyone is safe" and that this calls for collective pushback.[46]

There is a global movement for a people's vaccine and feminists should support this movement and bring feminist perspectives and analysis. It is also imperative that feminists are involved in vaccine and treatment research and manufacturing processes so that issues that specifically affect women are addressed. Some considerations include:

- **Access in terms of mobility** - what challenges will women face in reaching designated health facilities, what are the travelling distances, what is the cost, how many times do they need to get to the facility etc.
- **Access to technology** - if access to information or registration is largely electronic, this will exclude large proportions of the population, thus plans should include a range of ways to share information about vaccine access and safety to ensure there is equal access to information.
- The **limited decision-making power of women in seeking healthcare** and their limited access to health resources.

[45] Massaya Llavaneras Blance from DAWN at AWID's Vaccine Justice Teach-in
[46] Sachini Pereea from Realising Sexual and Reproductive Justice (RESURJ) at AWID's Vaccine Justice Teach-in

- **Documentation required**, will this prevent women, especially non-citizens, particularly migrants and refugees, from receiving the vaccination.
- The **safety of women** should be a key consideration, particularly sex workers, gender non-conforming people and migrants and refugees at risk of experiencing sexual harassment, exploitation, disrespect and other forms of GBV when seeking health services.
- Analysis of data **disaggregated by sex** along the clinical pathway - from testing to vaccination - to understand the differential impact of the pandemic on women and men, how vaccines are being rolled out and who has access to testing and services. It is imperative that countries prioritise disaggregating data to ensure fair and equal access to vaccinations for all.

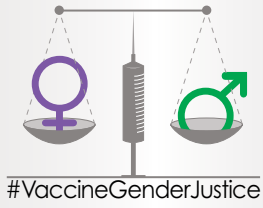
Biological sex is relevant and sex-disaggregated analysis important for a range of different reasons. A growing body of research highlights the influence of biological sex in clinically relevant health outcomes, including sex-specific differences in immunity, pharmacology, and vaccines outcomes (side-effects and efficacy). In vaccine studies, cisgender females tend to develop higher antibody response and, relatedly, higher efficacy and more side-effects, suggesting the need for sex-differentiated dosing regimens.[47]

It is for these reasons that it is essential for researchers and regulatory agencies to include biological sex as a variable in trial data analysis and reporting, to inform policies and programmes to address the impact of the pandemic on SRHRs.

As we are still in the very early stages of the vaccination roll-out there are still many unknowns in terms of the side-effects of the vaccine. More research is needed but reports from women who have been vaccinated should be an important identifier of potential side-effects. For example, there have been concerns relating to the vaccine's impact on reproductive health after some women reported getting heavier periods after the first dose of the vaccine. Women took to Twitter to share their experiences about excessive bleeding following being vaccinated. While medical practitioners have cautioned against associating these symptoms with the vaccine because there is no conclusive evidence to show this,[48] it is imperative that this evidence be gathered so that women can make informed choices about their bodies.

#VaccineGenderJustice call to SADC Heads of State, August 2021

We, the representatives of the Southern African Gender Protocol Alliance, women's rights net-works in 16 SADC countries that campaigned for the SADC Protocol on Gender and Development and now its implementation.



Noting that only 4% of the 360 million people in SADC have been partially vaccinated and only 2% fully vaccinated.

Mindful of the devastating impact of COVID-19 on the lives and livelihoods of all citizens of SADC, especially women and marginalised groups.

Call on Heads of State to

- Remove barriers to widespread delivery and uptake of effective vaccines across SADC.
- Ensure that all SADC citizens, especially women and marginalised groups have access to, and information on, the most effective vaccines, as soon as possible.
- Provide sex, region and age specific data for effective monitoring of the roll out.
- Support the World Trade Organisation Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) waiver proposal on COVID-19 vaccines.

#VoiceandChoice; #VaccineGenderJustice

[47] Lancet, Sex-disaggregated data in COVID-19 vaccine trials, Published Online March 5, 2021, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00384-6/fulltext, accessed 10 July 2021
[48] Halima Zoha Ansari, The Global COVID-19 Vaccine Roll-Out Shows The Lack Of Research On Women's Biology, 5 May 2021, https://feminisminindia.com/2021/05/05/the-global-covid-19-vaccine-roll-women-health/ , accessed 20 July 2021

Global commitments to gender justice



All SADC member states subscribe to the **Sustainable Development Goals (SDGs)** adopted in 2015. Indeed, the SADC Protocol on Gender and Development is the only SADC Protocol that has been updated in line with the SDGs and now has a Monitoring, Evaluation and Results Framework incorporating the 35 gender indicators of the SDGs.

The specific goals referred to in this Barometer are Goals three (Good Health and Well Being), five (Gender Equality) and goal 13 (Climate Action - reducing greenhouse gas emissions and investing in climate resilience). Goal 3 of the SDG includes SRHR targets of reducing maternal mortality, child mortality, ending AIDS, tuberculosis, malaria, tropical diseases, hepatitis, and other communicable and water-borne diseases,[49] 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.

2020 marked a five-year milestone towards achieving the 2030 Agenda for Sustainable Development. It is therefore a pivotal year for accelerating progress towards the attainment of gender equality and the empowerment of all women and girls, everywhere. The global community marked the twenty-fifth anniversary of the **Beijing Declaration and Platform for Action (1995)**. The Political Declaration set to be tabled during the 2020 Commission on the Status of Women but postponed due to the COVID-19 pandemic aims to[50]:

- Undertake a review and appraisal of the implementation of the Beijing Declaration and Platform for Action and the outcome documents of the twenty-third special session of the General Assembly, entitled "Women 2000: gender equality, development and peace for the twenty-first century".
- Assess current challenges and gaps that affect the implementation of the Beijing Declaration and Platform for Action and the achievement of gender equality and its contribution towards the gender-responsive implementation of the SDGs.
- Ensure the acceleration of the implementation of the Platform for Action, with a commitment to ensuring the mainstreaming of a gender perspective into United Nations conferences and summits in the development, economic, social, environmental, humanitarian and related fields so that they effectively contribute to the realisation of gender equality and the empowerment of all women and girls.

GENERATION EQUALITY

The 25th anniversary of the Beijing Conference gave rise to the **Generation Equality Forum**, convened by UN Women and co-hosted by the governments of Mexico and France. On 1 July 2020, the convenors announced the leaders of

[49] Sustainable Development Goals
[50] United Nations Political Declaration on the Twenty-Fifth Anniversary of the Fourth World Conference on Women, 2 March 2020

the Generation Equality Action Coalitions to deliver concrete and transformative change for women and girls around the world in the coming five years. They will focus on six themes that are critical for achieving gender equality: gender-based violence, economic justice and rights, bodily autonomy and sexual and reproductive health and rights, feminist action for climate justice, technology and innovation for gender equality, and feminist movements and leadership. Adolescent girls and young women will be at the heart of each **Action Coalition**'s work[51]. Gender Links, as secretariat of the Southern African Gender Protocol Alliance, is a co-leader of the feminist movement building Action Coalition.

In 2021, GL and Alliance partners assisted in co designing the actions, targets and indicators specific to Action Coalition 6 ahead of Mexico and Paris forum in March and June/July respectively. The four actions drafted and agreed include:

1- By 2026, double the global annual growth rate of funding from all sectors committed to women-led and feminist led movements, organisations, and funds in all their diversity, including those led by trans, intersex, non-binary people.
2- Promote, expand, protect, civic space across all domains, including online, and support the efforts of women and feminist human rights defenders and women peacebuilders - including those who are trans, intersex, non-binary - to defend civic space and eliminate barriers to feminist action, organizing and mobilization in all its diversity.
3- By 2026, increase the meaningful participation, leadership and decision-making power of girl leaders, and of women and feminist leaders, including those who are trans, intersex, non-binary, through efforts to: (1) Advance gender parity in all aspects of public and economic decision making, including the private sector, civil society, international organizations, political and government institutions including executive and legislative positions. (2) Promote and expand feminist, gender transformative and inclusive laws and policies.
4- Dedicate specific, flexible financial, technical, and other resources for adolescent girls and young feminist leaders and their movements and organizations to strengthen them and create safe and inclusive spaces for their meaningful participation in decision-making processes.

Twenty-five years ago, the **International Conference on Population and Development (ICPD)** endorsed a Programme of Action that laid out an ambitious population and deve-lopment strategy. In November 2019, the world commemorated the 25th anniversary of ICPD in Nairobi. The Nairobi summit aimed to:

- Obtain political reaffirmation of the ICPD Programme of Action, within the context of the 2030 Agenda for Sustainable Development and the SDGs.
- Build political and financial momentum to fulfil the unfinished business of the ICPD Programme of Action.
- Reinvigorate and expand the community of people necessary to push forward the ICPD agenda on all fronts.[52]

The summit's 12 global commitments highlight three zeros:

- The end to preventable maternal mortality,
- Unmet need for contraceptives, and
- Gender-based violence and harmful practices.

Other commitments made at the summit include, achieving SRHR as part of universal health coverage, respond to demographic diversity, end gender-based violence and harmful practices, uphold sexual and reproductive health and rights in humanitarian and fragile contexts, and mobilise more financial resources to achieve SRHR.

[51] UN Women, Announcement of Global Leaders to Accelerate Gender Equality, July 2020
[52] UNFPA, Report on the Nairobi ICPD25 Summit.

More than 350 organisations signed on to a **joint declaration on abortion** for ICPD25 developed by the Asian-Pacific Resource and Research Centre for Women (ARROW), Center for Reproductive Rights, CHOICE for Youth and Sexuality, Ipas, Marie Stopes International, Realising Sexual and Reproductive Justice (RESURJ), Spectra, and Vecinas Feministas. The Declaration states that the world will not meet the SDGs if governments do not urgently address access to safe abortion, with support from UN agencies, civil society organisations, health providers, the private sector, and the donor community. It notes that this means abortion must be safe, legal, available, accessible, and affordable.

This year marks 40 years since the reporting of the first case of AIDS; 25 years since the Joint United Nations Programme on HIV/AIDS commenced its work as a unique multi-stakeholder and multisectoral programme to lead the efforts of the United Nations system against the global AIDS epidemic and 20 years since the landmark 2001 Declaration of Commitment on HIV/AIDS and the decision to establish the Global Fund to Fight AIDS, Tuberculosis and Malaria[53]. In 2021 world leaders adopted the "Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030" - follow up to the 2020 targets set out in 2016 political declaration on and AIDS[54].

UN Women and women's rights organisations have demanded that **gender be integrated into COVID-19 response plans**, not only to achieve better outcomes for women and girls, but to build stronger and more resilient economies and societies for everyone[55]. UN Women's Data Hub dashboard provides a compilation of indicators that will inform gender-responsive policy action on COVID-19.

The African context



African Union (AU) Heads of State and Government declared 2020 to 2030 as the African Women's Decade on Financial and Economic Inclusion during the 33rd Ordinary Assembly held in Addis Ababa, Ethiopia. The AU in collaboration with the United Nations Economic Commission for Africa (UNECA), launched the African Women Leadership Fund (AWLF) with the aim of mobilising resources from the global private sector to fund women initiatives and promote an enabling environment for the increased participation of women across the continent. The Africa Continental Free Trade Agreement (AfCFTA) promises to benefit women in business, especially women cross-border traders across the continent[56].

The African Union Commission affirmed its preparedness for the COVID-19 virus through the Africa Centre for Disease Control and Prevention (Africa CDC), which activated its Emergency Operation Centre, to support Member States with the necessary surveillance and responses. In March the AU called on governments to enhance the rights and opportunities of women and girls during the COVID-19 pandemic.

[53] 74th UN Assembly Declaration on HIV and AIDS, https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf accessed 8 August 2021.
[54] Declaration on HIV and AIDS , https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf accessed 8 August 2021
[55] UN Women COVID-19 and Gender Monitor, June 2020
[56] Message of the Chairperson of the African Union Commission H.E. Mousa Faki Mahamat on the occasion of International Women's Day, March 2020

Goal three of the **African Union Agenda 2063** aims to increase 2013 levels of SRHR Services to women by at least 30%. Agenda 2063 provides for equal, affordable and timely access to independent courts and judiciary that deliver justice without fear or favour. 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. AU Agenda 2063 provides that all harmful social practices (especially female genital mutilation and child marriages) will be ended and barriers to quality health and education for women and girls eliminated. 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, female genital mutilation and virginity testing.[57]

The **Maputo Protocol** is a ground-breaking Protocol on women's and girls' human rights, both within Africa and beyond, and was adopted in 2003 and came into force in 2005. This Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa compensates for shortcomings in the African Charter (1981) with respect to women's and girls' rights. It includes 32 articles on women's and girls' rights, and provides an explicit definition of discrimination against women, which was missing in the African Charter:

> Discrimination against women means 'any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life'.

Women's rights organisations have played a key role in adoption of the Maputo Protocol, and continue to play a critical role in its further ratification, domestication and implementation. The Barometer refers to progress made on the Maputo Protocol in some themes.

SADC context

The **Southern African Gender Protocol Alliance** (the Alliance) is a "network of networks" that campaigned for the adoption of the SADC Protocol on Gender and Development (the Protocol) in 2008 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. The Alliance has spearheaded women's political participation and SRHR campaigns including during the COVID-19. Each year since 2009, the Alliance has produced a Barometer, using the Protocol as the main standard setter for gender equality in the region. Although the #VoiceandChoice Barometer draws from a range of normative frameworks, the SADC Gender Protocol is the key yardstick in all barometers because this instrument incorporates all the existing continental and global commitments to gender equality.

Articles 12 to 13 of the **SADC Protocol on Gender and Development** outline the provisions for women's equal and effective participation in political decision-making. This includes use of special measures to ensure that women have the opportunity to contest in elections. Articles 15 to 19 of the Protocol highlight the provisions that concern economic justice, a chapter included in this #VoiceandChoice Barometer. Article 26 concerns Sexual Reproductive Health

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

and Rights provisions and Article 27 concerns HIV and AIDS provisions. Gender and Climate Change provisions are outlined in Article 31 of the Protocol and these are cross-referenced with the Protocol on Environment[58]. These provisions are relevant to this edition of the Barometer. The Southern African Gender Protocol Alliance has been tracking implementation of the provisions and advocating for its domestication by Member States.

In June 2021, Gender Links participated in the Regional Dialogue for Non-State Actors on the SADC Regional Indicative Strategic Development Plan (RISDP) 2020-30. The Alliance coordinator facilitated a dialogue discussion on "implementing the SADC Protocol on Gender and Development in the time of Covid-19".

Another key instrument is the Annual SADC Head of States, which in 2021 holds the 41st Ordinary Summit of Heads of State and Government to be held in Lilongwe, Republic of Malawi on 17-18 August 2021. The Summit theme *"Bolstering Productive Capacities in the Face of COVID-19 Pandemic for Inclusive, Sustainable, Economic and Industrial Transformation"* seeks to accelerate the implementation of the SADC Regional Indicative Strategic Development Plan (RISDP) 2020-2030, in particular, the Industrialisation and Market Integration pillar.

While specific SRHR SADC strategies include the Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030 and corresponding Score Card to measure progress towards SRHR access and achievements in the region. The objectives of the SRHR 2019-2030 Regional Strategy are to strengthen the capacity of SADC Member States to deliver combined and inclusive SRHR services, which bring together policies, guidelines and protocols, to enhance synergy of strategies and programmes at national and regional levels and to enhance sharing of information, experiences and best practices among Member States. The age of consent and access to SRHR services provided in the SRHR 2019 -2030 plan set target that facilitate review of archaic policies that prevent the realisation of full SRHR provisions in the 15 member states.

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 Members of Parliament 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.

The SADC Key Populations strategy provides guidelines for HIV prevention, treatment and care and sexual and reproductive health and rights among key populations[59]. The Key Populations strategy is a result of a series of participatory and interactive processes that involved members of key populations, governments, civil society and development partners. SADC Ministers responsible for Health and HIV and AIDS approved it, in November 2017. The Strategy is in line with the revised Regional Indicative Strategic Development Plan (RISDP), which provides the Secretariat and other SADC institutions with a clear view of SADC's approved economic and social policies and priorities.

In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 **SADC member states approved the groundbreaking 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

[58] SADC Protocol on Gender and Development, revised in 2016
[59] SADC, 2018, Key Populations Strategy

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.[60]

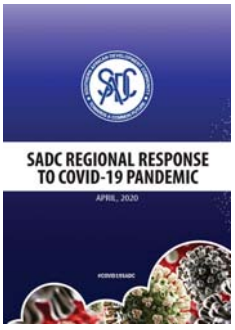
The Alliance also worked with the SADC Women's Parliamentary Caucus, SAfAIDS and the Southern African Aids Trust to lobby for the SADC SRHR strategy 2019 to 2030 and annually host national consultations on its implementation. The parallel mapping of laws for the #VoiceandChoice Barometer provides a rich database for developing model laws based on regional experiences.

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 sustainable development goals.[61]

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).



SADC response report on COVID-19, April 2020.
Photo courtesy of SADC

In April 2020, **SADC produced an analytic report on the regional response and impact of COVID-19**. The report acknowledged the gendered dimensions of the pandemic. In the report, SADC recommends that Member States need to pay special attention to the rising cases of domestic violence and gender-based violence during the COVID-19 pandemic by ensuring that women and girls are protected from all forms of abuse. Further, Member States need to incorporate gender perspectives in all responses to COVID-19 to ensure that actions during, and after the COVID-19 crisis aim to build more equal, inclusive and sustainable economies and societies[62]. SADC has produced at least 10 reports on the pandemic excluding sectoral impact reports. However, there is need for political commitment by Member States to guard gender equality gains made in the past two decades as the pandemic rages on.

[60] The SADC SRHR Strategy, 2019 - 2030
[61] https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval
[62] SADC, 2020, Regional Response to COVID-19 Pandemic, April 2020

The #VoiceandChoice campaign

SADC Protocol@Work Summit

Sommet Protocole au travail de la SADC

Cimeira do Protocolo@Work da SADC

The *#VoiceandChoice* campaign, launched in August 2018 by the Alliance, 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 campaign aims 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 the SRHR regional and global commitments.
- 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.



Learners from various schools in Windhoek commemorating Menstrual Health & Hygiene Day.
Photo: Veronika Haimbili

In August 2018 the Alliance focal networks in 15 SADC countries[63] and representatives from the 400 Centres of Excellence (COEs) for Gender in Local Government[64] met to map out joint strategies for attaining SRHR in SADC countries. Over the last two years, with the support of the Amplify Change Fund, national and local partners have developed SRHR campaigns in 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.

[63] Comoros had not yet joined
[64] A GL Programme that has been running to over a decade in ten SADC countries to promote gender responsive local governance.

Table 1.6: Campaigns conducted by the Southern African Gender Protocol Alliance

Country	Menstrual health		Maternal health		ASRHR		Teenage pregnancy		Safe abortion		HIV and AIDS		Child marriage		GBV		Sexual Diversity		National	Local
	N	L	N	L	N	L	N	L	N	L	N	L	N	L	N	L	N	L		
Angola	1		1		2		1				1								**6**	**0**
Botswana					1				1								1		**3**	**0**
DRC													1		4				**5**	**0**
Eswatini	1	10			1										1		1		**4**	**10**
Lesotho	1	5							1	5		5	1	5					**3**	**20**
Madagascar	1	10			2	10	1												**4**	**20**
Malawi			1						1				1		1		1		**5**	**0**
Mauritius													1				1		**2**	**0**
Mozambique	1	10											1	10					**2**	**20**
Namibia	1	5		3	1	5						2					1		**3**	**15**
Seychelles									1						1		1		**3**	**0**
South Africa		3		4						3						3			**0**	**13**
Tanzania		1			2								1						**3**	**1**
Zambia	1	5	1		2		1		1				1						**7**	**5**
Zimbabwe	1	10	1	10									1	6	1				**4**	**26**
TOTAL	**8**	**59**	**4**	**17**	**11**	**15**	**3**	**0**	**5**	**8**	**1**	**7**	**8**	**21**	**8**	**3**	**6**	**0**	**54**	**130**

N=National; L=Local

Source: Southern Africa Gender Protocol National Reports.

Table 1.6 shows that the #VoiceandChoice coalition has implemented 54 national and 130 local government campaigns. GL has connected the dots at local level through developing youth and gender aware policies, services and service directories in 100 COEs and through running 174 local-level campaigns. Junior councils and other youth formations in the COEs have conducted community dramas and surveys on ASRHR services in eight countries. These showed that providers denied two-fifths of young people access to services because an adult did not accompany them.

In 2020/2021 Alliance focal networks in all SADC countries except for Mozambique[65] and Comoros held COVID-19 learning meetings and action planning workshops. Each network launched the Barometer in the 14 countries. The sessions included reviewing an SRHR policy checklist to ensure crucial advocacy and service delivery during lockdowns.

The Alliance networks completed 13 COVID-19 learning papers with case studies of best practices and challenges. During the Sixteen Days of Activism on GBV GL and the Alliance networks conducted ten cyber dialogues on GBV and COVID-19; Maternal and Menstrual Health; HIV and AIDS; Sexual diversity; Media; Safe abortion and ASRHR.

Zambia held the highest number of national campaigns (7) followed by Angola (5). Zimbabwe held the highest number of local level campaigns (26). The menstrual health local level campaign was implemented the most (59) followed by the child marriage campaign. The menstrual health, child marriages and GBV campaigns were the most popular campaigns at a national level. Six countries (Botswana, Eswatini, Malawi, Mauritius, Namibia and Seychelles) are implementing the sexual diversity campaign despite the restrictive laws and attitudes towards LGBTI in most countries. National and local networks in Botswana, Lesotho, Malawi, Seychelles, South Africa, Zambia and Zimbabwe have taken up safe abortion campaigns.

[65] The Alliance network partner faced institutional challenges due to COVID-19 restrictions, also lost a critical staff member to the pandemic.

The Eswatini Young Women Alliance

EYWA strongly campaigns for ASRHR rights for youth in Eswatini with the specific aim of ensuring that every young woman in Mbabane, Zulwini, Ngwenya, Lavumisa and Mankayane get access to sanitary pads even during the school closure. During lockdown the EYWA conducted several virtual consultative meetings in awareness raising in Menstrual Health Campaigns. The 2020 National Youth Policy in Eswatini has strengthened the campaign: "the Policy had been shaped by the voices of young people & represents a new gear in how Government seeks to implement rapid youth development in Eswatini"[66]. The key advocacy challenges in 2021 in ASRHR have been service disruptions in contraceptive access, HIV antiretroviral (ARV) access and sanitary pads provision.



The Eswatini Young Women Alliance marching for gender justice.
Photo: Thandokuhle Dlamini

Angola, **Platforma Mulhers Emaccao (PMA)** has been implementing maternal; menstrual health and teenage pregnancy campaigns. The current focus has been on increasing men and boy's engagements in GBV awareness raising. Due to the impact of the pandemic, GBV has increased and PMA has started to work on GBV response with the police in Angola in response to the growing need. **Teenage pregnancy** campaigning has led to partnership with government mobile prenatal clinics as an outreach service for pregnant women and girls during the COVID-19 pandemic lockdown. Youth championship has taken a new form with active participation in the SRHR campaigns that form part of the Alliance network.

Southern Africa AIDS Dissemination Service, **SAfAIDS** has been conducting the "My Choice, Our Choice" (MCOC) Regional Campaign on Ending Unsafe Abortion among Adolescents Girls and Young Women in SADC. SAfAIDS successfully established a Regional Coalition of Champions and Allies. These are policy-makers, including Members of Parliament and senior officials from Ministries of Health, Gender and Education, Sectoral leadership; and Allies (secondary targets) representatives of adolescent girls and young women (AGYW) and Men and Boys bodies. The Alliance is lobbying and advocating for a teenage pregnancy model law and the removal of abortion criminalising laws.

Safe Abortion campaigns in Seychelles and Zambia have continued to intensify in the current pandemic crisis. With a maternal mortality rate of 380 per 100 000 live births, maternal mortality remains persistently high in **Botswana** which is classified as a Middle Income Country. The Young Women Alliance member in the gender sector of the **Botswana Council of Non-Governmental Organisations (BOCONGO)** reported that more women are resorting to unsafe abortion procedures, which have also added to the number of maternal mortality rates in the nation. There has also been an increase in number of foetal corpses found in the aftermath of Covid-19 lockdowns. The Alliance network is campaigning against discrimination experienced by key populations (men who have sex with men, female sex workers and transgender persons) when accessing services.

[66] Government of Eswatini Publication available on Eswatini Government published 1 October 2020, accessed 24 July 2021.

To date, only **Mozambique** has drafted legislation on decriminalisation of abortion, which lawmakers constituted as the Law on Decriminalisation of Abortion (2019). Mozambique and South Africa are the only two countries that offer abortion on demand in policy and law. Elsewhere, activists are campaigning for less restrictive laws. In Zimbabwe, the Termination of Pregnancy Act allows women access to post-abortion care, yet women are subject to arrest for the abortion act itself. The **Alliance Chairperson Emma Kaliya** together with Chief Mabulabo have publicly spoken out on the urgent need to address unsafe abortions provision and decriminalisation in **Malawi**.

Eight countries have implemented and intensified **child marriage** campaigns. Mozambique has a National Strategy for Preventing and Combating Child Marriages (2016-2019). In **Mauritius**, the Seventh National Assembly of the Mauritius Parliament in November debated and examined the Children's Bill, the Children's Court Bill and the Child Sex Offender Register Bill for the first time. The Children's Bill has two significant provisions: it proposes raising the legal age of criminal responsibility from 12 to 14 years and raising the age of marriage from 16 to 18 years. This will protect children; align with the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. Other key changes include new protections for young children from early child marriage because of harmful religious and cultural customs.

In **Lesotho**, local councils are working with community leaders in ensuring that child marriages halt. The campaigns have seen organisations and government ministries work together in preventing child marriages with the Alliance Lesotho lead, **Women in Law Southern Africa Lesotho (WILSA-L)**. Setbacks in access to family planning services have seen increases in teenage pregnancy that in some cases lead to illegal and unsafe abortions (abortion remains illegal in Lesotho). The Social and Behaviour Change Communication Strategy for Sexual and Reproductive Health and Rights and HIV/AIDS in Lesotho (2020-2021 to (2022-2023) makes provision for prevention against **Child marriages** however, due to the increases of crime, transactional sex and other social challenges due to COVID-19 these protections are ignored.

Alliance Partner **Union Congolaise des Femmes des Medias (UCOFEM)** an association of women journalist has spear-headed a concerted campaign against GBV during the COVID-19 lockdowns. SADC Secretariat GBV data shows that of the eight countries that have data on the proportion of women who have experienced IPV and/or sexual violence at least once in their lifetimes, DRC ranks highest at 64% of women, followed by Zambia at 49%[67]. Awareness raising and assistance for mining communities in Eastern DRC, Lualaba, Kongo Central, Kasa Central and Kinshasa intensified as child marriages have become a prevalent crisis.

Alliance networks have devised **Climate Justice Action Plans**. Actions include awareness raising of a stand-alone article on climate justice in the SADC Gender Protocol as well as input on the region's environment Protocol. **Seychelles** is one of four SADC island countries (together with Madagascar, Mauritius and Comoros) that suffers frequent flooding and landslides that cause food insecurity and fish industry challenges. Seychelles national youth council "*Perseverans An Mouvman*" together with **Gem Plus** in 2020 worked on a community clean up expedition as part of environmental cleanliness awareness raising observing COVID-19 protocols.

The **Tanzania Gender Networking Program (TGNP)** is planning to implement the climate justice, action plan, which includes country initiatives on climate justice with civil society, policymakers, women and women champions, higher learning and research institutions.

[67] Lowe Morna, C., Rama, K. and Dube, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/ , accessed: 20 July 2021.

Madagascar, Alliance network partner, Fédération pour la Promotion Féminine et Enfantine (FPFE) have been advocating for food security, clean drinking water supply and irrigation mostly within the mining communities. The campaign site is a mining town called Ambatovy with major environmental, public health and economic challenges. Plans include mitigating bush fires that increased due to lack of income generating activities. Climate-induced natural disasters limit access to SRH services, safe water and sanitation, food security, and education.

Methodology

Table 1.7: Structure of the #VoiceandChoice Barometer

Chapters	Relation to previous Barometer Chapters
1. Introduction	Introduction
2. Sexual and Reproductive Health	Health
3. ASRHR	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 since 2019
9. Women's Political Participation	Gender and Governance
10. Gender and media	Gender and media
11. Climate Justice	Climate Change

Table 1.7 summarises the eleven chapters of the 2021 Barometer. The first eight chapters are the same as 2020. Chapters that have been added, and correlate to chapters in the original Barometer include Gender and Governance; Gender and Media and Climate Justice. Each chapter in the 2021 #VoiceandChice Barometer includes:

- A section on how the COVID-19 virus has affected all aspects of #VoiceandChoice. Each chapter includes an analysis on the pandemic as well as the vaccine roll out and how this might change the situation in the short and medium term.
- The SRHR chapters include an analysis of Alliance campaigns by SRHR theme (through national and local level campaigns done by the Alliance partners).
- The Barometer includes Comoros in the analysis as it is now the sixteenth member of SADC.
- The chapters include an analysis of youth involvement. In particular, the ASRHR chapter includes information on the rapid assessment to determine the availability and uptake of SRHR services by youth conducted by Gender Links in eight SADC countries.
- New SADC Protocol@Work case studies highlighting various aspects of #VoiceandChoice and collected through the learning aspects of the annual summits.
- Relevant findings from the Gender Progress Score (GPS), the Southern African Gender Attitude Survey.

Normative frameworks

The provisions of the SADC Protocol guide the chapters on Gender and Development. However, to strengthen the arguments, the #VoiceandChoice Barometer brings in other relevant gender provisions, which 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).

Updated Audit of SRHR Laws and Policies in SADC

The updated 2021 Audit of SRHR Laws and Policies is mainstreamed across the SRHR chapters of the Barometer. The audit includes information on Comoros, the newest member to join SADC as well as additional information and updates at various points within the SRHR themes presented. What unfolds is a picture of a region with a diverse SRHR landscape. The audit reviewed sexual and reproductive health laws strategies and reports, academic research, analysis of laws and practice as well as newspaper articles across all 16 SADC countries.

There are areas with strong legislative and policy framework such as GBV and HIV, and there are others where legislation and policies are patchy. Despite presence of strong legislation, GBV however, remains at crisis levels and is a huge concern for SADC. The region has even moved a step further to start consultations on establishing a GBV Model Law for SADC[68]. There is need however to reflect on the impact the available legislation is making in preventing and responding to GBV. Coupled with the presence of the COVID-19 pandemic that has threatened the fragile gains made on ending GBV in the region, focus on primary prevention as well as strengthening coordination efforts is more crucial at this point.

Developing indicators - quantitative measures

Each chapter begins with a table of key indicators for which data could be reliably obtained across the 16 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.
- **Gender 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

[68] https://www.sadc.int/news-events/news/sadc-secretariat-engages-members-parliament-regional-gbv-legislative-response/

role in driving or deterring reform agendas. For the period 2019-2020 GL and Alliance partners gathered 34,323 surveys, 49.5% women, 49.4% men and 0.1% non-binary. A technical note on this study is attached at **Annex B**.

Table 1.8: Classification of SRHR indicators

Thematic area	Emperical data	Public attitudes	GRA	TOTAL	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		***20***	5	11
Adolescent SRHR	5	0		***5***	1	1
Safe abortion	3	1		***4***	1	2
HIV and AIDS	23	1		***26***	3	3
Gender-based violence	12	4		***16***	1	2
Harmful practices	5	0	7	***12***	1	1
Sexual Diversity	15	2		***17***	0	0
TOTAL	***85***	***8***	***7***	***100***	***12***	***20***

Table 1.8 shows that:

- There are a total of 100 quantitative indicators that can be used to measure SRHR across the seven SRHR themes. The largest number of these (26) is HIV and AIDS followed by SRH (20). These indicators are found in each chapter of the Barometer.
- 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 last year conducted the first shadow report of the SADC SRHR score card (see Executive Summary). This has been updated in 2020. It gives a preliminary indication of how SADC countries are performing, using the colour coding agreed for the score card.

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

3. Percentage of obstetric and gynaecological 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

Several sources of qualitative data have been used in the Barometer:

Case studies: Evidence is gathered through the case studies presented at the #VoiceandChoice SADC Protocol@Work summits. The national summits in 2019 and 2020 culminated in a regional #VoiceandChoice summit held partly in country gatherings and partly virtually for the first time.

Table 1.9: 2019/2020 SADC Protocol@Work summit entries

Country	SRHR	Economic justice/ Education	Drivers of Change	Media	Climate change	Local government COEs	Entrepre-neurship	Constitutional, legal and Governance	Total
Zimbabwe	43	22	21	42	11	59	11	12	221
Madagascar	32	41	23	7	24	30	9	12	178
South Africa	35	10	15	3	8	3	12	2	88
DRC	27		7	36	9			5	84
Lesotho	7	3	8	10		46	7	2	83
Botswana	34	13	5	5		16	6		79
Namibia	25	3	9	20	2	13	4		76
Mauritius	11	18	7	15	7	6	2	6	72
Eswatini	21	11	6	9	1	11	10	1	70
Mozambique	17	2	3	12	2	18	9	3	66
Tanzania	7	1	4	51				1	64
Malawi	15		4	15				2	36
Angola	3		1	20					24
Zambia	1	1	3	5		5		2	17
Seychelles	2	1		4	3				10
Total	**280**	**126**	**116**	**254**	**67**	**207**	**70**	**48**	**1168**

Table 1.9 shows that Alliance partners collected 1,168 case studies between 2019 and 2021. The SRHR theme category had the highest number of case studies (280) followed by the media theme (254) and local government Centres of Excellence (207). The theme on Constitutional, legal and governance had the least number of case studies (48). The Protocol@work case studies provide evidence from the ground on implementation of the SADC Protocol on Gender and Development and other gender equality frameworks. The case studies are collated from local government, civil society, media, faith based organisations, entrepreneurs and individual activists.

Media articles from the journalists trained in 15 countries on coverage of gender equality issues. GL trained journalists from around the region in April 2019, and an in-country training in DRC, Madagascar, Mauritius, Mozambique, Tanzania and Zimbabwe between May and June 2019. A total of 132 articles have been produced by the journalists. These are referenced in the Barometer where relevant.



Rapid response on SRHR

Gender Links, the SADC Gender Protocol National Alliance partners, and local governments with youth leads conducted an Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment in eight out of 16 SADC countries between 2019 and 2021. The findings of the 8-country study are found in the ASRHR chapter of this Barometer.

Limitations

The COVID-19 pandemic continued to pose constraints on the processes linked to the Barometer. Unlike in the pre-COVID-19 era where the SADC Protocol@Work summits were held within 2-3 days at one venue, summits had to be decentralised. For example, due to COVID-19 restrictions Zimbabwe and Lesotho held three Summits between September and October 2020 including Entrepreneurship; Local Government Centres of Excellence and one focusing on thematic areas such as SRHR. For the first time ever GL convened the regional summit virtually in March 2021. Winners convened in-country and presented across borders via zoom. While this proved to be an innovative solution, the biennial gatherings at regional level provide a rare opportunity for networking and community building that is not as effective in cyber space.

Data on Comoros, SADC's latest member, is limited. An Alliance national network will be identified for the island as soon as logistically feasible. #VoiceandChoice campaigns have not yet taken off in Comoros as an Alliance focal network is still being identified.

Menstrual Health, Family Planning and Maternal Health 2



Piggs Peak maternal menstrual health campaign. Photo: Thandokuhle Dlamini

KEY POINTS

- While there has been good progress, the Maternal Mortality Rate (MMR) remains unacceptably high in SADC. Only two of the 16 SADC countries, Seychelles and Mauritius, have met SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100,000 live births, seven times higher than the SDG target.
- Neonatal deaths also remain high in the region. Only three SADC countries (Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.
- More countries understand the importance of women's menstrual hygiene to their overall health and wellbeing. Seven SADC countries have removed VAT on menstrual products. Seven countries now provide free sanitary ware in schools.
- Local government plays a key role in providing access to SRH services and should develop SRHR specific policies, including provisions on national health emergencies.
- Most pregnant women in the region have access to at least one antenatal visit, but women in rural areas have less access than those residing in urban areas.
- The COVID-19 pandemic has strained public health systems globally, interrupting and delaying many kinds of critical health care. A survey by the World Health Organization (WHO) of 105 countries across the globe, found that family planning and contraception were among the most frequently disrupted health services, with seven in ten countries experiencing disruptions.
- Health expenditure as a proportion of SADC budgets remains low. Only two countries, Eswatini and Malawi have met the recommended goal of 15% total government expenditure on health.

Introduction

Sexual and reproductive health rights (SRHR) are the basic rights of any individual, regardless of whether they are young or old; female, male, or any other sexual or gender identity, HIV positive or negative. All have the right to make their own choices regarding sexuality and reproduction, provided these respect the rights of others to bodily integrity. It also includes the right to access information and services that are needed, not only to support these choices but also to optimise their health.

> All have the right to make their own choices regarding sexuality and reproduction

The International Conference on Population and Development (ICPD) defines **reproductive health** as

> "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable 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 the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[1]

Realising SRHR is integral to achieving gender equality, the United Nations Population Fund (UNFPA) draws a clear connection between reproductive health, human rights and sustainable development, highlighting that when SRH needs are not met, individuals are deprived of the right to make crucial choices about their own bodies and futures, which in turn impact on their families' welfare and future generations.[2]



Making the right choices - vaccinating our young in Lesotho.
Photo: Thandokuhle Dlamini

1 International Conference on Population and Development (ICPD), Programme of Action, Para 7.2 (2014)
2 UNFPA, Sexual & reproductive health https://www.unfpa.org/sexual-reproductive-health, accessed 13 July 2021
3 Ibid

Sexual and reproductive health is a lifetime concern for both women and men, from infancy to old age. As the bearers and principal carers of children, SRHR is of particular importance to women. From adolescence to old age women have needs for comprehensive sexuality education, menstrual hygiene, and health, contraception and family planning, access to safe and legal abortion, antenatal, safe delivery care, post-natal care, services to prevent sexually transmitted infections (including HIV), and services facilitating early diagnosis and treatment of reproductive health illnesses (including breast and cervical cancer).[3]

SRHR is comprehensively covered in eight of the Sustainable Development Goals targets through:

- SDG 3: Ensure healthy lives and promote well-being for all at all ages
  - Target 3.1 - By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
  - Target 3.2 - By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
  - Target 3.7 - By 2030, ensure 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.
  - Target 3.8 - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
  - Target 3.b - Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
- SDG 5: Achieve gender equality and empower all women and girls
  - Target 5.6 - Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.
- SDG 6: Ensure availability and sustainable management of water and sanitation for all
  - Target 6.1 - By 2030, achieve universal and equitable access to safe and affordable drinking water for all.
  - Target 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.[4]

[4] United Nations, Sustainable development goals, https://sdgs.un.org/goals accessed 14 July 2021

Table 2.1: SRH indicators in 2021

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Existence of SRHR policies/guidelines	No	Guidelines	Yes	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2015 - 2019 Policy	2011 - 2015 Guidelines	2008 Policy	2010 - 2015 Policy
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	No	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
Provision of free menstrual ware	No	Yes	No	No	No	Yes	Yes	No	No	No	Yes	Yes	No	No	Yes	No
Removal of Value Added Tax (VAT) on menstrual ware	No	No	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Basic drinking water status (%)[5]	56	99	80	43	69	69	54	69	100	56	83	96	93	57	60	64
Access to basic sanitation (%)[6]	50	77	36	21	58	43	11	26	96	29	35	100	76	30	26	36
Contraceptive prevalence rate amongst all women aged 15-49 (%) any method[7]	16	57	20	23	54	53	41	48	43	26	52	No data	50	36	37	49
Unmet need for contra-ception amongst all women aged 15-49 (%)[8]	27	8	19	21	10	11	15	13	8	19	10	No data	11	16	15	8
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[9]	62	No data	21	31	49	61	74	47	49	49	71	No data	65	47	47	60
Age of access to contraception	16	12	TBA	18	15	No age stipulated	12	16	16	16	12	15	12	12	16	16
Maternal Mortality Ratio (per 100,000)[10]	241	144	273	473	437	544	335	349	61	289	195	53	119	524	213	458
Antenatal Care Visits (At least one visit) %[11]	82	94	92	82	99	95	82	98	No data	87	97	No data	94	98	97	93
Antenatal Care Visits (At least four visits) %[12]	61	No data	No data	43	No data	77	51	51	No data	51	No data	No data	76	62	64	76
Skilled attendance at birth (%)[13]	50	100	82	80	88	78	44	90	100	54	88	99	97	64	80	78
Postnatal care coverage %[14]	23	No data	49	44	88	62	No data	42	No data	No data	69	No data	84	34	54	57
Neonatal mortality (per 1000)[15]	28	18	30	27	18	43	20	20	10	29	19	9	12	20	23	26
Nursing and midwifery personnel per 10 000 of the population[16]	4	54	6	11	41	33	3	4	35	5	20	98	13	6	10	19
Universal Health Coverage index (0 worst - 100 best)[17]	40	61	52	41	63	48	28	46	63	46	62	71	69	43	53	54
Health expenditure as proportion of GDP[18]	2,5	5,8	4,5	3,3	6,5	9,2	4,7	9,3	5,8	8,1	8	3.9	8,2	3,6	4,9	4,7
Health expenditure as proportion of total government expenditure[19]	5	8.8	8,6	11	16.5	13	10.1	16.7	10	8.8	13.8	9.7	14.2	12.3	11.3	8.4

[5] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles, accessed 7 July 2021
[6] Ibid
[7] UNFPA, World Population Dashboard, https://www.unfpa.org/data/world-population-dashboard, accessed 7 July 2021
[8] Ibid
[9] Ibid
[10] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles , accessed 6 July 20212
[11] World Bank Data, https://data.worldbank.org/indicator/SH.STA.ANVC.ZS?view=chart , accessed 6 July 2021
[12] UNICEF, Maternal and Newborn health coverage database, https://data.unicef.org/topic/maternal-health/antenatal-care/ , accessed 6 July 2021
[13] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles , accessed 7 July 2021
[14] WHO, The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/women-age-15-49-years-who-received-a-health-check-within-2-days-after-delivery-of-their-most-recent-live-birth-in-the-last-2-years-(-) , accessed 7 July 2021
[15] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles, accessed 6 July 2021
[16] WHO, The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/nursing-and-midwifery-personnel-(per-10-000-population) ,accessed 7 July 2021
[17] SDG Report 2021, Country profiles , https://dashboards.sdgindex.org/profiles , accessed 7 July 2021
[18] World Bank, World Development Indicators, https://databank.worldbank.org/data/source/world-development-indicators#, accessed 7 July 2021
[19] Ibid

Table 2.1 shows that:

- Seven SADC countries (Lesotho, South Africa, Zimbabwe, Zambia, Seychelles, Mauritius and **Namibia**) have now removed VAT on menstrual products, Namibia being the latest country to do so. Seven countries (Lesotho, Zambia, Seychelles, Botswana and Madagascar, South Africa, Zimbabwe) provide free sanitary ware in schools; this is up from five countries in 2021.
- Mauritius is the only country that provides drinking water to 100% of the population. Of the other countries coverage ranges from 43% in DRC to Botswana at 99%.
- Just one SADC country, Seychelles, provides basic sanitation to its entire population. Madagascar has the lowest coverage with just 11% of the population having access to basic sanitation.
- The contraceptive prevalence rate (CPR) for all women aged 15-49 using all methods ranges from 16% in Angola to 57% in Botswana. Just six countries (Botswana, Eswatini, Lesotho, Namibia, Zambia and Zimbabwe) are above the global average of 49%.
- Angola has the highest unmet need for contraception with 27% of women of reproductive age (15-49 years) having a need for family planning, but not having access to contraception.
- Women in SADC have limited control over decision-making on SRHR. This ranges from 21% in Comoros to 74% in Madagascar of women aged 15-49 and who make decisions on SRHR.
- Just two of 16 SADC countries, Seychelles and Mauritius have met the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100 000 live births.
- Just three SADC countries (Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 neonatal deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.
- No country in SADC provides universal health care. Access to essential health services ranges from 71% in Seychelles to 28% in Madagascar.

This chapter focuses on three key areas of SRH - menstrual health, family planning and maternal health - measuring the progress countries in realising the targets set out in the 2016 SADC Protocol on Gender and Development, the Sustainable Development Goals (SDGs), and the SADC SRHR strategy (2019-2030). These are analysed against the backdrop of the COVID-19 pandemic and its profound effects on the sector, as well as the vaccine roll out and what this could portend.

SRH and the COVID-19 pandemic

At the start of the pandemic in 2019 much was being written about the potential effect that pandemic would have on women's SRHR[20]. While some global surveys have been conducted, information on the impact on the pandemic on SRH is lacking at the country level.

Tracking access to essential health services during the pandemic is critical to achieving the optimal balance between fighting the COVID-19 pandemic and maintaining these services. As part of their response, countries need to have defined the set of essential services to be maintained during the pandemic, to assess how these services are being affected and to track any changes that may be occurring as the outbreak progresses along its various stages.[21]

National, regional and international data on the impact of the pandemic is urgently needed to advocate for resources for the most affected populations, and to help target efforts to maintain

[20] UNFPA, Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage, Interim Technical Note, 27 April 2020
[21] World Health Organisation, Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report, 2020

health services for the populations in greatest need.[22] This data will also be crucial in developing responses to other health emergencies.

The COVID-19 pandemic presented an opportunity for states to integrate SRHR into state of emergency responses. SADC countries with standalone policies and guidelines should find it easier to do this as part of their COVID-19 response. A local council in Zimbabwe showed how this can be done.



Murehwa Rural District acts on SRHR amidst the COVID-19 pandemic

Early on in the COVID-19 outbreak Murehwa District Council in Zimbabwe recognised the risks that COVID-19 posed to SRHR. Together with key stakeholders the Council developed a COVID-19 and Sexual Reproductive Health and Rights Response Plan. Murehwa RDC is also a key member of the Murehwa COVID-19 Gender Sub-Committee.

The plan included seven strategic priorities:

- Personal Protective Equipment (PPE) at Council Rural Health Centres.
- Ensuring access to contraceptives and reproductive health services.
- Ensuring that menstrual education and sanitary ware is accessible to women and girls.
- Making sure that maternal health services (including waiting mothers homes) are accessible to Murehwa community.
- To ensure that cervical cancer screening, STI treatments and HIV/AIDS services exist during the period.
- Ensuring continuity of public awareness on SRHR and GBV issues.
- Rapid response services for GBV cases and provision of shelter to victims.



Murehwa RDC junior Councillors and youth campaign on SRHR and ending child marriages. Photo: Tapiwa Zvaraya

A COVID-19 gender committee at district level is responsible for implementation, making use of the provisions in the Council Gender and other committees' budget. Councillors who have close links to the community, assist with continued awareness to the public on SRHR issues and the council will seek to partner with development partners and Government Ministries in the district.

Source: Murehwa Rural District Council SRHR Strategy

[22] Ibid

The need for sex disaggregated data

Sex-disaggregated data from testing through to vaccinations is critical to understanding the differential impact the virus is having on women, men and gender non-conforming people. Disaggregating data on who is being tested, confirmed cases, hospitalisation, ICU admissions, deaths and vaccinations will help to inform response. This information is, however, completely lacking in some countries. At the very least countries should be disaggregating data on confirmed cases, deaths and now vaccinations to ensure there is equal access.

According to the COVID-19 Sex disaggregated data tracker, which tracks sex disaggregated data across the globe, "very few countries are reporting this data in its entirety."[23] Of 198 countries, only 139 disaggregate data on confirmed cases and only 107 on deaths. South Africa is the only country that has reported disaggregated data on cases and deaths in the past month, and Mozambique has reported disaggregated data on confirmed cases in the past month. No other SADC countries have reported on sex disaggregated data.[24] Globally only 16 countries disaggregate data on testing and 42 on vaccinations,[25] no SADC countries are reporting sex-disaggregated data on vaccinations.

Biological sex is relevant and sex-disaggregated analysis important for a range of different reasons. A growing body of research highlights the influence of biological sex in clinically relevant health outcomes, including sex-specific differences in immunity, pharmacology, and vaccines outcomes (side-effects and efficacy). In vaccine studies, cisgender females tend to develop higher antibody response and, relatedly, higher efficacy and more side-effects, suggesting the need for sex-differentiated dosing regimens.[26]

It is for these reasons that it is essential for researchers and regulatory agencies to include biological sex as a variable in trial data analysis and reporting, to inform policies and programmes to address the impact of the pandemic on SRHRs.

Sex-disaggregated data from testing through to vaccinations is critical in assessing the impact of COVID-19

As we are still in the very early stages of the vaccination roll-out there are still many unknowns in terms of the side-effects of the vaccine. More research is needed but reports from women who have been vaccinated should be an important identifier of potential side-effects. For example, there have been concerns relating to the vaccine's impact on reproductive health after some women reported getting heavier periods after the first dose of the vaccine. Women took to Twitter to share their experiences about excessive bleeding following being vaccinated. While medical practitioners have cautioned against associating these symptoms with the vaccine because there is no conclusive evidence to show this,[27] it is imperative that this evidence be gathered so that women can make informed choices about their bodies.

[23] Global Health 50/50, The COVID-19 Sex-Disaggregated Data Tracker, https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/ accessed 28 June 2021
[24] Ibid
[25] Ibid
[26] Lancet, Sex-disaggregated data in COVID-19 vaccine trials, Published Online March 5, 2021, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00384-6/fulltext, accessed 10 July 2021
[27] Halima Zoha Ansari, The Global COVID-19 Vaccine Roll-Out Shows The Lack Of Research On Women's Biology, 5 May 2021, https://feminisminindia.com/2021/05/05/the-global-covid-19-vaccine-roll-women-health/ , accessed 20 July 2021

SRHR policy and legislative framework in SADC

Article 6.1 (a) of the SADC SRHR Strategy (2019-2030) obliges member states to establish a multi-sector 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.

SDG 3.7 call on states to integrate reproductive health into national strategies and programmes. Stand-alone policies on SRHR are a marker of political commitment to realising the SRHR of women and girls and the will to domesticate regional, continental, and global SRHR instruments.

Status of national SRHR policies and laws in SADC

The vision of the SADC SRHR strategy 2019-2030 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 realize and exercise their SRH rights, as an integral component of sustainable human development in the SADC region. The strategy is aligned with the SDG, and aims to achieve ten outcomes:

1. Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG3.1.);
2. New-born mortality ratio reduced to fewer than 12 deaths per 1,000 births (SDG 3.2.);
3. HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
4. Sexual and gender-based violence and other harmful practices, especially against women and girls, eliminated (SDGs 5.1, 5.2 and 5.3);
5. Rates of unplanned pregnancies and unsafe abortion reduced;
6. Rates of teenage pregnancies reduced;
7. 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);
8. Health systems, including community health systems, strengthened to respond to SRH needs; (SDG 5.6);
9. 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);
10. Barriers - including policy, cultural, social and economic - that serve as an impediment to the realization of SRHR in the region removed (SDGs 5.1 and 5c)."[28]

Over the last 17 years, 14 of the 16 SADC countries have developed stand-alone SRHR policies or guidelines.

[28] SADC Secretariat, Strategy for Sexual and Reproductive Health Rights in the SADC Region 2019-2030, p12, 2019

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Older than ten years		
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
Older than five years		
Seychelles	Reproductive Health Policy for Seychelles	2012
Eswatini	National Policy on Sexual and Reproductive Health	2013
South Africa	Sexual and Reproductive Health and Rights: Fulfilling our Commitments and "National Adolescent Sexual and Reproductive Health and Rights Framework Strategy"	2014 - 2019
Adopted in the past five years		
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
Comoros	Adolescent and Youth Health Strategy	2018
No SRHR policy or guidelines		
Angola	Included in the Constitution	1975
DRC	Included in the Constitution	2011

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

Table 2.2 shows, of the 14 SADC countries that have either stand-alone SRHR policies or SRHR guidelines, ten countries adopted these between 2001 to 2015. Madagascar is the only country with a policy less than five years old. Some of these policies are for reproductive health only, while SRHR is broader including sexual rights, this points to the need for countries to update their policies to align with international standards on SRHR.

Countries need to update their policies to align with international standards on SRHR

Angola and the DRC are the two countries that have no standalone policy or guidelines.



While the DRC does not have a standalone policy, its parliament signed a revised comprehensive public health bill into law in 2018. The law creates a new legal environment favourable to family planning and reproductive health, repealing and replacing a colonial law from 1920 prohibiting any form of action against or preventing procreation. The family planning provisions contained in the new law enable access to family planning services for all women, including adolescents and young people, and legally protect a women's ability to choose to use family planning even if her spouse objects. The law officially took effect on March 13, 2019.[29]

[29] https://www.advancefamilyplanning.org/drc-passes-new-public-health-law-provisions-family-planning

Role of local government

Local government, is responsible for primary healthcare services, including maternal health and family planning services; have HIV and AIDS policies, and take responsibility for ARV treatment.

The Centres of Excellence (COE) in local government programme, is the most far-reaching systematic and sustained effort to promote gender mainstreaming in local government in SADC. Gender Links is working with 380 local councils in ten countries - Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe covering a population of 99 810 806 people. GL has worked with councils to developed gender, GBV and SRHR strategies and action plans aligned with the SADC Gender Protocol, updated in 2016 in line with the Sustainable Development Goals. As a result many councils are implementing specific programmes on SRHR.



Local authorities in Zimbabwe have been actively involved in maternal health. All council clinics in Zimbabwe provide maternal health services. These include access to contraception, provision of waiting mothers' shelters for pregnant girls and mothers.

All 92 local authorities in Zimbabwe are reviewing their Sexual Reproductive Health and Rights action plans. Most of the local authorities including Chinhoyi Municipality, Epworth Local Board, Murehwa Rural District Council, Bulawayo City Council, Guruve Rural District Council, Bikita Rural District Council, and Umguza Rural District Council are conducting SRHR youth-led campaigns and dialogues. The campaigns focus on, menstrual health, child marriages, gender-based violence, child sexual abuse, and teenage pregnancies.

In rural local authorities where most pregnant women have to walk long distances to clinics, there has been a deliberate attempt by local authorities like Murehwa RDC, Umguza RDC, Guruve RDC, Nyanga RDC and Mutoko RDC to construct Waiting Mothers' Shelters so that pregnant women can have a place to stay prior to giving birth as well as after giving birth before they can go back to their places of residence.

Source: GL Zimbabwe Office

Menstrual health

Menstrual health relates to human dignity, and it is a fundamental right for every girl and woman to live a healthy life during menstruation. Menstruation is a monthly occurrence for every woman and girl, yet stigma based on myth and cultural beliefs continue to exclude them from public and family life during this period. Unaffordable sanitary products drive desperate women and girls to improvise sanitary pads, using leaves, cloth, and other unsafe methods of menstruation management. UNICEF estimates that 1.8 billion girls, women, and non-binary persons menstruate, yet millions of them across the world cannot manage their monthly cycle in a dignified, healthy way.[30]

[30] UNICEF, WASH: Mentrual hygiene, https://www.unicef.org/wash/menstrual-hygiene, accessed 16 July 2021

Aside from health and hygiene risks, this causes adolescent girls and young women (AGYW) to miss school activities including lessons and sports activities, due to lack of sanitary pads, which affects their performance at school.

COVID-19 posed many challenges for menstruating AGYW. Lock-downs, border closures and supply disruptions have limited access to menstrual hygiene products and increased price of sanitary products as a result. According to Plan International, "With the pandemic significantly affecting livelihoods and household incomes, it is harder now for people, including adolescent girls, to afford to buy sanitary products than before the COVID-19 pandemic began, even when products are available."[31] In addition, lock-downs have affected access to reliable information and support around menstrual health and hygiene, access to clean water to maintain good menstrual hygiene and less hygienic environment for disposal of products and waste-management.[32] This highlights the urgent need for safe water and sanitation facilities, and safe and effective means of managing menstruation.



Eswatini - Lavumisa menstrual health campaign. Photo: Thandokuhle Dlamini

Governments can show their commitment to addressing women's menstrual health needs by scrapping value-added tax (VAT) on sanitary ware, also known as "tampon tax", and by providing free sanitary products to all school girls, particularly in rural areas. Improving access to sanitary ware for schoolgirls will ensure improved educational performance of AGYW. Safe menstruation management will advance their overall health.

Table 2.3: Menstrual products in SADC

Country	NO VAT on sanitary ware	Free sanitary ware in schools[33]
Lesotho	Yes	Yes
South Africa	Yes	Yes
Zimbabwe	Yes	Yes
Zambia	Yes	Yes
Seychelles	Yes	Yes
Namibia	Yes	No
Mauritius	Yes	No
Botswana	No	Yes
Madagascar	No	Yes
Angola	No	No
Comoros	No	No
DRC	No	No
Eswatini	No	No
Malawi	No	No
Mozambique	No	No
Tanzania	No	No

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2020.

Table 2.3 shows that

- Five SADC countries have removed VAT on sanitary ware and provide free sanitary ware in schools. These are: Lesotho, South Africa, Zimbabwe, Zambia and Seychelles.
- Two countries (Namibia and Mauritius) have removed VAT on sanitary ware but do not provide free sanitary ware in schools.
- Two countries (Botswana and Madagascar) provide free sanitary ware in schools but have not removed VAT on sanitary ware.
- Seven SADC countries have neither removed VAT on sanitary ware nor provide free sanitary ware in schools.

[31] Plan International, Periods in a Pandemic - Menstrual hygiene management in the time of COVID-19, 2020
[32] Ibid
[33] Largely of rural schools and indigent populations

Woman at forefront of scrapping 'tampon tax' in Namibia[34]



Emma Theofelus.
Photo courtesy of Shelleygan Petersen, The Namibian

On 3 March 2021 Deputy Minister of Information and Communication Technology in Namibia, Emma Theofelus, tabled a motion in the National Assembly for a tax exemption on menstrual products. "I ask that this matter be referred to the relevant standing committee and for the finance ministry to consider bringing an amendment to the tax laws relevant to this motion," she said.

Theofelus, an advocate for young women to be safe during their menstrual cycle told *The Namibian* that "Period poverty is one of the undignified processes women and young ladies have to experience. Your period is such a natural process and not something they can opt out of. There are not enough social and economic circumstances to create safety for young women," she said.

Following the motion being tabled at the beginning of March, the Namibian government eliminated VAT on sanitary products, on 17 March 2020 meaning that women and girls in Namibia will no longer be charged a luxury tax rate of 15% of VAT on sanitary products.

The exemption will take effect in the 2022/2023 financial year, according to Finance Minister Iipumbu Shiimi. "I wish to announce this to enhance affordability by the girl child and urge suppliers and retailers to pass on this relief to consumers once enacted," Shiimi told The Namibian.

Theofelus, at 25, is one of the youngest cabinet members in the region. She was appointed as Namibia's information, communication and technology deputy minister in April 2020. One of her key roles since coming into office has been to help lead communication to the public on preventative steps against the COVID-19 pandemic, which hit Namibia in March.



Hygiene Day at Coastal Resources Center in KwaZulu-Natal, 2020.
Photo courtesy of Coastal Resources Center

While menstrual health and hygiene is something that affects women of all ages, AGYW experience the biggest challenges. Local councils are working with partners to raise awareness around menstrual health and to raise funds for sanitary products for AGYW, especially those in rural areas, as illustrated in the case study that follows:

[34] Adapted from an article in The Namibian, 'Theofelus puts sanitary pads in spotlight' , 5 March 2021, https://www.namibian.com.na/209330/archive-read/Theofelus-puts-sanitary-pads-in-spotlight accessed 24 July 2021

Zambia: Council works to 'Keep a Girl Child in School'



Kabwe Municipal Council Dreams project. Photo: Albert Ngosa

Kitwe City Council has allocated $3036 towards provision of reusable sanitary pads and face masks to adolescent girls in peri-urban areas (Mwekera, Kamfinsa, Miyombo, Garneton) in Kitwe district. Girls in this area walk 5km to 10km to get to school. The Local Participation in Governance (LoPaGo project is a partnership with Gesellschaft für Internationale Zusammenarbeit (GIZ)) The District Education Board Secretary (DEBS) identified schools and assisted in information dissemination.

The project found that girls in these areas use unhygienic materials during their menstrual periods such as old clothes, *chitenge* materials and papers. They are often absent from school during their menstrual period. This distribution of reusable sanitary pads took place from 15th October to 30th November 2020. During the distribution schoolgirls were sensitised on myths and misconceptions surrounding menstrual health.

The goal of the initiative is to empower vulnerable girls through provision of reusable sanitary pads and capacity building on menstrual hygiene management and reproductive health for improved self-esteem. By acquiring knowledge on menstrual hygiene management, the overall health status of the girls is enhanced. One packet of reusable sanitary pads distributed through this project is sufficient to meet the sanitary needs of a girl for three years at a cost of less than one dollar.

Source: Regina Musa, SRHR Most Significant Result 2021

In addition to AGYW there are other at-risk groups, including women in prisons who are not able to manage their menstruation in a dignified and hygienic way. Special efforts need to be made to ensure that all women and girls everywhere have access to menstrual products and hygiene.

Special efforts needed to ensure all women and girls everywhere have access to menstrual products and hygiene



Malawi: Promoting menstrual health in prison



Kabwe Municipal Council Dreams project. Photo: Albert Ngosa

Activists in Malawi have applauded the allocation of funds to cater for Menstrual Hygiene Management (MHM) for women and girls in detention saying it will improve their wellbeing.

The Malawi Parliament approved a K30 million ($36,896) increase in the Malawi Prison Service health budgetary allocation in the 2019/2020 national budget after the Centre for Human Rights Education Advice and Assistance (CHREAA) with funding from Amplify Change advocated for allocation of funds to cater for Menstrual Hygiene Management in Prison.

Executive Director for CHREAA, Victor Mhango said the move will improve the wellbeing and dignity of female inmates as enshrined in Malawi Constitution. Section 42 (1) of the Constitution which stipulates that "every detained person be held under conditions consistent with human dignity, which shall include at least access adequate nutrition and medical treatment at the expense of the state."

Women in prisons have no income to buy basic necessities including sanitary pads, under wear and soap, making them prone to infections as a result of poor menstrual health. " A lot of them suffer from candidiasis," says Annie Kitalo an official at Chichiri Prison.

"The Government should also remove VAT on sanitary pads so that a lot of women can afford to buy sanitary pads as it is a basic need for all girls," Mhango says. There is also a need to support women and girls in rural areas who cannot afford to buy sanitary pads because they are expensive. Pressure is mounting in Malawi for Government to remove VAT on sanitary pads and support groups to make reusable sanitary napkins for schools.

Excerpt from article by Jenipher Changwanda GL 16 Days SRHR News Service[35]

[35] Additional reporting by the Center for Human Rights Education Advice and Assistance (CHREAA). Picture courtesy of CHREAA.

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 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking water for all

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.

In early July 2021 the World Health Organisation's (WHO) Joint Monitoring Programme (JMP) released a report - Progress on household drinking water, sanitation and hygiene 2000 - 2020, presenting estimates on household access to safely managed drinking water, sanitation and hygiene services over the past five years. The report assesses progress toward achieving the sixth Sustainable Development Goal (SDG) to "ensure availability and sustainable management of water and sanitation for all by 2030." The report notes that billions of people around the world will be unable to access safely managed household drinking water, sanitation and hygiene services in 2030 unless the rate of progress quadruples, according to a new report from WHO and UNICEF.[36]



Students use a new tippy tap wash station to prevent the spread of COVID-19 in Botswana in May 2020. Photo courtesy of JG Afrika

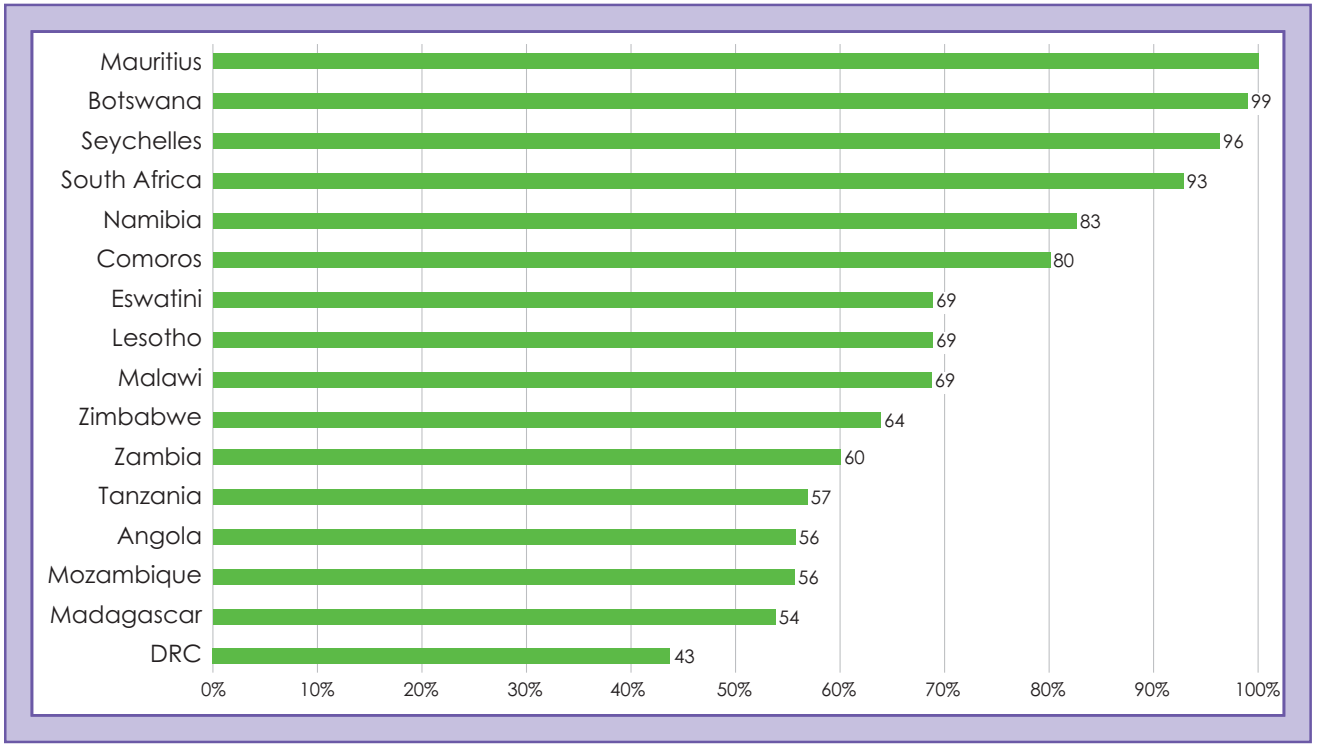
In 2020, around one in four people lacked safely-managed drinking water in their homes. Nearly half the world's population lacked safely managed sanitation. COVID-19 has highlighted the urgent need to ensure everyone can access good hand hygiene. At the onset of the pandemic, 3 in 10 people worldwide could not wash their hands with soap and water within their homes. While there has been progress over the last five years since the SDGs were adopted, there are still millions of people who lack access to basic water and sanitation.

Safely managed sanitation services reached 62% of the world's urban population, but only 44% of its rural population. Sub-Saharan Africa is experiencing the slowest rate of progress in the world, with only 54% of people using safe drinking water.[37]

[36] WHO, Billions of people will lack access to safe water, sanitation and hygiene in 2030 unless progress quadruples - warn WHO, UNICEF, 1 July 2021 https://www.who.int/news/item/01-07-2021-billions-of-people-will-lack-access-to-safe-water-sanitation-and-hygiene-in-2030-unless-progress-quadruples-warn-who-unicef accessed 16 July 2021

[37] Ibid

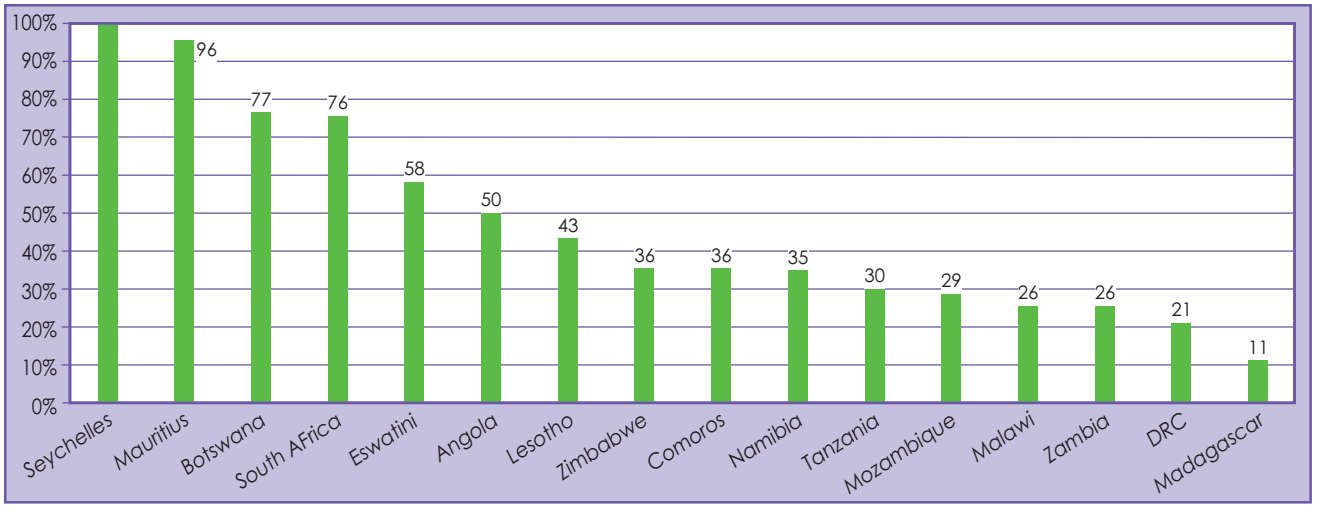
Figure 2.1: Access to basic drinking water in SADC



Source: SDG Report 2021, country profiles.[38]

Figure 2.1 shows that Mauritius is the only country that provides basic drinking water to 100% of the population. Botswana (99%), Seychelles (96%) and South Africa (93%) are close to achieving universal coverage, but still fall short. Most countries have between 54% - 83% coverage. The DRC has just 43% coverage.

Figure 2.2: Percentage population using basic sanitation



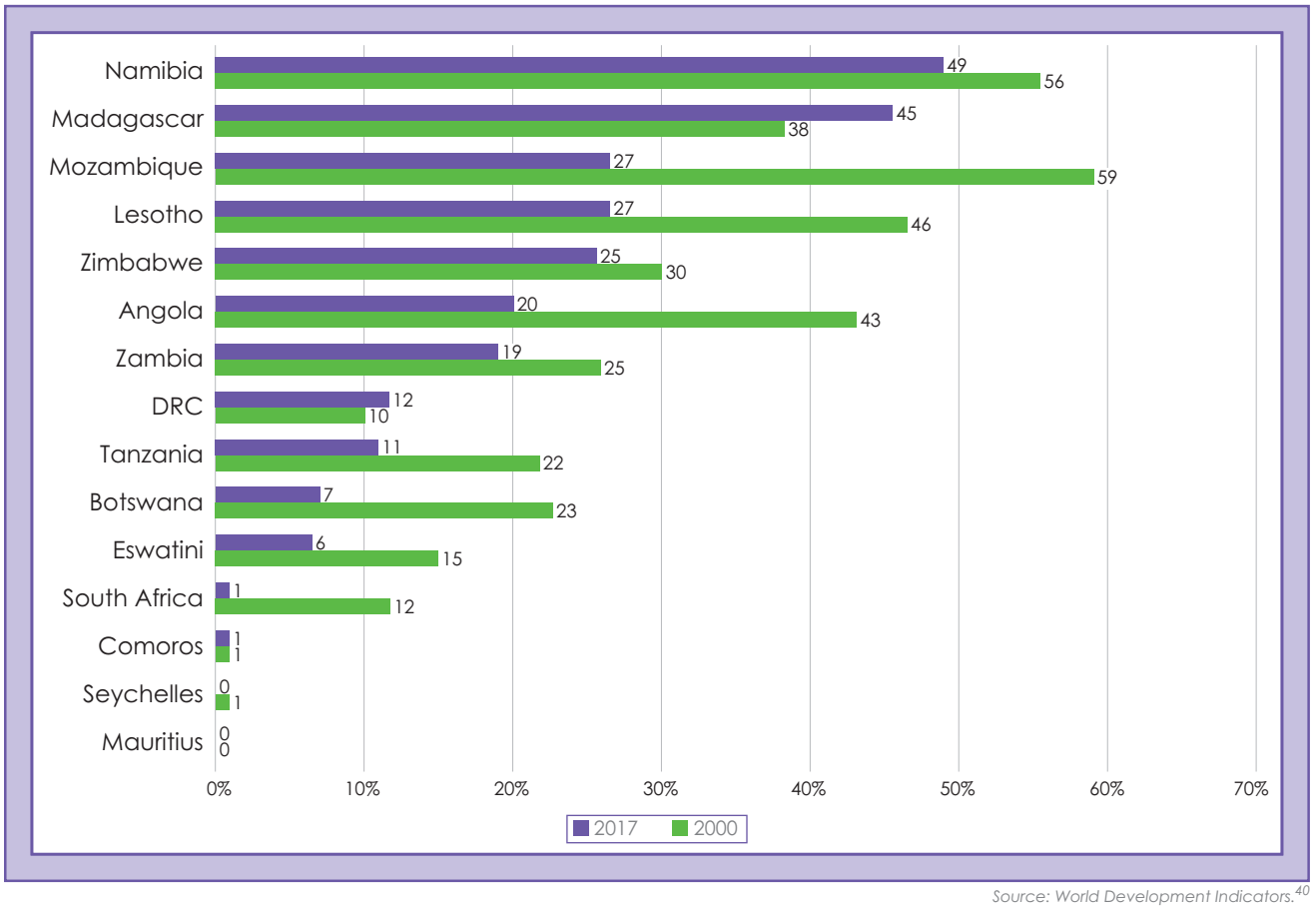
Source: SDG Report 2021, country profiles.[39]

[38] https://dashboards.sdgindex.org/profiles accessed 12 July 2021
[39] https://dashboards.sdgindex.org/profiles accessed 12 July 2021

Figure 2.2 shows that only one SADC country, Seychelles, provides basic sanitation to its entire population. Mauritius is close to achieving universal coverage. Botswana (77%) and South Africa (76%) are three quarters of the way to this target. Eswatini (58%) and Angola (50%) are half way or further. The other ten countries are lower than 50%, with Madagascar (11%) having the lowest coverage.

People practicing open defecation refers to the percentage of the population defecating in the open, such as in fields, forest, bushes, open bodies of water, on beaches, in other open spaces or disposed of with solid waste. There is a correlation between access to sanitation and percentage of the population practising open defecation.

Figure 2.3: Percentage of population practicing open defecation 2000-2017



Source: World Development Indicators.[40]

Figure 2.3 shows that just two (Mauritius and Seychelles) of the 16 SADC countries have eradicated the practise of open defecation. There has, however, been marked progress in most countries over the last 17 years.

Madagascar, DRC and Tanzania all recorded an increase in the proportion of the population practicing open defecation. Namibia still has the highest prevalence of this practise.

Marked progress in the eradication of open defaecation has been made in most countries over the last 17 years

[40] https://data.worldbank.org/indicator/SH.STA.ODFC.ZS Accessed 14 July 2020.

Access to Family Planning (FP) Services

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.

CEDAW: Article 14 (b): To have access to adequate health care facilities, including information, counselling and services in family planning.

Access to contraception is a universal human right that dramatically improves the lives of women and children in poor countries. Contraception is a lifesaver for women trying to prevent unplanned or unwanted pregnancies. When women can exercise their right to bodily autonomy, by deciding when and how many children they want have, they are able to make informed choices about their lives and wellbeing. Access to contraception improves maternal health and child survival, reduces the number of abortions overall, especially unsafe abortions and it empowers women and promotes social and economic development and security.

The 2030 Agenda for Sustainable Development reaffirms the commitments made in the Programme of Action of the International Conference on Population and Development (ICPD), adopted by 179 governments in Cairo, Egypt in 1994. The ICPD Programme of Action recognized the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. While much progress has been achieved in expanding access to contraception since 1994, significant challenges persist.

Of the 1.9 billion women of reproductive age (15-49 years) living in the world in 2019, 1.1 billion have a need for family planning, meaning that they are either current users of contraceptives or have an unmet need for family planning. Worldwide, in 2019, 49% of all women in the reproductive age range (15-49 years) were using some form of contraception, an increase from 42% in 1990.[41] The proportion of women with unmet need for family planning stands currently at 9%, a proportion that has remained unchanged since 2000.



Zimbabwe - Contraceptive shots at Gweru City Council, Zimbabwe.
Photo: Gender Links

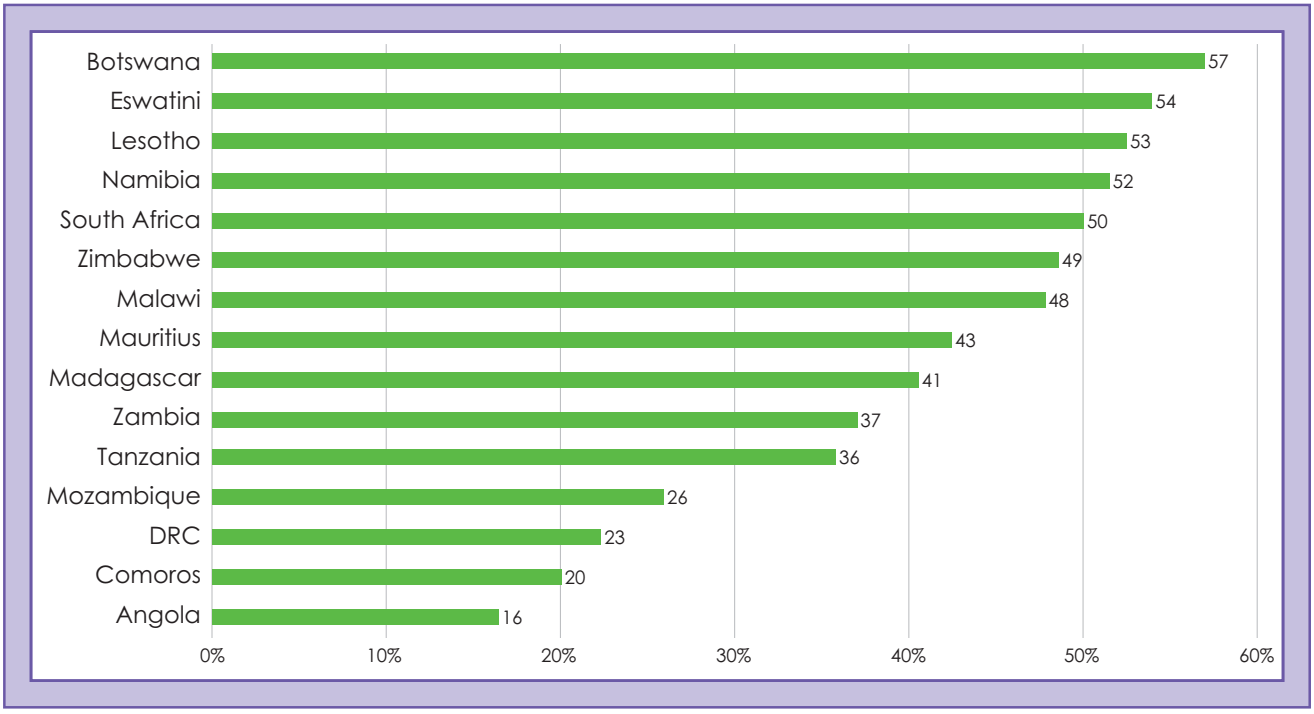
There are a number of reasons why women are not able to control their fertility, including high levels of GBV and women's inability to negotiate safe sex, customary laws and culture and lack of access to modern contraceptive methods.

[41] United Nations Department of Economic and Social Affairs, Population Division (2020). World Fertility and Family Planning 2020: Highlights pp.13

Contraceptive prevalence rates (CPR)

Contraceptive prevalence rate in this report refers to the percentage of all women[42] of reproductive age (15-49) who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used.[43]

Figure 2.4: Contraceptive prevalence (CPR) amongst all women aged 15-49 (%) any method



Source: UNFPA, World Population Dashboard.[44]

Figure 2.4 shows that the CPR in the SADC region ranges from 57% in Botswana to a low 16% in Angola. Six countries (Botswana, Eswatini, Lesotho, Namibia, South Africa and Zimbabwe) meet or exceed the global average of 49%.

Unmet contraception need

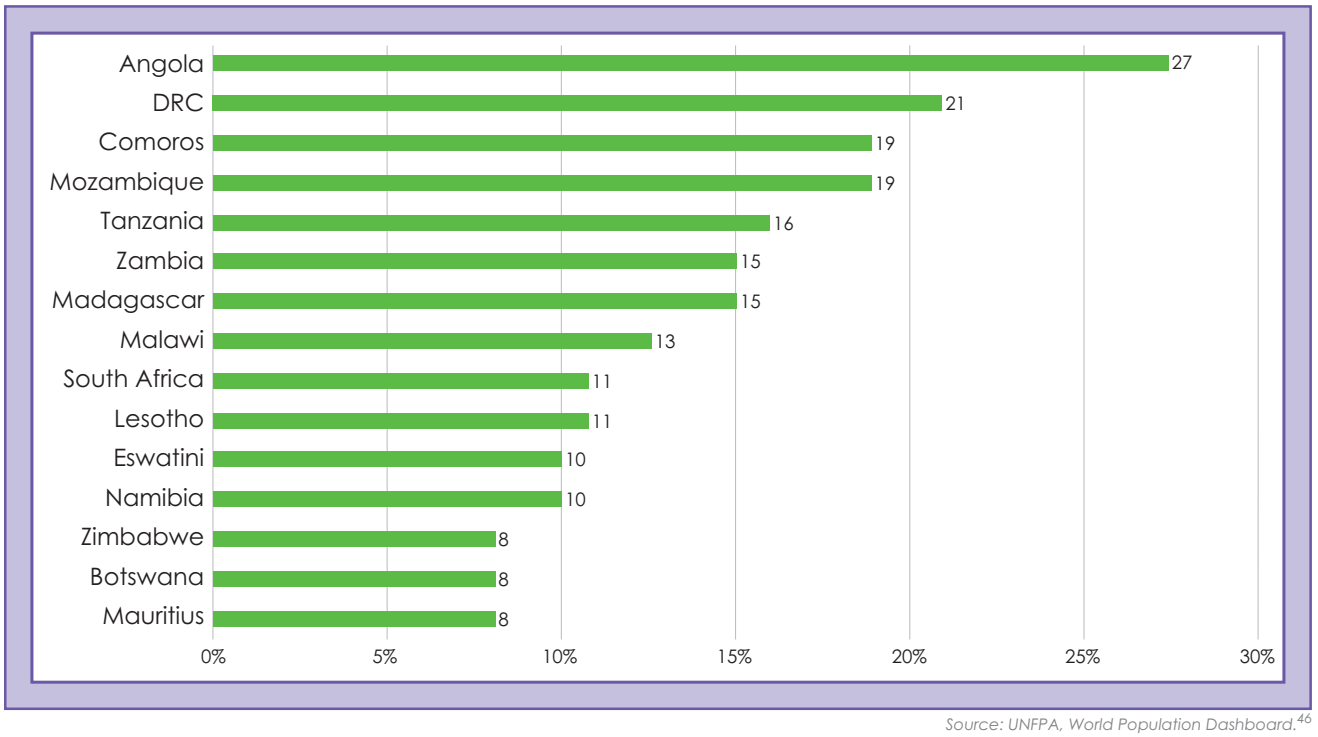
Women with unmet need are those who are sexually active, but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. This unmet need for family planning points to the gap between women's reproductive desire to avoid pregnancy and contraceptive behaviour.

The reasons for this are complex but anecdotal testimony of field workers shows that "the obstacles to contraception go well beyond access to services that are of good quality and affordable. Non-access barriers include fear of health side effects, normative acceptability (including religious concerns), social accept-

[42] This is often reported for married/in union women only, which is how we have reported on it previously. In this report we use the broader definition, which includes all women of reproductive age using any method of contraception.
[43] WHO, Sexual and Reproductive Health, https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/ accessed 27 July 2021
[44] https://www.unfpa.org/data/world-population-dashboard accessed 12 July 2021

ability (including the important matter of the partner's approval), and various possible informational and other cultural factors. Uncertainty and ambivalence about the desire to avoid pregnancy can also figure in, as can perceptions of the actual risk of becoming pregnant.[45]

Figure 2.5: Unmet need for family planning rate women aged 15-49, all women (%) 2021



Source: UNFPA, World Population Dashboard.[46]

Figure 2.5 shows the proportion of women who have unmet needs for contraception. Angola has the highest unmet need with 27% of women of reproductive age (15-49 years) having a need for family planning, but not having that need met. Three countries (Mauritius, Botswana and Zimbabwe) are below the global average of 10%, and Namibia and Eswatini are both at 10%.

The rest of the countries range from 11% in South Africa in Lesotho, to 27% in Angola.

There is a correlation between low CPR and high unmet needs for contraception. The seven countries with the lowest CPR (Angola, DRC, Comoros, Mozambique, Madagascar, Tanzania and Zambia) have the highest proportion of women with an unmet need for contraception.

The effects of COVID-19 on Family Planning (FP)

At the start of the pandemic, UNFPA, Avenir Health, Johns Hopkins University and Victoria University modelled the potential impact of the pandemic on family planning services. They found that six months of severe health system disruptions in 114 low- and middle-income countries could lead to 47 million women unable to use contraceptives, leading to 7 million unplanned pregnancies.

[45] Machiyama, K., Casterline, J.B., Mumah, J.N. et al. Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. Reprod Health 14, 23 (2017)
[46] https://www.unfpa.org/data/world-population-dashboard accessed 12 July 2021

Reasons for the disruption include:

- Clinical staff occupied with the COVID-19 response may not have time to provide services, or may lack personal protective equipment to provide services safely.
- Health facilities in many places closing or limiting services.
- Women refraining from visiting health facilities due to fears about COVID-19 exposure or due to movement restrictions.
- Supply chain disruptions limiting availability of contraceptives and stock-outs of many contraceptive methods were anticipated.
- Product shortages and lack of access to trained providers or clinics mean that women may be unable to use their preferred method of contraception, may instead use a less effective short-term method, or may discontinue contraceptive use entirely.[47]

As predicted, the pandemic has strained public health systems globally, interrupting and delaying many kinds of critical health care. The World Health Organization (WHO), conducted two surveys on the continuity of essential health services during the COVID-19 pandemic. The first covers the period January-March 2020 in 105 countries and the second the period June-March included responses from 135 countries. In the second survey all SADC countries were included except Tanzania and Zimbabwe.

The first survey found that family planning and contraception were among the most frequently disrupted health services, with 7 in 10 countries experiencing disruptions.[48] The results showed that most countries reported some disruption in reproductive, maternal, new-born, child and adolescent health (RMNCAH) and nutrition services. Family planning services were disrupted in 68% of countries (59% partially disrupted and 9% reporting severe/complete disruption.)[49] The number of countries reporting disruptions in family planning services decreased in the second survey, to 44%, indicating that services have improved as the pandemic has progressed showing resilience in health systems to ensure continuity of health care services.

A regional survey conducted by the WHO that included responses for 17 African countries - including DRC, Madagascar, South Africa, Tanzania and Zimbabwe - found that 59% of the countries that participated in the survey reported a reduction in the use of FP since the beginning of the pandemic. Twelve (71%) countries reported a reduction in uptake of FP commodities, showing the need to continuously educate the public on health seeking behaviour even during the pandemic. Eight (47%) countries reported stock out of FP commodities, most reporting implants and IUDs as the major stock outs.[50]

Evidence and data needs to be continuously gathered in each country to assess the overall impact on women accessing SRH services. This data is crucial to informing policy and practise now and to learn for future health emergencies or disasters. The case study that follows is one example of innovative strategies.

COVID-19 has strained public health systems globally, interrupting and delaying many kinds of critical health care

[45] Machiyama, K., Casterline, J.B., Mumah, J.N. et al. Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. Reprod Health 14, 23 (2017)
[46] https://www.unfpa.org/data/world-population-dashboard accessed 12 July 2021
[47] UNFPA, Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage, Interim Technical Note, 27 April 2020
[48] World Health Organisation, Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report, 2020
[49] Ibid, p 8
[50] Continuity of Essential Sexual and Reproductive Health Services During Covid-19 Pandemic In The WHO African Region, pp4

Mbabane, Eswatini - Once a month, Nolwazi Myeni receives a message on her mobile phone notifying her that family planning services are available despite the pandemic-related lockdown. "I felt very encouraged to be assured that I could visit any clinic amid COVID-19 for my contraceptive needs," the 24-year-old said.

This service has encouraged thousands of women in Eswatini to access contraceptives, and also provided welcome monthly reminders lest they forget.

"With the lockdown movement restrictions, it's easy to forget the date to return to the health facility. These [messages], beyond encouraging us to go for the service, also act as a reminder," Myeni said.

Myeni is the mother of a 6 year old and a mentor to dozens of adolescent girls in her community. She hopes to continue her youth-empowerment efforts by becoming a teacher. Family planning will help her realize this dream, she says, by helping her avoid pregnancy so she can complete her studies and receive a primary teacher's diploma.

The short message service (SMS) programme is part of a partnership between UNFPA, the World Food Programme (WFP) and the health ministry's Sexual Reproductive Health Unit.

The programme not only encourages recipients to learn about family planning services, it also provides information about food relief. The campaign aims to reach 80,000 young women receiving assistance through the WFP COVID-19 relief project in Eswatini.

Experts are concerned the COVID-19 pandemic may be undermining women's ability to choose whether and when to have children. In April, UNFPA and partners projected that 6 months of lockdown-related service disruptions could result in at least 47 million women around the world unable to use modern contraceptives.



Women in Eswatini get SMS reminders on family planning.
Photo: Thandokuhle Dlamini

There are some indications this may be happening in Eswatini. The country saw a 47 per cent drop in use of family planning services between January and May compared to the previous year, according to a recent report by the Social Protection Cluster Partners.

An increase in unintended pregnancies will not only disrupt women's and girls' ability to achieve their full potential, it will also endanger their lives by exposing them to possible pregnancy complications in an uncertain time.

Some health facilities, especially those in rural areas of the country, are already reporting a decline in women attending antenatal clinics and an increase in home deliveries.

"Since the start of the lockdown, we have noted an increase in incidents of women delivering babies either at home or on their way to the facility," midwife Lobesutfu Nkambule told UNFPA.

"Ensuring that women continue accessing these services is one way we can mitigate COVID-19's impact on the health of vulnerable groups like women and girls," said Margaret Thwala-Tembe, UNFPA's acting head of office in Eswatini.

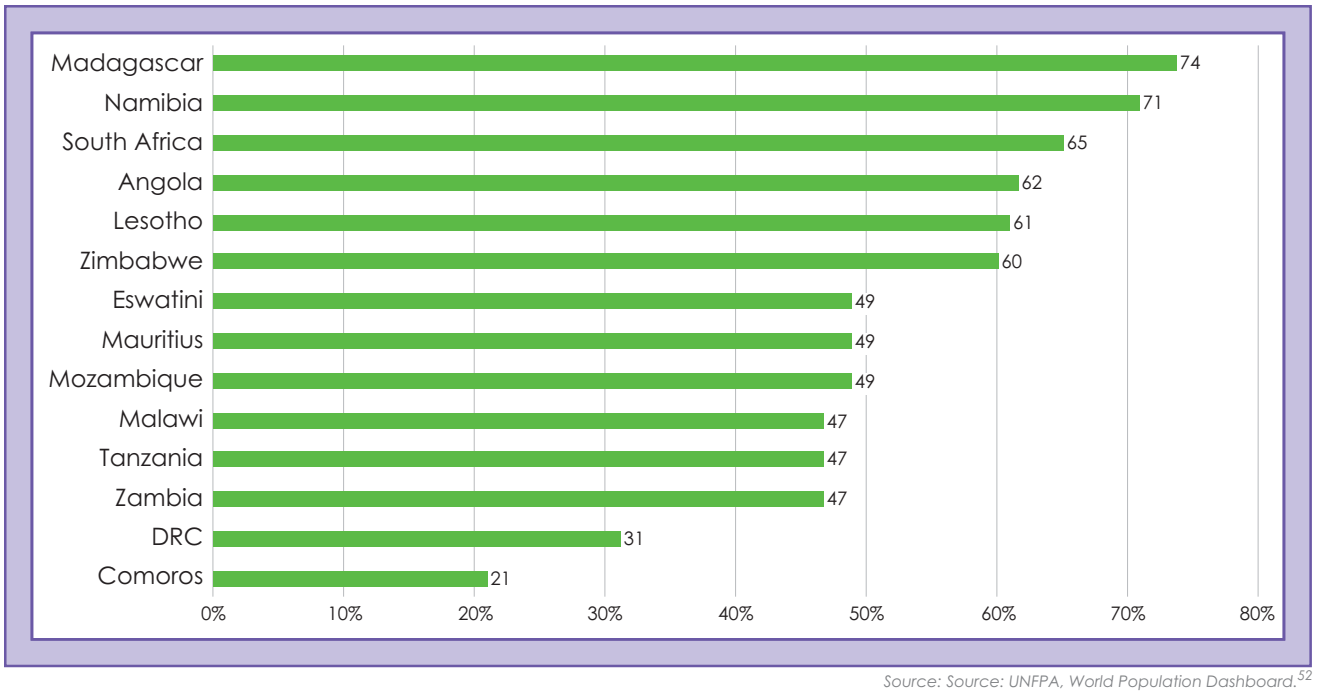
Source: UNFPA, Eswatini SMS service helps women access family planning, food amid pandemic, 30 July 2020[51]

[51] https://www.unfpa.org/news/eswatini-sms-service-helps-women-access-family-planning-food-amid-pandemic accessed 16 July 2021

Female decision making on SRHR

Overall, the right to bodily autonomy and women's right to make decisions about their own bodies is remarkably low throughout SADC.

Figure 2.6:Female decision making on SRHR 2021



Source: Source: UNFPA, World Population Dashboard.[52]

Figure 2.6 shows that there is no country in which all women have control over decision-making on SRHR. Madagascar has the highest proportion of women involved in decision-making on SRHR at 74%, followed by Namibia (71%), South Africa (65%), Angola (62%), Lesotho (61%) and Zimbabwe (60%). In eight countries less than 50% of women are involved in decision-making on SRHR, with DRC and Comoros well below 50% at 31% and 21% respectively.

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, appropriate and affordable quality health care, in particular, to:

SDG 3.1: By 2030, Reduce maternal mortality to fewer than 70 deaths per 100 000 live births.

[52] https://www.unfpa.org/data/world-population-dashboard Accessed 14 July 2021

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 health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Although important progress has been made in the last two decades, about 295 000 women died during and following pregnancy and childbirth in 2017. This number is unacceptably high.[53]

Maternal mortality

Maternal mortality refers to deaths due to complications from pregnancy or childbirth. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anaemia, malaria, and heart disease. Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment.[54]

There has been progress globally from 2000 to 2017 by reducing maternal deaths 38% from 342 deaths to 211 deaths per 100,000 live births, which is an average annual rate of reduction of 2.9%. This is less than half the 6.4% annual rate needed to achieve the Sustainable Development global goal of 70 maternal deaths per 100,000 live births.[55] But MMR stills remain high in many parts of the world.

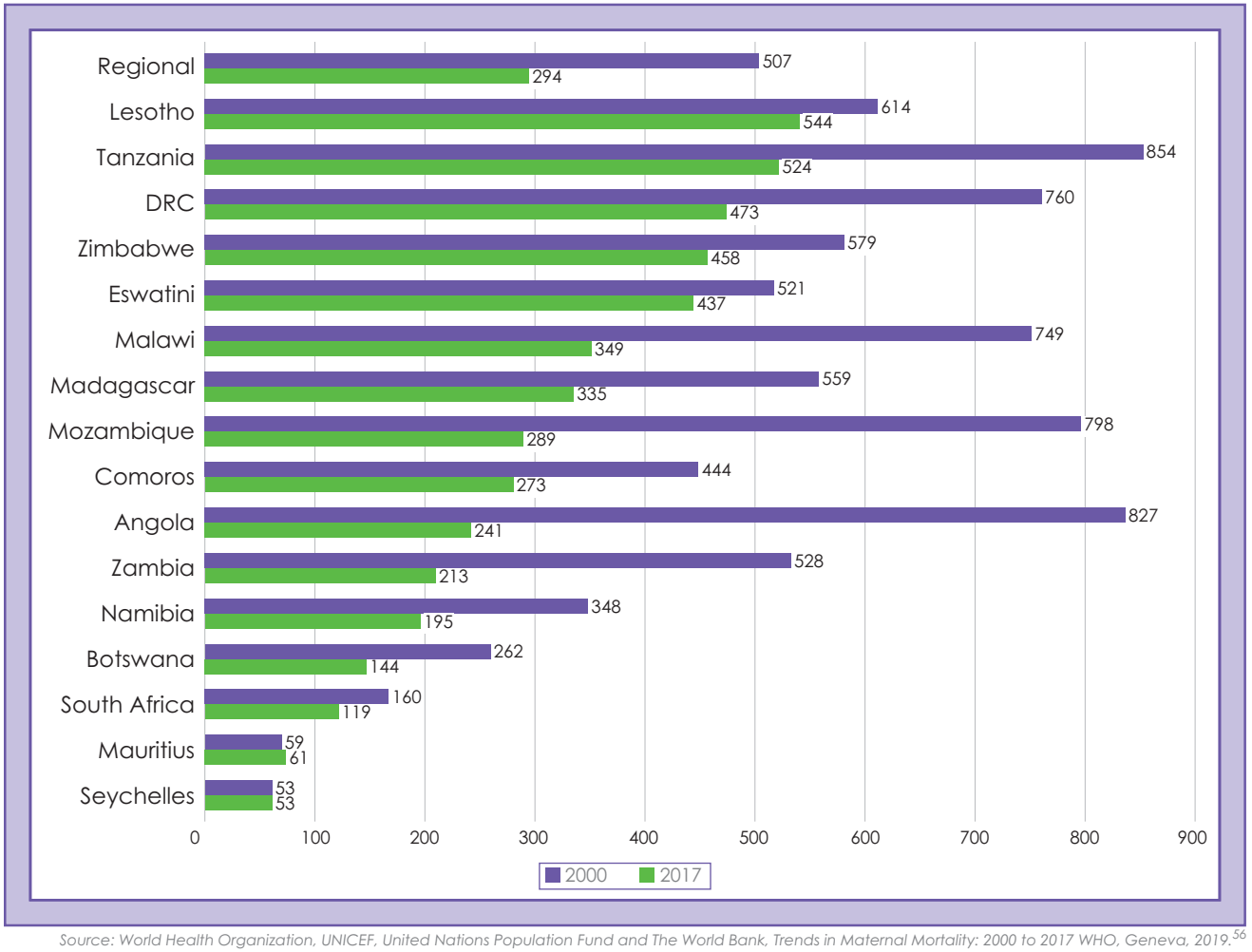
Most countries in Southern Africa are still far from reaching the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births by 2030.



Health professionals in Botswana are committed to saving the lives of women. Photo: Gender Links

[53] https://www.who.int/health-topics/maternal-health#tab=tab_1
[54] Ibid
[55] UNICEF maternal mortality database https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 14 July 2021

Figure 2.7: MMR per 100,000 in SADC 2000-2017



Source: World Health Organization, UNICEF, United Nations Population Fund and The World Bank, Trends in Maternal Mortality: 2000 to 2017 WHO, Geneva, 2019.[56]

Figure 2.7 shows that just two SADC countries, Seychelles and Mauritius have met SDG Target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100 000 live births. Eleven countries have a MMR in excess of 200 deaths per 100 000 live births.

However, comparative figures from 2000 show tremendous progress. Overall, the regional average has improved from 507 to 294 deaths per 100,000 over the last 17 years. All countries except Seychelles and Mauritius have experienced a reduction. This is most pronounced in Angola (from 827 to 141 deaths per 100,000) and Mozambique (from 798 to 189 per 100,000).

Global progress has been made from 2000 to 2017 by reducing maternal deaths by 38%

[56] https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 12 July 2021

Table 2.4: Rate of MMR decrease in SADC 2000-2017

Country	2000	2017	Decrease	% decrease	Decrease/year		Reduction needed to achieve SDG 3.1 of 70 by 2030
Lesotho	614	544	70	11%	4	1%	474
Tanzania	854	524	330	39%	19	2%	454
DRC	760	473	287	38%	17	2%	403
Zimbabwe	579	458	121	21%	7	1%	388
Eswatini	521	437	84	16%	5	1%	367
Malawi	749	349	400	53%	24	3%	279
Madagascar	559	335	224	40%	13	2%	265
Region	507	294	213	42%	13	2%	224
Mozambique	798	289	509	64%	30	4%	219
Comoros	444	273	171	39%	10	2%	203
Angola	827	241	586	71%	34	4%	171
Zambia	528	213	315	40%	19	4%	143
Namibia	348	195	153	44%	9	3%	125
Botswana	262	144	118	45%	7	3%	74
South Africa	160	119	41	26%	2	2%	49
Seychelles	53	53	0		0	0%	Met
Mauritius	59	61	-2		0	0%	Met

Source: World Health Organization, UNICEF, United Nations Population Fund and The World Bank, Trends in Maternal Mortality: 2000 to 2017 WHO, Geneva, 2019.[57]

Table 2.4 shows the progress that has been made in SADC countries over the last seventeen year and how far they still have to go to reach SDG Target 3.1. Overall, the MMR in SADC has decreased by 42%, over 17 years. At this rate (a decrease of 13 deaths every year) it will take the region 17 years to achieve the target of 70 deaths per 100 000 live births. With just nine years to go to 2030, countries will need to bolster their efforts to reduce maternal mortality. Lesotho, Tanzania, and DRC face the greatest challenge. Namibia, Botswana and South Africa are within reach of this goal.

Access to maternal health services

Table 2.5: Antenatal care coverage rural and urban

Country	Year	ANC at least one visit			ANC at least four visits		
		National	Area		National	Area	
			Rural	Urban		Rural	Urban
Angola	2016	82	63	92	61	39	74
Botswana	2007	94	94	94	73	70	76
Comoros	2012	92	91	95	49	49	50
DRC	2018	82	77	90	43	38	51
Eswatini	2014	99	98	99	76	74	82
Lesotho	2018	91	91	92	77	74	80
Madagascar	2018	85	84	92	51	47	66
Malawi	2017	98	98	98	51	49	59
Mozambique	2018	94	93	97	51	45	65
Namibia	2013	97	97	97	63	61	64
South Africa	2016	94	96	92	76	80	73
Tanzania	2017	98	97	99	62	57	76
Zambia	2019	97	96	99	64	65	61
Zimbabwe	2019	93	92	96	72	73	68

Source: UNICEF global databases, 2021, of antenatal care, based on MICS, DHS and other nationally representative household survey data.[58]

[57] https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 12 July 2021
[58] https://data.unicef.org/topic/maternal-health/newborn-care/ accessed 16 July 2021

Table 2.5 shows antenatal coverage in SADC at the national and rural and urban areas. No country in the region has all women being attended at least once during pregnancy by skilled health personnel. Angola has the lowest proportion of mothers having at least one visit to skilled health worker, with 82% of pregnant women having access to this health service. Eswatini has the highest proportion of women attending at least one visit. The table shows that in most countries women in rural areas have less access than those residing in urban areas.

A much lower proportion of women have at least four antenatal visits. It is encouraging to see that in five countries (Botswana, Lesotho, Eswatini, South Africa and Zimbabwe) over 70% of pregnant women have at least four antenatal visits. In almost all countries the urban/rural divide is bigger, partly as a result of access to clinics and the distances that pregnant women have to travel to get to them.

The WHO Pulse Surveys on the continuity of health services during the COVID-19 pandemic, found in the first survey (July to August 2020) that antenatal and especially delivery care services were rarely severely disrupted during the pandemic. However, 53% of countries reported partial disruptions in antenatal care services and 32% in facility-based birth services.[59] As with family planning services, the countries reporting disruptions decreased in the second survey period January to March 2021 with 39% reporting disruption to antenatal services and 25% in facility-based births.

Table 2.6: Percentage of births delivered by a skilled health personnel[60]

Country	Year	National	Area	
			Rural	Urban
Botswana	2017	100		
Mauritius	2019	100		
Seychelles	2012	99		
South Africa	2016	97	95	98
Malawi	2016	90	89	95
Eswatini	2014	88	86	93
Namibia	2013	88	82	95
Lesotho	2018	87	84	90
Mozambique	2018	87		
Zimbabwe	2019	86	82	94
DRC	2018	85	79	95
Comoros	2012	82	79	92
Zambia	2019	80	73	93
Tanzania	2016	64	55	87
Angola	2016	50	21	68
Madagascar	2018	46	40	72

Source: UNICEF global databases, 2021, of antenatal care, based on MICS, DHS and other nationally representative household survey data.[61]

Table 2.6 shows that only in Mauritius and Botswana do all women have access to skilled birth attendants during delivery. Angola (50%) and Madagascar (46%) have exceptionally low proportions of pregnant women with a skilled attendant during delivery. The table shows that as in the cases of other maternal health services the urban/rural divide is marked, highlighting challenges for women in rural areas to access such services.

[59] World Health Organisation, Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report, 2020
[60] Typically doctor, midwife and/or nurse
[61] https://data.unicef.org/topic/maternal-health/newborn-care/

Table 2.7: Postnatal care coverage per country, national, urban and rural

Country	Year	National	Area	
			Rural	Urban
Eswatini	2014	88	85	94
Lesotho	2018	84	82	87
South Africa	2016	84	81	85
Madagascar	2018	72	70	79
Zambia	2019	70	64	82
Namibia	2013	69	69	69
Zimbabwe	2015	57	53	67
DRC	2018	50	41	63
Comoros	2012	49	46	56
Malawi	2016	42	41	52
Tanzania	2016	34	29	48
Angola	2016	23	12	31

Source: UNICEF global databases, 2021, of antenatal care, based on MICS, DHS and other nationally representative household survey data.[62]

Table 2.7 shows that the proportion of women (age 15-49) who received postnatal care within two days after birth is low, with no country achieving 100% coverage. Coverage of these services ranges from 23% in Angola to 88% in Eswatini. In four countries (Angola, Comoros, Malawi and Tanzania) less than half the women who have given birth receive postnatal care. There is no data for Botswana, Mauritius, Mozambique and Seychelles.



COVID-19 affecting maternal health in DRC

For many women who are pregnant during this time of corona virus this journey in their lives has been uncertain.

Arlette Mali Mungu Bahati, resident of Kinshasa city, is just a month away from the birth of her second child, but her anxiety has remained constant feature of her pregnancy since COVID-19 was reported in the Democratic Republic of Congo (DRC) in March. At one time when Bahati was feverish, she refused seeking medical attention owing to her anxiety and the risk of exposure to COVID-19 in hospitals.

Since March Bahati, who at the time was five months pregnant has witnessed several restrictions, including shutdown of the market where she makes an income from a clothing store. It was inevitable, her shop was located in one of the most frequented places in Kinshasa and government had to enforce social distance, an important protocol of curbing the spread of the virus.

With her livelihood affected, and her anxiety reaching new levels, Bahati says her pregnancy makes her more of prisoner than fulfilled."I have limited my outings because of the coronavirus, I hardly go out anymore for fear of being contaminated," the expectant mother said.

Afraid of being infected, Bahati decided to change hospitals. Her previous hospital located in Gombe municipality in Kinshasa City, the epicentre of Coronavirus, was one of 8 hospitals designated by the government to receive

[62] https://data.unicef.org/topic/maternal-health/newborn-care/

COVID-19 patients. and she could not risk it despite assurances of care against contracting the disease. She could no longer continue to be examined by her usual gynaecologist at Ngaliema Hospital, with whom she had established a good relationship since her last pregnancy. The change is also costing her dearly. She now has to pay $10 per consultation and $20 whenever she requires the attention of a gynaecologist, compared to the free care she received before.



UNFPA celebrating midwives in the time of COVID-19.
Photo courtesy of Junior Mayindu, UNFPA

"At my former hospital, I was very used to my gynaecologist because he understood me better. I could call him at any time in case of discomfort but now I consult a general practitioner doctor just to check the evolution of my health," she said. "If I have to see a gynaecologist, I must pay $20," she said. "It's true that they're all doctors and I trust them, but the problem is that I'm not used to them and have to start all over again. I have a lot of self-restraint and I'm anxious because I don't even know the health status of the doctor who consults me and the nurses who welcomes me, the situation is just complicated, but I trust God, he is in control, I will deliver my baby without complication."

Coronavirus pandemic caught the world unaware, affecting all facets of human lives and motherhood is not spared. Fear, anxiety and uncertainty are disrupting this normally happy period for expectant mothers. Pregnant women are increasingly changing their places of consultation with a large number of them stopping prenatal consultations and care.

Dr. Kabongo Kanyanya Jessy, Head of Programme at AFIA MAMA, a non-governmental organisation (NGO) working on promotion of women's rights and gender in Kinshasa City, noted that pregnancy itself is a period of anxiety for women. COVID-19 has added to the anxiety. He said the government should put in place a policy to take care of pregnant women at this critical time.

"The government should develop a policy for the management not only of COVID-19, but also to consider other associated pathologies and above all to capitalize more on the follow-up of pregnant women because they are much more exposed," he said.

Dr. Mukendi Richard, a gynaecologist at the University Hospital in Lubumbashi added, "to date there is no scientific evidence to indicate that pregnant women are more vulnerable to COVID-19. Pregnancy is, however, accompanied by physical changes, and pregnant women may sometimes be more exposed to viral respiratory infections insofar as there is a physiological decrease in natural immunity during pregnancy to enable the pregnant women to support the father's foreign cells present in the foetus."

Physical distancing is impossible in the management of delivery. Bahati, who is in her third trimester, finds it inconvenient to wear a mask as it prevents her from breathing well - an observation made by many pregnant women. This may account for the decline in prenatal care with more pregnant women reportedly relying on home and traditional care."In fact, we are seeing a significant drop in the number of pregnant women attending public hospitals because of the fear of easily contracting the virus. But also because of the fear of being held in isolation in case of suspicious symptoms or a positive COVID-19 result," Dr. Mukendi said.

By Gabrielle Nina Mitch. This story is part of the GL News Service Gender and COVID-19 series[63]

[63] https://genderlinks.org.za/news/covid-19-affecting-maternal-health-in-drc/ accessed on 8 August, 2021

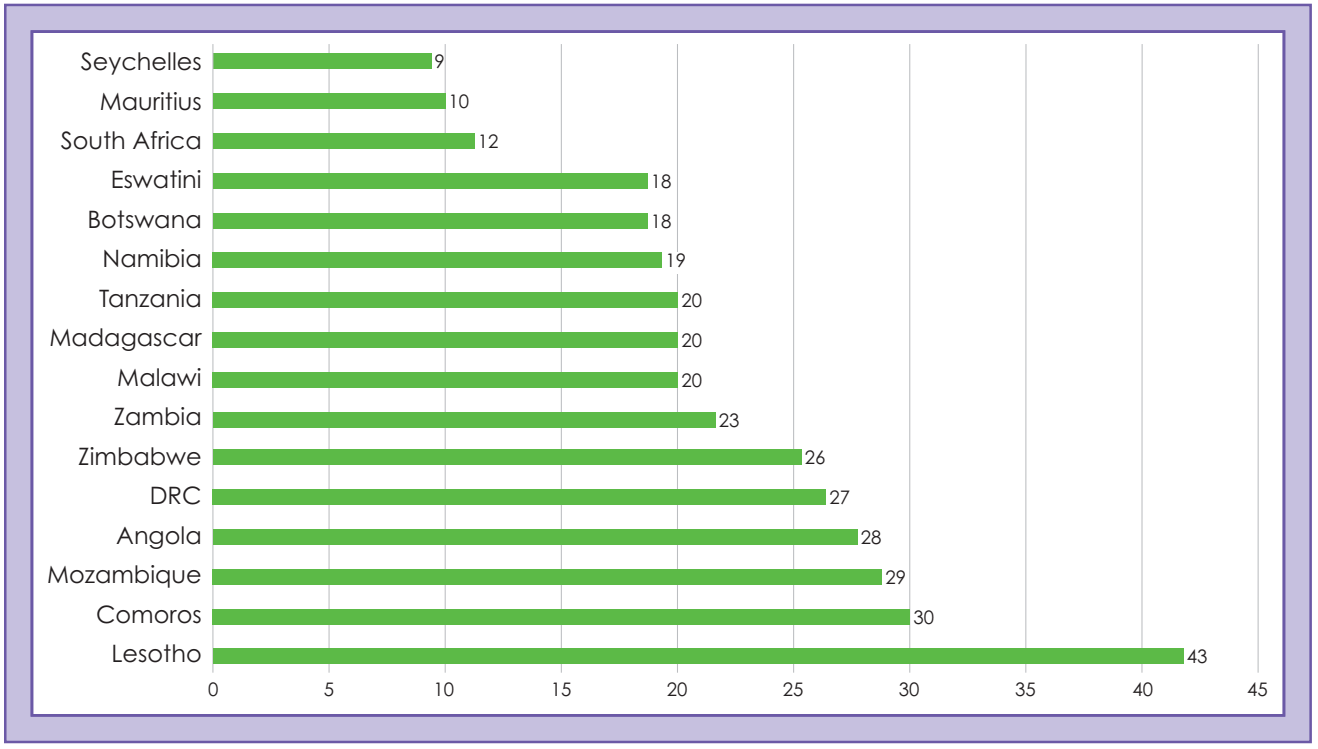
Neonatal mortality

Neonatal mortality refers to the number of deaths during the first 28 days of life per 1000 live births in a given year or period.[64] About a third of all neonatal deaths occurring within the first day after birth, and close to three-quarters occurring within the first week of life.[65]

SDG Target 3.2 reads: "by 2030, end preventable deaths of new-borns and children under 5 years of age." All countries aim to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

The first 28 days of life - the neonatal period - is the most vulnerable time for a child's survival. Children face the highest risk of dying in their first month of life at an average global rate of 17 deaths per 1,000 live births in 2019, down by 52 per cent from 37 deaths per 1,000 in 1990,[66] but still short of the SDG target 2.2 of at least 12 deaths per 1,000 live births.

Figure 2.8: Neonatal Mortality Rate per 1,000 by country 2021



Source: Sustainable Development Report 2021, Country profiles.[67]

Figure 2.8 shows that just three SADC countries (Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.

[64] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf
[65] https://data.unicef.org/topic/child-survival/neonatal-mortality/
[66] https://data.unicef.org/topic/child-survival/neonatal-mortality/
[67] https://dashboards.sdgindex.org/profiles accessed 12 July 2021

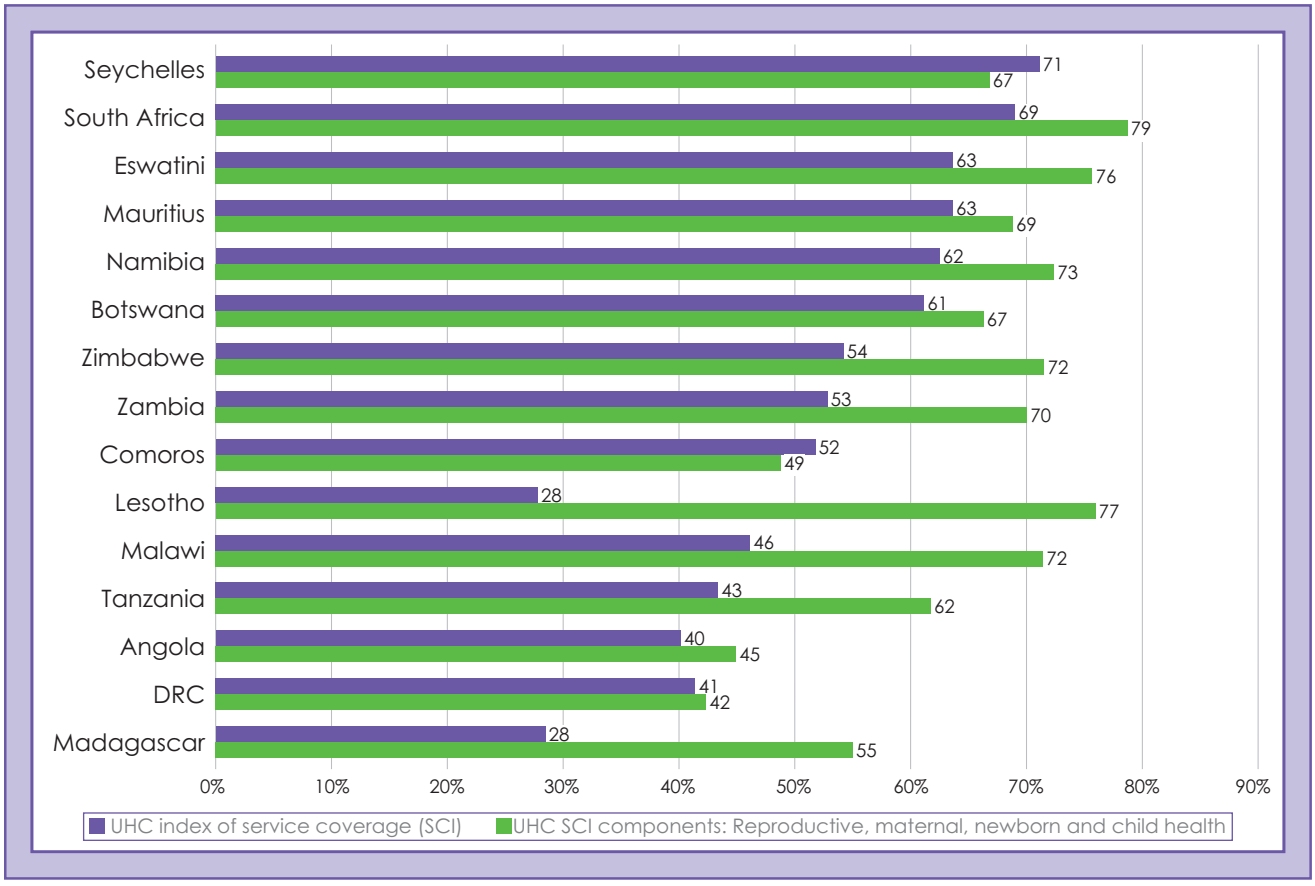
Universal health care (UHC)

SDG 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

According to the WHO "UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."[68] Sexual and reproductive health services are considered essential and are therefore included in this definition.

Currently, at least half of the people in the world do not receive the health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health.[69]

Figure 2.9: Percentage population receiving essential health services



Source: WHO, UHC Index of service coverage.[70]

[68] WHO, Fact Sgeet: Universal Health Cobverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 12 July 2021
[69] WHO, Universal health coverage, https://www.who.int/health-topics/universal-health-coverage#tab=tab_1 accessed 13 July 2021
[70] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage , accessed 15 July 2021.

Figure 2.9 shows that no country in SADC provides universal health care. Access to essential health services ranges from 71% in Seychelles to 28% in Madagascar. South Africa, Eswatini, Mauritius and Namibia have between 60% and 69% coverage, while Lesotho, Tanzania, Angola, DRC and Madagascar have less than 50% coverage.

It is encouraging that as a component of UHC of service coverage, access to reproductive, maternal, new-born and child health services is higher in than the overall coverage in all countries except Seychelles, with the highest coverage in South Africa (79%) and Lesotho (77%).

Cervical cancer

Human papillomavirus (HPV) is the most common sexually transmitted disease. While it is usually harmless some types cause long term health problems. HPV is one of the main causes of cervical cancer. Globally there were about 43 million HPV infections in 2018, many among people in their late teens and early 20s. There are vaccines to prevent HPV infection and HPV assays that detect nucleic acids of the virus. WHO has launched a Global Initiative to scale up preventive, screening, and treatment interventions to eliminate cervical cancer as a public health problem during the 21st century.

Cervical cancer continues to be a major public health problem affecting middle-aged women, particularly in less-resourced countries. The global scale-up of HPV vaccination and HPV-based screening has the potential to make cervical cancer a rare disease in the decades to come.[71]

Cervical cancer continues to be a major public health problem affecting middle-aged women

Approximately 570,000 cases of cervical cancer and 311,000 deaths from the disease occurred in 2018: a rate of 13 per 100,000 women globally. This varies widely between countries, with rates ranging from less than 2 to 75 per 100,000 women. Cervical cancer was the leading cause of cancer-related death in women in eastern, western, middle, and southern Africa.

Figure 2.10: Cervical cancer incidence and mortality rates per 100 000 in SADC



Source: The Lancet, Burden of Cervical Cancer Incidence.[72]

Figure 2.10 shows that the incidence of cervical cancer in the SADC region, at 43 per 100,000, is well above the global average of 13 per 100,000, The mortality rate is also high at 20 per 100,000. With approximately 65 per 100 000 women developing cervical cancer before age 75 years, Eswatini has the highest rate of cervical cancer in the region.

SADC countries must start rolling out vaccines as well as conducting education and awareness programmes on HPV, to increase the rate of vaccination. States should consider starting to roll out the vaccines as part of the inoculation regime.

[71] Marc Arbyn, et al. Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis, 4 December 2019
[72] https://www.thelancet.com/action/showFullTableHTML?isHtml=true&tableId=tbl1&pii=S2214-109X%2819%2930482-6 , accessed 16 July 2021

Health expenditure analysis

Health expenditure includes all expenditures for the provision of health services, family planning activities, nutrition activities and emergency aid designated for health, but it excludes the provision of drinking water and sanitation. Health financing is a critical component of health systems.

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 a country's Gross Domestic Product (GDP). The GDP represents the total value of everything produced in the country. It does not matter if citizens or foreigners produce it - if they operate within a country's boundaries, research includes this production in GDP.[73] Health expenditures are an important indicator of a government's commitment to UHC.

Table 2.8: Health financing analysis in SADC countries

Country	Health expenditure as % of total government expenditure	Health expenditure as % of GDP
Eswatini	16.5	6.5
Malawi	16.7	9.3
South Africa	14.2	8.2
Namibia	13.8	7.9
Tanzania	12.3	3.6
Zambia	11.3	4.9
Madagascar	10.1	4.7
Mauritius	10.0	5.8
Seychelles	9.7	3.9
Botswana	8.8	5.8
Mozambique	8.8	8.1
Comoros	8.6	4.5
Zimbabwe	8.4	4.7
Lesotho	13	9.2
DRC	11	3.3
Angola	5	2.5

Source: World Bank Data, World Development Indicators.[74]

Table 2.8 shows that only Eswatini and Malawi meet the recommended Abuja Declaration Goal of 15% of states annual budget to improve the health sector.[75] South Africa comes close with 14.2%. Namibia, Tanzania, Zambia, Madagascar and Mauritius spend between 10% and 14% on health. All other countries spend less than 10% of their GDP on health. DRC and Angola spend the least on health at 11% and 5% of total government expenditure. This poses a regional challenge to realising SRHR and achieving universal health coverage.

[73] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038
[74] https://databank.worldbank.org/data/source/world-development-indicators#. Accessed 15 July 2020
[75] WHO, Abuja Declaration - Ten years on https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf

Next steps

If states are to reach the targets set in the SADC gender Protocol and the SDGs they will need to takes steps to improve the SRHR of their populations including:

- **Updating guidelines and policies** - Of the 14 SADC countries that have either stand-alone SRHR policies or SRHR guidelines ten countries adopted these between 2001 to 2015. These policies need to be updated to align with international standards on SRHR. Angola and the DRC should prioritise developing stand-alone SRHR policies or guidelines. Policies must include responses to health emergencies.
- **Focus on maternal health care** - Maternal mortality remains unacceptably high in region, while progress has been made, in order to reduce maternal mortality to 70 deaths per 100,000 governments need to spend more on maternal health, including to improves access to antenatal care, to a skilled health care professional for delivery and postnatal care. Women in rural areas should be prioritised.
- **Addressing period poverty** - Governments should scrap VAT on menstrual products and provide free sanitary ware in schools, especially in rural areas.
- **Prioritising investment in clean water and sanitation** to ensure that they meet SDG targets 6.1 and 6.2 of achieving universal access to water and sanitation by 2030 states. Rural areas should be a priority. The government states should raise public awareness on sanitation, including building the capacity of community-led sanitation coverage.
- **Reducing women's unmet need for contraception** which is higher than the global average of 10% governments should work with civil society and suppliers to ensure that every woman who has a need for contraception has that need met.
- **Providing sex disaggregated data** Without sex disaggregated data we cannot understand the differential impact of the pandemic on women and men and ensure fair and equal access to vaccinations and treatment for all
  - There is a dire lack of country data on COVID-19 pandemic from testing through to vaccination. States should collect and disaggregate data on who is being tested, confirmed cases, hospitalisation, ICU admissions, deaths and importantly vaccinations.
  - There is currently no country data on the impact of the pandemic on women's SRHR. States should prioritise collecting this data so that response strategies and programmes address the needs of the most vulnerable.
- **Strategies to reduce cervical cancer** in line with WHO initiative, states must start rolling out HPV vaccines as well as conducting education and awareness programmes on HPV, to increase the rate of vaccination, and should consider starting to roll out the vaccines as part of the inoculation regime.

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Adolescent Sexual and Reproductive Health and Rights (ASRHR) 3



Youth in Botswana take part in a campaign event at a mall in Gaborone in 2020 as part of the Botswana Family Welfare Association (BOFWA) Youth Action Movement. Photo: Mboy Maswabi

KEY POINTS

- Except for Tanzania, 15 of the region's member states adopted a phased approach to re-opening schools following COVID-19 pandemic lockdowns, with standard operating procedures to ensure the safety of learners and staff.
- COVID-19 vaccine trials for adolescents form part of universal health coverage, which means that all persons must be able to access health services, medicines, and the vaccines they require regardless of age.
- Learning should integrate Comprehensive Sex Education (CSE) curriculum with indigenous African knowledge and practices on sexual education to provide legitimacy to CSE in the region.
- CSE refers to the provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships.[1]
- In February 2020, Angola and Mozambique updated their CSE programmes to meet international standards.
- Gender Links (GL), the SADC Gender Protocol National Alliance partners, and local governments with youth leads conducted the Youth Rapid Assessment Study in eight out of 16 SADC countries between 2019 and 2021.
- In and out of school, adolescents and young people must have access to good quality CSE, with linkages to youth-friendly sexual and reproductive health (SRH) and HIV services.
- Drivers of teenage pregnancies are context specific and can include child marriage, poverty, lack of access to ASRHR and effective CSE.

[1] SADC-SRHR-Strategy Publication 2019-2030. Available at https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/07/SADC-SRHR-Strategy-2019-2030-for-public.pdf, accessed 21 June 2021

Introduction

Despite considerable progress since the International Conference on Population and Development (ICPD) more than 25 years ago, millions of people especially youth, who constitute 60% of the population of SADC, still lack access SRHR information and services.



Zimbabwean gender activists take part in the Million Pads campaign in Harare in July 2019.
Photo: Tapiwa Zvaraya

Punitive policies and restrictive laws against vulnerable groups create barriers to their access to SRHR services.

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 inter-generational 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,
- High levels of GBV.
- Child marriages remain a huge concern with an increasing number of adolescent girls faced with the challenge.

National, regional, sub-regional and global instruments and frameworks guide CSE and ASRHR. Several indicators assess the advancement of CSE and ASRHR in SADC member states.

Table 3.1: Key CSE and Teenage Pregnancy Indicators

Countries/Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum reflects international standards	Yes[2]	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Yes	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives	N/A	12	N/A	18	15	N/A	12	16	16	16	12	15	12	12	16	16
Legal age to consent to sex (M)	18	16	13	18	16	16	14	16	16	18	14	18	16	18	16	16
Legal age to consent to sex (F)	16	16	13	14	16	16	14	16	16	18	14	18	16	15	16	16
Adolescent fertility rate (per 1000 women, 15-19 years of age)[3]	151	46	70	124	77	93	110	133	26	149	64	62	68	118	120	86
Adolescent birth rate (births per 1000 women, 15-19 years of age by %)[4]	163	51	70	109	87	91	151	137	23	180	64	68	41	139	135	108

Source: UNFPA regional data, World Bank, WHO Global Health Observatory.

2 UNFPA regional data, https://www.unfpa.org/data/AO, accessed 10 June 2021.
3 World Bank, 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, accessed 16 June 2021.
4 World Health Organisation, Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-(per-1000-women-aged-15-19-years), accessed 16 June 2021.

Table 3.1 illustrates some important ASRHR indicators in the SADC region, with new data this year that confirms very high adolescent birth rates for young women between the ages of 15-19. In the 2020 Barometer, this table showed only adolescent fertility rates. Birth rates speak to the number of live births out of 1000 in a certain age cohort, in this case ages 15-19.

Table 3.1 shows that:

- Eleven out of 16 SADC countries have higher teen birth rates than teen fertility rates. Those highlighted in red indicate a higher rate, while those in green indicate lower birth rates compared to fertility rates.
- Age of consent to sexual activity should align to the age of access to contraceptives, yet in DRC the age of access to contraceptives is 18 while age of consent to sex for females is 14.
- There is need to harmonise the age of consent to sex for boys and girls: they should have the same minimum age. Angola, DRC and Tanzania require legal reforms to make this happen.
- In February 2020, Angola and Mozambique updated their CSE programmes to meet international standards. Several other countries still need to do so.

The global pandemic has disrupted school-based Comprehensive Sexual Education (CSE) and sexual services provision. High COVID-19 infection and mortality rates have resulted in some in and out of school programme suspensions, while others closed entirely.

In this third edition of the #VoiceandChoice Barometer, the Adolescent Sexual Reproductive Health and Rights (ASRHR) chapter documents and profiles the impact of delayed (CSE) on teenage sexual behaviour and decision-making. According to a United Nations Educational, Scientific and Cultural Organisation (UNESCO) report, Sub-Saharan Africa is home to more out-of-school children than any other region in the world.[5] The COVID-19 school closures and re-openings exacerbated challenges accessing SRHR, especially for youth who rely on these services within school systems.

CSE provides young people with knowledge, skills and attitudes to develop and sustain positive, healthy relationships and protect themselves from unsafe situations. Yet access to CSE programmes remains a critical challenge. Over the last three years, SADC has seen growing contention about, and resistance to, CSE curriculum changes in the region, with the Zambian government leading a proposed removal of CSE from school curriculums. For consultation and transparency, the Zambian government formed a Technical Review Committee for CSE in May 2021 to investigate proposed bans to potential changes.

Matters related to sexuality, reproductive health and decision-making might include access to CSE and contraceptive information and services: all human rights linked to bodily autonomy and reproductive decision-making.[6] As such, the proposed ban in Zambia provides evidence that legislators continue to deem critical SRH services as "less essential." These services have suffered under SADC governments that divert capacity and funding, both of which become even more critical during times of crisis such as a global pandemic. When delivered effectively, CSE can help prevent gender-based violence (GBV), HIV and AIDS among young people.

This chapter will provide recommendations of how governments can position CSE within the anticipated rollout of vaccines in the region. Current COVID-19 research shows that the younger generation has the lowest mortality rate when infected.[7]

This year for the first time, this chapter explores the preliminary findings of the eight-country Youth Rapid Assessment surveys conducted by Gender Links (GL), Alliance partners, and local government municipalities with a youth lead. This

[5] UNESCO Institute for Statistics Database 2020. Available at http://data.uis.unesco.org/, accessed 10 June 2021
[6] UNFPA State of World Population Report 2021. My Body is my Own: Claiming the Right to autonomy and self-determination, page 55
[7] Bhopal, Sunil S et al. 2021 "Children and young people remain at low risk of COVID-19 mortality. Lancet Child Adolescent Health Publication.

includes the Young Women Alliance, junior councillors and other youth formations in the GL Centres of Excellence (COE) programmes.

This chapter explores the many dimensions of youth-friendly health education and services especially those linked to teenage pregnancy and teen fathers. In keeping with the tradition of the SADC Gender Protocol Barometer #VoiceandChoice publications, the chapter will also provide an update on progress made in ASRHR Alliance campaigns. In addition, it gives CSE updates for all SADC member states.

ASRHR during COVID-19

In March 2021, world leaders met at the World Health Assembly (WHA) Global Education Coalition high-level ministerial meeting to take stock of lessons learnt and discuss possible education strategies required in the second year of COVID-19. Two representatives from the South African Department of Basic Education stressed the crucial role of teachers in the context of the pandemic, noting that states should prioritise vaccination campaigns and distributions for teachers.[8] Fewer young people and adolescents die from COVID-19 infection compared to adults, so education and health experts noted the importance of preserving the custodians of education, especially linked to CSE and ASRHR delivery.

Because digital content can influence knowledge, attitudes and practices of adolescents and young people, leaders considered using these tools to disseminate COVID-19 information -including around vaccination rollout - alongside CSE and ASRHR education. When harnessed safely and thoughtfully, access to Information and Communication Technologies (ICTs) and digital spaces can add value to CSE delivery. At the WHA meeting, ministers commended innovative new teaching methods that prioritise learner wellbeing and psychosocial support in the pandemic context.

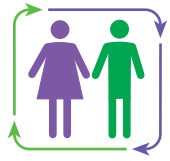


The pandemic has negatively affected and killed many more elderly people than young people. However, vaccine research suggests that youth and adolescents aged 15 to 19 years are more prone to COVID-19 infection and to transmitting the virus as adults. At the time of publication, many governments had authorised Pfizer's vaccine for youth aged 12 and older, with the Moderna and Johnson & Johnson vaccines available to those aged 18 and older.[9] Officially, because researchers only tested vaccines on

[8] Ibid.
[9] Salazar, J.C. (2021). When Will the COVID-19 Vaccine Be Available for Kids, and Will It Be Safe for Your Family? https://www.connecticutchildrens.org/coronavirus/when-will-the-covid-19-vaccine-be-available-for-kids-and-will-it-be-safe-for-your-family/, accessed 17 July 2021.
[10] WHO, 2021. The Pfizer BioNTech (BNT162b2) COVID-19 vaccine: What you need to know, https://www.who.int/news-room/feature-stories/detail/who-can-take-the-pfizer-biontech-covid-19--vaccine#:~:text=The%20vaccine%20has%20only%20been,high%2Drisk%20group, accessed 24 June 2021.
[11] Archyde, 2021. Delta variant virus is most vulnerable to infection in children and young people with different symptoms | Anue Ju Heng-International Politics and Economics https://www.archyde.com/delta-variant-virus-is-most-vulnerable-to-infection-in-children-and-young-people-with-different-symptoms-anue-ju-heng-international-politics-and-economics/, accessed 11 July 2021.

children older than 12, the World Health Organisation (WHO) has not recommended vaccination of children younger than 12, even those in high-risk groups.[10] Scientists continue to research the medical impact of COVID-19 on youth and children as emerging variants of the pandemic seem to pose a greater threat to the younger generation. Many European countries, India, the United States and Africa, specifically South Africa, were struggling against the Delta variant at the time of publication. It is 60% more infectious than the SARS-CoV-2 Alpha variant and reportedly manifests in different symptoms in children and youth.[11]

CSE frameworks and indicators



Sustainable Development Goal (SDG)-4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

SDG 5.6.2 measures the "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."

International Conference on Population and Development (ICPD) paragraphs 4.29, 7.37, 7.41, and 7.47: Sexuality education to promote the well-being of adolescents 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 SADC countries signed the Commitment, which 20 countries endorsed and affirmed in 2013 (the ESA-CSE commitment). Education and health ministers from these countries committed to accelerate access to CSE and health services for young people in the region. Comoros is the only SADC country that is not part of this commitment.

SADC Gender 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 CSE notes 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:

- 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 both in and out of school have access to quality, comprehensive, age-appropriate, scientifically accurate life skills-based CSE with linkages to youth-friendly SRHR services and the youth sector more broadly.

- The importance of 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, the creation of intra-curricula school CSE programmes.
- The need to build and strengthen the skills of those working in wider youth and community interventions to expand capacity within member states to reach out-of-school youth.
- That stakeholder should explore creative approaches to build the capacity of media, including radio, to reach out-of-school youth.

Lack of basic SRHR education increases gender inequalities and leads to poor sexual and reproductive health outcomes, including sexually transmitted infections (STIs), unintended pregnancies and HIV and AIDS, to mention a few. Adolescents and young people represent the region's best opportunity for economic and social development; they form the foundation for growth and stability in all SADC countries. To realise the potential of youth, decision makers must educate them, keep them healthy, and maximise their potential to participate in national and regional economic growth and development. Regional and national policies that champion CSE and ASRHR help ensure that the educated, healthy and empowered youth of today become productive and thoughtful adults of tomorrow who contribute to positive futures for all SADC nations.



The Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), the SRHR Cluster led by the SADC Gender Protocol Alliance, mobilises civil society and youth organisations in the region. It also supports the Eastern and Southern African (ESA) Ministerial Commitments, including those on CSE and SRH services for adolescents and young people agreed to by 21 SADC and East African countries in 2013 that expired in 2020. With support from UNESCO under the Secure the Future project, SAfAIDS recently began work to increase support for new Ministerial Commitments beyond 2020. SAfAIDS supports this work through television and radio programmes on CSE and radio listening clubs formed to enlighten citizens about sex education.

Table 3.2 illustrates highlights from all 16 national policy frameworks as well as monitoring and evaluation strategies for CSE. This 2021 data includes Angola, DRC, Mauritius and Seychelles, which all revisited monitoring and evaluation of CSE in late 2020 and early 2021. Two countries have stand alone policies; nine have integrated these into other policies or strategies; in two countries CSE is fragmented, or found in several different places. In Zimbabwe, a CSE policy is in progress.

Adolescent girls and boys deserve an opportunity to learn about their bodies

The table provides a short description of how various countries conduct monitoring and evaluation and assess the impact of specific SRHR health indicators, including prevention of new HIV infections, prevention of child marriages, and other areas. Child marriages remain a huge concern with an increasing number of adolescent girls facing this challenge. A key variable of ASRHR that curriculum in the DRC recognises the inclusion of SRH outcomes such as knowledge, perceptions and behaviour. While named differently by each country, the function of ASRHR policies or programmes remains the same: to provide school-based sexual health education in both primary and secondary schools.

Table 3.2: CSE national policy frameworks in SADC[12]

Country	Approach to CSE	M&E and CSE strategies
Eswatini	Stand alone	The policy and curriculum have a monitoring, feedback and evaluation strategy that aligns with, and ensures the effective implementation of Life Skills Education (LSE). The Sexual Offences and Domestic Violence Act (SODV) enactment in 2018 supports better outcomes in reduced GBV among adolescents, mostly advocated by youth.
Malawi	Stand alone	The government, with support from UNESCO, has developed a CSE monitoring tool that ensures trained teachers receive regular support and supervision. Malawi has seen improved outcomes in reduction of child marriages and community leaders have taken on the fight through initiatives such as "One community."
Namibia	Stand alone	Namibia has made limited progress in reduction of teenage pregnancy, which is a government priority.
South Africa	Stand alone	South Africa has a four-pronged approach to curriculum assessments, monitored by curriculum specialists and governed by the Curriculum Assessment and Policy Statement. This includes annual monitoring visits to provinces and schools by the national coordinator of the Life Skills programme.
Botswana	Integrated	CSE content is age-appropriate and taught within the context of culture.[13] CSE is compulsory and examinable, although examination tends to concentrate on core competency requirements.
Comoros	Integrated	Integrated provision for CSE, however mostly civil society and international institutions deliver it. The Association Comorienne pour le Bien-Être Famille (ASCOBEF) delivers a comprehensive range of school SRH programmes and services in collaboration with the government.
DRC	Integrated[14]	The National Sexuality Education curriculum has other sex education courses taught in schools in DRC.
Lesotho	Integrated	The Ministry of Education and Training introduced the Curriculum and Assessment Policy of 2009 in Lesotho schools.[15] Although it is a slow and ongoing process, knowledge levels have increased because of the advanced Life Skills syllabus.
Madagascar	Integrated	The Direction des Curricula et des Intrants' (DCI's) M&E plan integrates key performance indicators about supervision and evaluation of activities, as well as impact on learners starting at the primary school level. In addition, the DCI and Institut National de Formation Pédagogique (INFP) have plans to monitor the rollout of training.[16]
Mozambique	Integrated	The Department of School Health (Departamento de Saúde Escolar) has ensured widespread dissemination of SRHR and HIV and AIDS materials.
Seychelles	Integrated[17]	Personal, Social and Civic Education Programme (PSCE) offered in public schools from year 1 to year 15.
Tanzania	Integrated	While outcome evaluations of CSE programmes frequently focus on measuring results, such as increased knowledge, the Ministry of Education Science and Technology made a commitment in March 2020 to reach more than 6.5 million secondary school students with specific mention of non-discrimination of pregnant girls. Additionally, school heads have been trained how to monitor and report on CSE.
Zambia	Integrated	Zambia commissions and undertakes research studies to monitor delivery and quality of CSE, including tracking of progress made towards policies such as the National AIDS Strategic Framework (2011-2016 and 2017-2021) and the Adolescent Health Strategic Framework (2010-2016 and 2017-2021).
Angola	Fragmented[18]	CSE appears in the National Strategy for HIV, TB and Malaria for the Education Sector (2013-17). In 2020, Angola began integrating it into curricular materials within the scope of the Curriculum Adequacy Program for the period 2018-2026.
Mauritius	Fragmented[19]	Collaboration between the ministries of education and health includes drafting of the Sexual Education National Curriculum Framework. The Mauritian Institute for Education leads on this.
Zimbabwe	In progress	Guidance and Counselling (G&C) has tools to monitor implementation of life skills, which include the evaluation of the National Adolescent Sexual and Reproductive Health Strategy (2010-2015).

Source: GL Mapping of SRHR Policies and Laws updated 2020, APHRC, UNESCO, UNFPA.

[12] Gender Links conducted SRHR Research audit of laws and policies, researcher in 15 SADC countries conduct the research May 2020
[13] MIET together with SADC Secretariat as its implementing partner, Review Meeting of Future Life Now, CSTL project 2020.
[14] APHRC, 2019 report https://aphrc.org/wp-content/uploads/2020/03/CSE-in-DRC.pdf, accessed 21 June 2021
[15] Gender Links (2019), https://genderlinks.org.za/casestudies/lesotho-demystify-sexual-education-in-secondary-schools/
[16] 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
[17] Gender Links 2020 SRHR policy and laws audit by Benjamin Vel
[18] UNFPA Report February 2020, https://angola.unfpa.org/en/news/international-workshop-comprehensive-sexual-education-hosted-ministry-education-inide-and-unfpa, accessed 20 June 2021
[19] Emambokus, W.B.S., Oogarah-Pratap, B. (2019). Exploring Parents' and Teachers' Perspectives about School-Based Sexuality Education in a Multicultural Context: A Case Study in Mauritius. Educational Process: International Journal, 8(3), 185-195.



Seychelles offers CSE curriculum in both primary and secondary school. Called the Personal, Social and Civic Education Programme (PSCE), public schools deliver it from year 1 to the last year in school. It includes tailored training and advocacy to close ASRHR gaps, offered in partnership with UNFPA. The hallmark of the CSE implementation is support in the reduction of teenage pregnancies and advocacy for youth-friendly services and life-skills education. Together with supportive laws and policies, the programme assists in extending HIV testing and counselling and strengthens the monitoring of HIV and AIDS patients. However, the fact that some teachers do not take it seriously presents a challenge, as teachers sometimes opt out to use the time to cover other subjects. Others seek the help of nurses to conduct these sessions in secondary schools and others do not teach it at all because they feel ill equipped or uncomfortable. This is a common complaint of students: teachers often skip sessions on SRHR.



Mauritius has taken a fragmented approach to CSE with no formal sex education in its primary and secondary school curricula. It also has a high-unmet need for CSE, as noted in its National Sexual and Reproductive Health Policy, which also highlights the high teenage pregnancy and child marriage rates in the country. Implementation of CSE and SRH services in schools for adolescents and youth does not occur regardless of policy provision. In the past, Mauritius Family Planning Association (MFPA) launched sex education in selected primary schools. However, according to GL 2020 desktop research, the Ministry of Education has shown a willingness to introduce sex education in schools but this intention has been subject to much controversy. Thus, no formal CSE exists for youth, mainly because legislators have neglected to implement a common approach in the multi-ethnic and multi-religious "rainbow nation"[20] of Hindus (48%), Muslims (20%), Christians (27%) and Chinese (3%). In 2020, UNFPA prioritised delivering adolescent SRH services, especially for very young adolescent girls. It also emphasised the need for increased availability of CSE.



DRC has taken an integrated approach in that the National Reproductive Health Programme and the National Adolescent Health Policy both provide for CSE. However, sex education and CSE in DRC face patriarchal cultural limitations. For one, the issue of condom use as a contraceptive method remains frowned upon in traditional Congolese cultural settings. The Union Congolaise des Femmes des Medias (UCOFEM), a #VoiceandChoice Alliance partner, campaigns against the patriarchal structures that lead to high rates of GBV. While the national policy and CSE programme encourage condom use and multiple contraceptive methods, cultural resistance remains strong. According to GL desktop research on SRHR policies and laws in 2020, DRC faces challenges and gaps in youth-friendly services and facilities. The National Reproductive Health Programme ensures that pregnant adolescents have the same rights as adults to antenatal, natal and postnatal care in all health zones, but challenges abound in ensuring a uniform client-focused approach by healthcare specialists. Girls in DRC need community-based psychosocial care to prevent cases of backstreet abortions. DRC has the fourth lowest contraceptive prevalence, which explains its high teenage pregnancy rates, according to the Guttmacher Institute.[21]



The definition of CSE and language around it remains a matter of contention among SADC member states. Conservative movements and organisations such as the **South Africa**-based online group #LeaveOurKidsAlone have rejected CSE outright. The anti-CSE group took the Department of Basic Education in South Africa to task on the newly implemented CSE lesson tools in 2019 and 2020. The group formed to oppose the implementation of CSE and scripted lessons in schools. The group's founder said, "Our children are being sold out to organisations like the United Nations, who want the resources of

[20] Rambaree, K., Mousavi, F., Magnusson, P. and Willmer, M., 2020. Youth health, gender, and social media: Mauritius as a glocal place. Cogent Social Sciences, 6(1), p.1774140.
[21] Guttmacher Institute, 2021. https://www.guttmacher.org/report/unintended-pregnancy-abortion-kinshasa-drc, accessed 22 June 2021

our country."[22] Due to COVID-19 lockdowns, parents had to teach much of the 2020 educational curriculum as a strategy to help their children continue to learn despite school closures.



Similarly, anti-CSE groups in **Zambia** have claimed that CSE runs counter to the country's religious and cultural norms. Churches and church-related entities have made submissions against CSE to parliament and the education department, leading in some cases to petitions and protests. Their main argument is that Zambia signed the ESA Ministerial Commitment on CSE and SRH services for adolescents and young people without consulting Zambian society and communities.[23] Despite this, educators and activists in Zambia have successfully used innovative approaches to delivering CSE via mass and digital media. This includes the Zambian Alliance network member Women in Law Southern Africa Zambia (WILSAZ), whose programmes have campaigned for CSE through mass and social media.

The definition of CSE and language around it remains a matter of contention among the member states



Zambians remain divided over CSE

Members of the Zambia parliament recently shot down a regressive motion that sought to suspend the teaching of CSE in schools pending wider consultations by stakeholders.

News reports indicate that most MPs voted against this proposed suspension, with some members of civil society and teacher unions collaborating under the banner "Pro-CSE." These groups welcomed guidance provided by Vice President Inonge Wina on the floor of the National Assembly on 2 October 2020 that government would initiate wide consultation with key stakeholders to inform its review of CSE framework.

Lenganji Nanyangwe, Zambian director of the Sexual Reproductive Health and Rights Africa Trust, noted that the Private members' motion to suspend CSE in schools proposed by MP Sebastian Kopulande "was not consistent with the executive order by the Vice President of Zambia. Wina rightly commissioned a review of CSE curriculum prior to the withdrawing of CSE from current implementation in Zambian schools.



Zambian society fully supports CSE, says Lenganji Nanyangwe, Zambian director of the Sexual Reproductive Health and Rights Africa Trust.
Photo courtesy of Twitter

"Society fully supported the introduction of CSE in Zambia and incorporated into the school curriculum only after extensive and inclusive consultations led by the CSE Task Force. It was premised on a strong national legal and policy framework and in the context of regional, continental and indeed global protocols, such as the Education Act No. 23 of 2011, the Maputo Protocol, The SADC Gender Protocol and the Sustainable Development Goals 3,4 and 5, all of which Zambia is party to. It demands

[22] Kiewit, L. (2020). Online group wants new curriculum to make a #sexit, Feb 2020.
[23] Kachikoti, C. (2021). Zambia Times, Sunday 12 June 2021

therefore that the review of CSE in Zambia is done in cognisance of broader commitments made as a country and importantly should be domesticated in the context of the health and educational needs of our children and the community at large."

Anti-CSE proponents claim that CSE in schools erodes Christian values and cultural norms, arguing that the CSE curriculum in its current state should be more accurately called "abortion, promiscuity and gay rights education."

Speaking at a regional SRHR virtual meeting, Lubna Bhayani of Frontline AIDS noted that, "CSE is essential for young people to be able to protect themselves from unintended pregnancies and HIV - the two biggest killers of young women and adolescent girls in Sub-Saharan Africa. Integrating CSE into school curricula provides the opportunity for young people to engage in discussions on sex, gender, rights, sexuality and sexual orientation and is a key strategy to guaranteeing bodily autonomy and ensuring sexual and reproductive health and rights upheld."

Conservatives often cite CSE as a reason for young people becoming more promiscuous, especially in conjunction with high teenage pregnancy rates.

CSOs, faith-based organisations and community members need to be educated and involved in advocacy regarding the scientific evidence of the benefits of CSE, as well as what it sets out to achieve. Zambia has a history of commissioning and undertaking research studies to monitor delivery and quality of CSE, including tracking of progress made towards policies such as the National AIDS Strategic Framework (2011-2016 and 2017-2021) and the Adolescent Health Strategic Framework (2010-2016 and 2017-2021).

A lesson learned as schools have reopened in these COVID-19 pandemic times is that continued commitment and evidence-based research remains critical for tackling the misconceptions about CSE. It is crucial that CSE and ASRHR advocacy and awareness raising goes beyond passing of motions that reverse progress made to actual countering challenges beliefs and perceptions and ensuring age appropriate CSE benefits young people.

Source: Shamiso Chigorimbo, Gender Links
Opinion piece as part of a submission for the
SADC Protocol @ Work Media articles October 2020

In May and June 2021, Eswatini and Mozambique represented the only two SADC countries to sign a draft resolution alongside other countries at a meeting at WHA, the decision-making body for the WHO. The resolution, *Ending violence against children through health systems strengthening and multisectoral approaches*, aims to end violence against children and calls for changes and improvements to existing sexual education curricula. The resolution urged all member states to "provide accessible gender-sensitive, free from gender stereotypes, evidence-based and appropriate to age and evolving capacities sexuality education to children. With appropriate direction and guidance from parents and legal guardians, with the best interests of the child as their basic concern to empower and enable them to realise their health, well-being and dignity, build communication, self-protection and risk reduction skills, as a fundamental part of the efforts to prevent, recognise and respond to violence against children."[24] Activists see the commitment as a bold move to creating a more enabling environment for protection against child abuse.

[24] WHO (2021), Ending Violence against children through health systems strengthening and multi-sectoral approaches. Available on. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_ACONF8-en.pdf, accessed on 24 June 2021.

CSE e-tools ensure ongoing learning during pandemic school closures

The region has seen an increase in digital learning platforms for school-age children, starting from early childhood education (ECD) up to tertiary education. Due to the pandemic, learning platforms moved to the internet, and the need to incorporate ASRHR and CSE curriculum into online platforms increased. Given improvements in internet accessibility on smart phones and various other technological advances, local and international research indicates that more young people rely on the internet and other online sources for information.[25] Likewise, advances in CSE and adolescent SRH knowledge and services must transition to include internet-based curriculum and awareness raising. While this is an overall positive development, it can worsen education inequalities and accessibility for learners living in remote areas with limited internet access or for those who cannot afford it.[26]

As a rights-based approach to adolescent sex education, CSE seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality. The UNESCO curriculum development and review department in 2020 made improvements to the Sexuality Education Review and Assessment Tool (SERAT). SERAT helps collect data on school-based sex education programmes. Zambia and Zimbabwe accompanied its implementation with the International Technical Guidance on Sexuality Education. CSE aims to help young people develop positive sexual behaviours so, when used effectively, the SERAT tool reviews school-based CSE programmes against international standards. Users can customise it to fit the context and specific programmes of each country.

Schools, youth-friendly health facilities and youth centres usually deliver CSE, with instruction from teachers, health providers and trained peers. With the limitations and concerns of COVID-19 infections and physical distancing, regional regulations resulted in school interruptions, closures and re-openings, moving CSE and other curriculum to online platforms. The SERAT tool, housed on the UNESCO Health and Education Resource Centre, provides an online library with access to more than 6000 downloadable resources. It includes research papers, evaluations, tools and guidance to support ministries and other stakeholders. Social and economic challenges to accessing online learning have arisen as a substantial concern and limitation to continued access to learning while students remain at home in many parts of the region. To mitigate this, ministries of education and partners have developed further resources to support both learners and teachers.

Schools, youth-friendly health facilities and youth centres usually deliver CSE

New resources include a combination of printed curriculum materials for home use and scripted lesson plans for TV and radio learning.[27] Digital spaces offer new options for learning that include reaching marginalised young people along with new possibilities to influence knowledge creation and sharing. Access to digital sex education offered by such tools helps fill gaps in places without sufficient or effective sex education in

[25] Ubisi, L. (2020), Analysing the hegemonic discourses on comprehensive sexuality education in South African schools, Durban, Journal of Education UKZN.
[26] The Impact of COVID-19 on Young People and Adolescents in the SADC Region - Report Out Now, MIET and HSRC 2021 report, https://mietafrica.org/the-impact-of-covid-19-on-young-people-and-adolescents-in-the-sadc-region-report-out-now/, accessed 17 July 2021.
[27] SADC-Webinar-Reopening-Schools-in-the-time-of-COVID19-Record-Report. 2020 available on https://www.mietafrica.org/wp-content/uploads/2020/10/SADC-Webinar-Reopening-Schools-in-the-time-of-COVID19-Record-Report.pdf, accessed 24 June 2021.

schools. It can also complement and strengthen school-based sex education. However, technological interventions must not completely replace interpersonal and traditional education methods. A 2020 UNESCO report warns that sex education for young people should translate to digital spaces alongside the safe and age appropriate continuation of other CSE.[28]

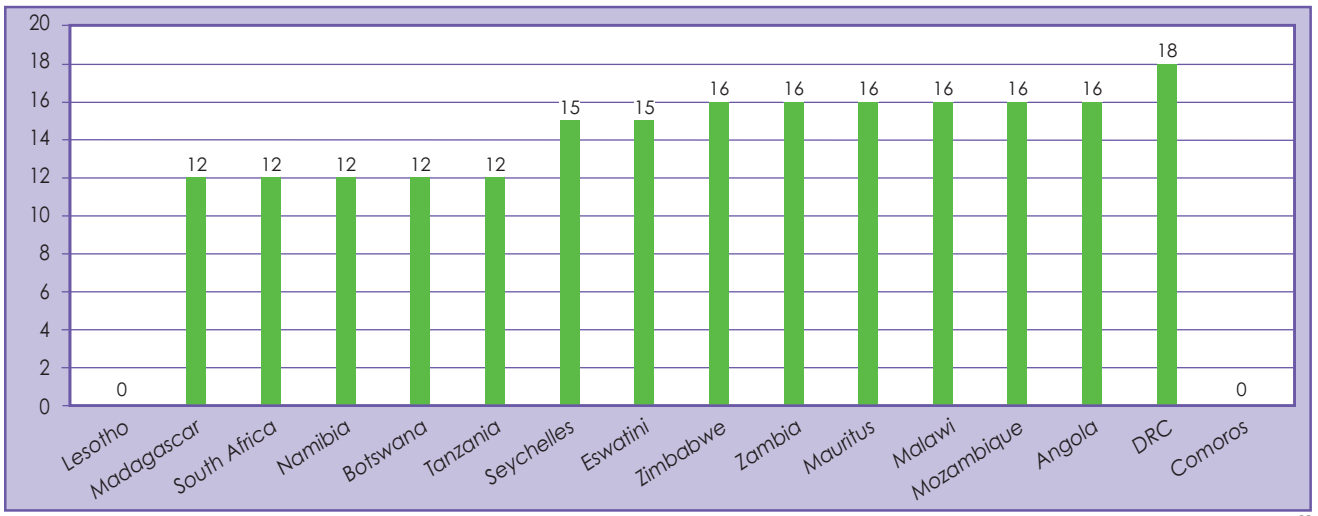


In **South Africa**, organisations such as the Earth Child Project have devised strategies to reach young girls within marginalised and impoverished communities. This includes providing digital training on life skills and SRHR. South African Women in Development (SAWID), a GL Alliance partner, has engaged in numerous discussions and dialogues together with Young Women Alliance on the topic. SAWID demonstrated that lockdowns led to heightened levels of GBV, which affected young girls. It is clear from the discussions that schools provide places of escape and solace for many children. School closures left vulnerable children stuck in households with their abusers in many cases. Some case studies show that, due to poverty, food insecurity and abuse, children had to bargain with abusers to receive food during the pandemic. Lack of emergency contraception and post-exposure prophylaxis (PEP) treatment led to many of these children falling pregnant and contracting HIV. World Vision International indicated that more than one million girls across Southern Africa might not return to schools in 2022 due to teenage pregnancy.

Access to contraceptives and age of consent to sex

Policies on access to contraceptives and age of consent to sex directly influence teenage pregnancy rates. Synergies in policies can ensure better decision-making and avoidance of teenage pregnancy and fatherhood. An enabling legal and policy environment is critical to the promotion of sexual health.

Figure 3.1: Age of access to contraception



Source: UNAIDS Select data 2020.[29]

[28] UNESCO (2021), One year into COVID-prioritizing education recovery to avoid a generational catastrophe available at https://events.unesco.org/event?id=3620682418&lang=1033, accessed 24 June 2021
[29] UNAIDS, 2017-2020, http://lawsandpolicies.unaids.org/jointanalysis?id=young_people&a=LSO&lan=en, accessed 12 July 2021

Figure 3.1 shows age of access to contraceptives in SADC as of 2020 and illustrates that Lesotho has no specification on minimum age of access to contraception. No data currently exists on the minimum age of contraceptives in Comoros.

According to UNAIDS, the unmet contraceptive need in the 15 to 49 age cohort for Lesotho and Comoros stands at 16% and 35%, respectively, in 2020.[30]

Table 3.3: Requirements for parental consent for ASRHR in SADC[31]

Country	Not required	Yes, if younger than 14	Yes, if younger than 16	Yes, if younger than 18	Data not available
Madagascar	✗				
Mozambique	✗				
Namibia	✗				
South Africa	✗				
Tanzania	✗				
Angola					✗
Comoros					✗
Lesotho		✗			
Malawi		✗			
Mauritius		✗			
Botswana			✗		
Zambia			✗		
Zimbabwe			✗		
DRC[32]				✗	
Eswatini				✗	
Seychelles				✗	

Source: UNAIDS, 2020.[33]

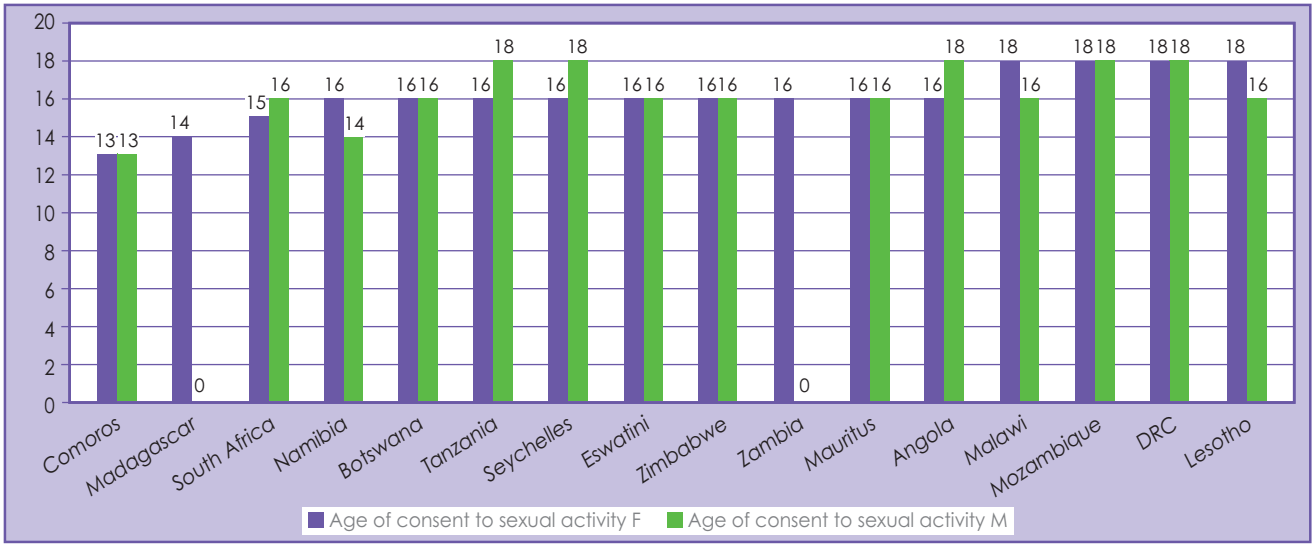
Table 3.3 maps laws in all SADC countries on age of parental consent for adolescents to access SRH services. Lesotho, Malawi and Mauritius require parental consent for youth younger than 14; the same applies in Botswana, Zambia and Zimbabwe for those younger than 16. Meanwhile, citizens of DRC, Eswatini and Seychelles must be 18 or older to access SRHR without parental consent.

Allowing young people to access ASRHR services without parental consent removes a critical barrier to youth getting information about their health, such as HIV status and information on STIs. Requiring parental consent for ASRHR services and information prevents adolescents from exercising their basic human rights.

Allowing young people to access ASRHR services without parental consent removes a critical barrier to youth getting information about their health

[30] Family Planning Organisation 2020 https://www.familyplanning2020.org/lesotho, accessed 21 June 2021
[31] Lowe Morna, C et al (eds) (2020) Adolescent Sexual and Reproductive Health, in SADC Gender Protocol 2020 Barometer, Gender Links, Johannesburg, pp 22
[32] World Bank, 2020, https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html, accessed 28 April 2020
[33] UNAIDS, 2017-2020, http://lawsandpolicies.unaids.org/country?id=MOZ&lan=en UNAIDS Laws and Policies Analytics, accessed 20 June 2021

Figure 3.2: Age of consent to sexual activity by sex



Source: GL Mapping of SRHR Policies and Laws updated 2020.

Figure 3.2 shows differing legal age of sexual consent for males and females in Angola, Lesotho, Malawi, Namibia, Tanzania, South Africa and Seychelles. The data also illustrates a large range between countries, with the age of consent as young as 13 years in Comoros.

The minimum age of consent to sexual activity protects adolescents and children against sexual exploitation. The African Charter on the Rights and Welfare of the Child, 1990, Article 27: Sexual Exploitation obligates member states to:

1. Undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:

(a) The inducement, coercion or encouragement of a child to engage in any sexual activity;

as such, it is paramount that the implementation of age of consent legislation, to protect young people, both female and male, from sexual abuse and sexual exploitation by predatory adults.

Countries that do not have the same age of consent for males and females have not used a gender-neutral approach to age of consent to sexual activity. Varying arguments and debates accompany this issue, with many noting that females mature earlier than males, making them more vulnerable to sexual exploitation.

Youth-friendly services



The International Planned Parenthood Federation (IPPF) provides guidelines on youth-friendly services and the key elements that should be included for effective service delivery. Youth-friendly service delivery is about providing health services based on a comprehensive understanding of what young people in any given society or community want and need. It bases these on an understanding of, and respect for, the realities of young people's diversity and sexual rights. A youth-friendly approach requires offering young people a wide range of SRH services, including:

- Sexual and reproductive health counselling;
- Contraceptive counselling and provision (including emergency contraception);
- Abortion services;

- Prevention, testing and counselling services for HIV and other STIs;
- Prenatal and postpartum services;
- Sexual abuse counselling; and
- Relationship and sexuality counselling.

Youth-friendly service delivery should also take into account the special needs of young people including:

- Where possible, facilities should provide services in an integrated manner at the same delivery point to allow for ease of access for young people.
- Recognising the financial barriers that young people can face, services should be free of charge or provided at a discounted rate to young clients.
- Services are only truly youth-friendly if young people themselves help determine the content, scope, and monitoring and evaluation of such services.

Youth-friendly health services work hand-in-hand with meaningful CSE services for all adolescents and youth. Access to information, education and adolescent-friendly comprehensive services requires adequate policy provision. Ensuring quality and timely services for youth so they can make free and informed decisions and choices about their sexuality and reproductive lives starts from the policy level before implementation at institutional and community levels.

Table 3.4: SADC countries with adolescent and youth SRHR policies[34]

Country	Stand-alone ASRHR policy or strategy
Botswana	Yes, Adolescent Sexual and Reproductive Health Strategy
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020[35]
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
Zimbabwe	Yes, National Adolescent and Youth Sexual and Reproductive Health Strategy 2015-2020
Angola	No
Comoros	No
Eswatini	No
Mauritius	No
Mozambique	No
Namibia	No
Seychelles	No
Tanzania	No

Source: African Health Observatory, Gender Links Policies Audit updated 2021.

Table 3.4 shows that half of all SADC countries do not have stand-alone ASRHR policies. However, all 16 countries committed to the International Conference on Population and Development (ICPD), which informs provisions in national ASRHR and other general SRHR policies in all member states. Gender activists want to address the challenges youth face in accessing SRHR services, including age limitations.



South Africa has its Adolescent Sexual and Reproductive Health and Rights Framework Strategy (ASRH&R, 2018) and the National Integrated Sexual and Reproductive Health and Rights Policy (2018). Both provide for Adolescent SRH and youth-friendly services. Five priority areas underpin the ASRH&R policy, accompanied by a set of objectives focusing on coordination, colla-

[34] Updated 2021 to include Botswana ASRHR strategy and DRCs Plan Strategique National de la Sante et du Bien Etre des Adolescents 2016-2020.
[35] National strategic plan for adolescent and youth health and wellbeing 2016-2020, implemented since March 2016 by Ministry of Health Secretary General DRC

boration, information, and knowledge sharing. ASRHR knowledge sharing between stakeholders includes developing innovative approaches to SRHR information, education, and counselling for adolescents. This includes provisions to strengthen ASRHR service delivery and support various health concerns. These policies aim to create effective community support networks for adolescents while formulating evidence-based revisions of legislation, policies, strategies and guidelines on ASRHR.



Namibia has a standalone approach to CSE, but no standalone ASRHR policy. The National Policy on Sexual, Reproductive and Child Health provides for adolescent SRH. The policy requires the government to promote adolescent friendly health services in collaboration with other stakeholders, committing health facilities in Namibia to provide "All sexually-active adolescents, regardless of age, shall have the right to confidential handling of all aspects of their personal health information, including testing behaviour, risk behaviour, and diagnoses."[36] With pandemic travel and trade restrictions and border closures, Namibia faced a contraceptive shortage. The Education Sector Policy for the Prevention and Management of Learners Pregnancy review report of 2020 reported an increase in teenage pregnancy following the initial lockdown in March 2020. Adolescents in Namibia typically have access to contraceptives at age 12.



Malawi has a standalone ASRHR policy, the National Youth Friendly Health Services Strategy, as well as a standalone approach to CSE. Its national SRHR policy ensures strategies for sexual education services for adolescents and the youth. The policy aims to improve access and availability to youth-friendly health services and strengthened behavioural change interventions in the Youth Friendly Health Services (YFHS). Under the family planning section, the policy addresses teenage pregnancies aligned with their contribution to maternal and child mortality rates. The issue of teenage pregnancies addressed as one element of a larger problem of unmet needs for family planning for women does not tackle economic and cultural challenges. However, the policy is progressive in terms of male involvement, encouraging male participation in reproductive health and highlighting the challenges in ensuring male involvement in maternal and neonatal health care.

Traditionally, women in Malawi serve as custodians of maternal health, hence maternal and post-natal health care services have focused on women with very little male involvement. The policy puts forward strategies to improve male involvement in reproductive health and encourages the empowerment of men to promote and support SRHR services. In addition, the policy encourages women to invite their husbands to support and utilise SRHR services.[37] Successfully tackling traditional and conservative mind-sets involves mobilising communities and increasing awareness of the importance of male involvement through information, education and communication. The policy also challenges harmful practices deeply rooted in traditional and cultural conservatism. Despite its strong feminist activism, Malawi remains a deeply conservative society in which sexual activity, contraceptives, and SRHR remain taboo topics for open discussion in most places. However, civil society organisations, health care providers and the government continue to carry out campaigns to raise awareness, increase SRHR conversation and grow community.



Zimbabwe has both CSE and reproductive health policies, but no standalone ASRHR policy. Its health policy includes guidelines on youth-friendly clinical SRH service provision developed under the National Standard Training Manual on ASRH. It guides the work of health facilities and provides a framework for SRHR for adolescents. The country is currently reviewing age of access to contraceptives alongside proposals to harmonise age of sexual consent and marriage to 18 years. Women's organisations and the Ministry of Health

[36] Government of Namibia, 2012, National Policy on Sexual, Reproductive and Child Health Sexual & RH Policy Zero Draft (who.int), accessed 20 June 2021
[37] Government of Malawi, 2015-2020, Malawi policy National Youth Friendly Health Services https://surveygizmoresponseuploads.s3.amazonaws.com/fileuploads/382553/5541426/168-50a5b3c1cd6bc46489185d76ea47e10e_National_Youth_Friendly_Health_Services_Strategy.pdf, accessed 20 June 2021

suggest leaving age of consent at 16 years because of anticipated challenges in getting contraceptives to adolescents due to the mismatch in age to access and age of consent. They worry that unmet need for contraceptive use in adolescents will remain high, exacerbating existing challenges faced by sexually active girls younger than 16 in accessing contraceptives. The debate around age of consent remains contentious and legislators paused some discussions on this because of the COVID-19.



In **Angola**, which does not have a formal ASRHR policy or strategy, the government partners with Acção Angolana para a Mulher (AAM) and other organisations to provide comprehensive SRHR policies and services, especially to reach underserved areas and population groups.[38]



Botswana has an Adolescent Sexual and Reproductive Health Strategy that allows adolescents to access SRHR services without restrictions. Botswana's CSE policy provides for an integrated approach, and the guidance and counselling division of each school delivers it. This ensures a standalone approach in a specific allocated school programme.

Youth led ASRHR research 2020 to 2021

Nearly two fifths of young people who sought Sexual and Reproductive Health (SRHR) Services in eight Southern African countries were denied these services because they were not accompanied by a parent or family member. More than two thirds had to pay a fee for the health services they received. These services cost an average of $2, which is 9-20% of the daily income in the countries surveyed. But 81% of the those who accessed services said that health personnel treated them confidentiality. These are among the findings of the Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment undertaken in Botswana, Eswatini, Lesotho, Madagascar, Mauritius, South Africa, Zambia and Zimbabwe from November 2019 to December 2020.

The purpose of this research is to strengthen youth-led and focused efforts to promote ASRHR through gender and youth responsive local governance. The research included 13395 adolescents between ages 10 and 19 in eight countries, 6916 (52%) females and 6445 (48%) males and 34 people identifying as gender non-confirming (GNC). The survey is being carried out with the Centres of Excellence for Gender in Local Government with the support of HIVOS and Amplify Change.

As part of the study, junior councils and other youth formations in the GL COEs conducted a survey on ASRHR services, with results showing that providers denied two-fifths of young people access to services because an adult did not accompany them. The Young Women's Alliance leads advocacy on ASRHR in the 15 national country campaigns.

South Africa conducted the research in the highest number of clinics (168) and Zimbabwe had the most respondents at 2998. Lesotho, with only nine clinics, had the fewest respondents at 585.

[38] SRHR Internal Audit Gender Links and Angola researcher Isabel de Almeida, 2020

Table 3.5: Key findings of the GL ASRHR Rapid Response Survey 2019-2020

Indicator/country	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe	Overall
Logistic information on health facilities (% yes)									
Health facility within 10 km from your home	78	29	68	65	95	75	89	67	73
Does the facility open after school?	22	27	43	77	57	86	76	63	57
Does the facility open on weekends	59	45	41	74	59	44	93	77	71
Comfortable waiting area?	70	92	80	82	90	78	80	77	80
Proportion of respondents who paid a fee?	0	87	42	83	0	2	80	72	35
How much is the fee in USD?	0	2	2	2	0	2	2	4	$2
Quality of care (% yes)									
Are peer counsellors available?	61	16	56	77	13	65	62	71	64
Young people are treated with respect	97	96	69	91	90	88	94	82	89
Young people have privacy and confidentiality	85	95	67	73	92	87	98	74	81
Young people are treated without parental consent	71	88	38	68	57	53	49	55	60
Health workers spend sufficient time with young people	54	95	42	80	84	81	94	68	75
Young people receive appropriate information	47	91	86	80	54	84	75	73	72
Sexual and reproductive health services (% yes)									
Young people requested contraceptives	36	16	50	40	3	42	28	26	31
Young people received contraceptives	94	95	77	82	21	90	84	80	84
Young women requested a pregnancy test	31	22	35	37	2	36	27	24	30
Young women received a pregnancy test	74	92	65	82	33	88	71	57	75
HIV and AIDS (% yes)									
Requested HIV test	30	81	69	22	2	46	59	37	41
Received HIV test	87	98	95	90	15	92	99	83	92
Requested sexually transmitted infection (STI) test	21	4	24	18	0	31	15	14	18
Received STI test	98	89	87	86	0	89	92	74	89
Requested anti-retrovirals (ARVs)	2	2	7	8	0	19	3	8	7
Received ARVs	100	43	59	68	0	80	90	84	78
Follow up and referral (%yes)									
Made a follow up appointment	6	79	80	77	29	68	45	54	53
Referred to a relevant facility	9	57	68	84	56	64	61	62	59

Source: GL ASRHR Rapid Response Survey 2019 to 2020.

- 73% of the sample had a health facility within 10 km of their homes. This ranged from 29% in Eswatini to 89% in Zambia.
- 64% of the respondents reported meeting peer counsellors in the health facilities they visited. This ranged from 16% in Eswatini to 77% in Madagascar.
- 31% of the sample requested contraception and 84% of these received contraception. Lesotho (50%) had the highest proportion of young people requesting contraceptives. South Africa has the highest percentage (90%) of youth asking for, and receiving contraceptives.
- 30% of the female respondents requested a pregnancy test and 75% received one. Madagascar (37%) had the highest percentage of those requesting a pregnancy test. Eswatini (92%) had the highest percentage of those asking for a pregnancy test receiving one.
- 41%, of respondents requested an HIV test and 18% requested a sexually transmitted infection (STI) test; most received these tests.
- 72% of the sample received materials tailor made for their needs. About a quarter of the sample did not receive youth friendly information that is relevant and responds to their needs.
- 53% of the sample received follow up appointments and 59% received a referral to another facility. Lesotho (80%) had the highest proportion of those receiving follow up referrals.

These findings point to some good practises in the region, but also the need for youth-led policy and advocacy for consistent policies and standard setting on ASRHR across the region, consistent with the SADC SRHR Strategy 2019-2030.



Young activist hopes to inspire Lesotho youth to learn about SRHR issues

One young woman in Lesotho has energetically taken the reins from older gender activists to lead on SRHR empowerment and education in her community.



Participants, SRHR public gathering - Maoa Masaoana Village, Sephokong Council, Leribe in September 2020. Photo: Ntolo Lekau

Ntsoaki Mosala, 20, a participant in SRHR outreach activities hosted by Sephokong Council from Maoa-Masooana in Lesotho's Leribe district, said she is never afraid of new challenges. Therefore, it is no surprise that Mosala embraced local activism following her participation in a public gathering for SRHR activities in her village. She says it changed her life.

Mosala vividly remembers the very first time she encountered Gender Links at the SRHR action planning for councils. The Sephokong Council had invited her to represent youth and she took part in training objectives to deepen local government SRHR plans, facilitate better service delivery, and increase awareness on SRHR.

Additionally, the programme aimed to inspire youth involvement in SRHR campaigning and advocacy, which affected her directly. The council came up with the action plan, which clearly showed the need for a joint collaboration with youth and community members. Mosala did not waste any time. Immediately after the training, she talked to her councillor and local chief to get their help to mobilise youth in her village. After sharing the action plan with the youth, they drafted a strategy to implement ASRHR awareness-raising tasks and activities.

Mosala then led a focus group to create a youth strategy and she visited different ministries to canvass support. Leading the whole process, she consulted with representatives from Lesotho's Ministry of Health and shared how they could improve youth services at various different clinics. She also convinced a local clinic to create a youth health day and a youth corner. In addition, her campaign successfully advocated for the distribution of sanitary pads and towels at the local clinic.

"The workshop was an eye opener and boosted my self-confidence and knowledge," said Mosala.

Sadly, COVID-19 delayed her work and limited visits to district hospitals. Once the spread of COVID-19 decreases, Mosala hopes to visit other clinics and influence young leaders to join her and lead similar campaigns across the country.

Source: Ntsoaki Mosala, Lesotho Youth Award as part of a submission for the SADC Protocol@Work Gender Links Summit case study 2020

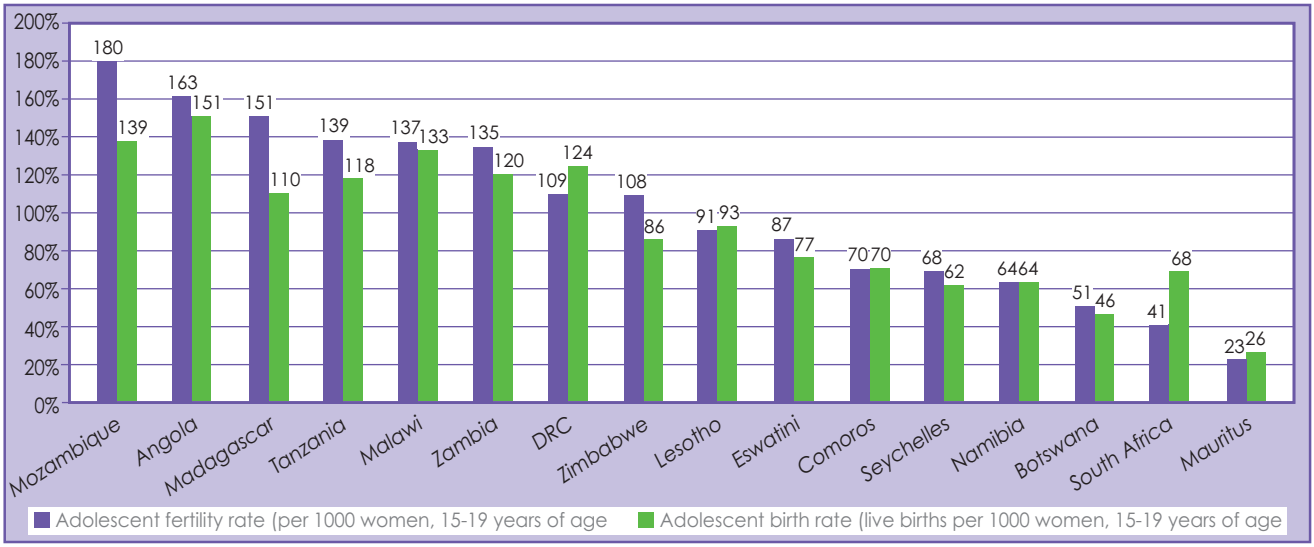
Teenage pregnancy



Teenage boys engage in a menstrual health workshop in Kitwe City Council in Zambia in May 2021. Photo: Samuel Biemba

Two indicators measure the prevalence of teenage pregnancy: country level adolescent fertility rates per every 1000 women between the ages 15 to 19 and adolescent birth rates representing the number of live births per 1000 females aged 15 to 19. Women and girls younger than 19 years old are twice as likely to die during childbirth compared to women older than 20.[39] Complications of pregnancy, abortions and childbirth represent the leading causes of death among adolescent women between the ages 15 to 19. Researchers calculate adolescent birth rate (BR) as total live births (for a specific area and time), divided by the total population (for the same area and time) multiplied by 1000. While the fertility rate (FR) represents the total number of pregnancies (for a specific area and time) divided by the female population at the ages specified.

Figure 3.3: Teenage pregnancy indicators



Source: World Bank, 2018.[40]

[39] UNFPA and ERASO teenage pregnancy data.
[40] World Bank, 2018, 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, accessed 16 June 2021

Figure 3.3 compares teenage pregnancy indicators of adolescent fertility and birth rates from 2018, the most recent figures. Mozambique has the highest adolescent fertility rate in the SADC region at 180 live births per every 1000 women aged 15 to 19. Both fertility and birth rates remain high in several other countries, including Angola, DRC, Madagascar, Malawi, Tanzania and Zambia. Goal 3.7.2 of the SDGs represents a target toward the reduction of adolescent birth rates, commonly reported as the age-specific fertility rate for ages 15-19 years in the context of calculation of total fertility estimates.[41] Some researchers also label birth rates as adolescent fertility rates in other contexts. A related measure is the proportion of adolescent fertility measured as the percentage of total fertility.

These rates underscore a critical need for accessible youth-friendly SRH services that cater for family planning knowledge. Mozambique is one of six countries in the world in which at least one in ten girls (14%) has had a child before they turn 15, and 57% before age 18.[42] To tackle high rates of adolescent fertility, activists recommend improving CSE and adolescent access to contraceptives.



COVID-19 leads to increase in child abuse and teenage pregnancy in Malawi



Learners at the Mphangala Primary School in Kasungu district in Central Malawi in May 2019. Photo: Thokozani-Matewe

School closures due to COVID-19 led to an increase in teenage pregnancies in Malawi, with 7274 teenage girls reportedly pregnant in Mangochi District alone, according to one recent report.

A 16-year-old secondary school student from that region shared her experience becoming pregnant after her stepfather raped her. "I've resisted him for years," she said. "He took advantage of the absence of my mother and my not going to school to force me in to bed with him; now look, here I am, seven-months away from giving birth."

She lamented that her dream of completing her education and the prospect of a promising future now seem dim. Sadly, she is one of many victims of sexual assault and abuse in the COVID-19 pandemic.

Recent statistics back up such stories from survivors and paint a gruesome picture of the extent of violence against women and girls, according to Stephano Joseph, social welfare officer for Blantyre District, whose jurisdiction has registered a record 77 GBV cases between March and May 2020.

"The month of April alone my office received 23 cases, whilst in May we received 30 cases and 24 cases in June," said Joseph. "Factually, the figures have tripled as the same period last year we recorded an accumulative figure of

[41] UN, 2018, https://sdg.tracking-progress.org/indicator/3-7-2-adolescent-birth-rate/, accessed 19 June 2021
[42] Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), e ICF. 2019. Inquérito de Indicadores de Imunização, Malária e HIV/SIDA em Moçambique 2015: Relatório Suplementar Incorporado os Resultados de Biomarcadores de Antiretrovirais. Maputo, Moçambique. Rockville, Maryland, EUA: INS, INE, e ICF. Online: https://www.dhsprogram.com/pubs/pdf/AIS12/AIS12_SP.pdf

20 cases, which is an unprecedented record being registered since schools were closed to help combat the spread of COVID-19."

In an interview, the district's traditional leader Senior Chief Malemia warned of stiffer punishment for offenders inflicting harm on girls and women. "I will tell you this; desperate times need desperate solutions. As a traditional leader, I will not sit and watch this rot happening in my district. It's now time to put in place legislation at local levels in form of by-laws to tame these evil injustices against girls," he said.

People Serving Girls at Risk, an advocate group, blames Malawi's government for its failure to create policies and safeguards to protect children. Caleb Ng'ombo, the group's executive director, worries that adults have taken advantage of the crisis to abuse the fragile and vulnerable in Malawian society.

"What we are calling for from government is that first they must ensure full implementation of the laws and policies the country has, like the Child Care and Justice Protection Act, which is very clear about child protection and safe guarding their rights," Ng'ombo said.

In an interview with GL, human behaviour psychologist Moses Muotcha suggested that it is time Malawi strengthened its psychosocial support base to help victims of social injustices. Patricia Kaliati, Malawi's minister of gender, community development and social welfare, committed to deploy a team of social warfare officers to Mangochi District to investigate the rapid rise in cases of teen pregnancies.

Tamanda Matebule is a journalist from MIJ FM in Malawi. This story is part of the GL News Service Gender and COVID-19 news series



Teenage pregnancy has increased in **Angola** in part due to a lack of contraceptives. According to a 2019 Guttmacher Institute report, the country has a 67% unmet need for contraceptives among women and girls between the ages 15 and 49. The US-based institute conducts country-level research that estimates adolescent pregnancy rates and documents adolescent access to SRH information and services. Ensuring that young women and girls have support and access to family planning services allows them to exercise their reproductive rights. Unintended pregnancies arise from unprotected sexual intercourse and, while CSE reduces the likelihood that youth engage in unprotected intercourse, some will still practice riskier sexual behaviours even after acquiring knowledge. Access to contraceptive methods reduces risk and provides options for young women and girls.



In **Eswatini**, limited or no access to healthcare facilities coupled with a high proportion of young women and girls out of school and employment (compared to boys in the age range of 15 to 24) has created a headache for lawmakers.[43] According to a United Nations Statistics Division (UNSD) SDG report released during the COVID-19 pandemic, 41% of women, compared to 30% of men, do not attend school or work in formal employment or training. The report also uses the Sexual, Reproductive, Maternal, Child and Adolescent Health (SRMNCAH) monitoring tool to analyse contraception use among women between the ages 15 and 49. Pandemic school closures restricted access to school nutrition programmes, and information on disease prevention and contraception. This contributed to increased rates of SGBV and teenage pregnancy, according to Lomcebo Dlamini from the group Global Advocacy on HIV Prevention Eswatini (AVAC). She notes that educating adolescents about contraception ensures they make informed choices about their sexual and reproductive health and wellbeing.



In March 2020, **Madagascar** began providing CSE education in a more systematic manner, partially because

[43] World Vision, 2020. Covid19 Aftershocks Access Denied, https://www.wvi.org/sites/default/files/202008/Covid19%20Aftershocks_Access%20Denied_small.pdf

of high rates of teenage marriage and pregnancy in the country. Previously, Madagascar, Mauritius and Seychelles only taught school-based sex education within the curriculum for other subjects such as biology, life-skills and civics education initiatives.[44] A 2019 formative research study in two regions of Madagascar used a socio-ecological lens to explore the influences on first time young parents (FTYPs) including teen fathers at the individual, couple, family, community, and system levels. The study included a combination of 44 interviews and 32 focus group discussions for publication in *African Journal of Reproductive Health*.[45] The findings spoke to the need for services geared towards a critical increasing demographic: first time adolescent mothers and fathers, referred to as young parent couples. It reaffirmed the need for a systematic in- and out-of-school CSE and ASRHR programmes.

Teenage fatherhood

The global pandemic shed light on some perennial challenges for teenage fathers, who faced heightened financial challenges during COVID-19 and pressures around their role as caregivers for their children. CSE gaps on the topic of teenage fatherhood point to a need for increased psychosocial support and education aimed specifically at young fathers. One recent study noted that CSE should consider that "psychological health and well-being can be fragile throughout adolescence and some forms of mental illness, such as anxiety or depression, are more likely to start in adolescence than in later life."[46]



Participant Letlatsa demonstrating male condom use in Quthing, Lesotho Youth Workshop, September 2019. Photo: Ntolo Lekau

Combining national policies, international CSE standards and teacher training will help ensure a holistic approach to adolescent SRHR that incorporates the specific needs of adolescent fathers. Ongoing teacher training in CSE content through participatory methodologies remains an essential ingredient for success. This does not mean all teachers must be experts on sexual health and psychological well-being, but they must be able to bridge the gap on specific CSE topics - for example addressing the topic of puberty in reproduction and biology classes as well as its affects in the daily lives of their students. Teachers are also important role models for adolescents, and their actions and behaviours shape the views and attitudes of young learners. Continued pandemic school closures unfortunately meant reduced access to teachers and peer-to-peer support across the region. As the pandemic evolves, education leaders and policymakers must consider all risks associated with ongoing lockdowns, including the risk of adolescents missing the social and health benefits of being in school.

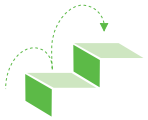
[44] 2020 SRHR Barometer in the time of COVID-19, ASRHR chapter.
[45] 2019 Reaching the youngest moms and dads: a socio-ecological view of actors and factors influencing first-time young parents' use of sexual and reproductive health services in Madagascar, Susan Igras, Melanie Yahner, Haingo Slowdown, Jean Pierre Rakotovao, Rachel favero, Sandrine Andriantsimietry and Justin Ranjalahy Rasolofomanana
[46] Care Knowledge Research Study 2021, https://www.careknowledge.com/media/47368/adolescence_parental-neglect_during_covid-briefing.pdf, accessed 10 July 2021

Backstreet abortion and HIV and AIDS prevention

Infection and prevention rates for HIV and AIDS intertwine with teenage pregnancy and backstreet abortion. A Joint United Nations Programme on HIV/AIDS (UNAIDS) study indicates that 45% of first-time teenage pregnant mothers did not know the risks involved in their actions or did not understand how pregnancy works. The 2019 analysis reveals that young women and girls engage in risky sexual behaviour due to lack of knowledge about STIs or the biology involved in fertility and pregnancy.[47] CSE education thus represents a critical protective factor against HIV infection and teenage pregnancy, especially where teenage pregnancy results in backstreet abortions. UNAIDS found that adolescent young women and girls (AGYW) aged 15-24 account for about 30% of all new HIV infections in Southern Africa.[48]

Findings from the Youth Rapid Assessment Survey research conducted among youth ages ten to 19 illustrate that in six out of eight countries less than 70% of respondents said they had ever requested an HIV test. Moreover, less than 30% of youth in all ten countries reported they had requested an STI test in their lifetimes. Mauritius, at just 2% of respondents that ever requested an HIV test, came in last place on this indicator, while Eswatini led the way, with 81% of youth there saying they had requested an HIV test.

Contraception use and access to emergency contraceptives represent key indicators of adequate SRHR facilities and services for youth. According to Yah et al, unprotected sex, STIs, HIV and pregnancy comprise significant elements of ASRHR and intersect with unsafe abortions and maternal mortality rates in adolescents.[49] Policies should consider age of consent to sexual activity and age of access to contraception, which also link to minimum age of marriage in each member state.



Next steps

Adolescents face many challenges and obstacles as they mature. International CSE standards reviews and tools enable country CSE policies to remain evidence-based and measurable against universal tools such as SERAT, mentioned earlier in the chapter. Even governments committed to CSE must continually work to overcome negative public attitudes and practices. Thus, they should always make the case that CSE forms an essential part of an overall good quality education, helping prepare young people for a fulfilling life in a changing world. It also improves SRH outcomes, promotes safe and gender-equitable learning environments, and improves education access and achievement.

Age of consent to sexual activity should align with age of access to contraceptives

[47] UNAIDS 2019 Women And HIV A Spotlight On Adolescent Girls And Young Women; https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf, accessed 22 June 2021
[48] Yah CS, Ndlovu S, et al (2020) The prevalence of pregnancy among adolescent girls and young women across the Southern African development community economic hub: A systematic review and meta-analysis. Health Promote Perspect.
[49] Ibid

Governments must also address capacity and resource constraints that limit the achievement of quality education. This includes ensuring teacher capacity, modern curriculum content and necessary tools for assessment, monitoring and evaluation. When teachers know about policy provision and protection for adolescent rights to contraception and age provisions in their specific countries, youth will be empowered to access the necessary services.



Masvingo City Council junior councillors provide toiletries for distribution at a Zimbabwe school in July 2021. Photo: Tapiwa Zvaraya

As this research has outlined, social, cultural, political, and religious influences affect age of access to contraception, particularly in more conservative countries. Activists must remember this when recommending policies and approaches that enhance ASRHR. For example, policy provision should synergise with the minimum age consent to sexual activity, which for Lesotho is 16 years, and 13 in Comoros. In Lesotho, the National Reproductive Health policy does require the country to provide family planning services for all citizens. The SADC SRHR policy, however, recommends early access to ASRHR as a way to delay sexual debut. Information provides adolescents with the tools and skills they need to make good personal decisions and access necessary SRH measures. Without policies and laws that ensure their education and protection, young people face a greater risk of abuse and are likelier to remain ignorant about SRH issues that could keep them healthy and safe. The intersecting challenges linked to climate change, COVID-19, gender inequality and poverty require gender activists and governments in SADC to redouble their efforts to ensure adolescents throughout the region can realise their rights. Key next steps needed to do this include:

- ***Expand the Gender Links Youth Rapid Response Survey*** to all SADC countries and use the results of this study to spur development of an ASRHR checklist to set standards for the development of policy and legislation.
- ***Vaccinate all eligible teens and educators against COVID-19***: Health systems must prioritise teachers as well as adolescents 12 years and older as part of regional and national vaccination strategies.
- ***Governments need to invest in ICTs*** that offer educational and training opportunities to help educate youth on SRHR issues and ways they can help combat the spread of COVID-19.
- ***Strengthen national policy and legislation*** to assist local authorities to develop protective measures that prohibit and sanction perpetrators of sexual exploitation or abuse against girls during times of crisis.
- ***Continue formal education despite school closures*** and provide safe spaces for CSE, including through online ICT programmes, TV, mobile clinic outreach, or dual approaches.
- ***Align CSE and ASRHR services*** with HIV and AIDS prevention as well as universal health coverage indicators and measures, such as age of consent to SRHR services and age of consent to contraceptives.
- ***Fulfil the unmet*** need for contraceptives to assist in reducing teenage pregnancy and ensure SRHR programmes help young people make well-informed choices.
- ***Consider the risk of not reopening schools and health centres alongside other COVID-19 risks***: Continued pandemic school closures reduce access to teachers and peer-to-peer support. As the pandemic evolves, education leaders and policymakers must consider the risks for adolescents of missing the social and health benefits of being in school.

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State of World Population 2021 This report was developed under the auspices of the UNFPA Division for Communications and Strategic Partnerships. Editor-In-Chief Arthur Erken EDITORIAL TEAM Editor: Richard Kollodge Features editor: Rebecca Zerzan Creative direction: Katie Madonia Digital edition managers: Katie Madonia, Rebecca Zerzan Digital edition adviser: Hanno Ranck

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Safe Abortion 4



March for safe abortion outside Parliament in Namibia. Photo: Gender Links

KEY POINTS

- Africa has the highest rates of unintended pregnancies in the world at 91 per 1000 women aged 15 to 49, as compared to 35 per 1000 women in Europe and North America. This region has the highest pregnancy rate overall (218 per 1,000)[1].
- 89% of unintended pregnancies in Sub-Saharan Africa occur among women with unmet need for contraception: 11% result from failure of a modern method[2].
- The abortion rate in Africa has increased from 27 per 1000 women aged 15 to 49 to 33, representing a 24% increase since 1990[3].
- Unsafe abortions affect mostly poorer, unmarried women and adolescents fuelling high maternal mortality rates in the region.
- US President Joe Biden rescinded the Global Gag Rule, enabling resumption of US government funding for the United Nations Fund for Population Activities (UNFPA).
- Disruptions resulting from the COVID-19 pandemic were not as dire as the UNFPA had initially predicted. But the pandemic led to increases in unwanted pregnancies and demand for safe abortion, while slowing down campaigns for safe abortion.
- There is debate on whether to advocate for decriminalisation of abortion or legislation for safe abortion, a medical procedure that should be available to all women.

[1] Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019 Lancet Glob Health 2020; 8: e1152-61 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X%2820%2930315-6.pdf, accessed June 12, 2021
[2] Ibid
[3] Ibid

Introduction

Every woman, irrespective of age, locality, socioeconomic or any other status, should have the inalienable right to decide whether to have a child, when to have a child, how many children to have and with what spacing between those children. And yet many women do not enjoy this right. Often those who are least able to make and act on such decisions are poor, rural and young. Unintended pregnancies result from unplanned and often non-consensual sex or from absence or failure of contraception. The Southern African Development Community (SADC) Sexual and Reproductive Health and Rights (SRHR) Strategy notes that 24% of all pregnancies in Southern Africa end in abortion.

Ironically, abortion is one of the safest medical procedures if done following the World Health Organization's (WHO) guidance[4]. Conversely, unsafe abortion is the cause of at least one in six maternal deaths[5]. The WHO has shown that the broader *the legal grounds for abortion, the fewer deaths there are from unsafe abortions*.[6]

Throughout SADC and beyond many activists have joined forces over many years to build coalitions, conduct workshops, lobby with traditional and religious leaders, march and petition for changes to the legislation on abortion. These vibrant coalitions must regroup after every election as they begin again to develop relationships with new parliamentarians.

They are up against well-funded conservative groups that fuel the opposition to abortion. This is a highly emotive issue with strong opinions, morality and religious fervour brought to the debate. When other crises, such as COVID-19, become more pressing, the abortion issue is pushed to the back burner. Even though abortion is regulated by such a maze of laws, with hefty sentences for both the woman who seeks the abortion as well as providers of abortion, many women still procure abortions.

In reality, abortions occur in virtually every country in the world. Even where the legal framework is extremely restrictive women chose to terminate unintended pregnancies. The major difference is that where abortions are legal women have access to safe abortions. A restrictive legal environment on the other hand drives women to use unsafe and even dangerous abortion options with heavy consequences for their physical and mental health. Many countries which restrict access to legal abortion services provide post abortion care, which is invariably much more expensive.

The World Health Organization (WHO) distinguishes abortions into



SAFE: Carried out (1) using a method that is recommended by World Health Organisation (WHO), that is appropriate to the pregnancy duration, and (2) when the person carrying out the abortion has the necessary skills.



LESS SAFE: When only one of the criteria above is met.



UNSAFE: When carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.



DANGEROUS or **LEAST SAFE:** Do not meet either of the criteria and involve ingestion of caustic substances or untrained persons use dangerous methods.[7]

4 World Health Organisation. Safe abortion: Technical and policy guidance for health systems. Geneva: WHO; 2012. [Google Scholar]
5 Kassebaum N. J., Bertozzi-Villa A., Coggeshall M. S., et al. "Global, regional, and national levels and causes of maternal mortality during 1990-2013: A systematic analysis for the Global Burden of Disease Study 2013" Lancet. 2014;384(9947):980-1004. [PMC free article] [PubMed] [Google Scholar]
6 World Health Organization. Primary Health Care: Now More than Ever. World Health Report 2008. Geneva: WHO; 2008. p. 65.http://www.who.int/whr/2008/whr08_en.pdf [Google Scholar]
7 WHO. Preventing Unsafe Abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion;, accessed 30 May, 2021

A review of research on abortions, which found many more studies in the United States than in other countries, found evidence to link legal abortion to advancement of women in education and the labour market. Women who were denied abortion were less likely to be employed full time, more likely to live in poverty and to require state assistance. The review found that children born after the US Roe Vs Wade ruling were more likely to graduate from college and less likely to be on welfare. The review suggested that this may be the case as parents had children that they wanted and that they were able to invest in. The same review found that less restrictive abortion legislation in Sub-Saharan Africa is associated with more investment in girls' education. It is suggested that parents believe that their daughters are more likely to complete their education.[8]

US: The Global HER Act revokes the Gag Rule

A critical change in the global context since the 2020 #VoiceandChoice Barometer is the rescinding of the universal Gag Rule on the 28th of January 2021, by United States President Joe Biden in one of his first executive orders on assuming office. Biden stated:

> "Section 1. Policy: Women should have access to the healthcare they need. For too many women today, both at home and abroad, that is not possible. Undue restrictions on the use of Federal funds have made it harder for women to obtain necessary healthcare. The Federal Government must take action to ensure that women at home and around the world are able to access complete medical information, including with respect to their reproductive health."

In one move he restored UNFPA (United Nations Population Fund) funding and reinstated the ability of USAID to fund safe abortion, the first steps in reversing the controversial damage that the Donald Trump administration wrought through an expanded Gag rule for exactly four years. Though the impact for many organisations will take some time to be felt the act will free up at least $7.3 billion in United States funding for global health, a much needed injection for global NGOs working in sexual and reproductive health.[9]

Representatives Barbara Lee, Ami Bera, Jan Schakowsky and Senator Jeanne Shaheen and more than 46 co-sponsors introduced the Global Health, Empowerment and Rights Act otherwise known as the (Global HER Act) introduced to Senate on 28 January 2021. If passed, the Global HER Act will permanently repeal the Global Gag Rule, disallowing any future presidents from enacting the Rule again[10].

Originally imposed in 1984 by the Reagan administration, President Bill Clinton rescinded the Gag Rule in 1993. In 2001 President George W. Bush Jr reinstated the rule, only for President Barack Obama to rescind this in 2009. In 2017 Trump reinstituted a new version of the policy, the worst of them all for global health. The yo-yo effect has made it difficult to plan health efforts across the globe. The Trump administration showed that the Gag Rule could go beyond what many imagined. It jeopardised years of hard work into safeguarding women's lives and reclaiming their rights.

The Global Gag Rule struck beyond abortion, removing funding from organisations such as the International Planned Parenthood Federation (IPPF) who refused to sign the clause on abortion. This affected other programmes, particularly contraception and other aspects of SRHR and maternal health. Ironically, an Act intended to curtail abortion is likely to have reduced access to contraception thus increasing unintended pregnancy and need for abortion.

[8] Rodgers, Y. et al. (2021) 'The macroeconomics of abortion: A scoping review and analysis of the costs and outcomes', PLoS ONE, 16, p. e0250692. doi: 10.1371/journal.pone.0250692, accessed 17 June, 2021

[9] The White House. 2021. Memorandum on Protecting Women's Health at Home and Abroad https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/, accessed 30 May, 2021

[10] Congresswoman Barbara Lee. 2021 Lee, Bera, Schakowsky and Shaheen Introduce Legislation to Permanently Repeal Harmful Global Gag Rule https://lee.house.gov/news/press-releases/lee-bera-schakowsky-and-shaheen-introduce-legislation-to-permanently-repeal-harmful-global-gag-rule-, accessed 30 May, 2021

Table 4.1 Comparative Global statistics on Unsafe Abortion

	Unsafe abortions		Dangerous %age of all abortions	Risk of dying from unsafe abortion per 100,000 abortions
	%age of all abortions	Number million per year		
Global	45	35	33	
Africa	77	6,2	49	185
Latin America			17	14
Asia			8	16
Europe & North America			Undetectable	

Source: WHO, Factsheet: Preventing Unsafe Abortion.

As reflected in Table 4.1, Africa has the highest proportion of dangerous or least safe abortions of any region in the world. The risk of dying from an unsafe abortion is much higher in Africa than in any other region. This rate has declined in the last 20 years, likely as a result of expanded access to safer medication abortions and provision of post abortion care. However, Africa still accounts for 62% of the global deaths resulting from abortion. This is about 15,000 preventable maternal deaths each year.

The costs of abortion care, including ancillary costs such as transport, prevent many women from accessing safe and timely care. Delayed access may result in less safe options. There is little evidence about how adolescents navigate the costs of abortion care.

Traditional unsafe abortion methods used in Sub-Saharan Africa include:[11]

- Substances ingested/inserted
  - Plants/plant-based infusions: Aloe vera/burnt bean ashes/cassava leaves/garlic/gourd/



honey/lime tree root/mango tree seeds/ plectranthus (spurflower)/ papaya-leaf poultice/boiled henna root/ sisal leaves.

- Store-bought non-pharmaceutical items, usually consumed in large quantities: Ammonia-based cleaning products (Handy Andy, Jeyes Fluid)/baking soda/ beer/ blood tonics/brandy/chalk/ Coca-Cola/Maggi cube (concentrated bouillon)/fish poison/ Nescafé/steel wool mixed with Oros-Crush (soft-drink syrup)/ toothpaste.
- Combinations of store-bought and plant-based substances: Bark steeped in alcohol/ lemon juice on a vaginal suppository/plants soaked in alcohol/strong black tea plus chloroquine (antimalarial).

• Pharmaceuticals
  - Over-the-counter, usually in large quantities: Aspirin/Cafemol (caffeine plus paracetamol)/ folic acid/laxatives (castor oil and Epsom salt)/paracetamol/ potassium permanganate (wound cleaner)/snake antidote.
  - Antibiotics; Antimalarials; Deworming agents; Vasodilators Uterotonics Hormonal contraception.
  - Objects inserted into cervix: Cassava sticks, metal rods or wires, scissors, tree roots.

As abortion-related deaths contribute to high maternal mortality across SADC, it is not possible to achieve the SADC Gender Protocol ambition of eliminating maternal mortality.

[11] Bankole, A. et al From Unsafe to Safe Abortion in Sub Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute 2020

Table 4.2: Key facts on abortion in Southern Africa

Country	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Laws																
Abortion on request	Yes	Not specified	No	No	No	No	No	Not specified	No	Yes	No	Not specified	Yes	Not specified	Not specified	No
	Penal Code 2017	Penal Code 1991	Penal Code 1995	Penal Code 2004	Constitution 2005	Penal Code 2010	Penal Code 1998, Criminal Procedure Law	Penal Code	Criminal Code Act 2012	Penal Code 2015	Abortion and Sterilisation Act 1975	Termination of Pregnancy Act 1994	Choice of Termination of pregnancy Act (92/1996) amended in 2008	Penal Code	Termination of Pregnancy Act 2005 and Penal Code 2014	Abortion Law 1977
Unmet Need for Modern method of Contraception																
% of unmarried sexually active women 25 - 49 with unmet need	45		58	64	30	22	51	41		41	15		24	33	43	21
% of married women 15 - 49 with unmet need	39		38	40	28	19	29	20		24	18		15	29	22	11
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	40	36		24	20	26	18	28	41	24	16	33	35	25	47	22

Source: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey. WHO, Global Abortion Policies Database: https://abortion-policies.srhr.org/, accessed 15 April 2020.

Table 4.2 shows that:

- Abortion is available under certain circumstances in all SADC countries, most commonly to save the woman's life; in cases of foetal impairment, rape, and incest; or for mental or physical health reasons. The reasons are very restrictive in most countries, with only South Africa, Mozambique and Zambia having less restrictive legislation.
- The response to abortion has largely been reactive. Eight countries (Botswana, Madagascar, Malawi, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe) have comprehensive post-abortion care guidelines.
- The GL attitude survey shows that in all SADC countries, fewer 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 35% of those polled agree with this statement. However, attitudes on this controversial topic are beginning to change.

This chapter highlights the high rates of unsafe abortions in SADC and the challenges this presents for the region's development against the backdrop of the COVID-19 pandemic and the roll out of vaccinations. The chapter examines the root causes of safe abortion - unwanted pregnancies and unmet contraception needs - that need to remain a primary focus. It presents the international, African and regional normative frameworks relevant to safe abortion, underscoring the many gaps that have resulted in restrictive legislation.

The chapter details ongoing advocacy efforts and gradual changes taking place despite the odds, notably the *My Choice, Our Choice* campaign led by SAfAIDS, the SRHR cluster lead of the Southern African Gender Protocol Alliance. As consensus is built around the need for a model law or guidelines for the region, the chapter introduces an important debate as to what the best legal approach should be: decriminalisation of abortion or introduction of pro-abortion legislation or a combination of the two. In the meanwhile, expanded access to medication abortion is playing a crucial role in providing access to safe, effective, and acceptable abortion care in many regions of the world. Post abortion care, while skirting the real issue, shows that this is a matter that the region ignores at its peril.

Impact of COVID-19 on unintended pregnancy and abortions

On March 11 2021, the first anniversary of the declaration of COVID-19 as a pandemic, the United Nations Population Fund (UNFPA) released an assessment of the impact of COVID-19 on supplies and distribution of contraceptives compiled with Avenir Health using modelling technology with available data. UNFPA projected at the start of the pandemic that restrictions on movement, disruptions in supply and delivery of contraceptives would overwhelm health facilities. UNFPA also predicted that fear of going to health facilities for routine care would have a drastic impact on women's access to, and use of contraception.

UNFPA estimates COVID related disruptions resulted in 1,4 million unwanted pregnancies in 2020

So far, the impact has proved less drastic than feared, occurring mostly from March to May 2020. Thereafter, governments, UNFPA and partners such as Marie Stopes International (MSI), International Planned Parenthood Foundation (IPPF) and DKT International re-established

supplies using swift and innovative approaches. Overall, UNFPA estimates the pandemic disrupted contraceptive use for about 12 million women resulting in about 1.4 million unintended pregnancies during 2020 across 115 low- and middle-income countries[12]. The data is not disaggregated by country, thus it is unclear how many Southern African countries are included in this data. Anecdotal evidence gathered through the Southern Africa Gender Protocol Alliance points to some of the challenges and innovative solutions.



Madagascar: When travel restrictions and closures of markets meant that women were not able to move freely and thus to access services MSI Reproductive Choices (formerly Marie Stopes International), got permits for their buses to deliver services to women at their homes and to transport women to receive services at health facilities. This enabled women to continue receiving services safely.[13]



In **Malawi**[14], COVID-19 has seen authorities divert financial, infrastructural and human resources from SRHR. Women have struggled to access family planning services as they would usually receive these at points which are currently inaccessible. This has led to an increase in unwanted pregnancies and an increase in the numbers of women seeking unsafe abortions.

Malawi has one of the highest maternal mortality rates in the world with 18 % attributed to unsafe abortions- an estimated 23 women per 1,000 induced abortions. Clandestine abortions are widespread due to the restrictive nature of the law as and lack of access to safe abortion services, adequate family planning and youth friendly services. Stigmatization is common, leading to delay in seeking post abortion care, increasing mortality.

The National Sexual and Reproductive Health and Rights policy (2017-2022) is the overarching SRHR policy which addresses: family planning, maternal, neonatal and postnatal health, sexually transmitted infections and HIV, reproductive cancers, infertility, young people in reproductive health, obstetric fistula, harmful practices and male involvement in reproductive health.

COVID lockdowns resulted in increased violence and adolescent pregnancy

Abortion is only allowed in circumstances where the woman's life is in danger by the Malawian penal code (sections 149-151), which also stipulates imprisonment of between 7 to 14 years for abortion related offences.

School going youth have been affected by the school closures, leaving more idle time where they participate in sexual activity that cn result in unwanted pregnancy. The youth were also affected by a lack of peer to peer education having been reduced by the amount of face-time they experience. COVID-19 has created gaps in outreach activities and created fear amongst communities of accessing healthcare as they fear contracting COVID-19. There are also fears that even less money will be directed to SRHR in the next fiscal year, with the pandemic continuing.

In its review of the NGO Gender Coordinating Network, the Malawi focal network of the Southern Africa Gender Protocol Alliance, urged that family planning service providers be trained to provide services to the youth during the pandemic. The network also advocated for strengthening meaningful youth engagement, especially through social media and USSD (Unstructured Supplementary Service Data) platforms and community engagement. "This

[12] UNFPA COVID Impact: What we know 1 year into the pandemic https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf
[13] MSI Reproductive Choices. Stories from the frontline: in the shadow of the COVID-19 pandemic. https://www.msichoices.org/covid-19/stories-from-the-frontline, accessed 20 June, 2021
[14] Gender Links 2021. Malawi Report for the Analysis of SRHR Campaigns - Unsafe Abortions (Impact of COVID-19)

will provide a platform for the youth to assist in structuring the scope, direction and activation of SRHR initiatives. Further, we must leverage innovation and self-administration of SRHR interventions where possible," NGOCC stated.

Stakeholders agreed to:

- Message the campaign through established traditional institutions which are readily available in communities such as chiefs and *anamkungwi* (older women and instructors).
- Develop hotspots in communities for the youth and service providers to interact.
- Advocate for a decentralisation of abortion care services.

In countries and areas that have good Internet and telephone coverage there has been a great expansion of **telemedicine**. Unfortunately, such determined and resilient adaptations underscore the digital divide in which many women and girls are being left behind. For every instance of innovations there are several of girls and women who have not had access to technology and have experienced early, and unintended pregnancy, without recourse. Across the world governments and donors have continued to prioritise delivery of contraceptives to women and this has enabled services to rebound when there are lulls in the COVID-19 waves.

A WHO Pulse Survey on continuity of essential health services conducted in 105 countries released in August, 2020[15] found the most severe disruption of all health services in the Eastern Mediterranean region, followed by Africa and South East Asia, with the least disruption in Europe and West Pacific. The highest levels of disruption in reproductive, maternal, newborn, child, adolescent and nutrition services were in outreach for routine immunisation (18% severe disruption, 53% partial disruption) followed by family planning and contraception (9% severe disruption, 59% partial disruption). The lowest level of disruption was facility based births.

The most recent UNICEF dashboard (March 2021)[16] shows that:

- Three of the 18 countries[17] in East and Southern Africa reported new family planning services compared to pre COVID-19;
- Seven countries reported disruption in family planning services of up to 10%;
- Two countries reported disruption of 25% to 49%; and
- One country reported reduction in services of 50% to 74%.

Although data is not readily available, it is likely that young, unmarried, poor and rural girls and women, those who struggle the most to access contraception in "normal" times due to stigma, attitudes of providers, lack of confidentiality, distance to services and other barriers, suffered more severe disruption of access during COVID-19 than did married, urban and more wealthy women and girls.

A Rutgers report on services for adolescents conducted with partners in two global initiatives (Right Here, Right Now and Get Up, Speak Out for Youth Rights!) in Ghana, Indonesia, Kenya, Nepal, Uganda and **Zimbabwe**, found that almost all adolescents were impacted by extended school closures. While some children, particularly in urban areas, and those from higher socio-economic groups continued learning through Internet, TV and radio based approaches, poor and rural adolescents often did not have this luxury. Further, what lessons were available focused on the "hard core" subjects and comprehensive sexuality education was not often part of this.

Adolescents were also not able to participate in school clubs and other groups through which they access accurate information. The study found that telephone hot lines, the Internet and Whats app provided the most available source of information. Even NGO sensitisation services have migrated to online formats which are

[15] WHO. August 2020. Pulse Survey on Continuity of Essential Health Services during the COVID-19 pandemic. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1, accessed 18 June, 2021
[16] UNICEF. 2021. Tracking the situation of children during COVID-19. Dashboard. https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz/, accessed 17 June, 2021
[17] Does not include two SADC countries; Angola and DRC; does include four East African countries: Kenya, Uganda, South Sudan, Ethiopia, Somalia

available to some but not all young people. Although some contraceptives, especially condoms and injectables are still available to young people, there are limitations such as: condoms which were previously available for free must now be bought from a pharmacy, during the day due to curfews.



Junior councillors in Zimbabwe, who provide peer support, have had to scale down their SRHR campaigns during the pandemic. Photo: Colleen Lowe Morna

Many young people reported that it was now more difficult to obtain contraception. Overall, one young Zimbabwean woman said, "I feel that things are out of control and out of my hands, because I had plans at the beginning of the year. I would have done something in June, but then COVID-19 broke out and now, due to the restrictions, I cannot travel to South Africa, which is what I planned to do. I also wanted to travel to Harare, but have had to put that on hold as well. I don't know any more when COVID-19 will end, and this leaves me with so much uncertainty about the future."[18]

Due to lack of peer groups, young people reported less information about and less access to safe abortion services, leading to greater dependence on unsafe methods. Twenty nine percent of young men[19] and 35% of young women in Zimbabwe perceived themselves as being at risk of physical, emotional or sexual abuse. The survey found that gender based violence, including forced sex increased during the lockdowns. There has been marked increase in adolescent pregnancy reported across the region, as young girls were at home, without the protection afforded by being at school.

Using data about increases in teenage pregnancies in Sierra Leone during school closures from the Ebola crisis, World Vision has estimated that up to one million girls in Sub-Saharan Africa will fall pregnant during the COVID-19 related school closures.[20] This is corroborated by a news report in Namibia in November 2020, in which the Ministry of Education, Arts and Culture confirmed that at least 3 323 girls were impregnated during the lockdown from March to July. As 25,235 children did not return to school when schools re-opened, the number that failed to do so due to pregnancy could be much higher.[21]

Unintended pregnancy - the root cause of abortion

The root cause of abortions is unintended pregnancy. This may be the result of unprotected sex between two consenting people. Lack of protection may be from lack of adequate knowledge, or preparation or unavailable or inaccessible protection. It may also be the result of coerced sex (rape), in exchange for money or other favours. The consequences of an unintended pregnancy, particularly for a young, unmarried adolescent girl or woman include: being rejected by school or other educational/ training institutions and forced to withdraw, being

[18] Both, R. et al. 2021. I feel that things are out of my hands. Utrecht, the Netherlands. Rutgers. Rutgers SRHR & COVID 19 Report_International Study.pdf, accessed 21 June, 2021
[19] Studies on Violence against Children show that boys are at higher risk of physical violence (bullying, beating, fighting) than girls, and at risk of verbal / emotional abuse. They also suffer sexual abuse but at much lower rates - or at least lower reported rates - than girls.
[20] World Vision. 2020. COVID-19 Aftershocks: Access Denied. Teenage Pregnancy threatens to block a million girls from Sub-Saharan Africa from returning to school. www.wvi.org/sites/default/files/2020- 08/Covid19%20Aftershocks_Access%20Denied_small.pdf.
[21] The Namibian. 2021. 3 300 schoolgirls pregnant after Covid lockdown https://www.namibian.com.na/206504/archive-read/3-300-schoolgirls-pregnant-after-Covid-lockdown, accessed 16 July, 2021

rejected by family, friends and faith community and losing opportunities for improved livelihood possibilities.

Even where laws allow girls who have been pregnant to return to school, this may not be possible without support in raising and caring for the child. Stigma and unwelcoming attitudes in the schools or educational institutions may also make return to school difficult. Adolescent mothers are prone to higher rates of maternal depression than older women; experience higher rates of HIV transmission and are also more likely to experience obstetric problems such as fistula. Pregnancy in adolescents is often a precursor of child marriage. Older women may not be able to care for another child or feed another mouth. The result is that even where abortion is illegal many women - adolescents, young women and older women still make the choice to access abortion. Addressing abortion must therefore be accompanied by efforts to reduce the rates of unintended pregnancy. Thus, Chapter Three which focuses on adolescent SRHR and Chapter Two on SRH in general must be considered with this chapter.

Rates of unintended pregnancy and unmet need for contraception are derived from Demographic Health Survey (DHS) survey data. MSI estimates that globally 218 million women want to access contraception but are not able to[22] and Guttmacher institute estimates that this contributes to 121 million unintended pregnancies annually, which is equivalent to a rate of 64 per 1000 women aged 15 to 49 between 2015 and 2019[23].

Increasing access to contraceptives reduces unintended pregnancy, decreasing demand for abortion

Table 4.3 Selected Data on Fertility, Age first sex and first marriage from available DHS data

Country and year	Total fertility rate (lifetime births per woman*)	Total wanted fertility rate (lifetime births per woman)†	Difference total fertility rate and total wanted fertility rate	% of recent births unplanned	Median age at first sex	Median age at first marriage	Difference of median age at first sex and first marriage
Mozambique, 2011	5,9	5,2	0,7	16	16,1	18	1,9
Madagascar 2008-9	4,8	4,2	0,6	13	17,1	18,2	1,1
Malawi 2015-16	4,4	3,4	1	43	17,4	18,6	1,2
Zimbabwe, 2015	4	3,6	0,4	35	18,6	19	0,4
DRC, 2013-2014	6,6	5,7	0,9	32	17	19,3	2,3
Tanzania 2015-16	5,2	4,5	0,7	34	17,5	19,7	2,2
Zambia, 2018	4,7	4	0,7	38	16,9	19,8	2,9
Angola 2015-16	6,2	5,2	1	35	16,7	20,4	3,7
Lesotho, 2014	3,3	2,3	1	52	18,5	21	2,5
Comoros, 2012	4,3	3,8	0,5	33	21,1	21,1	0
Eswatini, 2006-7	3,8	2,1	1,7	67	18,2	25,6	7,4
Namibia, 2013	3,6	2,9	0,7	53	19,2	30,4	11,2
South Africa 2016	2,6	2	0,6	55	18	31	13

Source GL adapted from Unsafe to Safe Abortion in Sub Saharan Africa: Slow but steady progress.[24]

[22] MSI Reproductive Choices. Making Choice Possible. https://www.msichoices.org/, accessed June 14, 2021
[23] Bearak et al, 2020. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019 Lancet Glob Health 2020; 8: e1152-61 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X%2820%2930315-6.pdf, accessed June 12, 2021
[24] Ibid

Table 4.3 shows a growing gap between median age of sexual debut and median age of marriage. This is lowest in Comoros where there is no gap and Zimbabwe where the gap is 0.4 years and highest in Namibia and South Africa with gaps of 11,2 and 13 years respectively. This gap is consistent with an increase in the median age of first marriage which is lowest at 18 in Mozambique and highest at 31 in South Africa. Table 4.3 also illustrates a shift in total wanted fertility rate which is highest at 5,7 in DRC and 5,2 in Angola and Mozambique and lowest in South Africa (2), Eswatini (2,1) and Lesotho (2,3). There is also a gap between wanted fertility rate and actual fertility rate which is highest in Eswatini (1,7) and lowest in Zimbabwe (0,4). This is reflective of an intersection between what women want and how they are able to act on those choices which is partly a result of access to contraception and is also mediated by other factors.

The growing gap between age of sexual debut and of marriage increases need for contraception in unmarried women

Abortion around the world, in Africa and in SADC

Similar to the variations found in SADC, globally legislation on abortion varies from very liberal to highly restrictive. Many abortions are procured in secret to avoid the penalties which range in SADC from three years imprisonment in Botswana and Lesotho to fourteen in Seychelles and Malawi. Little accurate information on abortions is available which makes collection of data on abortions very difficult. The Guttmacher Institute has developed modelling approaches to estimate the number of abortions in any country or region and has been refining these as new information becomes available. Estimates tend to be available in five year time bands. A 2020 report published in the Lancet provides information on both unintended pregnancies and abortion rates from a database that covers 166 countries (previous estimates were made on the basis of information from 92 and 105 countries). This report estimated that 73,3 million unintended pregnancies per year ended in abortion which is a rate of 39 abortions per 1000 women aged 15 to 49. The report examined abortions and abortion rates across geographic regions and World Bank economic bands.

Legal abortion is linked to advancement of women

[23] Natércia de Almeida, Andreia Teixeira, Alberto Capoco Sachiteque, José R. Molina, Hamilton dos Prazeres Tavares & Carla Ramalho (2020) Characterisation of induced abortion and consequences to women's health at Hospital Central do Huambo - Angola, Journal of Obstetrics and Gynaecology, 40:4, 558-563, DOI: 10.1080/01443615.2019.1635096
[24] Unsafe abortion worries Ministry http://www.dailynews.gov.bw/news-details.php?nid=35333 accessed 26 April 2020.
[25] https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-deaths
[26] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205239 and http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/12/Zimbabwe-National-FP-Strategy-2016-2020_9.12.16.pdf

Table 4.4: Comparative data on abortion1990-4 and 2015 - 19

Region	Unintended Pregnancy Rate per 1000 women aged 15 - 49			Abortion rate per 1000 women aged 15 - 49			Unintended pregnancies ending in abortion		
	1990 - 4	2015-19	Change	1990 - 4	2015-19	Change	1990 - 4	2015-19	Change
World	79	64	-18%	40	39	-3%	52	61	18%
Sub-Saharan Africa	103	91	-12%	27	33	24%	26	37	41%
W Asia & N Africa	126	86	-31%	61	53	-14%	48	61	25%
Central & South Asia	89	64	-28%	40	46	15%	45	72	59%
East & South East Asia	60	58	-4%	38	43	13%	63	74	16%
Latin America	94	69	-27%	35	32	-8%	37	47	26%
Europe & N America	67	35	-47%	46	17	-63%	69	49	-29%
Australia & New Zealand	42	38	-9%	19	25	-19%	45	41	-11%
Rest of Oceania	82	78	-4%	22	34	51%	28	44	54%

Source: Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019.[25]

Table 4.4 shows that Africa has the highest rates of unintended pregnancies in the world at 91 per 1000 women aged 15 to 49, as compared to 35 per 1000 women in Europe and North America. The region also has the highest pregnancy rate overall (218 per 1,000) which represents a decline of 12% since 1990. The proportion of pregnancies reported as unintended is actually lowest in Sub-Saharan Africa, at 42%. But 89% of unintended pregnancies in Sub-Saharan Africa occur among women with unmet need for contraception, with 11% resulting from failure of a modern method. The abortion rate in Africa has increased from 27 per 1000 women aged 15 to 49 to 33: a 24% increase. Oceania (without Australia and New Zealand) experienced the highest rate of increase while the highest rate of decrease occurred in Europe and North America. With abortion rates of 17 per 1000 among women aged 15 to 49, these regions now have the lowest abortion rates in the world.

Africa has the highest rates of unintended pregnancies in the world

Table 4.5 Abortion 1990-4 and 2015 - 19 by legality of abortion

	Unintended Pregnancy Rate per 1000 women aged 15 - 49			Abortion rate per 1000 women aged 15 - 49			Unintended pregnancies ending in abortion		
	1990 - 4	2015-19	Change	1990 - 4	2015-19	Change	1990 - 4	2015-19	Change
Abortion broadly legal (excluding India & China)	76	50	-34%	46	26	-41%	61	53	-13%
Abortion restricted	91	73	-20%	33	36	12%	36	50	39%
Abortion prohibited	110	80	-27%	35	40	11%	32	50	52%

Source: Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019.[26]

The data in table 4.5 suggests that countries in which abortion is broadly legal also have more available and accessible sexual and reproductive health services overall, reducing the rates of unintended pregnancy. Conversely countries where abortion is restricted and even

[25] Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019 Lancet Glob Health 2020; 8: e1152-61 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X%2820%2930315-6.pdf, accessed June 12, 2021
[26] Ibid

prohibited have fewer and less accessible SRHR services, resulting in higher rates of unintended pregnancy. This converts to higher rates of abortion, despite the legal restrictions, and similar proportions of unintended pregnancy ending in abortion regardless of whether abortion is legal or not.

In the period 2015-2019, the abortion rate in Sub-Saharan Africa is estimated as 33 per 1,000 women aged 15-49, with little variation across the continent. *This rate has been relatively stable over the past 25 years.* However, the total number of abortions has increased significantly as the total population has grown over the same period. The annual number of abortions is estimated to have increased from 4.3 million to 8 million between 1995-1999 and 2015-2019. Abortion rates are higher in urban than rural areas, in younger women than older women and in more wealthy than poorer women. This may indicate that urban and more wealthy women have greater access to those abortion services that are available.





Better dead than mocked

In eastern DRC, most unwanted pregnancies are a result of sexual violence. Rape is seen as dishonourable and women are blamed for the sexual violence. Husbands whose wives have been raped often abandon their wives. Wives would rather avoid this by having a clandestine abortion. Young unmarried women who fall pregnant as a result of sexual violence are referred to as "goats". Goats are perceived to not know who the "owner" of their pregnancies are, and therefore the women are the same, where the common phrase is that they "picked up the pregnancy in the street".

In Eastern DRC, most unwanted pregnancies are a result of sexual violence

Living with this shame is an enormous burden for women, who therefore opt for a clandestine abortion. Children born out of these pregnancies suffer similar fates. In the DRC, a child's identity is formed after the father, not knowing who the father is means the child has no identity. Often times the child is even nicknamed after the armed group that was active at the time of the mother's rape, continuing the cycle of shame.

A second cause of unwanted pregnancy is transactional sex. Women and girls with no viable financial options or support from family, spouses or their own work have sex for food, money or gifts. Even women who are married are reduced to serving cohabitation and sexual roles. They are sometimes not cared for financially, pushing them into transactional sex to make financial ends meet. Women are mainly seen as tools to service the physical needs of men. There are abortion practitioners who demand sex from women who cannot afford to pay for their clandestine abortions.

The plight of women in transactional sexual relationships could be eased by improved access to contraceptives and better health education.

The local proverb "better dead than being mocked" illustrates how women and girls would rather risk death than face stigma if they continue with an unwanted pregnancy. Young girls for instance are abandoned by their families and face homelessness. Young girls are de-valued, mocked and shunned by members of society. If a woman falls pregnant while breast-feeding, she would rather terminate than face the shame of the pregnancy. In these situations however, abortion is seen as necessary for the protection of the child who is still feeding.

Source: "Better dead than being mocked": an anthropological study on perceptions and attitudes towards unwanted pregnancy and abortion in the Democratic Republic of Congo[27]

Normative frameworks

BPFA+25 Africa declaration 9: Accelerating the implementation of Sustainable Development Goal (SDG) 3 on universal health and well-being for all, to reduce the prevalence of disease in women and girls, and to mitigate the dispro-portionate burden of care affecting women: (b) Ensure universal access to good-quality health care, including testing and treatment for HIV and AIDS, and sexual and reproductive health; (d) Reduce maternal mortality rates and prevent deaths of newborn babies and children under the age of five years.[28]

Nairobi Statement on ICPD25: Accelerating the Promise[29]
2. Zero unmet needs for family planning information and services, and universal availability of quality, accessible, affordable, and safe modern contraceptives.

3. Zero preventable of maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national Universal health coverage (UHC) strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights.[30]

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 2019-2030: Rates of un-planned pregnancies and unsafe abortion are reduced.

[27] Burtscher, D et al. 2020 "Better dead than being mocked": an anthropological study on perceptions and attitudes towards unwanted pregnancy and abortion in the Democratic Republic of Congo. Sexual and Reproductive Health Matters, 28:1, DOI: 10.1080/26410397.2020.1852644
[28] UNECA African Regional Conference on Women Beijing+25 Political Declaration and key messages and priority actions on the implementation of the Beijing Declaration and Platform for Action - https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf, accessed 27 May, 2020
[29] Nairobi Statement on ICPD25: Accelerating the Promise https://www.nairobisummiticpd.org/content/icpd25-commitments, accessed 27 May, 2020
[30] UNFPA, 2020. Accelerating the Promise. The Report on the Nairobi Summit on ICPD25. New York. https://www.nairobisummiticpd.org/sites/default/files/Nairobi%20Summit%20Report%20on%20ICPD25_0.pdf accessed May 31, 2020.

Ironically the continent with the first human rights instrument to recognise abortion under certain conditions as a woman's human right to be claimed without restriction or fear of being prosecuted is still also a region of extremely restrictive legislation and practice on abortion.

The Protocol to The African Charter on Human and People's Rights on the Rights of Women in Africa (commonly referred to as the Maputo Protocol) aims "to ensure that the rights of women are promoted, realised and protected in order to enable them to enjoy fully all their human rights." The Assembly of the African Union adopted the Maputo Protocol at its meeting in Maputo, Mozambique, on July 11, 2003. Twenty member states had signed the protocol by the end of 2003. It entered into force in November, 2005 after 15 nations had ratified it (including five nations in SADC.)

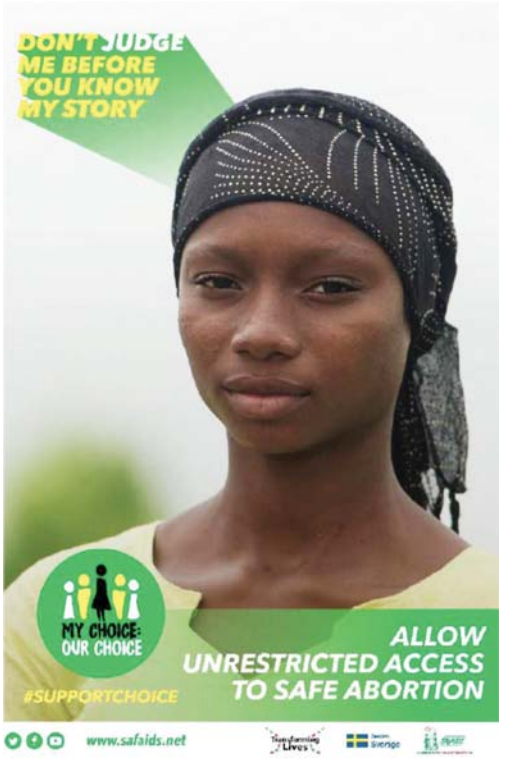


Table 4.6 Ratification of the Maputo Protocol by SADC Member States

COUNTRY	DATE OF SIGNATURE	DATE OF RATIFICATION	DATE DEPOSITED
Comoros	26/02/2004	18/03/2004	16/04/2004
Namibia	09/12/2003	11/08/2004	26/08/2004
Lesotho	27/02/2004	26/10/2004	05/11/2004
South Africa	16/03/2004	17/12/2004	14/01/2005
Malawi		20/05/2005	29/06/2005
Mozambique	15/12/2003	09/12/2005	30/12/2005
Seychelles	24/01/2006	09/03/2006	25/04/2006
Zambia	03/08/2005	02/05/2006	07/06/2006
Tanzania	05/11/2003	03/03/2007	07/05/2007
Angola	22/01/2007	30/08/2007	09/11/2007
Zimbabwe	18/11/2003	15/04/2008	05/09/2008
DRC	05/12/2003	09/06/2008	09/02/2009
Eswatini	07/12/2004	05/10/2012	06/11/2012
Mauritius	29/01/2005	16/06/2017	23/06/2017
Madagascar	28/02/2004		
Botswana			

Source: Adapted from African Union. List of Countries which have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.[31]

Table 4.6 shows that all member states of SADC have ratified the Maputo Protocol except Botswana and Madagascar.

[31] African Union. List of Countries which have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf, accessed 14 June, 2021

Table 4.7: Legal provisions regarding abortion in SADC[32]

Country	Law	Conditions under which an abortion may be granted	Gestational limits	Consent	Provided by	Penalties for an illegal abortion
ABORTION AVAILABLE ON DEMAND						
South Africa	Choice of Termination of pregnancy Act (92/1996) amended in 2008[33]	N/A Available on demand	Within the first trimester	Right to terminate without consent of other parties apart from medical practitioners		None
Mozambique	Amended Penal Code	N/A	On demand to 12 weeks; in the case of incest, 16 weeks; in the case of foetal anomalies, 24 weeks	Parental consent for minors; a health unit committee determines legal grounds[34]	A certified practitioner must perform termination at designated facilities[35]	None
ABORTION AVAILABLE IN FOUR CIRCUMSTANCES						
Zambia	Termination of Pregnancy Act, 13 October 1972, amended in 2005 and Penal Code	If the pregnancy will cause death to the mother, mental or physical damage to the woman, or if the child is at risk of mental and physical deformities		Once three medical practitioners have agreed		Seven years for person who administers; seven years for woman who administers own abortion
Botswana	Penal Code (Amendment) Act, 1991 - Section 160	In cases of rape or incest, if the mother's life is at risk, or the pregnancy may cause mental harm; if the unborn child will suffer or later develop physical or mental abnormality; in cases of defilement	Termination must be performed before 16 weeks[36]	Consent of parent or next of kin for minors; two doctors	Licensed facility	Three years for procurement; seven years for aiding
ABORTION AVAILABLE IN THREE CIRCUMSTANCES						
Angola	Penal Code 2017[37]	To save the life of a woman; If there are strong reasons to believe the foetus is unfeasible; If the pregnancy is the result of a crime against freedom and sexual self-determination	16 weeks to preserve health, foetal impairment no limit specified	Parental consent for minors	Licensed facility and one doctor	Four to ten years in prison

Country	Law	Conditions under which an abortion may be granted	Gestational limits	Consent	Provided by	Penalties for an illegal abortion
Comoros	Comoros-Penal-Code-1995	In the case of rape or incest; for a very serious medical reason, if a mother's mental state is at risk, or the child's life is at risk	Not specified	Two doctors	One doctor	Penalties for the woman and provider
DRC	Penal Code 2004, superseded by Maputo Protocol, 2018	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		Parental consent for minors		Yes, for the woman, provider, and person who helps a woman obtain abortion
Zimbabwe	Termination of Pregnancy Act of 1977, Chapter 15: 10[39]	In cases of incest, or rape, but not marital rape, under circumstances where the life of the mother is in danger, if the child will suffer from complications after birth		A magistrate must grant permission		Five years in prison and/or fine not exceeding $5000
Lesotho	The Penal Code (2012)[39]	In cases of incest or rape; to save the woman's life, to prevent the birth of a child who will be seriously physically or mentally handicapped		By a registered medical profes-sional, with the written opinion of another regis-tered medical professional		A fine of M5000-M10 000 or imprisonment of up to three years
Mauritius	Penal Code 1983; Criminal Code Amendment Act 2012[40]	To save the life of the woman; or prevent permanent physical damage; If the foetus may suffer severe mal-formation or abnormalities; if the woman younger than 16	If a pregnancy is within 14 weeks and the girl is younger than 16	Parental consent for minors		Imprisonment of up to ten years
Namibia	Abortion and Sterilisation Act 2 of 1975	When two other medical practitioners confirm that the woman has been raped or is a victim of incest; If the pregnancy poses a threat to the physical and mental health of the pregnant woman;[41] If the woman is deemed to be an idiot or imbecile as per the Immorality Act 1957, which criminalises sex with her ; If the unborn child is at risk of a serious mental or physical deformity and handicap		Two medical practitioners must approve in writing that the preg-nancy is a risk	Licensed facility	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both

Country	Law	Conditions under which an abortion may be granted	Gestational limits	Consent	Provided by	Penalties for an illegal abortion
ABORTION AVAILABLE IN ONLY TWO CIRCUMSTANCES, EXCLUDING SEXUAL ASSAULT						
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	If the woman's life is deemed to be in danger or 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[42]		If three medical practitioners agree in good faith, termination can be under-taken at Victoria Hospital in Mahe		Imprisonment up to 14 years
Tanzania	Penal Code 1981[43]	If a woman is at risk of death, or the preg-nancy threatens her mental and physical wellbeing; If a pregnancy threatens the mental and physical wellbeing of the pregnant woman				Seven years for procurement; three years for suppliers
Eswatini	The Constitution	Only if the life of the woman is in danger[44] Or in cases of unlawful intercourse with mentally retarded female		One doctor		Life imprisonment
ONLY ONE GROUND FOR TERMINATION						
Malawi	Penal Code	Only to save a woman's life				14 years for having an abortion; 3 years for supplying instruments to conduct an abortion
Madagascar	Reproductive Health and Family Planning Law 2017	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

[32] This table is reproduced from Gender Links 2019 Abortion Fact Sheet, with some additions from WHO Global Abortion Policies Database https://abortion-policies.srhr.org/, accessed 15 April 2020.
[33] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[34] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[35] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[36] 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
[37] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf
[38] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[39] https://lesotholii.org/ls/legislation/num-act/6
[40] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[41] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[42] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[43] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
[44] http://srhr.org/abortion-policies/country/swaziland/

Table 4.7 shows that almost all member states in SADC still have very restricted abortion legislation, which is quite anachronistic in the twenty first century. South Africa has the most modern Choice of Termination of Pregnancy Act (1996) allowing for safe abortion on demand within the first trimester. Mozambique has modernised its Penal Code.

Table 4.8: Grounds for obtaining an abortion in SADC countries

Country	Stand alone law/Penal Code	1. Risk to life	2. Rape or sexual abuse	3. Serious foetal anomaly	4. Risk to physical and sometimes mental health	5. Social and economic reasons	6. On request
South Africa	SAL	1	1	1	1	1	1
Mozambique	PC	1	1	1	1	1	1
Zambia	SAL	1	1	1	1		
Namibia	SAL	1	1	1	1		
Botswana	PC	1	1	1	1		
Angola	PC	1	1	1	1		
Comoros	PC	1	1	1	1		
DRC	PC	1	1	1			
Zimbabwe	SAL	1	1	1			
Lesotho	PC	1	1	1			
Mauritius	PC	1	(statutory rape)	1			
Seychelles	SAL	1		1			
Tanzania	PC	1		1			
Eswatini	Const	1			1		
Malawi	PC	1					
Madagascar	SAL	1					
Total		16	10	13	8	2	2

Source: Gender Links 2021. SAL= Stand Alone; PC= Penal Codes; Const= Constitution.

Table 4.8 is an analytical summary of the information in the previous table. The first column concerns the legislation that governs abortion in SADC countries. Six SADC countries have stand alone abortion laws (South Africa, Zambia, Namibia, Zimbabwe, Seychelles and Madagascar). In one case the (Eswatini) the Constitution spells out how abortion is to be handled. In nine countries (Botswana, Angola, Comoros, DRC, Lesotho, Mauritius, Tanzania and Malawi) abortion is covered under Penal Codes (a code of laws concerning crimes and offenses and their punishment[45]) many inherited from colonisers who have since radically adapted their own codes, granting women greater freedom and enabling progression in education and their careers.[46]

Former colonies, many of which achieved independence following bitter armed struggles for self-determination (for example Namibia) have clung to legislation that amounts to structural violence perpetrated in highly patriarchal systems against women, denying them self-determination. This violence targets the weakest women - young, poor and rural - as those who can afford to procure abortion, at home or abroad.

The table lists the six main grounds for allowing abortion ranging from the mot exceptional to the least restrictive grounds.

[45] Meriam Webster Dictionary
[46] Rodgers, Y. et al. (2021) 'The macroeconomics of abortion: A scoping review and analysis of the costs and outcomes', PLoS ONE, 16, p. e0250692. doi: 10.1371/journal.pone.0250692

Figure 4.1: Legal grounds for permitting an abortion



The analysis shows that *all* SADC countries allow abortion on some grounds, in other words, no SADC country outlaws abortion completely. All SADC countries allow abortion if it is a risk to the woman's life. This is consistent with global trends. By the end of the twentieth century, abortion was legally permitted to save the life of the woman in 98% of the world's countries.[47]

However, only two countries, South Africa and Mozambique permit abortion on demand. Five SADC countries, (Namibia, Botswana, Angola, Comoros and Zambia) permit abortion on four out of the six grounds. Four SADC countries (DRC, Zimbabwe, Lesotho and Mauritius) allow abortion in three out of the six grounds. Three SADC countries (Seychelles, Tanzania and Eswatini) permit abortion on two grounds. It is significant that in these countries *abortion is not permitted in the case of rape*. Abortion laws are most restrictive in Madagascar and Malawi where the only ground for abortion is *risk to life*. It is significant that no SADC country (except for South Africa and Mozambique that allow abortion on demand) allows for abortion for social and economic reasons; a highly significant factor in a region with high levels of poverty. Examples from around the SADC region show how advocacy on safe abortion is gradually gaining momentum. The analysis also suggests the need for a more clear and concerted regional strategy.

Mozambique has set a good precedent for the region[48] (reported in previous Barometers) by reforming its penal code holistically and addressing several key issues from a more progressive perspective. These include safe abortion, sexual diversity, sexual assault, human trafficking and domestic violence. Abortion had previously been legal only in the case of a threat to a woman's life or health. Women can now terminate pregnancies during the first 12 weeks, extended to 16 weeks in the case of rape. The code stipulates that abortions must be carried out in approved health centres by qualified practitioners and is available as a free service.

Women over the age of 16 provide consent for themselves. Below the age of 16 consent must be provided by a parent, or other trusted adult over the age of 21 (age of majority in Mozambique) to have an abortion. There is a 48 hour waiting period before the woman receives an abortion.

Good laws are only meaningful if implemented

The liberalisation of abortion in the 2015 Penal Code is the culmination of over 30 years of activism by medical professionals and SRHR activists. The main challenge now is the implementation of these new laws.

The Associação Moçambicana de Obstetras e Ginecologistas (AMOG) has been working with

[47] United Nations Population Division. Abortion policies: A global review. 2002 http://www.un.org/en/development/desa/population/publications/abortion/abortion-policies-2002.shtml major dimensions of abortion policies.
[48] Gender Links: Mozambique Penal Code Reform Case Study for the Equality & Justice Alliance (EJA) 2018

the government of Mozambique and several other partners, including the Ministry of Health, IPAS, DKT and Pathfinder International, to create materials to sensitise health workers about the change in the legislation around abortion and their responsibilities under the new legislation. The group is also raising awareness with women that such services are available.

Professor Fernanda Machungo, AMOG member said, *"the 10 years of work that resulted in the law on the decriminalization of abortion (…) were the beginning of a new battle: to make the law known to all girls and women, particularly in rural areas; create conditions for them to have access to quality services for safe abortion and post-abortion services; train quality personnel to carry out these services."*[49]

AMOG strives towards a future where all women in Mozambique have access to Family Planning and Safe Abortion services, regardless of their socioeconomic status, race, religion, culture and marital status. AMOG works with civil society, community and religious leaders, women and youth, the providers of safe abortion services, key government partners (Ministries of Health; Education; Youth and Technology; Women, Gender, Children and Social Action; and Justice) as well as legislators.[50]



When **Angola** gained independence in 1975, they adopted the colonial penal code that had been in effect since 1886 in its entirety. The Penal Code was only reviewed in 2019, and finally enacted in February 2021. The Penal Code reform now allows same sex relations, but still does not include abortion on demand.[51] Rather, women can now access abortions when their life or mental health is in danger, when the child will suffer deficiencies after birth or in the event of rape. The Catholic Church has been instrumental in lobbying for the ban of abortion, while the president's daughter, business woman Isabel Dos Santos spoke out against the lack of abortion rights during the iconic march in 2017 which saw over 200 women take to the streets in protest against a total ban on abortion.



DRC: A study conducted in North and South Kivu in the Eastern DRC, where abortion is still highly stigmatised, found that discussions with communities could begin to address stigma which is associated with abortion being viewed as repudiation of traditional female roles of motherhood and procreation. Community attitudes on abortion were initially negative but most expressed understanding and empathy for women who opt for abortion after rape or sexual assault perpetrated by armed groups in the ongoing conflict; when a woman's husband was unsupportive, unfaithful, or abusive; when a couple could not afford to feed another child; if a woman had recently given birth or already had many children; an unmarried girl who would want to avoid the stigma of becoming an unwed mother, or who wanted to finish her education. Many community members agreed that abortion should be allowed to save a woman's life. Almost all members agreed that a woman who had made the personal decision to induce an abortion should receive post abortion care and be reintegrated into society. Many said they would support a woman to access post abortion care.[52]

In late 2020 Youth organisations, including the Youth Action Movement, Afia Mama, Habari RDC, and the African Youth and Adolescents Network (AfriYAN) led an online campaign to promote SRHR during the coronavirus pandemic and beyond. IPAS DRC was one of the "Abortion: Let's Talk About It!" campaign coordinators. "Young people are seeking reliable information about their sexual and reproductive health and need access to services during COVID-19," said Dr. Jean-Claude Mulunda, country representative of Ipas DRC. "There is an increase in the number of unwanted pregnancies, sexual violence and maternal deaths due to clandestine abortions,

[49] Figo.org. OBGYNs in Mozambique call to strengthen gender equality and access to safe abortion https://www.figo.org/news/obgyns-mozambique-call-strengthen-gender-equality-and-access-safe-abortion, accessed 22 June, 2021
[50] Ibid
[51] Agencia EFE. 2019. Angola decriminalizes same-sex relations, allows abortion in certain cases. https://www.efe.com/efe/english/life/angola-decriminalizes-same-sex-relations-allows-abortion-in-certain-cases/50000263-3877510, accessed 26 June 2021.
[52] https://theconversation.com/attitudes-towards-abortion-in-the-drc-suggest-there-are-ways-to-overcome-stigma-156392,, accessed June 14, 2021

while access to services is more difficult. Reproductive health services, including abortion, must be part of essential health care."



"Access to health care is a right and not a favour that we grant to young people," says Benjamin Sabue of the Youth Action Movement. "Young people in good health are the future of the country."[53]



In **Namibia**, debate on review of the Abortion and Sterilization Act 2 of 1975, which has been raging for several years, continues. The current act which was adopted from an apartheid era South African law (long since abandoned in South Africa) stipulates that abortion is allowed:

- In order to save the life or the mental or physical wellbeing of the woman.
- In the event the child will suffer physical or mental defects.
- In the event that the pregnancy is as a result of rape, incest or unlawful sexual relations whereby a woman has severe mental incapacity.

Further to this, two medical professionals need to advocate for the abortion, and in the case of rape or incest, a magistrate must approve[54]. South African adopted the Choice of Termination of Pregnancy Bill in 1996. The Namibian law on the other hand has not changed. In June 2020, Namibian feminist and psychologist Beauty Boois, started a pro-abortion petition. At the time of writing this had over 62,000 signatures. Zelda Van der Colff has started a counter an anti-abortion petition.

The Deputy Minister of Health and Social Services, Esther Muinjangue tabled a motion in parliament in June 2020 noting that whether abortion was legal or not, young women and girls were engaging in backyard abortions and that Parliament needed to debate the issue. She said, "Let us acknowledge the devastating effects of illegal backyard abortions on girls and women. Let us acknowledge that women cross the border into South Africa or elsewhere where abortion is legal."[55] In February, 2021, a spokesperson for the National Assembly confirmed that although the Deputy Minister still expected the matter to be debated, abortion had only been tabled for discussion, not debate, and that it had since lapsed.[56]



Esther Muinjangue, Deputy Minister of Health and Social Services.
Photo courtesy of New Era Live

[53] Source: IPAS https://www.ipas.org/news/social-media-campaign-in-drc-reaches-youth-with-abortion-information/, accessed on 18 June, 2021
[54] Legal Assistance Center. Abortion Current Law http://www.lac.org.na/index.php/projects/gender-research-advocacy-grap/abortion/#:~:text=Current%20law,her%20physical%20or%20mental%20health, accessed 22 June, 2021
[55] The Namibian. 2020. Parliament asked to consider abortion https://www.namibian.com.na/202039/archive-read/Parliament-asked-to-consider-abortion, accessed 16 July, 2021
[56] Windhoek Observer. 2021. Abortion debate huddles in Parliament https://www.observer24.com.na/abortion-debate-huddles-in-parliament/, accessed 16 July, 2021



Zambia is one of ten countries in Africa and Latin America that are being supported by FIGO (the International Federation of Gynecology and Obstetrics) which is a professional organisation that brings together obstetrical and gynaecological associations from all over the world to support women to achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives) in a programme to build the capacity of National Member Societies to lead advocacy on safe abortion in their countries. This programme has included engaging with traditional healers who are often the first point of call for women seeking abortion[57].



On 24 June 2021, the **Malawi** High Court reaffirmed the statutory protections for legal abortion under narrow circumstances[58]. The case concerned a 15 year old girl who experienced statutory rape and fell pregnant during the COVID-19 lockdown. In seeking a safe abortion, she claimed that this affected her physical and mental health[59].

In the ruling, Justice Mzonde Mvula clarified that women and girls seeking abortion should demonstrate to the doctor how a pregnancy would undermine their health and life in general. While the Penal Code only allows for abortion when the life of the woman or girl is in danger because of the pregnancy, the court recognised in this ruling that preservation of life also entails safeguarding the mental and physical health of the woman or girl.

The ruling follows the withdrawal of an abortion bill from debate following opposition to the proposal to liberalise the country's law, which only allows abortions when the mother's life is at risk. The current 160-year-old law criminalizes abortion, with the only exception being if the mother's life is in danger. Offenders face up to 14 years in jail. The measure could have allowed abortions in cases of rape and incest. Mathews Ngwale is chairperson for the Parliamentary Committee on Health that was tasked with presenting the bill in parliament. A joint study by Malawi's College of Medicine and the U.S.-based Guttmacher Institute reveals more than 140,000 backstreet abortions take place illegally every year in Malawi and 12,000 deaths result.[60]



Reacting to the High Court ruling, Dr. Godfrey Kangaude, an attorney and reproductive health scholar, said: "This is a good development since current legal provisions on termination of pregnancy are couched in language that makes it difficult for health providers to implement. This ruling is a welcome step towards an authoritative interpretation of the abortion law and opens the door for women and girls to seek lawful access to safe abortion in Malawi." Dr. Kangaude expressed optimism that the Ministry of Health will take the initiative to advance necessary legal and policy reforms to address the inconsistencies between the current law and Malawi's obligations under national and international law on reproductive rights of women and girls."[61]

[57] Figo.org Advocating for Safe Abortion Project ; https://www.figo.org/advocating-safe-abortion-project; accessed 30 May, 2021, accessed 30 May, 2021
[58] Chitete, Suzgo, the Nation, 25 June 2021
[59] Ibid
[60] Masina, Ameck, Voice of America, June 19, 2021 01:42 PM
[61] Chitete, Suzgo, the Nation, 25 June 2021

Media NGO campaigns for termination of pregnancy bill

Since Malawians voted in the disputed May 21, 2019 elections, the public sphere for policy debates has shrunk. Despite this, the Centre for Solutions Journalism (CSJ) declared the year 2020 'the year for the new abortion law'.

The proposed Termination of Pregnancy (T.O.P) bill, which was developed by the Law Commission in 2015 as one way of reducing maternal deaths, still needs to be tabled in parliament. The TOP allows for conditional relaxation of restrictions to cater for certain instances where termination of pregnancy should be permissible. Termination of a pregnancy may be performed by a certified health service provider where he /she is of the opinion in good faith that:

- The continued pregnancy will endanger the life of a pregnant woman;
- It is necessary to prevent injury to the physical or mental health of a pregnant woman;
- There is severe malformation of the foetus which will affect its visibility or compatibility with life; or
- The pregnancy is as a result of rape, incest or defilement. Provided the incident of rape, incest, defilement has been reported to police and that the pregnancy has not exceeded sixteen (16) weeks from the date of conception.

To advocate for the awareness of SRHR and the passing of the bill to law, CSJ is running a multimedia programme mobilizing support among faith-based groups, policy makers and members of the general public. CSJ is using various platforms to engage experts and members of the general public on issues of safe abortion. These include training, newspaper columns-opinion and analysis, Chichewa language radio programmes on local radio stations called Uchembere ndi Ufulu loosely translated as Motherhood and Rights. So far CSJ has conducted training for Members of Parliament, religious leaders, NGOs and youth groups to orient these stakeholders on the contents of the bill so that they fully understand it. The programmes also aim at neutralizing anti-choice activities.

Part of the campaign is documenting stories of survivors; they premiered a documentary on three national television channels: Times, ZBS and Mzati. Mdula Moyo wa Chinunu (Silent Killer on the Prowl) is based on true stories of women in Lilongwe and Blantyre districts in Malawi who died due to pregnancy related causes.

Experts provide evidence-based background and context for the TOP bill. For instance, Dr. Chisale Mhango, a gynecologist with the College of Medicine, has been running a column in the Daily Times on safe abortion and the proposed law. CSJ sponsors opinion and analytical articles in the daily newspapers as a way of challenging anti-choice sentiments among members of the public.

Some articles are published by pastors drawing lessons from scriptures. Pastor Esitedi Chikopa, for example, intimates in one of the entries that the death of two members in his congregation due to unsafe abortion sparked his interest in the debate on abortion. He says the condemnation of women who procure abortion distresses him while observing that: "As master condemners, we have no compassion for many women who induce abortion in Malawi annually. We have no concern for women who die due to unsafe abortions because we are disciples of Biblical literalism instead of being experts in practical hermeneutics (interpretation, especially of the Bible or literary texts)."

"Malawi's political turbulence since May 2019 elections and the nullification of the elections has created a hostile environment for the enactment of the bill as most MPs are afraid to discuss abortion issues to avoid losing their political support base. The COVID-19 pandemic has also limited awareness campaigns as social

distancing measures and restrictions prohibit mass gatherings", says Brian Ligomeka, Executive Director, CSJ.

However, positive impacts of the initiative by CSJ are now visible. An increased understanding of the bill and acceptance of its benefits are reflected in the signing of a communique to lawmakers by chiefs, religious and political leaders from across the country who urged law makers to pass the TOP Bill in parliament.

Many faith leaders have joined the movement to make the public and policy makers understand the importance of having such a law in place. One of the participants Rev. Cliff Nyekanyeka said: "People need to have their physical, psychological and emotional needs met. If one is sick the hospital is the best place to seek medical attention. In the same way if the people are facing spiritual problems, the best place to rush to is the church. This is why churches are building hospitals and clinics. … It is not our duty as churches to make laws for all citizens. We simply make rules and regulations for our members." Nyekanyeka feels the government must be allowed to make good laws on abortion so that those desperate for such services should not die.

Source: GL Media, 2021. Malawi Media NGO defies political crisis to build momentum for Termination of Pregnancy Bill[62]



In February, 2021 Nifin'Akanga (a women's advocacy group named after a plant that is used as an abortifacient in **Madagascar**) released a documentary on 15 women who accessed illegal and unsafe abortions. Mbolatiana Raveloarimisa, one of the founders of Nifin'Akanga, commented, "The word that always comes up in the women's stories .. is 'fear': fear of society, fear of dying, fear of the law, and fear of being frowned upon. Ultimately, it is this fear that is undermining people and causing collective hypocrisy to grow day by day. But this fear also opens the door to going underground. And to expose all the terrible practices that can kill women, practices that cost women's lives in some cases. So apart from those who provide clandestine abortion in a professional manner, there are plenty of others who butcher women, who are killing women and without qualms because they know the women are afraid, and they take advantage of that."

"During our field surveys, we noticed that whatever the reasons; whatever the constraints; if a woman decides to have an abortion, there is nothing that is capable of dissuading her. When a woman is pregnant and decides to have an abortion in Madagascar, nowadays, in 30 minutes, she can find a solution, but obviously this solution may not be the right one. There is always someone who knows someone who has had an abortion before," explains Dr Fanzy Mefire, head of research in Nifin'Akanga. [63]

> If a woman decides to have an abortion…. Nothing will dissuade her

[62] Gender Links. Malawi: Media NGO defies political crisis to build momentum for termination of pregnancy bill - https://genderlinks.sharepoint.com/:w:/r/programmes/alliance/_layouts/15/Doc.aspx?sourcedoc=%7BC937DF39-5A6A-4B32-BD6F-5396F27B4AF9%7D&file=Malawi_Media%20NGO%20builds%20momentum%20for%20termination%20of%20pregnancy%20bill%5B1%5D.docx&action=default&mobileredirect=true

[63] International Campaign for Women's Right to Safe Abortion. 2021. Madagascar - Women testify on the risks they experienced with clandestine abortion https://www.safeabortionwomensright.org/news/madagascar-women-testify-on-the-risks-they-experienced-with-clandestine-abortion/, accessed 30 May, 2021

My Choice, Our Choice (MCOC) SADC campaign



Regional Coalition of Champions and Allies on Ending Unsafe Abortion. Photo: SAfAIDS

SAfAIDS, the Alliance SRHR cluster lead, launched the "My Choice, Our Choice" Campaign on ending unsafe abortion among adolescent girls and young women (AGYW) in the SADC region in 2020. The Campaign is premised on mobilising policy makers to review policies and remove restrictions, to close gaps in unmet need for contraceptives, to improve access to safe and legal abortion services; and to create an enabling environment for bodily autonomy of AGYW.

The campaign has been rolled-out at regional and national level concurrently with a series of regional and national Sectoral Policy Dialogues which has created an advocacy movement and impetus in the region to address policy barriers to provision of and access to Safe Abortion by Adolescent Girls and Young Women in SADC. The campaign has utilised virtual and online platforms including twitter, facebook and instagram and key campaign messages are digitally disseminated through animations, flash messages, Spotlight issues and video clips.

To strengthen synergies between the "My Choice, Our Choice" Campaign at regional and national levels, and create a collaborative and cross-learning mechanism which sustains and amplifies momentum on safe abortion policy advocacy, SAfAIDS established a Regional Coalition of Champions and Allies. The Coalition comprises Champions (primary targets of the My Choices, Our Choice Campaign), who are policy-makers, such as Members of Parliament and Sectoral leadership such as senior officials from Ministries of Health, Gender and Education; and Allies (secondary targets) representatives of Adolescent Girls and Young Women and Men and Boys bodies. Strategic partners include MenEngage, AfriYAN-ESA, SheDecides, the SADC Gender Protocol Alliance, FEMNET, Right Here Right Now, Sonke Gender Justice and Women's Action Group and media practitioners; representing the 16 SADC Member States.

The campaign is hinged on policy advocacy efforts to catalyse, stimulate or seed change in the SRH policy environment. This includes direct lobbying through one-on-one and roundtable meetings with senior SADC Secretariat, SADC-PF and Government Ministry officials, and broad Influencing through regional and national sectoral meetings and dialogues.

Campaign champions have been raising awareness on the prevailing status and extent of unsafe abortion and associated barriers in their respective countries and in the region.

- King Ntinu, President- Union of African Traditional Authorities, and King of the Kingdom of Kongo in **DRC** has been sensitising other traditional leaders on their role to address unsafe abortions in their chiefdoms and he

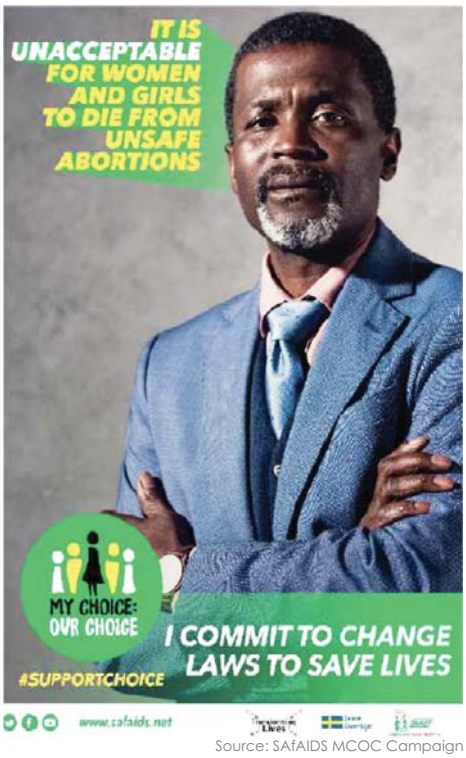
has actively been raising awareness of other traditional leaders on key policy gaps for provision of unrestricted safe abortion in the country.

- In **Lesotho** the campaign champion Fako Moshoeshoe, chairperson of the Lesotho SADC PF Parliament Cluster Committee, held joint radio/TV programmes on safe abortion. The Lesotho parliament tabled a motion to legalise abortion in November, 2020.
- In **Zimbabwe**, the Parliamentary Portfolio Committee on Health led by Dr Ruth Labode, a member of the SAfAIDS Regional Coalition of Allies and Champion, spearheaded week-long public hearings on age of consent as barrier to accessing sexual and reproductive healthcare services, including contraception, by young persons.
- In **Zambia** the campaign champion Dr. Christopher Karira argued against withdrawing Comprehensive Sexual Education (CSE) in Zambian schools, suggesting that CSE is a tool that can also help in reducing maternal deaths caused by unsafe abortion. The Motion to withdraw the CSE curriculum has since been withdrawn.
- In **Malawi** Chief Mabulabo has endorsed the urgent need to address unsafe abortions.

The Campaign has to date reached about 1,600,000 individuals in the SADC region including political, religious, traditional, health and justice leaders; media, adolescent girls, young women and boys and men. About 50,000 individuals have been reached through social media.

The 'My Choice, Our Choice' regional campaign has sparked regional discussion and dialogues on unsafe abortion among key stakeholders including the media and policy makers. It has contributed to enhanced capacity and understanding of policy makers on the impact of unsafe abortion at regional level.

Through the campaign, a regional advocacy movement and multi-point pressure has been created. There has been a positive transformation in the beliefs, opinions and attitudes of policy- and decision-makers' and leadership on abortion resulting in growing advocacy and resounding voice for change of policy environment for ending unsafe abortions amongst adolescent and young women.



Source: SAfAIDS MCOC Campaign

The Campaign has resulted in consensus amongst the policy makers and leaders to address policy barriers to provision and access of safe abortion services by Adolescent Girls and Young Women as part of the 2030 Agenda and SADC SRHR Strategy (2019-2030), through a harmonised regional approach.

Ultimately the campaign will result in SADC Member states developing a regional roadmap to support and guide the review of termination of pregnancy laws and policies for removal of restrictions for accessing safe abortion services by Adolescent Girls and Young Women and in turn mortality due to unsafe abortion will be reduced in the SADC region. SAfAIDS and the Southern African Gender Protocol Alliance plan to convene a group of technical experts to debate how to build on the momentum created thus far to come up with the best legal strategy for making safe abortion accessible to all SADC citizens.

Source: Chrispin Chomba, Head of Country Programmes, Strategic Evidence and Country Business, SAfAIDS

Decriminalisation or legalisation?

From an impassionate health and rights perspective, a woman's right to bodily determination is violated when she is denied health care which empowers her to exercise that right and which still too often leads to death and disability. Thus,

> Abortion legislation is structural violence against women

Professor Joanna Erdman has argued that laws to govern abortion, which is a medical procedure, amount to structural discrimination.[64]

Dr Lucía Berro Pizzarossa, argues that even certain models of abortion law which are seen as liberal, fail to comply with human rights. She argues that there should be no criminal or specific law on abortion. She asks:
Are we expending too much emotional energy on continuous, and seemingly never ending, battles to make minor changes to the "conditions under which abortion can be allowed" and losing sight of the war for women to have self-determination of their reproductive selves? Would it not be preferable to rather campaign for decriminalisation of abortion and removal of abortion from penal or other codes?[65].

Legalise or decriminalise: What's in a word?
By Marge Berer[66]

For many years, the abortion rights movement internationally has called for "safe, legal abortion." More recently, calls for the "decriminalisation of abortion" have also emerged. Do these mean the same thing? In simplistic terms, they might be differentiated like this: legalising abortion means keeping abortion in the law in some form by identifying the grounds on which it is allowed, while decriminalising abortion means removing criminal sanctions against abortion altogether.

Canada stands out as the only country to date that, through a Supreme Court decision in 1988, effectively decriminalised abortion altogether. No other country, no matter how liberal its law reform, has been willing to take abortion completely out of the law that delimits it. It is impossible not to think that no law is the best law when it comes to abortion, which brings us back to Canada, where abortion has not been restricted since 1988 and is available on request with no stipulations as to who must provide it or where. Although abortion is not easily accessible in remote areas, and Canada was exceedingly slow to approve mifepristone, opposition to abortion has never developed a foothold. The benefits for women of having no law are crystal clear.

Some abortion rights supporters seem to have an underlying fear that without leaving something in the criminal law, "bad things" may start to happen. Canada proves this is not the case. Granted, not everywhere is Canada. But there are general criminal laws that allow the punishment of wrongdoing-such as forcing a woman to have an abortion against her will, giving her medical abortion pills without her knowledge, or causing injury or death through a dangerous procedure. These are laws against grievous bodily harm, assault, or manslaughter,

[64] Stevens, Marion. 2020. Do we need the law to provide for a regular clinical medical procedure such as abortion? https://www.spotlightnsp.co.za/2020/08/12/do-we-need-the-law-to-provide-for-a-regular-clinical-medical-procedure-such-as-abortion/, accessed June 16, 2021
[65] Ibid
[66] Excerpts from Berer M. (2017). Abortion Law and Policy Around the World: In Search of Decriminalization. Health and human rights, 19(1), 13-27. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473035/, accessed 5 August, 2021

which can be applied without the need for a criminal statute on abortion.

Those unable to contemplate no law at all must confront the fact that each legal ground for abortion may be interpreted liberally or narrowly, and thereby implemented differently in different settings, or may not be implemented at all. The challenge is to define which abortions should remain criminal and what the punishment should be. Even if only some grounds would be considered acceptable, the question of who decides and on what basis remains when reforming existing law.

Restrictive abortion laws are being broken on a daily basis by millions of women and numerous abortion providers. Even in countries where the law is less restrictive, research shows that the letter of the law is being stretched in all sorts of ways to accommodate women's needs. Yet opposition and a stubborn unwillingness to act continue to hamper efforts to meet women's need for abortion without restrictions

It should be clear that the plethora of convoluted laws and restrictions on abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable-when it is available on the woman's request and universally affordable and accessible. From this perspective, few existing laws are fit for purpose but merely repeat every possible permutation of the self-same restrictions.

Treating abortion as essential health care is a major step forward, and where the national setting insists on some sort of law, advocates could draft the simplest, most supportive law possible, placing first-trimester abortion care at the primary and community level, ensuring second-trimester services, involving mid-level providers, increasing women's awareness of services and the law, aiming for universal access, integrating WHO-approved methods, and addressing social attitudes to reduce opposition.

If it were up to me, all criminal sanctions against abortion would be revoked, making abortion available at the request of the only person who counts-the one who is pregnant. And as with all pregnancy care, abortion would be free at the point of care and universally accessible from very early on in pregnancy.

Canada has proved that no criminal law is feasible and acceptable. Sweden has proved that abortions after 18 weeks can effectively disappear with very good services, and WHO has shown that first-trimester abortions can be provided safely and effectively at the primary and community level by trained mid-level providers and provision of medical abortion pills by trained pharmacy workers. Finally, web- and phone-based telemedicine services are showing that clinic-based services are not required to provide medical abortion pills safely and effectively.

Medication Abortion



In many Latin American countries, abortion laws have remained highly restrictive despite SRHR campaigns. As a result, women have been using misoprostol to self-induce abortion. The medication is widely available for gastric ulcers. After women n in Brazil started using it, the practise spread to many other countries and regions. Countries such as Brazil and Egypt have tried to restrict use of the medication to little avail.

Since women in Latin America began to use misoprostol for abortion in the 1980s its use has expanded around the world. WHO recommends the combination of: mifepristone, which is more expensive, and used only to terminate a pregnancy, as it interferes with hormonal processes with misoprostol, which causes the cervix to dilate

and the uterus to contract, is cheaper, used for other reasons, such as to treat ulcers, and thus more readily available.

Medication abortion, even with Misoprostol alone, is much safer than even the previously used (and no longer recommended) invasive surgical technique of D&C (dilation and curettage).

In 2018 the WHO began to promote the concept of Self Care as a means to expand access to health care, while acknowledging that the world is faced with a critical shortage of health care providers. WHO describes self- care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider. The scope of self-care as described in this definition includes health promotion; disease prevention and control; self-medication; providing care to dependent persons; seeking hospital/specialist/primary care if necessary; and rehabilitation, including palliative care".

One of the recommendations of the WHO Consolidated Guideline for Health: Sexual and Reproductive Health is REC 17: Managing the mifepristone and misoprostol medication without direct supervision of a health-care provider is recommended in specific circumstances. We recommend this option in circumstances where women have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.[67]

Despite the fact that self-care and telemedicine have become more important in COVID-19 lock down conditions, many laws require the involvement of medical practitioners in abortions, or that abortions be administered from a health care facility. As such, self-managed medication abortions are often illegal even where abortions are otherwise legal. However, self-managed medication abortions address many of the reasons that women turn to the informal sector for abortion where abortion is legal that include fear of mistreatment by staff, long waiting lists, high costs, inability to fulfil regulations, privacy concerns, and lack of awareness about the legality of abortion or where to procure a safe and legal abortion. Further, where abortion is legal under certain conditions, the process of proving such conditions is often so long drawn out as to deny the abortion within the accepted time frame.

Access to medication abortion reduces morbidity and mortality

Expanded access to medication abortion is playing a crucial role in providing access to safe, effective, and acceptable abortion care in many regions of the world, contributing significantly to the sharp decline in abortion related morbidity and mortality. There is need in SADC for expanding access to accurate information, support and access to misoprostol.

In Latin America it took many years for accurate information on the correct and safe use of Misoprostol to become widely and easily available. The MAMA network (Mobilising Activists around Medical Abortion) "understands that abortion pills create a universal opportunity for safe abortion regardless of how abortion is regulated by national laws. By providing women with accurate information about abortion with pills, activists challenge restrictive laws' legitimacy, contribute to dismantle abortion stigma and shame, foster women's empowerment and respect women's autonomy".[68]

[67] World Health Organization 2019. WHO Consolidated Guideline on Self Care interventions for Health: Sexual and Reproductive Health and Rights. Geneva. WHO. https://www.who.int/publications/i/item/WHO-RHR-19.14, accessed June 15, 2021
[68] Mama Network. https://mamanetwork.org/, accessed 18 June, 2021

MAMA network provides information materials for community distribution of protocols for medical abortion using Mifepristone and Misoprostol during the first 10 weeks of pregnancy which are readily available on their website. MAMA also offers helplines in local languages in several African countries, including DRC, Malawi, Tanzania and Zambia.

FIGO (the International Federation of Gynecology and Obstetrics) issued a statement on 18 March, 2021 endorsing the use of telemedicine for safe abortions which said in part, "FIGO considers reproductive autonomy, including access to safe abortion services, to be a basic and non-negotiable human right. Abortion is a time sensitive, essential medical service - one that should be provided in accordance with women and girls' preferences, and with safety, privacy and dignity at the forefront. FIGO demands that all governments remove the barriers that impede access to safe abortion services and ensure universal access to safe abortion for all girls and women - both during COVID-19 and afterwards. Telemedicine abortion programmes implemented during the pandemic have demonstrated that such services can provide efficacy, safety, efficiency and acceptability without an ultrasound scan." The statement quoted evidence from the UK and Australia to substantiate FIGO's claims that telemedicine has been proven to be safe and effective.[69]

Guttmacher compiled data from various surveys to estimate the source of support for abortion in eight Sub-Saharan countries including Malawi, Zimbabwe and Tanzania. Their estimations show that in 6 of these 8 countries the majority of abortions were supported by a non-clinician (being pharmacists, traditional providers and women themselves and Clinicians are nurses, midwives and doctors) the percentages attended by a non-clinician in the 3 countries are 74, 63 and 51 respectively.[70]



A qualitative study in **Zambia** interviewed pharmacy workers regarding how they made decisions regarding sale of Medication Abortion pills. The study found that many clients did not have prescriptions and the pharmacy workers became gate keepers of who could access medication abortion. They had to manage many risks which they did by, for instance, asking that the partner be involved in the decision, keeping in contact with the client while they were taking the pills to check on any complications and so on. The study found that pharmacies were playing an important, if sometimes conflicted role, in preventing unsafe abortions in an environment in which regulations are not clear and the overall system is failing women.[71]

Post-abortion care

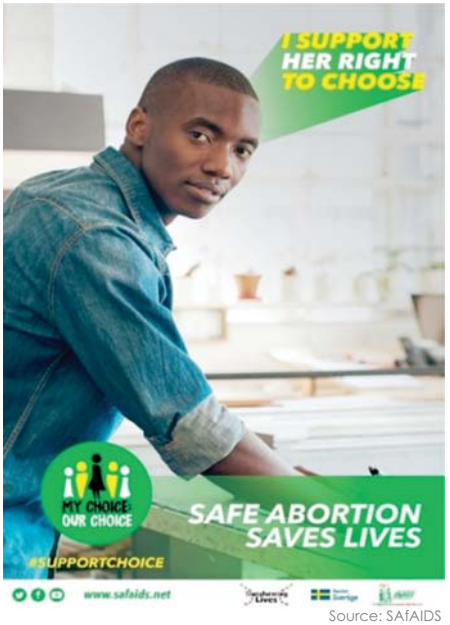
As abortion is still highly restricted and stigmatised, and access to contraception is inadequate, it is to be expected that clandestine and often unsafe abortions will continue. As such there is an ongoing need for post-abortion care. As shown in table 4.6 earlier, a number of member states have policies and guidelines on the provision of post abortion care.

[69] Figo. FIGO endorses the permanent adoption of telemedicine abortion services https://www.figo.org/FIGO-endorses-telemedicine-abortion-services, accessed 18 June, 2021
[70] Bankole, A. et al 2020. From Unsafe to Safe Abortion in Sub Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute https://www.guttmacher.org/sites/default/files/report_pdf/from-unsafe-to-safe-abortion-in-subsaharan-africa.pdf
[71] Footman, K. et al. (2021) 'Treading the Thin Line: Pharmacy Workers' Perspectives on Medication Abortion Provision in Lusaka, Zambia', Studies in Family Planning, p. sifp.12151. doi: 10.1111/sifp.12151.

Table 4.9: Policies and guidelines on post-abortion care

Country	Policies and 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.
Namibia	The Namibia standard treatment guidelines (2011)
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.



Source: SAfAIDS

The high costs to nations and individuals of unsafe abortion have been documented in several studies. It is estimated that $228 million is spent in Sub-Saharan Africa every year on the provision of post abortion care. Most studies show that the financial costs to the health sector of post abortion care are at least double those of safe abortions, and these do not take into account the high emotional toll and ancillary financial costs to the women.

With adequate training of nurses and midwives, who are more accessible to women living in rural areas, can provide quality post abortion care. Limited available evidence suggests that there are high rates of unsafe abortion in adolescents and young women, who are less likely to seek post abortion care. There is need for active programmes to reach out to these young women with young friendly post abortion services. It is important to integrate counselling and contraceptive services into post abortion care, so that women leave the site of care with an effective means to prevent further unintended pregnancy.

A study which quantified the health burden experienced by women presenting with abortion-related complications in 11 sub-Saharan African countries (including DRC, Malawi and Mozambique) across 13 657 women and 210 health facilities found :[72]

[72] Qureshi, Z. et al. (2021) 'Understanding abortion-related complications in health facilities: results from WHO multicountry survey on abortion (MCS-A) across 11 sub-Saharan African countries', BMJ Global Health, 6(1), p. e003702. doi: 10.1136/bmjgh-2020-003702.

- 2.3% severe maternal outcomes and 7.0% potentially life-threatening complications, indicating that unsafe abortion is still a major public health challenge.
- 58% moderate and 32% mild complications which may be indicative of changes in abortion practices as a result of wider access to medication abortion.
- Severe abortion-related complications were associated with being single, having a prior pregnancy and late gestational age (≥13 weeks), which led to a twofold increase in odds among severe maternal outcomes. Severe abortion-related complications were also associated with expulsion of products of conception (POC) before arrival at the facility. It is suggested that this may be a result of inaccurate information regarding dosage, when to seek post abortion care, side effects and symptoms of possible complications. Women might also not be aware of the services available, may fear stigma and mistreatment and use methods which are unsafe.
- The findings highlight the need for more training and resources to provide the best post abortion care.
- Approximately half of the abortion-related complications were treated with both uterotonics and uterine evacuation. This may be a result of over medicalization as it is not consistent with recommendations.
- The management of abortion-related complications using MVA (manual vacuum aspiration), which is safe, low cost and recommended is increasing across countries in the study, but the use of D&C which is more invasive and not recommended persists.
- Oxytocin was used more frequently for uterotonics than misoprostol, which is recommended to manage abortion-related complications.
- 3091 of the women were recruited and participated in an exit interview. Half reported that they had experienced an induced abortion with 54,3% using misoprostol, 40,5% other medicines either orally or vaginally, 18,7% using dangerous methods such as herbs, antimalarial drugs, bleach, petrol and detergents and 14.3% reported using traditional abdominal massage. This supports other findings that medication abortion is becoming more common and may be resulting in lower levels of severe complications. 10% of the women accessed information from social media or the internet. Though this is a small percentage it suggests that telemedicine may be more widely used in the future.



Tanzania: A study in Arusha found that only about 50% of women who procured abortions received any care in the formal health system, suggesting that methods of estimation of abortion rates that are based in hospital post abortion care may be substantially lower than the reality. Most women relied on traditional herbs for the abortion[73].

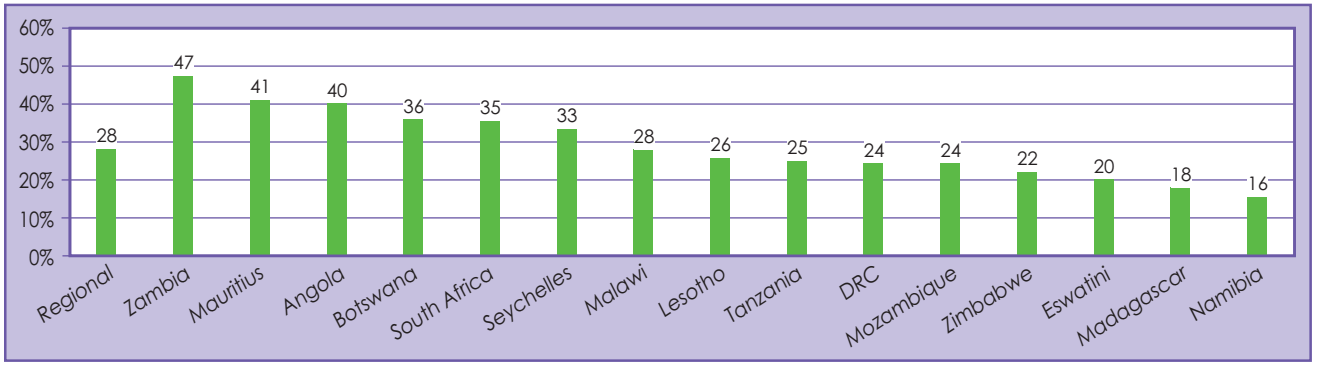
Changing attitudes

SADC Gender Protocol Alliance partners regularly conduct attitude surveys to gauge, and measure changes in, public opinion on relevant issues. Some questions help guide advocacy efforts. For example, the findings on the statement, "A woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy" suggest that there is need for continued discussion and debate on this issue to raise awareness about women's sexual and reproductive rights.

There is need to raise awareness about women's sexual and reproductive rights

[73] Estimating the lifetime incidence of induced abortion and understanding abortion practices in a Northeastern Tanzania community through a household survey - ScienceDirect (no date). Available at: https://www.sciencedirect.com/science/article/abs/pii/S0010782420303838?dgcid=raven_sd_via_email, accessed: 20 June 2021.

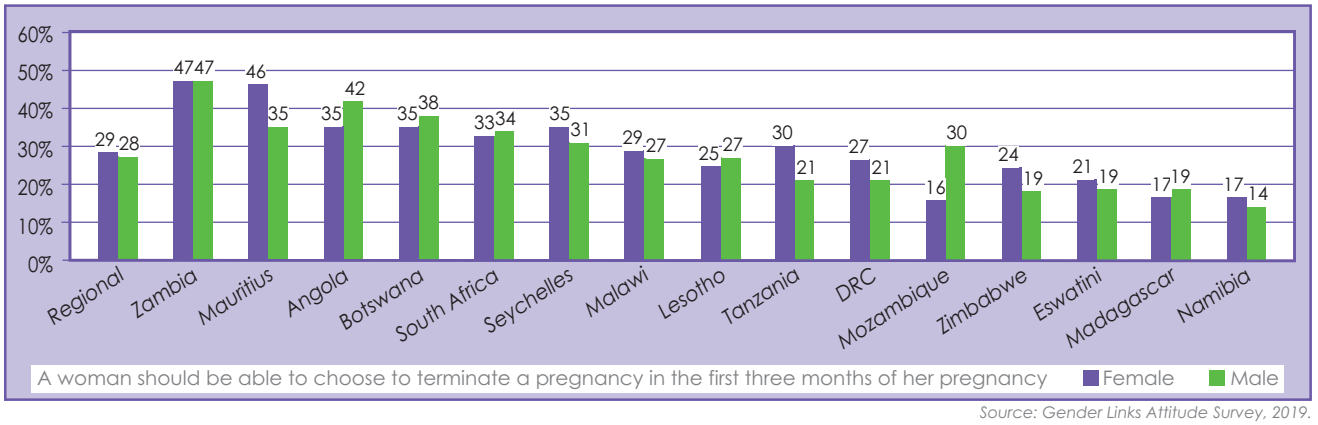
Figure 4.2: A woman should be able to choose to terminate a pregnancy, 2021



Source: Gender Links Attitudes survey, 2021.

Figure 4.2 shows that those who agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months across SADC is only 28% which is a slight shift from the last survey in 2019 of 26%. No country in the survey had 50% or more agreeing. This is a strong indication of the high levels of stigma that still exist in relation to abortion.

Figure 4.3: Attitudes on abortion by sex



Source: Gender Links Attitude Survey, 2019.

Figure 4.3 shows the differences in attitudes between men and women in 2021 in relation to the question. The regional average is very similar between women (29%) and men (28%). Across countries, women are generally more likely to agree with the statement than men, except in Angola, Botswana, Mozambique and Madagascar. Generally, the results show that concerted advocacy is required to change the attitudes of both women and men towards abortion in the region.

Concerted advocacy is required to change the attitudes of both women and men towards abortion in the region

Next steps

For SADC to significantly reduce maternal mortality it is essential that all member states urgently address the issue of dangerous and unsafe abortion. This includes the factors that fuel rising unintended pregnancies, including violence against adolescents and women; access to SRHR information and contraception in a non-stigmatising environment. It also means addressing the very emotive issue of safe abortion in a calm and dispassionate way.

Key recommendations and next steps include:

- SAfAIDS/Alliance expert reference group meeting on the best legal strategies for making abortion safe - to decriminalise, legalise, or both.
- During the continuing COVID-19 pandemic, governments must define access to comprehensive SRH services as an essential service for all, irrespective of age, socio-economic status, or any other factor.
- There is an urgent need for open acknowledgement of the manner in which abortion legislation deprives women of self-determination of their own reproductive selves and debate on urgent reforms to either totally remove abortion from the statute books or relax all restrictions.



Pro-abortion march outside parliament in Namibia. Photo: Gender Links

- SADC governments must pay attention to the high levels of unsafe abortion and implement urgent measures to reduce the need for abortion, particularly amongst younger women, including through:
  - Finding innovative ways to ensure that comprehensive sexuality education is always available for both boys and girls, including during COVID-19.
  - Expanding access to modern contraception for all, especially women in groups that governments often overlook, such as sex workers, those in remote communities, the disabled, and poorest.
- Community leaders and health care professionals need to pay attention to the high levels of stigma that prevent young and other marginalised women from accessing SRH services. There should be open dialogue between service providers and users of services.
- To save lives, all SADC member states should provide post-abortion care to all women with abortion complications and train staff in the safest and most up to date approaches as well as provide the necessary equipment and drugs.
- Activists and political leaders need to work together to share information about the conditions under which abortion can be accessed and ensure that both those that need abortions and those that provide abortions are aware of these circumstances.
- There is an urgent need for much better data to inform decision-making on the issue of abortion. Data needs to include: access (or lack of 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; and rate of unsafe abortions.
- Activists and governments should expand access to medication abortion which is much safer and less invasive than traditional methods.

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http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
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HIV and AIDS 5



Screening for HIV and AIDS in Madagascar. Photo: Zoto Razanadratefa

KEY POINTS

- SADC accounts for 46% of all people and 58% of the adolescents living with the Human Immunodeficiency Virus (HIV) in the world.
- The world missed the 2020 "90-90-90" targets set by UNAIDS (90% know their status; 90% on treatment and 90% virally suppressed) but made considerable progress.
- None of the prevention targets were met: 1.5 million new infections occurred globally in 2020 compared to the target of 500,000. SADC registered 587,000 new infections, compared to a target of 192,000.
- Of the eight countries in the world which achieved the 90-90-90 targets four are in Africa (Eswatini, Botswana, Malawi in SADC) and one (Uganda) in East Africa. A further 11 countries globally reached the overall 73% viral suppression target, including Zimbabwe, Lesotho, Namibia and Zambia in SADC; Kenya and Burundi in East Africa, but did not achieve one of the three 90s.
- The United Nations High Level Meeting in June 2021 adopted a new Global Strategy to address inequalities and end AIDS by 2030. This strategy has even more ambitious and urgent targets than the previous one.
- Eswatini has already achieved the 2025 target of 95- 95- 95.
- With the largest HIV burden in the world (7.8 million people living with HIV or 21% of the world total), South Africa's achievement of 92-72-66 is noteworthy.[1]
- The COVID-19 pandemic is disrupting HIV services. Much adaptation relies on community care givers.
- There is evidence that people living with HIV are at higher risk of serious illness and death as a result of COVID-19 than the general population.

[1] HIV & AIDS statistics South Africa, https://www.unaids.org/en/regionscountries/countries/southafrica, accessed 10 August 2021.

Introduction

Despite the raging COVID-19 epidemic, UNAIDS and partners convened hundreds of consultations around the globe to develop a new and more urgent Global AIDS Strategy 2021 - 26 End Inequalities, End AIDS. The strategy is still guided by the vision to end AIDS as a public health threat by 2030, founded on three zeros - Zero Discrimination, Zero new HIV infection and Zero AIDS related deaths. By the close of the previous strategy 84% of people living with HIV knew their HIV status, 73% were accessing treatment, 66% were virally suppressed. This meant that globally the world had missed the 90-90-90 targets set for 2020 in 2015 but showed that progress can be made with sufficient political will.



The new strategy builds on three interlinked strategic priorities:

- Strategic Priority 1: maximize equitable and equal access to HIV services and solutions;
- Strategic Priority 2: break down barriers to achieving HIV outcomes;
- Strategic Priority 3: fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

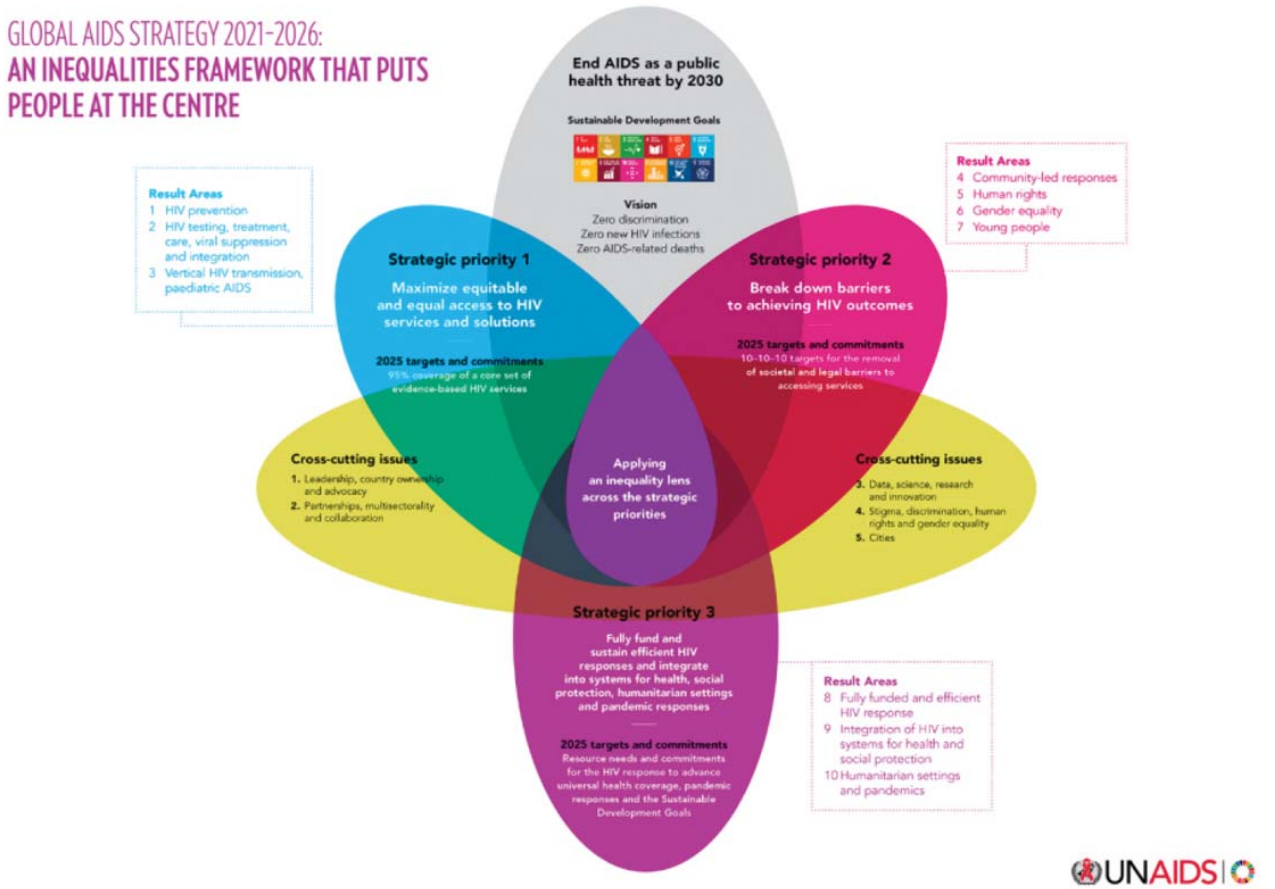
The ten result areas of the five-year plan are:

1. Primary HIV prevention for key populations, adolescents and other priority populations, including adolescents and young women and men in locations with high HIV incidence.
2. Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being.
3. Tailored, integrated and differentiated vertical transmission and paediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence.
4. Fully recognized, empowered, resourced and integrated community led HIV responses for a transformative and sustainable HIV response.
5. People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination.
6. Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV.
7. Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS.
8. Fully funded and efficient HIV response implemented to achieve the 2025 targets.
9. Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.
10. Fully prepared and resilient HIV response that protects people living with, at risk of, and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks.

The cross-cutting issues include:

1. Leadership, country ownership and advocacy: leaders at all levels must renew political commitment to, ensure sustained engagement with, and catalyse action from key and diverse stakeholders.
2. Partnerships, multi-sectoral collaboration: Partners at all levels must align strategic processes and enhance strategic collaboration to fully leverage and synergize the contributions to ending AIDS.
3. Data, science, research and innovation: data, science, research, and innovation are critically important across all areas of the Strategy to inform, guide and reduce HIV related inequalities and accelerate the development and use of HIV services and programmes.
4. Stigma, discrimination, human rights and gender equality: human rights and gender inequality barriers that slow progress in the HIV response and leave key populations and priority populations behind must be addressed and overcome in all areas of the Strategy.
5. Cities, urbanisation and human settlements: cities and human settlements as centres for economic growth, education, innovation, positive social change and sustainable development to close programmatic gaps in the HIV response.

Source: UNAIDS 2021.[2]



[2] UNAIDS Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS, https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy, accessed 10 August 2021.

Table 5.1: Key HIV data 2020

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV and AIDS Prevalence																
Overall prevalence adults aged 15 - 49 (%)	1.8	19.9	<0.1	0.7	26.8	21.1	0.3	8.1	1.7	11.5	11.6		19.1	4.7	11.1	11.9
Women who are HIV positive as a % of total	56	59	50	61	60	61	45	61	30	57	62		62	59	57	55
Women aged 15 to 49 HIV prevalence rate	2.3	24.8	<0.1	1.1	35.0	26.1	0.3	10.3	1.0	14.4	14.7		24.7	6.0	14.1	14.7
Men aged 15 to 49 HIV prevalence rate	1.3	15.2	<0.1	0.4	18.2	16.0	0.3	5.7	2.3	8.6	8.3		13.5	3.3	8.0	9.1
HIV prevalence among young women (15-24)	1.0	8.8	<0.1	0.4	12.2	9.0	<0.1	3.7	0.3	3	5.1		10.4	2.2	6.0	5.9
HIV prevalence among young men (15-24)	0.4	4.2	<0.1	0.2	4.7	3.9	<0.1	1.9	0.4	2.4	2.6		3.5	1.1	2.3	2.9
Sex workers																
HIV prevalence (%)	8	42.2	0.8	7.5	60.8	71.9	5.5	49.9	15		29.9	4.6	57.7	15.4	48.8	42.2
Condom use (%)	71.7	75.7	35.8	73.9	5.9	27	62.8	65	67,2		42.3	16	86.1	72.4	78.5	43.4
Men who have sex with men																
HIV prevalence (%)	2	14,8	0.4	7.1	27.2	32.9	14.9	12.9	17.2		7.8	13.2	18.1	8.4		21.1
Condom use (%)	59.1	77.5	56.2	50.6	79.6	46.4	57.2	79.4	53.1		54,8		71.8			69.2
Prevention																
Proportion of people age 15+ who know their HIV status																
Percent of people living with HIV who know their HIV status	54	91	88	75	>95	94	16	91		81	90		92	84	86	93
Condom use at last high risk sex																
Condom use at last high risk sex - women	32.1		28.4	22.6	53.9	76.0	5.0	49.9		42.0	65.5		61.4	30.3	34.5	66.7
Condom use at last high risk sex - men	63.3		59.7	30.7	67.3	76.6	13.1	76.3		46.5	79.7		73.1	46.5	53.5	85.4
Elimination of mother-to-child transmission																
Coverage of pregnant women who receive ARV for PMTCT (%)	68	>95		39	95	>95	17	>95	>95	>95	>95		>95	84	80	87
Mother to child transmission rate	18.6	1.9		27.8	3.7	6	39	6.3	13	13.5	3,8		3.9	11.1	13.4	8.7
Knowledge																
Comprehensive knowledge of HIV and AIDS	32.4	47.2	20.4	20.4	49.5	35.5	24.1	41.9	31.8	30.6	58.3		45.8	43.1	41.7	46.4
Knowledge about HIV prevention among young women aged 15-24	32.5	47.4	19.1	18.6	49.1	37.6	22.9	41.1	4.4	30.8	61.6		46.1	40.1	42.6	46.3
Knowledge about HIV prevention among young men aged 15-24	31.6	47.1	23.9	24.9	50.9	30.9	25.5	44.3	30	30.2	51.1		45.6	46.7	40.6	46.6
Attitudes																
% of women who say a woman has the right to insist on a man using a condom	36	47		46	60	63	50	59	54	17	23	68	50	49	63	67
% of men who say a woman has the right to insist on a man using a condom.	47	43		41	53	67	49	62	46	30	17	62	47	50	55	71
Treatment - Antiretroviral therapy (ART)																
% of those living with HIV who are on ART	33	87	62	75	>95	82	14	86	21	68	88		72	82	81	93
Women aged 15 and over receiving ART	39	95	63	74	>95	87	16	89	21	73	92		78	90	84	>95
Men aged 15 and over receiving ART	27	77	60	>95	94	74	12	83	21	62	82		63	74	80	92
Children aged 0 to 14 receiving ART	15	62	na	31	>95	83	7	73	48	64	75		47	54	58	72

Source: Gender Links computations and UNAIDS data, 2021.

Table 5.1 below shows that:

- In SADC, HIV and AIDS prevalence rates are beginning to fall slowly. There are now only two countries with HIV and AIDS prevalence above 20% (Eswatini and Lesotho), two with prevalence between 19% and 20% (Botswana and South Africa), four with prevalence between 11% and 12% (Mozambique, Namibia, Zambia and Zimbabwe).
- 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 (Comoros, Madagascar, Mauritius and Seychelles) where transmission is mainly within key populations. Very small populations in Comoros and Seychelles mean that data for these two countries is sparse.
- Coverage of adults and children receiving Antiretroviral Therapy (ART) has improved dramatically, but ranges from 14% in Madagascar to over 95% in Eswatini, 93% in Zimbabwe and over 80% in Botswana, Lesotho, Malawi, Namibia, Tanzania and Zambia.
- Women are generally much more likely than men to be on ART. One major exception is DRC where men are more likely to be on ART. In Mauritius the proportion is the same.
- Coverage of ART for Prevention of Mother to Child Transmission (PMTCT) is generally high but still low in post conflict countries such as Angola and the Democratic Republic of the Congo (DRC), and is not a priority in the islands, since this is not a primary means of transmission. Despite this, transmission rates from mother to child remain unacceptably high: 13.5% and 13.4% in Mozambique and Zambia, pointing to the need for more vigorous efforts to re-test mothers throughout pregnancy and breast-feeding.
- Responses among women to the question: "a woman has the right to insist on a man using a condom" varies from 17% in Mozambique to 68% in Seychelles. Amongst men this ranged from 17% in Namibia to 71% in Zimbabwe.



Male and female condoms. Photo Zoto Razanadratefa

Many gains have been made in the fight against HIV over more than three decades, and especially in this century. The chapter expands on these gains. However, most of these are critically threatened as a result of the COVID-19 crisis, which has impacted on communities across the globe in multiple devastating ways.

Experts from HIV epidemiology, research, vaccine development, and community mobilisation have emerged at the forefront of the fight against COVID-19 across the world. Established funding mechanisms such as the Global Fund were swiftly "pivoted" into also addressing COVID-19 needs. Expertise, analytical capacity, laboratories and testing, surveillance and monitoring systems developed through HIV funding are now underpinning COVID-19 responses. Activists and community organisations that have long been active in the HIV arena are leading efforts to support community prevention and management of COVID-19.

The Chapter starts with an analysis of COVID-19, HIV and AIDS. It touches on the vaccine roll out and the potential impact on HIV and AIDS. The impact is expanded on in each of the main sections - prevalence; prevention; treatment; care and the recommendations at the end.

COVID-19, HIV and AIDS

Inequalities highlighted in the new Global AIDS Strategy 2021-2026[3] are glaring in the COVID-19 response. Many HIV services experienced disruption during COVID-19 lockdowns when citizens struggled to access health facilities; were afraid to access health facilities, or when health workers were overwhelmed with COVID-19 cases. Testing services and new initiations on ART dropped in 2020 across most of SADC[4]. Prevention services, such as Voluntary Medical Male Circumcision (VMMC), suffered.

Overall HIV referrals were 37% lower in 2020 than in 2019 and HIV testing dropped by 41%[5]. In Africa, referrals dropped 29% and drug-sensitive TB diagnosis and screening services by 28%[6]. In community sites across the reporting countries in Africa, drug-sensitive TB diagnosis and screening services fell 58% between April and September 2020 relative to the same time period in 2019.[7]

Some HIV services, especially treatment, adapted quickly and continued provision during and after the COVID lockdowns. Adaptations included multi-month dispensing of antiretroviral therapy (ARV) and other essential medicines, often in collaboration with community based groups. Namibia achieved four to six month's supply of ARVs to 97% of the 172 000 people on treatment[8] supplemented by home delivery of different forms. In the second half of 2020, at least 80% of those receiving treatment from more than 1000 health facilities supported by PEPFAR across 11 countries in Africa received ARVs in time. Men and women showed similar uptake[9].

A study by the Global Fund which surveyed 15 health facilities in 24 countries in Africa (including DRC, Eswatini, Madagascar, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe in SADC) and seven in Asia in mid-2020 found decreased attendance in all sites; reduced general health education campaigns, reduction of antenatal visits (by 5% in Africa compared to 66% in Asia)[10].

Fifty percent of health facilities in African countries reported health staff ill with COVID-19 across all levels of health workers (including community health workers)[11]. This underscores the crucial importance of training and provision of adequate protective materials for all health workers. Only 38% of health facilities in Africa had sufficient Personal Protective Equipment (masks, disinfectants, gloves, and hand sanitizers) for all workers. Of these facilities, only 61% had surgical masks for all workers. 67% of health facilities in Africa reported up to 10% absenteeism between April and September, 2020. The majority of health workers are women.

Fragile health systems are poorly equipped to support the COVID-19 response. Only 11% of African facilities were able to conduct antigen rapid COVID-19 tests and only 8% could conduct the PCR tests. Health facilities are not well equipped to support roll out of COVID -19 vaccines: 23% of African health facilities did not have the requisite needles and syringes for vaccination.[12]

A recent World Health Organisation (WHO) report found that the risk of developing severe or fatal COVID-19 is 30% greater in PLHIV compared to people without HIV. HIV infection was associated with increased mortality, in Africa, but not in Western Europe or the Americas (sample sizes in

[3] UNAIDS Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS, https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy, accessed 10 August 2021.
[4] Global HIV Prevention Coalition. 2021. Preventing HIV infections at the time of a new pandemic. A synthesis report on programme disruptions and adaptations during the COVID-19 pandemic in 2020, https://www.unaids.org/en/resources/documents/2021/20210701_HIVPrevention_new_pandemic, accessed 08 August 2021.
[5] Global Fund; 2021. The impact of COVID-19 on HIV, TB and malaria services and systems for health: a snapshot from 502 health facilities across Africa and Asia https://www.theglobalfund.org/media/10776/covid-19_2020-disruption-impact_report_en.pdf accessed July 20, 2021.
[6] Ibid
[7] Ibid
[8] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.
[9] Harris TG, et al. Resilience of HIV activities during COVID-19 pandemic at health facilities in Africa. Conference on Retroviruses and Opportunistic Infections, 6-10 March 2021. Abstract 186
[10] Global Fund. Op Cit.
[11] Ibid
[12] Ibid.

other regions were too small to draw conclusions). The presence of underlying conditions increased the risk of mortality. Factors which increased the risk of in-hospital death among PLHIV were: being more than 65 years old, male, diabetes and hypertension.[13]

The World Health Organization (WHO) recommends that PLHIV should stay as healthy as possible, regularly access and take their ART and prevent and manage any other conditions such as diabetes and hypertension. The WHO also recommends that PLHIV should be prioritised for vaccination in most settings. By July 2021, 40 countries reported to have prioritised PLHIV for COVID-19 vaccination.[14]



Sharing the word across South Africa

In 1992, Prudence Mabele decided to break the silence on HIV and encourage everyone she came in contact with to know and understand HIV. She founded the Positive Women's Network in 1996. Mbele identified a general lack of knowledge around HIV and AIDS in people she interacted with. She insisted that with a healthy life PLHIV could still live long and healthy lives, that it is not the end of life.

Using this work as inspiration, the Siyakhula team has made it their mission to inform and change their community's perceptions on HIV and AIDS. The team is determined to educate their community on the importance of medicating on time and regularly, and switching to a positive attitude.

The team works to reduce the number of people dying due to factors such as feeling too embarrassed to go and seek help or medication. To tackle stigma, the team conducts door to door visits with community members to make sure they know they are supported and never alone. Door to door visits allow team members to provide medication on time, counselling, companionship, awareness of HIV as well as to share food that is donated periodically from different well-wishers.



Positive thinking: South African AIDS activist Prudence Mabele.
Photo courtesy of UNAIDS

The COVID-19 pandemic has taken its toll on the initiative. The need for protective clothing, sanitisers as well as social distancing have made the door to door initiative more difficult to carry out. Some members of the community believe that the COVID-19 vaccine will make them more sick, creating a new barrier to administering medication. In addition to HIV awareness, the team has now taken on the role of creating awareness on COVID-19 to aid their programme. The team continues to empower their community members in spite of the perceptions.

Source: Mkhize, Truth. Siyakhula Community Project. Alliance SRHR Most Significant Results. Voice and Choice Campaign, 2021

[13] WHO 2021. Clinical features and prognostic factors of COVID-19 in people living with HIV hospitalized with suspected or confirmed SARS-CoV-2 infection. https://apps.who.int/iris/bitstream/handle/10665/342697/WHO-2019-nCoV-Clinical-HIV-2021.1-eng.pdf, accessed July 24, 2021.
[14] WHO warns that HIV infection increases risk of severe and critical COVID-19, https://www.who.int/news/item/15-07-2021-who-warns-that-hiv-infection-increases-risk-of-severe-and-critical-covid-19, accessed July 24, 2021

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.

Many national HIV plans and strategies need to be updated

Table 5.2 below shows that all the SADC countries have an HIV and AIDS policy, strategy or plan. With the exception of Mauritius, the HIV and AIDS policies for all countries include other STIs and often also include TB. Though there are some plans that should have been reviewed, and others that require review now, it has not been easy to concentrate on policy in the midst of COVID-19. However, it is anticipated that the new Global Strategy 2021-2026, which was endorsed by a High Level UN meeting in June, will give impetus to policy reviews at country level.

Table 5.2: Most recent HIV and AIDS policy or strategy

Country	Most recent HIV strategy	Year
Zimbabwe	Zimbabwe National HIV and AIDS Strategic Plan IV (2021-2025).	2020
Angola	National strategic plan (NSP) for HIV, viral hepatitis, and other sexually transmitted infections. 2019-2022	2019
Botswana	Third National Strategic Framework for HIV/AIDS 2019 - 2023	2019
Seychelles	Third multi sectoral National Strategic Plan for HIV, AIDS & Viral Hepatitis 2019 - 2023	2019
Eswatini	National Multisector HIV & AIDS Strategic Framework 2018 - 2023	2018
Lesotho	National HIV and AIDS Strategic Plan 2018/19 - 2022/23	2018
South Africa	Let our actions Count: South Africa's National Strategic Plan for HIV, TB and STI's 2017 - 2022	2017
Tanzania	Health Sector HIV & AIDS Strategic Plan 2017 - 2022 (HSHSP IV)	2017
Zambia	National HIV & AIDS Strategic Framework 2017 - 2021	2017
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 - 2021/22	2017
Mauritius	National HIV Action Plan 2017-2021	2017
Mozambique	Plano Estratégico do Nacionale de combate HIV e SIDA 2016 -2020 (PEN IV)	2015
Malawi	National Strategic Plan for HIV and AIDS 2015 - 2020	2015
DRC	Plan Strategique National de lute contre le VIH et le SIDA 2014 - 2017	2014
Madagascar	Madagascar National Strategic Plan for STIs and AIDS (2013-2017)	2014
Comoros	National Strategic Plan 2011 - 2015	2011

Source: GL Audit of SRHR Policies and Laws 2020 .

Table 5.3: SADC HIV and AIDS laws scorecard

Country	Criminalising trans-gender people	Criminalising sex work	Criminalising same sex sexual acts	Drug use/ possession an offence	Parental consent for adolescents HIV test	Criminalising transmission/ non-disclosure of HIV	Restricted entry/stay of PLHIV	Mandatory HIV test for marriage/ work
Angola								
Botswana								
Comoros								
DRC								
Eswatini								
Lesotho								
Madagascar								
Malawi								
Mauritius								
Mozambique								
Namibia								
Seychelles								
South Africa								
Tanzania								
Zambia								
Zimbabwe								

KEY Not criminalised; No data; Criminalised; Parental consent younger than 14/16; Parental consent if younger than 12; No, but prosecutions exist based on general criminal laws; Prohibit short and/or long stay and require HIV testing or disclosure for some permits

Source: 2021 UNAIDS Global AIDS Update.[15]

[15] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Table 5.3 shows that the legal framework in SADC is patchy with regard to protecting the rights of members of key populations such as sex workers and people in same sex relationships. Approximately 32% of new infections in East and Southern Africa are in Key Populations. One of the goals of the new strategy is 10-10-10 for societal enablers. One of these goals is to ensure that less than 10% of countries have restrictive legal and policy environments that lead to the denial or limitation of access to services. Criminalisation of most key populations hinders their access to services and will continue to fuel the HIV epidemic. This issue will require attention in the next five years.



Article 27. 3: State Parties shall:
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:
- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

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.

HIV Prevalence

Table 5.4: Number of people living with HIV (LHIV), different groups

Country	All people LHIV	Women 15+ LHIV	Men 15+ LHIV	Adolescents LHIV	Young People LHIV	PLHIV over 50
South Africa	7 800 000	4 800 000	2 700 000	370 000	660 000	1 400 000
Mozambique	2 100 000	1 200 000	710 000	130 000	270 000	250 000
Tanzania	1 700 000	1 000 000	610 000	110 000	190 000	350 000
Zambia	1 500 000	850 000	520 000	90 000	190 000	250 000
Zimbabwe	1 300 000	720 000	470 000	81 000	120 000	240 000
Malawi	990 000	600 000	330 000	74 000	110 000	210 000
DRC	510 000	310 000	120 000	51 000	69 000	72 000
Botswana	370 000	220 000	150 000	12 000	28 000	92 000
Angola	340 000	190 000	100 000	24 000	44 000	34 000
Lesotho	280 000	170 000	110 000	13 000	26 000	65 000
Namibia	210 000	130 000	71 000	11 000	19 000	49 000
Eswatini	200 000	120 000	72 000	11 000	20 000	34 000
Madagascar	42 000	19 000	21 000	1 000	3 400	3 600
Mauritius	14 000	3 200	9 500	200	1 000	3 300
Comoros	200	100	100	0	100	
Total SADC	17 356 200	10 332 300	5 993 600	978 200	1 750 500	3 052 900
Global	37 700 000			1 700 000	3 300 000	8 100 000
SADC % Global	***46%***			***58%***	***53%***	***38%***

Source: Compiled from UNAIDS 2021 data.[16]

Table 5.4 shows the number of people living with HIV in different age groupings in SADC, compared to global totals. With 17.4 million people living with HIV, SADC accounts for 46% of all those living with HIV globally; 58% of all adolescents (aged 10 to 19) and 53% of young people (aged 15 to 24) living with HIV. With 7.8 million people living with HIV, South Africa has the largest epidemic in the world, accounting for 45% of the total in SADC and 21% of the global total of PLHIV. Mozambique accounts for 12% of the SADC and 6% of the global total of PLHIV. Tanzania accounts for 10% and 5% respectively. SADC accounted for 38% of PLHIV over the age of 50; an increase from 33% in 2020. This suggests that those that are living with HIV in SADC are living longer lives.

SADC, with 4,6% of the world's population, accounts for 46% of the total number of PLHIV, 58% of adolescents, 53% of young people and 38% of people over 50 living with HIV in the world

[16] https://aidsinfo.unaids.org/

Table 5.5: HIV Prevalence in SADC 2021

Country	Prevalence Adults 15 - 49	Prevalence Women 15 - 49	Prevalence Men 15 - 49	Prevalence Young women	Prevalence young men	Ratio Young women: young men
Eswatini	26,8	35	18,2	12,2	4,7	2,6
Lesotho	21,1	26,1	16	9	3,9	2,3
Botswana	19,9	24,8	15,2	8,8	4,2	2,1
South Africa	19,1	24,7	13,5	10,4	3,5	3,0
Zimbabwe	11,9	14,7	9,1	5	3	1,7
Namibia	11,6	14,7	8,3	5,1	2,6	2,0
Mozambique	11,5	14,4	8,6	6	3	2,0
Zambia	11,1	14,1	8	6	2,3	2,6
Malawi	8,1	10,3	5,7	3,7	1,9	1,9
Tanzania	4,7	6	3,3	2,2	1,1	2,0
Angola	1,8	2,3	1,3	1	0,4	2,5
Mauritius	1,7	1	2,3	0,3	0,4	0,8
DRC	0,7	1,1	0,4	0,4	0,2	2,0
Madagascar	0,3	0,3	0,3	0,1	0,1	1,0
Comoros	0,1	0,1	0,1	0,1	0,1	1,0
Seychelles (n/d = no data)	n/d	n/d	n/d	n/d	n/d	n/d

Source: Compiled from UNAIDS 2021 data.[17]

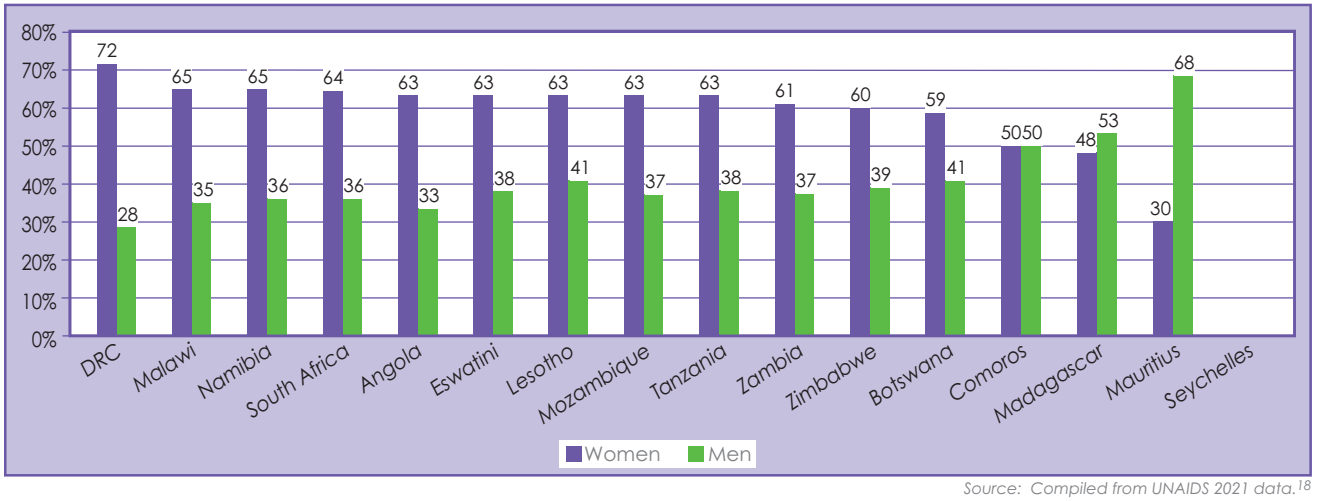
Table 5.5 shows wide variations in the HIV pandemic across SADC. The data shows that:

- Adult prevalence rates range from 0.1% in Seychelles to 26.8% in Eswatini. Prevalence in Botswana is now below 20% while that in South Africa is slightly higher than it was in 2020, due to higher prevalence among men. Eight SADC countries (Zambia, Mozambique, Namibia, Zimbabwe, South Africa, Botswana, Lesotho and Eswatini) have adult prevalence rates above 10%.
- Seychelles, with a population of 96,387 and a very low prevalence, has such small total numbers of people living with HIV that percentages are of little value. This explains the absence of Seychelles data and discussion in this chapter. Comoros and Mauritius have populations of 864,355 and 1.4 million respectively. They thus have more data available.
- The island nations have pandemics that are largely driven by key populations. As a result, prevalence is higher in men than in women. In contrast, HIV and AIDS is a heterosexual pandemic in the rest of SADC.
- The differences in prevalence rates are particularly high for young women as compared to young men. Table 5.5 shows that HIV prevalence is three times higher in young women than young men in South Africa and at least double in Eswatini, Zambia, Angola, Botswana, Lesotho, Namibia, Mozambique, Tanzania and DRC.



[17] https://aidsinfo.unaids.org/ accessed on 30 July, 2021.

Figure 5.1: Proportion of Women and Men Living with HIV in 2020



Source: Compiled from UNAIDS 2021 data.[18]

Figure 5.1 shows the proportion of women and men living with HIV across SADC. There are more women living with HIV in most of SADC with a marked difference in DRC (72% women compared to 28% men), and slightly lower in Malawi, Namibia and South Africa. Slightly more men than women are living with HIV in the island nations. This is particularly marked in Mauritius (68% men and 30% women).

Table 5.6: Progress towards achieving the 90-90-90 goals in SADC

Country	90-90-90 (all)	90-90-90 (children aged 0-14 years)	90-90-90 (women aged 15+ years)	90-90-90 (men aged 15+ years)	Viral suppression level (all)
Eswatini	>98->98-94	>98->98-91	>98->98-95	94->98-94	97
Botswana	91-95->98	62->98-94	94->98->98	88-87-97	85
Malawi	91-94-93	73->98-72	94-94-95	90-92-94	81
Zimbabwe	93->98-88	71->98-72	96->98-90	92->98-88	82
Namibia	89-97-91	80-92-80	92->98-92	86-94-89	80
Lesotho	93-87-97	83->98-91	94-92-97	93-79-97	79
Zambia	85-94-93	57->98-83	88-94-93	84-95-93	75

Source: Gender Links, with data from UNAIDS Special Analysis 2021.[19]

Table 5.6 shows the seven countries in SADC who are acknowledged globally for making significant progress towards the 90-90-90 goals. It is notable that Eswatini (with the highest global HIV prevalence) is also the country with the highest achievement and has already achieved the 2025 targets.



Eswatini's success is ascribed to strong national leadership and commitment, international support and intensive community mobilization and engagement. King Mswati III declared HIV a national emergency in 1999. Since then, traditional leaders and urban mayors have been

[18] Ibid
[19] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

in the forefront of the efforts to curb HIV. Civil society is actively engaged in awareness raising and service provision, including peer support. Nearly 40% of the national HIV budget is from domestic sources with additional support from international donors.[20]

While some countries in SADC have made tremendous progress, this is not even across the region. Many factors contribute to the differences. The example of Zimbabwe and Mozambique is cited for instance. Zimbabwe has been a leader in HIV testing and treatment. Zimbabwe's national AIDS Levy has mobilised significant domestic funding, communities are strongly engaged, and the country has received consistent international financial and technical support. This has enabled achievements that are consistent with the 90-90-90 targets. Achievements in neighbouring Mozambique, with a history of weak service provision, high levels of poverty, many years of armed conflict, and impacted by climate change related emergencies, are below the regional average.[21]

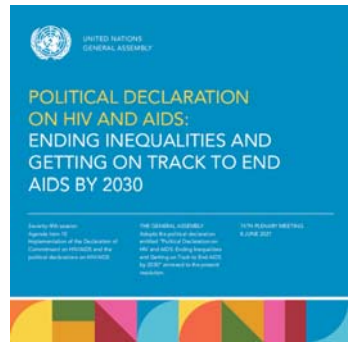


Eswatini is taking the lead in ending AIDS. Photo: Thandokuhle Dlamini

The new global strategy includes commitment to reach the new 95-95-95 testing, treatment and viral suppression targets within all demographics, groups and geographic settings, ensuring that at least 34 million people living with HIV access treatment by 2025.

Elimination of Mother to Child Transmission

Targets for the Elimination of Mother to Child Transmission in the 2021 Political Declaration on AIDS[22] are:

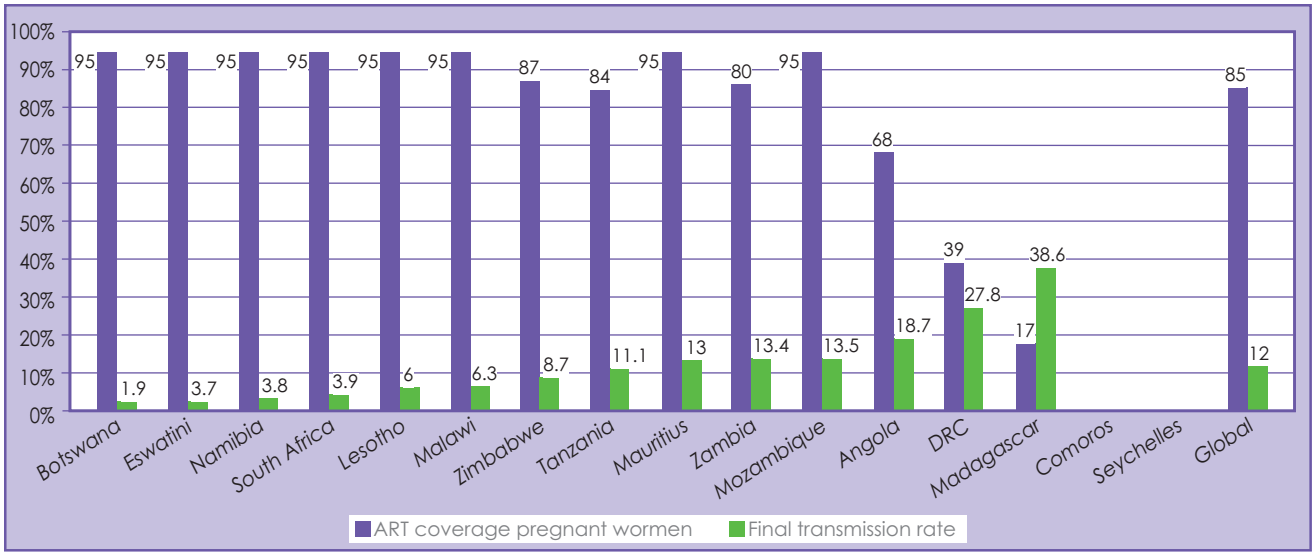


- Ensure that all children diagnosed with HIV are provided treatment that is optimized to their needs.
- Ensure that 75% of all children living with HIV have suppressed viral loads by 2023 and 86% by 2025, in line with the 95-95-95 HIV treatment targets.
- Ensure that 95% of pregnant women have access to testing for HIV, syphilis, hepatitis B and other sexually transmitted infections.
- Ensure that 95% of pregnant and breastfeeding women in high HIV burden settings have access to re-testing during late pregnancy and in the post-partum period.
- Ensure that all pregnant and breastfeeding women living with HIV are receiving life-long antiretroviral therapy, with 95% achieving and sustaining viral suppression before delivery and during breastfeeding.
- Ensure that all HIV-negative pregnant and breastfeeding women in high HIV burden settings or who have male partners at high risk of HIV in all settings have access to combination prevention, including Pre exposure prophylaxis (PrEP), and that 90% of their male partners who are living with HIV are continuously receiving antiretroviral therapy.
- Ensure that 95% of HIV-exposed children are tested by two months of age and after the cessation of breastfeeding.

[20] Ibid
[21] Ibid
[22] United Nations General Assembly, 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, https://undocs.org/A/RES/75/284, accessed 20 July 2021.

The Start Free, Stay Free, AIDS Free programme was launched in 2015 with bold targets to address HIV in children, adolescents and women as a critical component of the fast track programme to end AIDS by 2030. The START FREE component aimed to prevent children from acquiring HIV during pregnancy, birth and throughout breastfeeding. The programme put specific focus on 23 countries of which 21 are in Africa and 12 - Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe - are in SADC. The 21 countries in Africa accounted for 83% of all pregnant women living with HIV in 2020, 80% of children living with HIV and 78% of young women aged 15 - 24 newly infected with HIV. Six countries (Nigeria, 19%, Mozambique 11%, South Africa 11%, Tanzania 9%, DRC 8% and Zambia 7%) accounted for about 65% of children acquiring HIV in 2020.[23]

Figure 5.2: Elimination of Mother to Child Transmission, 2020



Source: Compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Figure 5.2 reflects tremendous progress. Eight countries have achieved at least 95% or better coverage of pregnant mothers living with HIV on ART. However, the figures also illustrate how fragile gains are. Coverage rates in Zimbabwe, Tanzania and Zambia have declined since 2019. Seven countries - Botswana, Eswatini, Namibia, South Africa, Lesotho, Malawi and Zimbabwe - have achieved a final transmission rate of less than 10%. Figure 5.2 also reflects gaps in progress. Though Angola is making progress in improving coverage, DRC and Madagascar are still far behind, with much higher levels of transmission.



In South Africa, failure to achieve viral suppression among pregnant women is mainly a result of late entry into antenatal care and late initiation of antiretroviral therapy. Some pregnant women do not access testing and never begin antiretroviral therapy (ART). Others begin ART but do not remain engaged in care throughout pregnancy and breastfeeding. Many women acquire HIV during pregnancy or breastfeeding experiencing high viral load, with increased potential for vertical transmission. It is important to track and re-engage mothers who drop out of care and to offer retesting for mothers during pregnancy and breastfeeding.[24]

[23] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.
[24] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.

Table 5.7: Pregnant women on ART 2010 - 2019

Country	ART coverage pregnant women	Final trans-mission rate	No. pregnant women receiving ART	Early Infant Diagnosis (EID)	New HIV infections averted due to PMTCT	No. HIV exposed, uninfected children
Botswana	95	1,9	12171	>95	2 500	180 000
Eswatini	95	3,7	8852		1 800	140 000
Namibia	95	3,8	14951		2 100	140 000
South Africa	95	3,9	299033	87	52 000	4 000 000
Lesotho	95	6	7461	71	1 700	120 000
Malawi	95	6,3	41391	79	10 000	540 000
Zimbabwe	87	8,7	51229	76	11 000	800 000
Tanzania	84	11,1	77036	55	18 000	1 000 000
Mauritius	95	13	125	64	<100	1 100
Zambia	80	13,4	50209	65	12 000	700 000
Mozambique	95	13,5	107148	83	20 000	930 000
Angola	68	18,7	19044	2	4 100	260 000
DRC	39	27,8	12456	11	3 100	320 000
Madagascar	17	38,6	259		<100	1 100
Comoros			3			
Seychelles						
Total SADC			701368		138 300	9 132 200
Global	85	12	1100000		220000	15 400 000
SADC as percent of global			64%		63%	59%

Source: Compiled from UNAIDS 2021 data.[25]

Table 5.7 shows the numbers of pregnant women who accessed ART in 2020; the percentage who accessed Early Infant Diagnosis (EID), the number of new infections averted and the number of HIV exposed but uninfected children. A total of 701,368 women in SADC received ART for their own health as well as to prevent the transmission of HIV infection to their children. This is about 64% of the global total. South Africa alone accounts for 43% of the women that accessed ART for PMTCT in SADC and 27% of the global total. SADC accounted for 138,300 averted new infections which is 63% of infections averted globally and SADC has 9, 132, 200 children that have been exposed to HIV but are uninfected. South Africa alone accounts for 26% of the global total of number of children that are HIV exposed and uninfected.

Since 2015, 15 countries have been validated as having eliminated mother-to-child transmission of HIV and/or syphilis. None of these are in Africa where base prevalence rates are very high. UNAIDS has introduced a path to elimination for countries with mother-to-child transmission less than 5%, maternal ART coverage rates higher than 90% and which achieve other specified case rates. Countries with a case rate of acquiring HIV less than 250 per 100 000 live births are categorized as "gold"; "silver" if their rate is less than 500 and "bronze" if their rate is less than 750.

Four SADC countries (Botswana, Eswatini, Namibia and South Africa) had mother-to-child transmission rates in 2020 of less than 5%. Lesotho and Malawi are close to bringing their rates under 5%. Botswana could be granted silver status (with a case rate of 406 per 100 000 births in 2020). Similarly, Namibia could be eligible for bronze status (case rate of 542 per 100,000 births)[26].

[25] https://aidsinfo.unaids.org/
[26] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.

Table 5.8: HIV transition metrics

Country	2000	2019	2020
Zimbabwe	7.12	2.92	1.95
Malawi	9.75	3.1	2.08
Botswana	9.34	2.49	2.37
Eswatini	13.37	2.23	2.42
Namibia	12.84	3.29	2.65
Lesotho	13.33	3.22	2.72
South Africa	16.76	2.63	2.98
Global	11.32	4.37	3.86
DRC	9.01	4.37	3.88
Tanzania	10.2	4.52	3.92
Zambia	9.27	4.08	4.75
Mozambique	17.9	5.92	4.76
Comoros	22.86	4.65	5.07
Angola	19.68	7.56	6.4
Mauritius			7.06
Madagascar	20.78	15.14	14.16

Source: Compiled from UNAIDS 2021 data.[27]

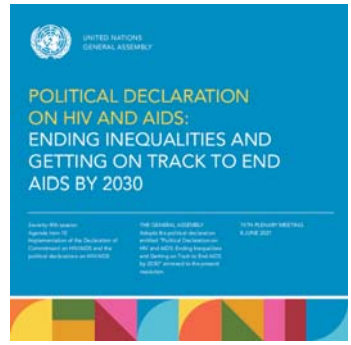
The incidence to prevalence ratio captures two desirable outcomes: long, healthy lives for people living with HIV and a rapid reduction in new infections. The metric assumes an average life expectancy of 30 years after a person acquires HIV infection. The calculations show that the AIDS epidemic (or total number of people living with HIV) will decline when there are fewer than three new HIV infections per 100 people living with HIV per year. This is an incidence to prevalence ratio of 3.

Table 5.8 shows that transition metrics for SADC countries have been improving since 2000. Data for 2020 indicate that Zimbabwe, Malawi, Botswana, Eswatini, Namibia, Lesotho and South Africa have achieved the tipping point of 3 and should all experience a decline of the AIDS epidemic. Zimbabwe now has the lowest incidence to prevalence ratio (1.95). Madagascar (14.16) has the highest. The only country which experienced increase in the metric between 2019 and 2020 is Comoros. Globally the incidence-prevalence ratio declined to 3.86.

Prevention

2025 Targets and Commitments in the 2021 Political Declaration on AIDS

- Reduce new HIV infections to under 370,000.
- Ensure that 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, have access to and use appropriate, prioritized, person centred and effective combination prevention options.
- Tailor HIV combination prevention approaches to meet the diverse needs of key populations, including among sex workers, men who have sex with men (MSM), people who inject drugs (PWID), transgender people, people in prisons and other closed settings and all people living with HIV.
  Reduce the number of new HIV infections among adolescent girls and young women to below 50,000.
- Ensure availability of Pre exposure prophylaxis (PrEP) for people at substantial risk of HIV and post-exposure prophylaxis for people recently exposed to HIV.
- 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people centred and effective combination prevention options[28].



[27] https://aidsinfo.unaids.org/
[28] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

The Prevention Road Map adopted in 2016 sought to achieve commitments towards reducing new HIV infections by 75% to fewer than 500,000 by 2020. These commitments include the following anticipated reductions in SADC:

Table 5.9: Global reduction in infection targets

Country	2016	2020 target
South Africa	260 000	88 000
Mozambique	70 000	30 000
Zambia	50 000	14 000
Tanzania	45 000	14 000
Zimbabwe	37 000	16 000
Malawi	32 000	11 000
Angola	21 000	5000
Lesotho	19 000	5000
DRC	10 000	3000
Namibia	9000	3000
Eswatini	8000	3000
TOTAL		192,000

Source: UNAIDS 2016: 2020 Prevention Road Map.[29]

Table 5.9 shows the targets for SADC countries in 2020. The region aimed to reduce new HIV cases to 192,000. Instead (as demonstrated in Table 5.10) the regional registered 587, 000 new infections.

Table 5.10: New infections and HIV incidence, 2021

Country	New infections						HIV incidence in adults (15-49)
	All	Change 2010-2020	Women (15+)	Men (15+)	Adolescents	Children (0-14)	
South Africa	230 000	-45	140 000	77 000	38 000	12 000	7,8
Mozambique	98 000	-33	55 000	30 000	17 000	13 000	7,2
Zambia	69 000	-6	39 000	21 000	12 000	8 300	6,8
Tanzania	68 000	-35	37 000	21 000	8 700	10 000	2,1
Zimbabwe	25 000	-66	13 000	7 300	3 000	5 100	2,9
Angola	22 000	-26	11 000	5 200	3 100	5 200	1,1
Malawi	21 000	-64	12 000	5 800	3 000	2 500	2,2
DRC	20 000	-50	8 500	2 300	2 100	8 800	0,23
Botswana	8 900	-37	5 400	3 300	1 200	<500	7,51
Lesotho	7 700	-59	4 600	2 700	1 000	<500	9,1
Madagascar	6 000	159	2 500	2 900	500	<1000	0,39
Namibia	5 500	-48	3 400	1 799	1 000	<500	4,3
Eswatini	4 800	-64	2 900	1 500	1 000	<500	10,4
Mauritius	1 000	-24	<500	<1000	100	<100	1,4
Comoros	100	-30	<100	<100	0		0,01
Seychelles							
Total SADC	587 000		334 300	181 799	91 700		
Global	1 500 000	-31			150 000		
SADC as a percentage of global	**39%**				**61%**		

Source: Compiled from UNAIDS 2021 data.[30]

[29] HIV Prevention 2020 Road Map - Accelerating HIV prevention to reduce new infections by 75%, https://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf, accessed 24 July 2020.
[30] https://aidsinfo.unaids.org/

Table 5.10 shows that the number of new infections is continuing to decline slowly, but not at a rate that will achieve the end of AIDS by 2030. The global total of 1,5 million (1 500 000) new infections in 2020 is three times higher than the goal for 2020 and four times greater than the target for 2025. SADC contributed 39% of global new HIV infections overall, with South Africa contributing 15%, Mozambique 7% and Tanzania and Zambia 5% each. Although the absolute number of new infections in Madagascar is comparatively low at 6000, Madagascar is the only country in SADC which is still seeing an increase in new infections. The change in new infections between 2010 and 2020 is 159%. The greatest reductions in new infections in the same period are in Zimbabwe (66%) and Malawi and Eswatini (64%).

SADC is also responsible for a staggering 61% of new HIV infections in adolescents globally which underscores the need for increased efforts in HIV prevention amongst adolescents. South Africa is responsible for 25% of all new infections in adolescents in the world, Mozambique 11%, Zambia 8% and Tanzania 6%. HIV incidence is also beginning to decline, with the highest rates of 10,4 and 9,1 per 1000 population in Eswatini and Lesotho. When the actual infections in 2020 is compared with the targets set in the Prevention Road Map (Table 5.11), it is clear that there is much work still required to end AIDS by 2030. The SADC total of 587,000 is also three times higher than the target of 192,000.

The Global HIV Prevention Coalition (GPC) brings together United Nations Member States (including the 25 highest HIV burden countries or the high priority countries), donors, civil society and implementers to strengthen and sustain political commitment for primary prevention. The coalition focuses on generating commitment, speed, investment and accountability towards large-scale, high coverage and good-quality implementation. Twelve SADC countries: Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe are included in the high priority group, which is receiving more focus and support for prevention activities.

Table 5.11: Prevention Score Card for SADC countries in the GPC *(scores 0 to 10)*

Country	Adolescent girls, young women and male partners	Sex workers	MSM	PWID	Condoms	VMMC	PreP
Angola	3	5			3		0
Botswana	5	5	6		9	3	5
DRC	4			0	3		3
Eswatini	7	4	3	3	7	5	8
Lesotho	8	4	5		8	8	10
Malawi	4	5	3		8	2	4
Mozambique	4	4		2	4	7	3
Namibia	5	6			8	5	8
South Africa	5	6	7	2	8	6	5
Tanzania	3	5	2	4	2	10	4
Zambia	3	5			5	9	6
Zimbabwe	4	6	5		8	6	5

KEY High Medium Low No data

Source: Gender Links compiled from HIV Prevention Score Card 2020.[31]

The scores in Table 5.11 are based on indicators that provide insight into the state of prevention programmes. Countries such as Lesotho are doing very well, while more investment is needed in DRC for instance. Many programmes are in an average range, which provides a foundation for continued investment to reach the ambitious 2025 targets.

[31] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/, accessed 10 August 2021.

Globally, the HIV pandemic is largely driven by new infections in certain key populations - sex workers, people who inject drugs, men who have sex with men, transgender people and prisoners and their partners. The proportion of new infections in key populations in east and southern Africa is increasing. In 2020 it is estimated that 32% of new infections were in: sex workers (8%), people who inject drugs (1%), gay men and other men that have sex with men (4%), transgender women (1%) and clients of sex workers and sexual partners of other key populations (18%).



In **Madagascar** HIV prevalence in the general population is believed to be 0.3% with high prevalence in key populations (Sex Workers, Men who have Sex with Men and Injecting Drug Users). Inconsistent use of condoms, multiple concurrent partners, widespread transactional sex, high sexually transmitted infection incidence and gender inequality fuel the spread of HIV in both key populations and the general population. Even though there are no reports of antenatal HIV prevalence of over 1%, the assessment found that Madagascar may be close to becoming a high-prevalence epidemic. The report recommended collection of more data with expanded HIV testing and case management.[32]

In east and southern Africa the epidemic is still mainly driven by new infections in adolescent girls and young women. The STAY FREE component of Start Free Stay Free AIDS Free, focused on preventing adolescent girls and young women from acquiring HIV as they grow up. The targets for adolescent girls include:

- Reduce the number of adolescent girls and young women newly infected with HIV to less than 100 000 by 2020.
- Provide voluntary medical male circumcision for HIV prevention to 25 million additional men by 2020, with a focus on young men aged 10-29 years.

The decline in new infections in adolescent girls from 280,000 to 200,000 is still double the target. Rates of decline varied across the focus countries, from over 50% in Eswatini to less than 10% in Angola and Zambia.[33] As the target for 2025 is half of that for 2020, there is need for reinvigorated investment into prevention.

Table 5.12: Selected indicators on Young Women and Men

Country	Condom use with non-regular partner Young Women 15 -24	Condom use with non-regular partner Young Men 15 -24	% who had multiple sexual partners sexually active Young Women 15 -24
Angola	33	52	3
Botswana			
DRC	24	31	5
Eswatini	71	93	4
Lesotho	82	79	9
Malawi	53	73	2
Mozambique	51	48	4
Namibia	64	78	5
South Africa	47	68	8
Tanzania	30	34	
Zambia	34	49	3
Zimbabwe	54	81	3

Source: UNAIDS GPC Scorecard HIV Prevention among young women.[34]

[32] Raberahona, M et al (2020). Is Madagascar at the edge of a generalised HIV epidemic? Situational analysis. Sexually Transmitted Infections. 97. sextrans-2019. 10.1136/sextrans-2019-054254. https://www.researchgate.net/publication/341466440_Is_Madagascar_at_the_edge_of_a_generalised_HIV_epidemic_Situational_analysis/link/5ec7f2c092851c11a881409c/download accessed 20 July 2021

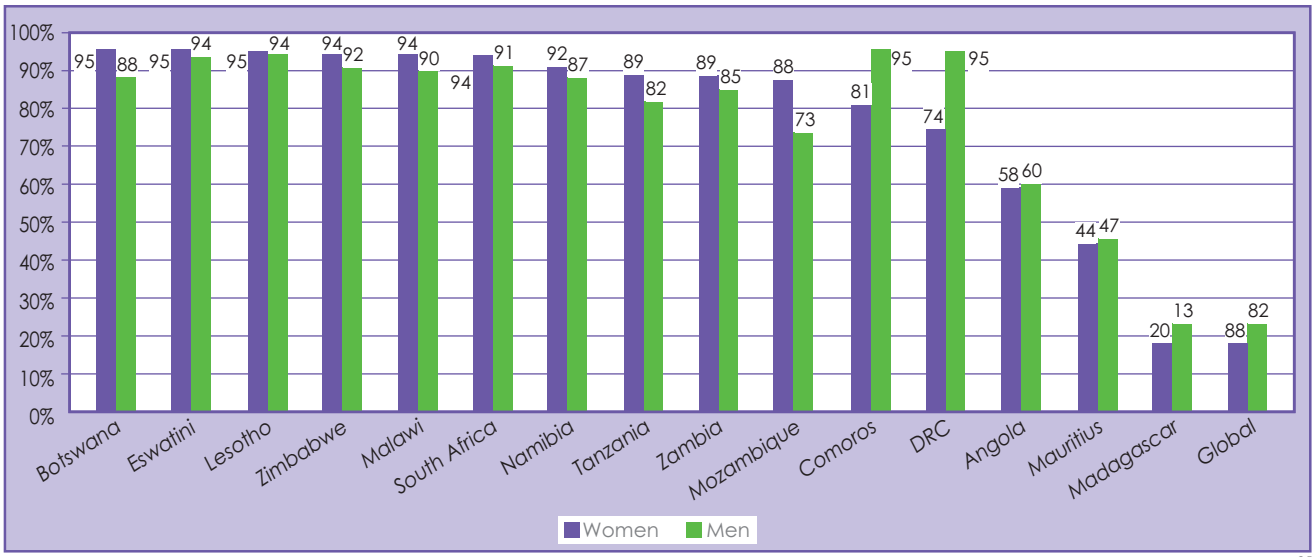
[33] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.

[34] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/, accessed 10 August 2021.

Table 5.12 indicates that across SADC, a relatively low percentage of young women and men report having multiple sexual partners. This is a promising sign. It also shows wide variation in condom use across the region with low use in both women and men in DRC and Tanzania and much higher use in Eswatini and Lesotho.

Knowledge of HIV status

Figure 5.3: Women and Men Living with HIV who know their status



Source: Compiled from UNAIDS 2021 data.[35]

The extent to which women and men know their HIV status is a key indicator and factor in reducing the rate of new infection. Figure 5.3 shows that the proportion of women who know their HIV status is generally high across SADC. Eswatini, Lesotho, Zimbabwe, Malawi and South Africa have achieved over 90% knowledge of HIV status in both women and men, while Botswana and Namibia have over 90% in women and 88% and 87% respectively of men with knowledge of their HIV status. Comoros and DRC have achieved 95% of men and 81% and 74% respectively of women with knowledge of their HIV status. Testing and knowledge of HIV status is an important first step in prevention of HIV and managing HIV infection. The new strategy upholds the Undetectable = Untransmittable (U = U) principle. This means viral suppression through antiretroviral therapy is a powerful component of combination HIV prevention because people living with HIV with undetectable viral loads will not transmit their infection to others.

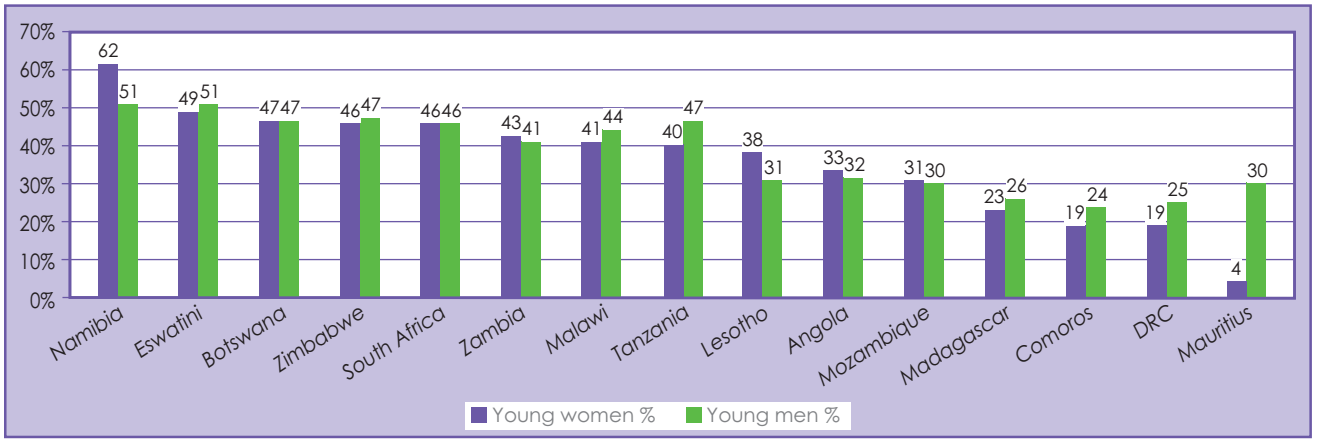
The WHO issued a policy brief in 2021 about improving HIV testing in men. The brief recommends that in high HIV burden settings it is important to test men in both general and key populations while in low burden settings focus should be on men from key populations; men with sexually transmitted infections; men with confirmed or suspected TB; men whose partners have HIV; and men who have HIV-related symptoms or indicator conditions.[36]

[35] https://aidsinfo.unaids.org/
[36] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593 accessed 2 August 2021.

Comprehensive, accurate knowledge of HIV and AIDS

The goal is to ensure that at least 90% of all young people have comprehensive knowledge of HIV so that they are able to protect themselves from it.

Figure 5.4: Knowledge on HIV prevention among young people



Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Figure 5.4 illustrates that levels of knowledge about HIV are still well below the goal of 90%. Knowledge levels are still below 50% for both males and females in all countries except Namibia and Eswatini. Poor knowledge contributes to low levels of risk awareness and poor prevention of HIV at a time when we need to redouble our efforts in prevention. New approaches and programmes are necessary to increase access to accurate information particularly in view of COVID-19 when most children are not in school, and when they are, teachers are focusing on the core curriculum rather than issues that are considered to be extra-curricular.

Condoms

Condoms continue to be a crucial component of a combination prevention approach. As consistent condom use in all high risk sex acts has proved difficult to achieve, it is not believed that condoms alone are sufficient. However, increasing access to condoms is a continuing priority.

Table 5.13: Number of Condoms distributed or sold in 2019

Country	Number of condoms distributed
Angola	54 000 000
Botswana	41 148 720
Comoros	930 007
DRC	168 000 000
Eswatini	15 000 000
Lesotho	38 000 000
Madagascar	17 682 860
Malawi	154 442 236
Mauritius	975 119
Mozambique	95 715 852
Namibia	29 000 000
Seychelles	452 772
South Africa	635 981 213
Tanzania	32 664 445
Zambia	62 000 000
Zimbabwe	94 849 706
Total	1 440 842 930

Source: Gender Links compiled from UNAIDS 2021[37] and Country Score cards[38]

[37] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/ global-dashboard-and-country-scorecards/, accessed 10 August 2021.
[38] Ibid

Table 5.13 shows that all countries are distributing condoms and a total of over 1,4 billion condoms were distributed in SADC in 2019.

Table 5.14: Condom availability and use in GPC Priority Countries

Country	Condom use with non-regular partner		Women justified to insist condom use if husband has an STI		No. condoms per man 15 - 64	% condom need met 2019
	Women 15 -49	Men 15 -49	Women 15 -49	Men 15 -49		
Angola	59	74	59	74	8	25
Botswana					53	100
DRC	68	79	68	79	7	25
Eswatini	94	96	94	96	38	77
Lesotho	92	90	92	90	56	100
Malawi	82	88	82	88	20	95
Mozambique	61	72	61	72	15	44
Namibia	93	91	93	91	37	100
South Africa					34	92
Tanzania					2	9
Zambia	73	81	73	81	13	51
Zimbabwe	87	85	87	85	20	83

Source: Compiled from Global dashboard and Country Score cards.[39]

Table 5.14 shows variations in the use of condoms with non-regular partners across different countries, with generally higher utilisation by men than by women. Higher rates of utilisation are generally correlated with higher availability. Five countries (Botswana, Eswatini, Malawi, Namibia and South Africa) are providing at least 90% of need for condoms. Men are as likely as women to agree that a woman is justified to insist on use of a condom if her husband has an STI.

Voluntary Medical Male Circumcision (VMMC)

Voluntary medical male circumcision provides partial lifelong protection against female-to-male HIV transmission. VMMC should be used in combination with wider sexual and reproductive health service provision for boys and men including correct and consistent condom use, 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 by UNAIDS for intense effort to increase levels of VMMC are in SADC (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe).

Voluntary Medical Male Circumcision was seriously disrupted by COVID-19

[39] Ibid

Table 5.15: Number of male circumcisions conducted

Country	2015	2018	2019	2020	Total 2015-20	Difference 2020:2019
Tanzania	435 302	885 599	799 456	539 859	3 939 041	-259 597
South Africa	485 552	572 442	451 636	164 499	2 763 256	-287 137
Zambia	222 481	482 183	549 655	661 796	2 711 723	112 141
Mozambique	198 340	311 891	390 589	113 227	1 582 506	-277 362
Zimbabwe	188 732	326 012	354 819	82 060	1 458 773	-272 759
Malawi	108 672	199 399	114 465	47 316	766 177	-67 149
Namibia	18 549	34 942	40 868	45 880	197 713	5 012
Lesotho	25 966	26 448	34 144	9 802	155 667	-24 342
Botswana	15 722	24 207	17 123	3 171	104 021	-13 952
Eswatini	12 952	14 316	17 360	8 639	88 779	-8 721
Total SADC	1 712 268	2 877 439	2 770 115	1 676 249	13 767 656	

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Table 5.15 shows the number of VMMCs conducted in the SADC priority countries in 2020. As a result of COVID-19, VMMC dropped by 40% from 2,770,115 in 2019 to 1,676,249 in 2020. Only Zambia and Namibia in SADC were able to conduct more VMMCs in 2020 than 2019. Adaptations included providing transport, moving services from health facilities, and provision of COVID-19 personal protective equipment to VMMC mobilisers. SADC priority countries conducted a total of about 13.8 million VMMCs from 2015 to 2020: much lower than the target of 25 million for these priority countries. VMMC uptake is higher in urban and higher socio economic groups. Thus, it is necessary to re-strategize to make the service available and to create demand for it in lower socio economic and rural populations.[40]

Pre-Exposure Prophylaxis (PrEP)

PreP is one of the five prevention pillars in the Prevention Roadmap of the Global HIV Prevention Coalition. Prep means taking an ARV 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.



GL programme officer Thandokuhle takes an HIV test at the Mbabane HIV campaign. Photo: Mancoba Vilane

[40] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Table 5.16: PrEP Coverage SADC members of GPC

Country	No. who received PreP at least once in last 12 months	
	July 2019	July 2020
South Africa	8 100	43 255
Lesotho	7 300	35 478
Zambia	8 991	23 250
Namibia	5 600	10 583
Zimbabwe	5 000	8 351
Mozambique	2 000	7 434
Eswatini	2 176	5 607
Tanzania	8 000	5 312
Botswana	298	1 954
Malawi	300	459
DRC	356	356
Total SADC members of GPC	48 121	142 039

Source: Gender Links compiled from ARV Based prevention thematic summary.[41]

Table 5.16 shows that countries are gradually adopting PrEP as an additional HIV prevention option. The rate of uptake is not the same, with the number offered PrEP in Tanzania declining between 2019 and 2020, very slow change in DRC and Malawi and fast uptake in countries such as Lesotho, South Africa and Zambia. The total number of people who opted to use PrEP globally in 2020 was only 28% of the 2020 target for PrEP of 3 million in low and middle income countries.

Some of the challenges associated with PrEP are:

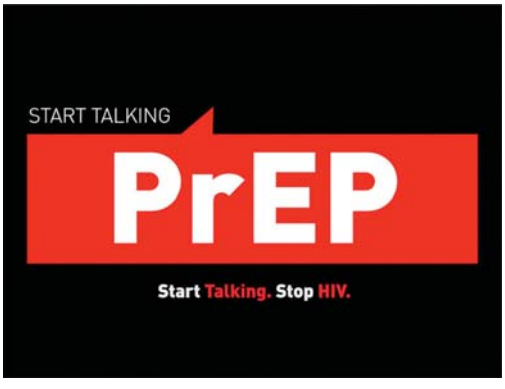
- Low levels of awareness in potential users.
- Self-perceptions of HIV risk.
- Ability to adhere to daily pills.
- Stigma, including from health providers and low levels of support, especially from the male partners of adolescent girls and young women.
- Problems attending clinic appointments.

Some solutions to increase uptake include:

- Building awareness of PrEP in parents.
- Social media to boost knowledge.
- Linking provision of PrEP to youth friendly services for sexually transmitted infections (STIs) and antenatal and postnatal care.
- Consulting with users about adaptations to increase uptake, build into peer networks.

Tests of long-acting injectable cabotegravir show that it reduces HIV infection even more than daily pills for men who have sex with men and for women. Injectable PrEP is administered every two months which is more discreet and easier to adhere to for many. However, it must be delivered by a health provider, there is still need to ensure that break through infections are managed well and the cost of injectable PrEP is still to be determined.

In January 2021, the World Health Organization (WHO) conditionally recommended use of the dapivirine vaginal ring, which has been found to reduce HIV infection by up to 50%, as an additional prevention method for women who are at substantial risk of HIV infection. Additional prevention methods being tested are a monthly PrEP pill, six-monthly injectable PrEP, as well as technologies for preventing both HIV infection and pregnancy.[42]



[41] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/, accessed July 15, 2021
[42] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Prevention among key populations

Key populations include sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons, prisoners and migrants. The goal is that 95% of members of all key populations access HIV combination prevention services and that those that test positive will access treatment, with ongoing support to be virally suppressed.

As new infections continue to decline in young people, the proportion of new infections from key populations is increasing (from 28% in 2019 to 32% in 2020). Key populations have higher HIV prevalence than the general population. Punitive laws and policies, police harassment, stigma and discrimination within health settings all deter members of Key Populations from accessing needed services. The largest proportion of new HIV infections within key populations is found in clients of sex workers and other partners of key populations (18%). HIV thus spreads into the general population. The paucity of data about the epidemic in key populations is indicative of the low priority that members of key populations have received so far in the HIV battle in SADC.

We cannot end AIDS without services to reduce transmission in Key Populations

Table 5.17: Selected data on HIV in Sex Workers

Country	Prevalence women 15 - 49	Prevalence in sex workers	Population size estimate	Condom use	Active Syphilis
Lesotho	26,1	71,9	7500	27	2,7
Eswatini	35	60,8	4000	5,9	
South Africa	24,7	57,7	24000	86,1	32,6
Malawi	10,3	49,9	36100	65	19,6
Zambia	14,1	48,8	126000	78,5	9,4
Botswana	24,8	42,2	6700	75,7	30,3
Zimbabwe	14,7	42,2	45000	43,4	
Namibia	14,7	29,9	4000	42,3	7
Tanzania	6	15,4	155500	72,4	6,4
Mauritius	1	15	6200	67,2	3
Angola	2,3	8	54000	71,7	32,8
DRC	1,1	7,5	350300	73,9	12,1
Madagascar	0,3	5,5	191200	62,8	
Seychelles		4,6	600	16	0,39
Comoros	0,1	0,8	1000	35,8	
Mozambique	14,4		27300		

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Table 5.17 show how widespread the pandemic is amongst sex workers in all countries of the region. Except in South Africa, and to a lesser extent in Zambia and Botswana, condom use by sex workers is still generally low and is particularly low in Seychelles, where the risk of HIV may be perceived to be low but is climbing in the sex worker community. The overall prevention score card showed that all GPC countries had programmes for sex workers. None were rated poorly nor were they rated as doing well. As long as sex work is criminalised, as it is in all countries except Mozambique, it is difficult to ensure that sex workers receive adequate services.

A study of sex workers in three urban areas of South Africa found that they were consistently less likely to be aware of their HIV status than other women and also that they were generally less likely to access treatment or be virally suppressed even after they became aware of their status[43]. Sex workers have been particularly hard hit by COVID-19, losing their source of income, without social or any other protection. Sex workers are much more vulnerable to violence and less able to access health services. Young and migrant sex workers are particularly vulnerable.

Table 5.18: HIV Epidemic in Men who Have sex with Men (MSM)

Country	HIV Prevalence Men	HIV Prevalence MSM	Population size estimate	Condom use	Active Syphilis
Lesotho	16	32,9	6100	46,4	5,1
Eswatini	18,2	27,2	2400	79,6	1,2
Zimbabwe	9,1	21,1	23000	69,2	0,4
South Africa	13,5	18,1	309700	71,8	
Mauritius	2,3	17,2	5500	53,1	14,2
Madagascar	0,3	14,9	17000	57,2	6,1
Botswana	15,2	14,8	2600	77,5	3,2
Seychelles		13,2	200		
Malawi	5,7	12,9	42600	79,4	9
Tanzania	3,3	8,4	49700		
Namibia	8,3	7,8	2200	54,8	
DRC	0,4	7,1	194900	50,6	42
Angola	1,3	2	29400	59,1	2
Comoros	0,1	0,4	600	56,2	0,41
Mozambique	8,6		15800		
Zambia	8		6500		12,4

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Table 5.18 shows high HIV prevalence in MSM in Seychelles and Mauritius, which otherwise have low rates of prevalence. Prevalence rates are similar to those of other men in countries such as Botswana. Similar to sex workers, MSM often do not access services such as HIV testing and treatment. However, there is data to suggest that when MSM do know their HIV status they are more likely than other men to access and to adhere to treatment[44]. This suggests that more effort should be invested in ensuring that services are available at times and places which are convenient for men, including MSM.

[43] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.
[44] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

People who inject drugs

Table 5.19: HIV in people who inject drugs

Country	HIV Prevalence	HIV Prevalence in People who inject drugs	Population size estimate	Condom use %	Safe injecting practices %	Active Syphilis
Comoros	0,1	1,8		43,8		
DRC	0,7	3,9	155800	26,5		42
Eswatini	26,8		300			
Madagascar	0,3	8,5	2300	41,8	68,4	
Mauritius	1,7	32,3	11700	45,4	92,2	53,6
Mozambique	11,5		2200			
Seychelles		23	2500	44,1	58,5	
South Africa	19,1	21,8	82500	57,1		
Tanzania	4,7	15,5	36000	29,4	84,2	
Zambia	11,1		26800			

Source: Gender Links compiled from UNAIDS 2021 data.[45]

Table 5.19 shows that the prevalence of HIV in people who inject drugs. Although people who inject drugs are not a large part of the SADC population, it is important that they should be able to access the same services as others. There are very few countries with programmes to promote safe injecting practices. There is evidence that countries are slowly beginning to pay attention at least to this population which may support increased service provision. In the island nations the difference in HIV prevalence between those that inject drugs and the rest of the population is very marked.

Prisoners

Table 5.20: HIV prevalence, prevention and management for prisoners

Country	Population size	HIV Prevalence	ARV coverage %	Condoms distributed
Angola		15,9	100	1161600
Comoros	2304			
DRC	36700	2,5		4003
Eswatini	46800	34,9		
Lesotho	2600	31,4	80,1	
Madagascar		0,3		7169
Malawi	14200	19	100	1500000
Mauritius	2300	17,3	79,1	343
Mozambique		24		
Seychelles	300	4,8		222
South Africa	166400	11,1	98,8	1169999
Tanzania		6,7		
Zambia	20800	27,4	100	
Zimbabwe	20900	28		

Source: Gender Links compiled from UNAIDS 2020 data.[46]

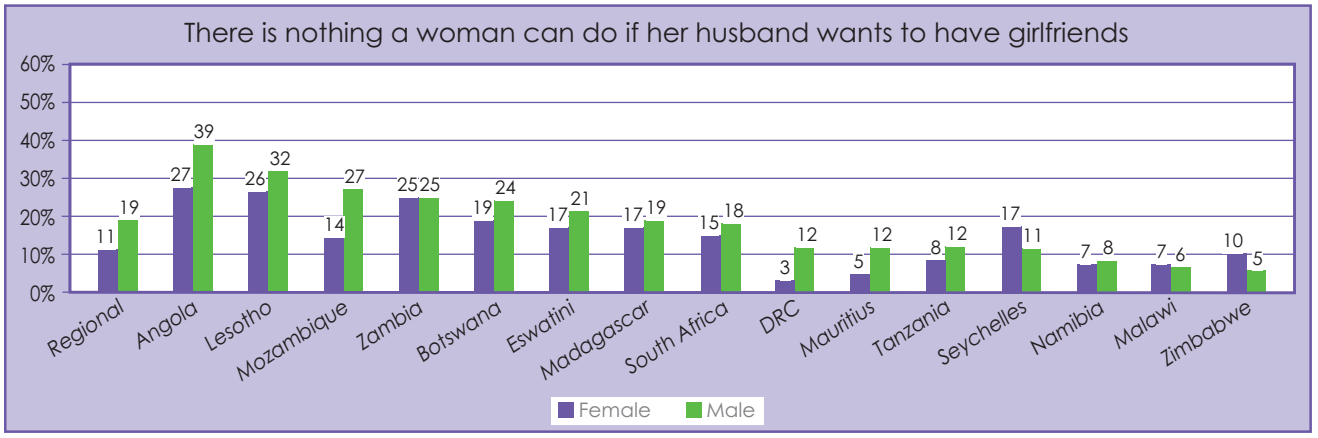
[45] https://aidsinfo.unaids.org/
[46] https://aidsinfo.unaids.org/

Table 5.20 shows that HIV prevalence is generally higher in prison populations than it is in the population at large. While the rates are lower than that of people who inject drugs or other key populations, it is critical that services are expanded to this neglected group. The number of condoms that are being distributed to prisoners is beginning to increase. It is important to link prisoners who have received care while in prison with services in their communities when they are released.

Attitudes

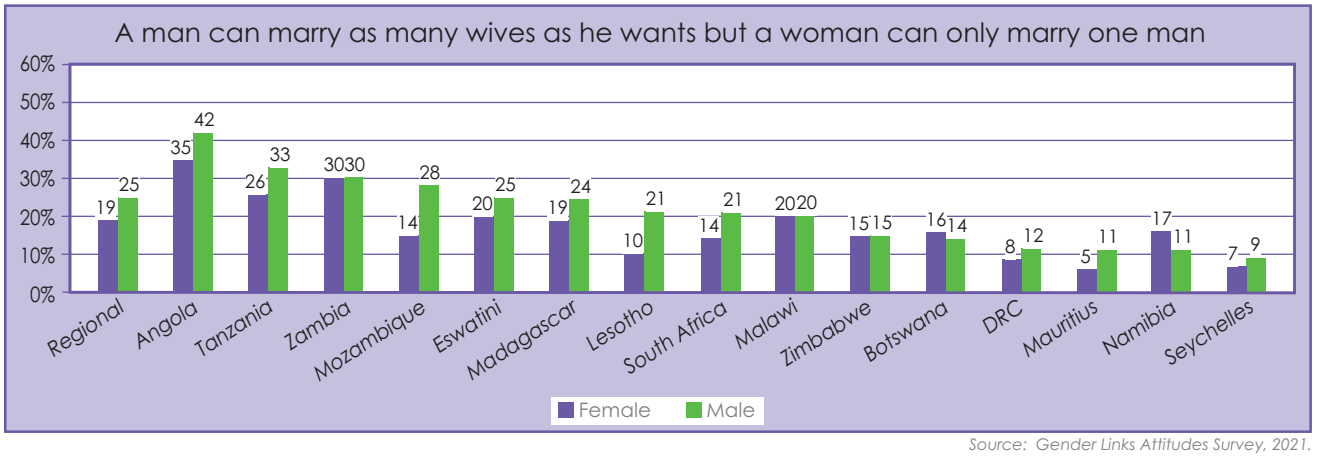
A critical test of HIV and AIDS prevention campaigns is the extent to which the attitudes that fuel this pandemic are changing. Alliance partners administer an attitudes survey. Several of the questions in the survey are pertinent to how successful HIV prevention campaigns will be.

Figure 5.5a: Attitudes on multiple concurrent partners



Source: Gender Links Attitudes Survey, 2021.

Figure 5.5b: Attitudes on polygamous marriages

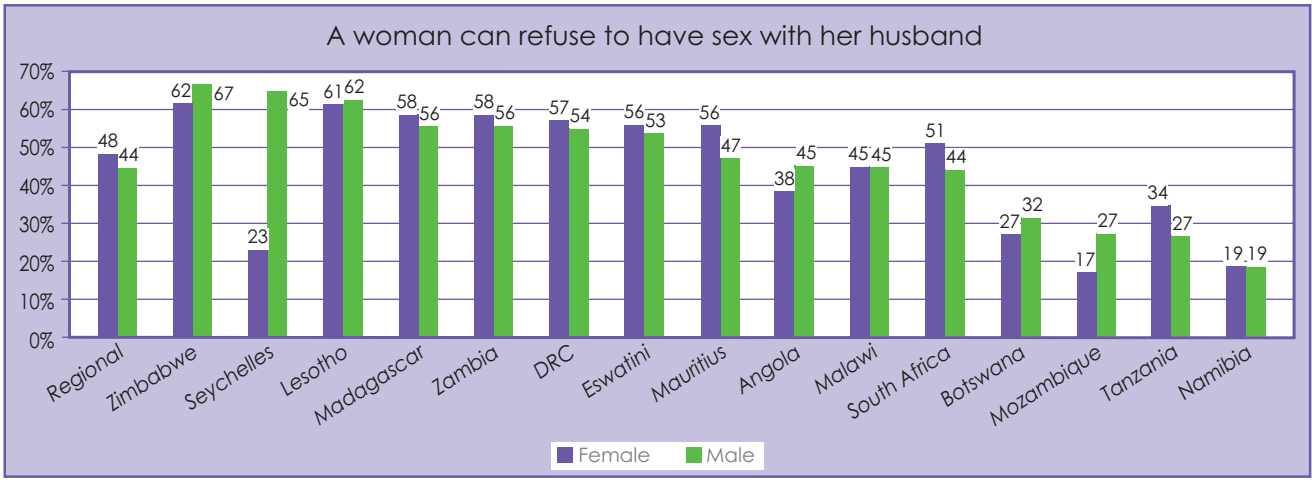


Source: Gender Links Attitudes Survey, 2021.

Figures 5.5a and 5.5b show the results of the Gender Links attitudes survey in respect of the percentage of women and men who agreed with the following statements: "there is nothing a woman can do if her husband wants to have girlfriends" and "a man can marry as many wives as he wants but a woman can only marry one man." Overall, less than 40% of either men or women agreed with these statements. The lowest rates of agreement were found in DRC, Mauritius, Namibia and Zimbabwe. Generally, more people agreed that a man could have more than one wife than agreed that there was nothing that a woman could do if her husband wanted to have many girlfriends, except in Botswana, Lesotho and Seychelles. As multiple concurrent partners have been a critical driver of HIV infection, it is important that attitudes are not accepting of either men or women having several sexual partners concurrently.

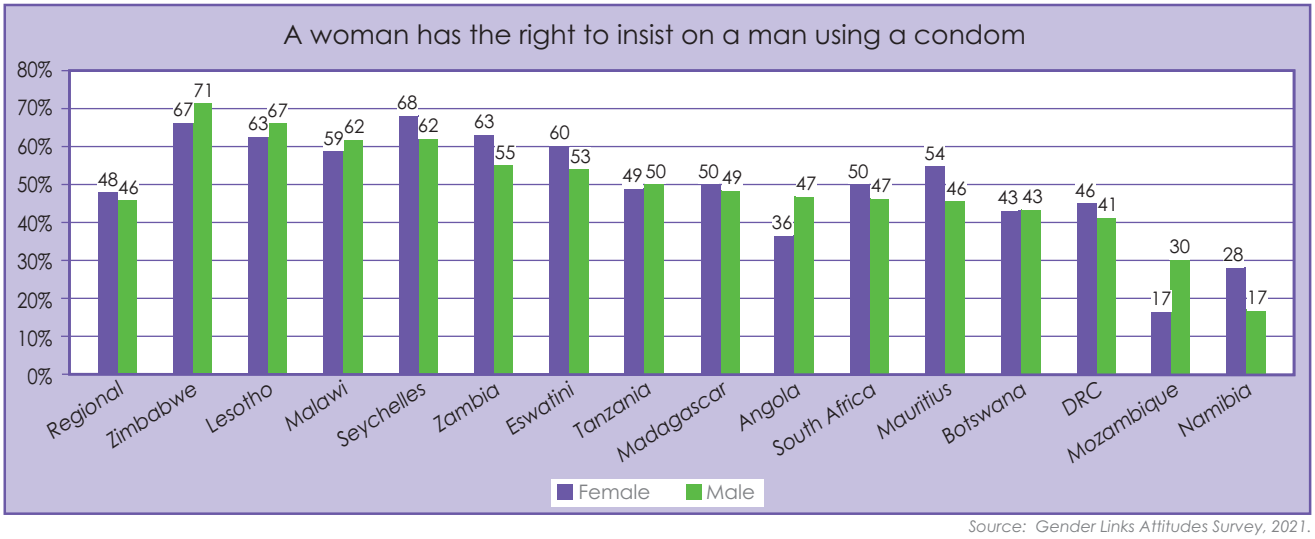
Neither women nor men had attitudes which condoned multiple concurrent partnerships

Figure 5.6a: Attitudes on sex which may not be safe



Source: Gender Links Attitudes Survey, 2021.

Figure 5.6b: Attitudes on the right to insist on condom use



Source: Gender Links Attitudes Survey, 2021.

Figures 5.6a and 5.6b show that regionally just under 50% of both women and men agreed with the statements: "a woman can refuse to have sex with her husband" and "a woman has the right to insist on a man using a condom". This indicates that women are generally not held as having power to negotiate or even to refuse sex if they consider that it may not be safe. Zimbabwe, Zambia, Seychelles and Lesotho had the highest proportions who agreed with both statements (except women in Seychelles, where a very small proportion agree that a woman can insist on condoms). This is clearly an area for greater advocacy and awareness raising across the region and especially in programmes addressing adolescent girls.

Female Genital Schistosomiasis - a missing link in HIV Prevention

Schistosomiasis is wide spread in tropical and sub-tropical regions of the world, especially in poor, rural communities in Africa who rely on open sources of water for cooking and bathing. As many as 56 million women in Africa are affected by female genital schistosomiasis (FGS) which is caused by schistosome eggs being trapped in the female genital tract. Untreated FGS can be mistaken as cervical cancer. Studies in Mozambique, Tanzania and Zimbabwe have shown that women with FGS have a three to four times greater risk of contracting HIV. In Zambia a study has linked schistosomiasis with increased risk of HIV in both women and men. Adolescent girls with FGS have a higher proportion of HIV receptors in their genital tissue.

FGS also causes lesions or tears in the cervix and vaginal mucosa of young women which also increases the chances of HIV transmission. Adolescents often contract FGS before their sexual debut. An important but neglected aspect of HIV prevention should be treatment for FGS in adolescent girls and older women. Raising awareness and skills of health providers to do this is a critical need.[47]

Women and health providers need to be aware of Female Genital Schistosomiasis

Treatment

Article 27.3

b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and

HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression

[47] UNAIDS (2019) No more neglect - Female genital schistosomiasis and HIV - Integrating sexual and reproductive health interventions to improve women's lives, https://www.unaids.org/en/resources/documents/2019/female_genital_schistosomiasis_and_hiv, accessed 2 August 2021.

Table 5:21: Number of people living with HIV on treatment

Country	2020				2010
	Women	Men	Children	Total	Total
South Africa	3 765 437	1 685 797	148 430	5 599 664	1 343 661
Tanzania	914 260	446 985	61 537	1 422 782	244 225
Mozambique	884 187	435 631	83 082	1 402 900	218 991
Zimbabwe	692 386	436 046	56 469	1 184 901	363 261
Zambia	710 457	421 071	47 503	1 179 031	349 076
Malawi	531 872	275 471	45 689	853 032	250 953
DRC	230 284	124 664	21 669	376 617	43 790
Botswana	203 292	116 977	4 662	324 931	159 350
Lesotho	146 626	79 104	7 254	232 984	94 287
Eswatini	127 558	67 816	8 912	204 286	60 757
Namibia	117 164	58 242	6 290	181 696	77 453
Angola	76 732	28 495	5 961	111 188	22 036
Madagascar	3 099	2 632	154	5 885	266
Mauritius	871	2 020	45	2 936	654
Comoros	46	34		80	17
Seychelles					
Total SADC	8 404 271	4 180 985	497 657	13 082 913	3 228 777
Global				27 500 000	7 800 000
SADC as percentage of Global				**48%**	**41%**

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

South Africa accounted for 20% of those on ART globally in 2020

Table 5.21 shows the progress that has been achieved in expanding access to treatment in SADC for all groups and in comparison to the numbers that were accessing treatment in 2010. Globally, the numbers of people on treatment has tripled over the decade from 7.8 million in 2010 to 27.5 million in 2020. The increase in SADC in the same time period has been fourfold from 3,228,777 to 13,083,913. SADC accounted for 41% of the global population on treatment in 2010 and 48% in 2020. South Africa accounted for 20% of all people in the world who were on ART in 2020. The numbers in all countries that are on treatment have increased with the greatest rates of increase being in those countries which began from a low total number - Madagascar, DRC - and significant increases in Mozambique and Tanzania.

The remarkable success that has been achieved is partly a result of sustained advocacy for access to cheaper, generic ART against fierce resistance from multinational pharmaceutical companies and developed countries. Civil society played a crucial role in this advocacy, led by organisations such as the Treatment Action Campaign in South Africa. The result has been increased production of much cheaper generic drugs and fall in the cost of ART per patient per year from US$ 10,000 in 1990 to under US$100 now.[48]

[48] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Viral suppression

UNAIDS TARGET 3: 90% of all people receiving antiretroviral therapy will have viral suppression.

As shown in Table 5.7 viral suppression overall reached the target of 73% or better in Eswatini, Botswana, Malawi, Zimbabwe, Namibia, Lesotho and Zambia.

Results from across Sub Saharan Africa have shown that support to continue in care is very critical. 19% of over 500 000 patients who initiated ART in 2009 were found to have dropped out by 2014.[49] People that have been found to be more likely to disengage from care include men, those who are unemployed, with less education, who have more advanced HIV illness, or poorer adherence to daily medication, who have not disclosed their HIV status or who live far from a health facility. Men are at greater risk of dying while on ART than women, partly because they are often diagnosed later and therefore start ART late.

Factors that can improve adherence include friendly, supportive health services; lack of stigma; emotional, practical and financial support. It is recommended that adolescent services should include peer support, be available at times which allow adolescents' schooling to continue without disruption and be responsive to adolescents' specific concerns[50].



South Africa: The Coach Mpilo programme is a peer support programme designed to engage men more effectively, based on research that found that men often have deep fears, associate HIV with abandonment and loss, and find health facilities to be more judgemental than supportive. The programme involves community based male peers that are living with HIV helping other men who have been diagnosed with HIV to overcome isolation and despair. The peers (or coaches) foster positive attitudes and confidence about HIV treatment, which improves treatment outcomes. In the seven-month long pilot phase of the programme, treatment uptake was 94% of newly diagnosed men, with 95% of participants retained on HIV treatment. Though 16% of participants interrupted treatment at least once, more than 80% of these were brought back onto treatment[51].

HIV and TB co-infection

Tuberculosis (TB) is both preventable and curable. However, without treatment, a person living with HIV who has TB is likely to die. Thus, the WHO has recommended, from 2010, that everyone with TB who is also living with HIV should be initiated on ART regardless of CD4 count and, in 2021, that ART be initiated as soon as possible. WHO has also recommended, since 2012, that

[49] Haas AD, et al. Retention and mortality on antiretroviral therapy in sub-Saharan Africa: collaborative analyses of HIV treatment programmes. J Int AIDS Soc. 2018;21: e25084. https://pubmed.ncbi.nlm.nih.gov/29479867/, accessed 5 August, 2021.
[50] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593, accessed 2 August, 2021.
[51] UNAIDS. 2021. Global AIDS Update. 2021. Confronting Inequalities Lessons for pandemic responses from 40 years of AIDS. Geneva, UNAIDS.

all people that test positive for HIV should also be screened for TB and receive "optimal TB care" which is:

- Those without symptoms of TB (cough, coughing up blood, fever, night sweats, weight loss, chest pain, shortness of breath or fatigue) should be given TB preventive treatment.
- Those with symptoms should be investigated for TB disease.
- If they have TB disease, they should start TB treatment immediately.
- If not, they should start TB preventive treatment.

Table 5.22: Number of TB related AIDS deaths

Country	2019	2019	2019	% change 2010-2019
South Africa	116000	158000	36000	77%
Tanzania	53000	40000	12000	70%
DRC	24000	18000	9600	47%
Mozambique	20000	21000	5600	73%
Zambia	20000	14000	9500	32%
Zimbabwe	14000	8000	4600	43%
Malawi	13000	18000	4200	77%
Namibia	4500	3800	1300	66%
Lesotho	4300	7900	3600	54%
Botswana	3700	2000	1100	45%
Eswatini	2400	2300	710	69%
Angola	1900	9100	2600	71%
Madagascar	36	54	280	-419%
Mauritius	11	2	8	
Comoros	0	0	0	
Seychelles	0	0	0	
SADC Total	276847	302156	91098	
Global Total	680000	570000	210000	
SADC as % global	**41%**	**53%**	**43%**	

Source: Compiled from UNAIDS 2021 data.[52]

In 2016, the United Nations set a global target to reduce TB deaths among people living with HIV by 75% between 2010 and 2020. Table 5.22 traces the number of TB related deaths in people living with HIV in SADC from 2000 to 2010 to 2019. By 2019, nine countries, including South Africa and Malawi, had achieved or exceeded the target ahead of schedule. In 2010 South Africa accounted for 28% of all TB deaths in the world among people living with HIV. Tanzania, Mozambique and Angola had achieved over 70% decline in deaths between 2010 and 2019. Madagascar still has increasing mortality, which is concerning, even as the absolute numbers are still relatively small. The 2021 Political Declaration on AIDS has set a target of 80% reduction in TB related deaths compared to 2010 by 2025.

The 2018 UN Political Declaration to End TB set a target of 6 million people living with HIV receiving TB preventive treatment, which reduces their risk of falling ill and reduces the risk of death by about 40%, by 2022. In 2018 and 2019, 5.3 million people living with HIV received TB preventive treatment (which is 88% achievement of the target). More than half of the 3.5 million people living with HIV who received TB preventive treatment in 2019 were in India, South Africa and Tanzania. The 2021 Political Declaration on AIDS target is at least 90% of people living with HIV receiving preventive treatment for tuberculosis by 2025[53].

Despite the gains, it is estimated that in 2019, only 49% of the estimated 815 000 people living

[52] https://aidsinfo.unaids.org/
[53] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

with HIV who also have TB disease were receiving both HIV and TB treatment. There are many gaps in screening, testing and treatment for both HIV and TB. Programmes need to find new ways of integrating care for both, as well as COVID, at community level[54].

Cervical Cancer

Cervical cancer is the fourth most commonly found cancer in women worldwide, with over 500,000 new cases and 311,365 deaths in 2018 globally. Women living with HIV are more likely to contract human papillomavirus (HPV) infection, which causes cervical cancer, than other women and less likely to clear the infection. HIV increases both the risk of cervical cancer as well as recurrence after treatment.

Cervical cancer is the most common cancer found in women living with HIV, who have a five to seven times greater risk of contracting it than other women. It is considered an AIDS defining condition. In 2018 it is estimated that 33,000 new cases of cervical cancer occurred in women living with HIV, of which 9,200 cases were in Southern Africa and 14,000 in East Africa (or 70% of all cases of cervical cancer in women living with HIV globally).

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 as well as support of people for people living with AIDS.

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.

Global AIDS Strategy 2021 - 2026:
Strategy 4
Fully recognized, empowered, resourced and integrated community led HIV responses for a transformative and sustainable HIV response

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;

[54] Tuberculosis deaths among people living with HIV are declining globally, but worrying gaps in TB care persist, https://www.unaids.org/en/resources/presscentre/featurestories/2021/march/20210324_tuberculosis-deaths-people-living-with-hiv, accessed 10 August 2021.

The Global AIDS Strategy High-level 2025 targets and commitments for achievement of Result Area 4 (Fully recognized, empowered, resourced and integrated community-led HIV responses for a transformative and sustainable HIV response) are:

- 30% of testing and treatment services to be delivered by community-led organizations.
- 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations.
- 60% of the programmes support the achievement of societal enablers to be delivered by community-led organizations.
- Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services.
- Less than 10% of people living with HIV and key populations experience stigma and discrimination.
- Less than 10% of women, girls, people living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence.[55]

Community based organizations and community caregivers, including peer supporters from affected populations, have long been recognized as vital in the HIV response, but have seldom received the support, training, materials and funding that they deserve.

The COVID-19 response has highlighted the urgent need for more attention and support to community based responses as many services are moved out of health facilities and into the community. Many countries, for instance, rapidly expanded multi-month dispensing of ART so that people living with HIV only come to health facilities once in three to six months. Other adaptations were more community based re-supply of ARVs.

COVID-19 response has highlighted the urgent need for more attention and support to community based responses

Such moves must be accompanied by increased community based support and follow up to ensure that all are adhering to their treatment. Based on evidence of growing numbers that are disengaging from care, the WHO's updated guidelines include a recommendation to trace people who have disengaged from care and provide support for re-engagement.[56]

Other services that have been disrupted by COVID-19, especially testing, need to urgently be supplemented by community based models which can reach people at times and places which are convenient to them. This is particularly important for reaching hard to reach populations and those most impacted by stigma. Where community testing is accompanied by community based initiation of ART it is critical that this includes sufficient support and counselling, with follow up. As illustrated in the case study that follows, local councils have a critical role to play:

[55] End Inequalities. End AIDS. Global AIDS Strategy 2021-2026, https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026, accessed 2 July 2021.
[56] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593 accessed 2 August, 2021.



Henties Bay District Aids Committee



The Henties Bay District Committee was established in 2004 in the coastal town of Henties Bay, Namibia. This is a sub-committee of the Arandis Constituency HIV and AIDS Coordinating Committee, which has 16 active stakeholders to date and is guided by the National Strategic Framework for HIV and AIDS response in Namibia.

The committee aims to reduce new HIV infections, reduce HIV related deaths, eliminate MTCT, support newly identified PLHIV and help them to stay enrolled and retained on ARV treatment. In addition, the committee contributes to resource mobilisation.

The committee focuses on social behaviour change awareness campaigns. As part of this, the committee conducts HIV testing and counselling, VMMC awareness drives, condom programming, HIV and TB defaulter tracing and adherence counselling. The committee also commemorates World TB Day and World AIDS day.

Partners in the committee include the office of the mayor, Henties Bay Clinic, Henties Bay Municipality, UNAM, Henties Bay Women's Association, Henties Bay Local Youth Forum and strategic partners who assist in rolling out the activities. To date, on a budget of N$60,000, the committee has managed to directly assist 100 beneficiaries, 75 of whom are women. The committee has also indirectly benefited 60 people through their networks and another 16 online.

Despite a lack of financial resources, the network continues to press forward with their plans, reviews and initiatives. To date, they have managed to assist the Henties Bay Women's Association to register as a welfare organisation with 75 women registered. The committee is committed to ensuring that residents across the community are protected from HIV and other sexually transmitted diseases and continuing to coordinate HIV prevention programming.

Source: Phillips, Seth. SADC Protocol@Work Summit 2019. Action and Youth Category - SRHR. Henties Bay District AIDS Committee

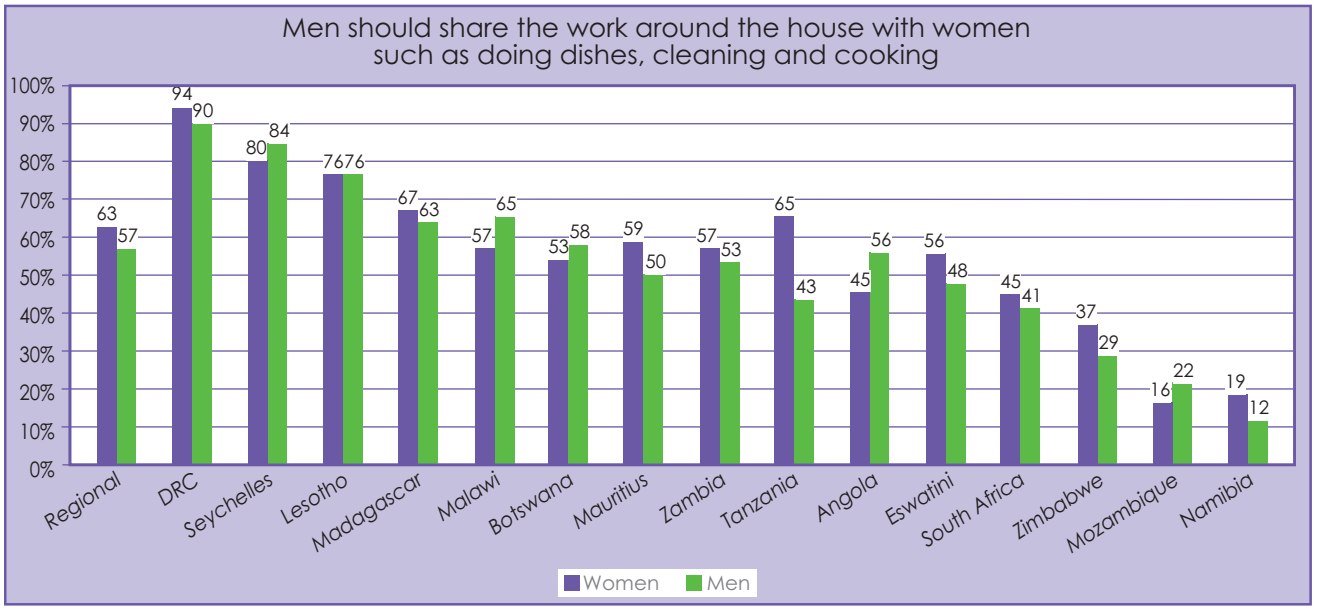
The WHO Guidelines recognise that peer support models can support adherence as more than 15% of all those on ART report that depression is a barrier to adherence, while adults and adolescents often report alcohol and substance misuse as barriers. Adolescents also face specific challenges such as peer pressure, inconsistent daily routines and the pressure to conform. Community programmes that engage caregivers of children and adolescents living with HIV are also important.

The WHO guidelines on task sharing include dispensing of ART between clinical visits by

trained and supervised community health workers. WHO further recommends that all health-care workers, including community health workers, should be appropriately trained, remunerated and supervised, as programme experience indicates that sustaining health services based on volunteerism alone is difficult[57]. This recommendation echoes what the Alliance has consistently called for over many years: all community caregivers (peer supporters, community health workers etc.) need good quality training, support and mentorship, provision of materials (including personal protective equipment against COVID-19 or any other infection) and to be remunerated.

The Gender Links Attitudes Survey included a question on whether men should share the housework with women.

Figure 5.7: Men sharing in care work



Source: Gender Links Attitudes Survey, 2021.

Figure 5.7 illustrates the attitudes regarding whether men should share work around the house with women. Sixty three percent women and 57% men agreed or strongly agreed with the statement. However, the response varied widely by country. The most positive responses came from DRC and the lowest from Namibia and Mozambique. Overall, responses between women and men were quite similar in each country, with the highest difference in Tanzania where 65% of women and only 43% of men responded positively.

Mental Health and Psychosocial Support

Research commissioned by United for Global Mental Health (UGMH), and conducted by Dr José Manuel Roche analysed the impact of integrating mental health and psychosocial services into HIV and TB programmes. The research found that by 2030:

- The rate of reduction in infection rate can be increased by 10-17% for HIV and 13-20% for TB.
- Up to 924,000 HIV infections could be avoided.
- Up to 14 million TB infections can be avoided.
- Integrating mental health treatment does not need to be expensive and it is cost-effective.

[57] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593, accessed 2 August, 2021.

There is a strong and bidirectional relationship between HIV/TB and poor mental health. On one hand, poor mental health is a risk factor for contracting both HIV and TB, while those with poor mental health are less likely to seek testing, treatment or adhere to treatment for either HIV or TB. On the other, living with HIV and/or TB is a risk factor for decline in mental health, especially if it is compounded by the stress of stigma and discrimination.

UGMH advocate for increased investment in mental health and psychosocial support within HIV and TB programmes. It is estimated that every US$1 invested in psychosocial support and mental health within HIV and TB programmes provides savings of $6,40 and $43 respectively by reducing community transmission and drug resistance, as well as social and economic costs to individuals and households.[58]

The new WHO HIV guidelines recommend psychosocial interventions for adolescents living with HIV to increase retention in care, improve adherence to treatment and reduce viral load. Interventions targeting the young people should be accompanied by interventions to expand their social network and targeting their families. The guidelines also recommend support and treatment for those with depression and anxiety, or who use alcohol and substances, as these result in poor adherence.[59]

The COURRAGE to change

The COURRAGE project being undertaken by Phola is a story-telling intervention or narrative based methodology that is designed for vulnerable women. These include women living with HIV and AIDS, sex workers, survivors of violence and abuse, women living with disabilities, young mothers, adolescent girls and other vulnerable groups. COURRAGE allows women to;

- Take steps to change their life circumstances and challenge inequalities in their personal, work and social lives.
- Understand factors that contribute to their psychosocial distress, find healing through drawing strength and lessons from group members and separate from shame, guilt, self-hate and blame that is associated with experiences of abuse, hardships, and GBV.
- Take collective action to address economic challenges, isolation, and other issues that impact their lives in their communities.
- Have control over their health, bodies, decisions, choices, resources and thoughts.



Grandaunts of the COURRAGE Programme. Photo: Colleen Lowe Morna

The current programme offers up to 13 workshop sessions where women come together and benefit from their collective story-telling and power. On completion of the programme, they are all welcomed as part of the Phola community structures, which provide ongoing support. The programme results in reduced anxiety, depression and stress as measured by the PHQ-9 test, which tests for levels of depression. When participants have high PHQ-

[58] United for Global Mental Health. 2021. Bending the curve: The impact of integrating mental health services on HIV and TB outcomes. https://unitedgmh.org/sites/default/files/2021-06/The%20impact%20of%20integrating%20mental%20health%20services%20on%20HIV%20&%20TB%C6%92%20%281%29.pdf, accessed 1 July 2021.
[59] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593, accessed 2 August 2021.

9 scores, facilitators work on improving mental health.

COVID-19 has put strain on the programme as venues for gatherings are closed. Some participants have dropped out of the programme altogether, which slows progress. Some women choose to work and make money during the uncertainty of job loss, rather than come for sessions. The Phola team offered catch up sessions and arranged transport for them to attend training in the Phola offices. Phola plans to extend the training to boys, under another banner - OUTTRAGED, which is similar to COURRAGE.

Phola has partnerships with multiple entities, such as Tosunga Baninga, 1 in 9, Treatment Action Campaign, Cosmo Women's Campaign, Cosmo Women's Forum and Following Jesus Church. COURRAGE aims to reach 250 vulnerable women and girls annually. So far the programme has reached 91 women and 22 men.



Phola receives award at the Women Voice & Leadership South Africa (WVLSA) Learning and Sharing Summit, 2021. Photo: Gender Links

Source: WVL SA Learning and Sharing Summit. 2021

Next steps

The world has adopted an ambitious new plan to end inequalities resulting from gender, sexual orientation, age, economic status, or geographical location, to end AIDS. Individuals, communities, governments and the whole region must invest all necessary resources to achieve these goals as we move towards the final effort to end AIDS by 2030. Some necessary immediate steps are:

- **Continued focus on the needs of women and girls, especially adolescent girls and young women**, including making all possible efforts to ensure that girls are able to resume their education following prolonged school closures during the COVID-19 lockdowns;
- **Continued focus on the epidemic of gender based violence against women and girls** with continued efforts at community level to make families and communities safe for girls and women;
- **Decriminalise sex work, same sex sexual acts and injecting drug use** as such laws only serve to drive people away from services which they desperately need. Unless SADC is able to tackle the HIV epidemic in sex workers, the LGBTIQ population and other key populations, it will not be possible to end AIDS by 2030.
- **Continue to invest in HIV prevention** for all people
- **Invest more in community interventions** to strengthen community capacity to address HIV and COVID-19 and support those that are affected, without stigma.
- **Recognise and value the contribution of women's work and unpaid care work** especially as more and more HIV services are moved from health facilities into communities. Those that provide care work must be trained, supported, provided with materials and remunerated. Community caregivers should be prioritised for vaccination against COVID-19.

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Gender-Based Violence 6



Palapye, Botswana Unite to End Gender Based Violence 2020 Campaign. Photo: Mboy Maswabi

KEY POINTS

- COVID-19 lockdowns remain a reality in SADC with pandemic-related challenges unrelenting in many countries, including increases in gender-based violence (GBV).
- The global "vaccine apartheid" is prolonging the agony of the pandemic, and correspondingly high levels of GBV.
- The Southern African Development Community (SADC) Secretariat has bemoaned the lack of critical GBV data submissions by member countries. Data on intimate partner violence is outdated and incomplete.
- In March 2021, the SADC Gender Unit convened two virtual workshops on GBV prevention and coordination. One of the outcomes included agreed GBV indicators that the unit will review annually.
- South Africa amended key legislation to fight GBV and femicide during the pandemic.
- Lawmakers in Lesotho drafted a domestic violence bill, which awaits cabinet approval. A Commonwealth study shows domestic violence costs Lesotho $113 million annually.
- To inform a comprehensive review of its Labour Act on sexual harassment at work, a Zimbabwe Parliamentary committee conducted public consultations across the country.
- Namibia is the only country in Africa to achieve a Tier 1 ranking on eliminating human trafficking in 2020, joining 34 nations globally. The country fully meets the US State Department's minimum standards for the elimination of human trafficking.

Introduction

GBV affects many women and girls in SADC, yet it remains sensitive, hidden, and stigmatised throughout the region. The SADC region continues to experience extremely high levels of gender violence, with an unprecedented surge reported during the COVID-19 lockdowns.

In March 2021, the SADC Secretariat collaborated with the Ford Foundation and GIZ, a German development agency, to conduct a two-day virtual workshop on gender-based violence (GBV) prevention and coordination. The Secretariat raised concerns about the lack of critical GBV data, low levels of reporting on GBV cases, insufficient disaggregation when reporting data, weak coordination, and the absence of common regional GBV surveillance systems. Prevalence data submitted to the Secretariat shows irregular reporting and outdated data on intimate partner violence (IPV). With the emergence of COVID-19 and related spikes in violence, regional GBV coordination has become more important than ever before.

The inherent challenges faced by low-income countries in accessing and providing vaccines, dubbed "vaccine apartheid," have fuelled fears that the disproportionate effects of the pandemic may further exacerbate gender inequalities and extend pandemic lockdowns and insecurity.

Women's rights activists have urged member states to consider the diverse needs of certain groups in vaccine roll out and as part of their overall COVID-19 response. This includes the safety of women, particularly sex workers, gender non-conforming people, and migrants and refugees at risk of experiencing sexual harassment, exploitation, disrespect, and other forms of GBV when seeking health services.

Member states have made progress in addressing GBV by implementing multi-sectoral approaches that include legislative and criminal justice responses. For instance, South Africa's fight against gender-based violence and femicide (GBVF) improved when the country amended key legislation, including the Social Assistance Amendment and the Prescription in Civil and Criminal Matters (Sexual Offences) Amendment bills. Additionally, the South African Parliament's Portfolio Committee on Justice and Correctional Services adopted the Criminal Law (Sexual Offences and Related Matters) Amendment Bill and the Domestic Violence Amendment Bill.

Elsewhere, Zimbabwe embarked on public consultations on sexual harassment in the workplace, with a view to amend its Labour Act and Botswana set aside special courts to expedite GBV cases, which surged during its lockdown.

Namibia is the only African country to achieve a US Department of State Tier 1 ranking in 2020, joining 34 nations globally. The department ranks each country on one of four tiers (Tier 1, Tier 2, Tier 2 watch list, and Tier 3), as mandated by the Trafficking Victims Protection Act (TVPA), an anti-trafficking Federal Law of 2000.[1]

"Vaccine apartheid" is the term used to describe the challenges faced by low-income countries in accessing vaccines

[1] United States Department of State (2020),Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.

Table 6.1: Key data on extent, response, support, and prevention of GBV in SADC

INDICATORS	Region	Angola	Botswana	Comoros	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)[2]	All 16 countries	50	35	40	58	43	41	42	43	25	48	39	30	31	47	47	43
Proportion (%) of ever-partnered women aged 15-49 years experiencing IPV and/or sexual violence at least once in their lifetime (2013)[3, 4]	Eight countries	N/A	N/A	6	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]	Ten countries	32	N/A	5	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/or 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	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[7]	13 countries	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Laws on sexual assault[8]	14 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Human trafficking laws[9]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexual harassment laws[10]	15 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Integrated approaches: national action plans[11]	All 16 countries	Yes	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[12]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Specialised facilities, including places of shelter and safety[13, 14, 15]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comprehensive treatment, including post-exposure prophylaxis (PEP)[16]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Gender Links, 2020.

2 United Nations, Sustainable Development Goal SDG Tracker, Our World in Data, https://sdg-tracker.org/gender-equality, accessed 18 June 2021.
3 'WorldsWomen2015_chapter6, https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf, accessed 18 June 2021.
4 WHO, Intimate partner violence prevalence data by country, World Health Organization, https://apps.who.int/gho/data/view.main.IPVv, accessed 18 June 2021.
5 WHO, Intimate partner violence prevalence data by country, World Health Organization, https://apps.who.int/gho/data/view.main.IPVv, accessed 18 June 2021.
6 'WorldsWomen2015_chapter6, https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf, accessed 18 June 2021.
7 Gender Links, (2019) 'Audit of SRHR Laws and Policies in SADC', Gender Links, https://genderlinks.org.za/gmdc/publications/audit-of-srhr-laws-and-policies-in-sadc/, accessed 18 June 2021.
8 Gender Links (2019) 'Audit of SRHR Laws and Policies in SADC', Gender Links, https://genderlinks.org.za/gmdc/publications/audit-of-srhr-laws-and-policies-in-sadc/, accessed 18 June 2021.
9 United States Department of State (2020),Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.
10 Gender Links (2019) 'Audit of SRHR Laws and Policies in SADC', Gender Links, https://genderlinks.org.za/gmdc/publications/audit-of-srhr-laws-and-policies-in-sadc/, accessed 18 June 2021.
11 Gender Links, Policy and action plans, https://genderlinks.org.za/what-we-do/justice/policy-and-action-plans/, accessed 18 June 2021.
12 Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/, accessed 18 June 2021.
13 Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/, accessed 18 June 2021.
14 GBV Prevention Network (2018) Seychelles: Shelter for Women Victims of Violence Opens in Seychelles, https://preventgbvafrica.org/seychelles-shelter-for-women-victims-of-violence-opens-in-seychelles/, accessed 18 June 2021.
15 UNFPA Comoros (2021) VBG_: L'UNFPA remet de matériels informatiques et de mobiliers aux comités de veille de Mohéli et d'Anjouan, UNFPA Comoros, https://comoros.unfpa.org/fr/news/vbg-lunfpa-remet-de-mat%C3%A9riels-informatiques-et-de-mobiliers-aux-comit%C3%A9s-de-veille-de-moh%C3%A9li-et, accessed 18 June 2021.
16 Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2019) SADC Gender Protocol 2019 Barometer. 12th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2019/, accessed 18 June 2021.

Table 6.1 resembles the data in the 2020 Barometer as no major surveys occurred in the region that would significantly alter the data in 2020 - the year of COVID-19 lockdowns- especially on intimate partner violence (IPV). However, desk research helped provide an update for Comoros[17] and Seychelles[18] pertaining to the indicator on "specialised facilities, including places of shelter and safety." As reported in the previous Barometer, several sections in Table 6.1 show irregular data across SADC countries. The SADC Secretariat is concerned with these gaps, which affect critical data indicators needed to track the extent of IPV. This is more important than ever as worries mount about increased GBV linked to COVID-19 lockdowns.

The existing data shows that:

- Only eight countries have data on the proportion of women who have experienced IPV and/or sexual violence at least once in their lifetimes. Of those, DRC ranks highest at 64% of women, followed by Zambia at 49%.
- Only ten countries have data on the proportion of women and girls subjected to physical and sexual violence by a partner. In some cases, data is old, underscoring the SADC Secretariat's concern about the dearth of reliable statistics on IPV within member states, a finding consistent with the SADC Gender Unit's GBV study.
- Thirteen SADC countries now have domestic violence legislation and 14 have sexual assault legislation.
- The Democratic Republic of the Congo (DRC), Lesotho, and Tanzania have yet to enact specific domestic violence laws. A recent SADC Secretariat virtual GBV meeting confirmed that Lesotho's cabinet is currently reviewing a new domestic violence bill.
- All SADC countries but Angola now have legislation on sexual harassment and all 16 countries have human trafficking laws.
- New data shows that Comoros and Seychelles, like other SADC countries, have specialised facilities, including places of shelter and safety, for GBV survivors.

This chapter assesses progress on GBV extent, prevention, response, and support across all 16 SADC countries against commitments made in normative frameworks including:

- The SADC Protocol on Gender and Development;
- Beijing Platform for Action (BPFA) +20 Africa Declaration;
- The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW);
- The UN 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.

This 2021 edition is a continuation of the *#VoiceandChoice* campaign, focusing on Sexual and Reproductive Health and Rights (SRHR). The chapter also analyses the impacts of the COVID-19 pandemic and response, as well as whether ongoing vaccination roll outs will help or undermine gender justice in the region.



Participants march during the 16 Days of Activism campaign in 2011 in the municipal council of Beau Bassin Rose Hill in Mauritius. Photo: Anushka Virahsawmy

[17] UNFPA Comoros (2021) VBG_: L'UNFPA remet de matériels informatiques et de mobiliers aux comités de veille de Mohéli et d'Anjouan, UNFPA Comoros, https://comoros.unfpa.org/fr/news/vbg-lunfpa-remet-de-mat%C3%A9riels-informatiques-et-de-mobiliers-aux-comit%C3%A9s-de-veille-de-moh%C3%A9li-et, accessed 18 June 2021.
[18] GBV Prevention Network (2018) Seychelles: Shelter for Women Victims of Violence Opens in Seychelles, https://preventgbvafrica.org/seychelles-shelter-for-women-victims-of-violence-opens-in-seychelles/, accessed 18 June 2021.

COVID-19 and GBV prevalence

Since December 2019, when scientists first detected the COVID-19 virus, it has mutated several times and been unrelenting in its global devastation. At the time of writing, SADC countries remained in various phases of lockdown, with some swinging back and forth between tighter and looser restrictions as they attempted to address social and economic concerns while also containing surges linked to new strains of the virus. Most countries have maintained or expanded movement restrictions.

For instance, on 27 June 2021, South Africa once again moved to alert level 4, just one level short of a total nationwide lockdown: the first time it had been at this alert level since May 2020.[19] A day later, Zimbabwe's government followed suit. As the ongoing crisis forces SADC lawmakers to bring in stricter restrictions, the plight of women and children facing abuse during the lockdowns remains mostly unchanged.

Reliable data on the impact of lockdowns on GBV is difficult to access. The biggest challenge with GBV is that much of it is either un-reported or under-reported, especially under lockdown. Police statistics are thus usually under-stated. However, the variation in police data over the last four quarters is a good indicator of the extent to which GBV is either increasing or decreasing.

Table 6.2: Total sexual offences from April 2020 to March 2021 in South Africa[20]

Crime category	April to June 2020	July to September 2020	October to December 2020	January to March 2021
Rape	5805	8922	12 218	9518
Sexual assault	1070	1758	2390	1910
Attempted sexual offences	271	451	625	433
Contact sexual offences	150	292	362	272
Total sexual Offences	7296	11 423	15 595	12 133

Source: South African Police Services sexual offences statistics.

Table 6.2 provides data on rape, sexual assault and other sexual offences in South Africa between April 2020 and March 2021, the months when the country experienced some of its most serious COVID-19 lockdowns and restrictions.

For all crime categories, cases increased sharply from April to December 2020, and then dropped from January to March 2021. There is therefore a direct correlation between the extent of lockdowns in South Africa and increase in reported cases of GBV, with the actual number of cases likely to be much higher.

This recent data has not been analysed against other regional data and trends, but it aligns with concerns expressed during the early days of the pandemic about a rise in GBV due to lockdowns. The sharp increase in reported rapes throughout 2020 represents an especially worrying trend, adding even more urgency to the government's ongoing push to review legislation to address GBV.

[19] South African Government COVID-19 alert system, https://www.gov.za/covid-19/about/about-alert-system, accessed 30 June 2021.
[20] South African Police Services sexual offences statistics, https://www.saps.gov.za/services/crimestats.php accessed 2 July 2021.

Implications of the SADC vaccine roll out

Recent studies show that women experience worse side effects from COVID-19 vaccinations

While the virus rages, scientists and pharmaceutical companies in several countries have successfully created a variety of vaccines to help curb the spread of the virus. However, the global vaccination roll out has laid bare the gross structural and systemic inequalities that exist within and between countries and the stark divide between the global north and south. Oxfam reports that the COVID-19 vaccines have created nine new billionaires with a combined wealth greater than the cost of vaccinating the world's poorest countries.[21] Activists in SADC have joined growing calls for a more equitable distribution of vaccines to ensure they reach the most vulnerable populations.[22]

Marginalised groups such as sex workers, women working in the informal sector, older women, women in rural areas, people with disabilities, and migrants and refugees are all at particular risk of contracting COVID-19 and struggling to obtain a vaccine. More research is needed on the biological effects vaccines have on women and girls. So far, data shows differences in efficacy (the percentage reduction in disease incidence in a vaccinated population) and side effects of the various vaccines on women.

According to Management Sciences for Health, women have higher innate immunity responses to antigen stimulation and create higher antibodies to a vaccine. Women also exhibit better efficacy, which means lower rates of hospitalisation and mortality in females compared to males.[23]

Recent studies, however, show that women experience worse side effects from COVID-19 vaccinations. A study by the Centers for Disease Control and Prevention (CDC)[24] found that women comprised 79% of reports of side effects from the Pfizer and Moderna vaccines and nearly all of the anaphylactic reactions to COVID-19 vaccines. These side effects could be especially distressing to survivors of violence, who already endure the physical, reproductive health and mental health effects of GBV.



SADC Executive Secretary Stergomena Lawrence Tax has expressed worries about increases in GBV during the pandemic. Photo courtesy of Twitter

[21] Oxfam (2021) COVID vaccines create 9 new billionaires with combined wealth greater than cost of vaccinating world's poorest countries, Oxfam International, https://www.oxfam.org/en/press-releases/covid-vaccines-create-9-new-billionaires-combined-wealth-greater-cost-vaccinating, accessed 16 June 2021.
[22] WHO (2021) Expanding reach: Addressing gender barriers in COVID-19 vaccine roll out, https://www.who.int/news/item/03-05-2021-expanding-reach-addressing-gender-barriers-in-covid-19-vaccine-roll out, accessed 16 June 2021.
[23] Lawry, L. (2021) 'Sex, Gender, and Vaccines: Considerations for COVID-19 Vaccine Immunity', https://www.msh.org/blog/2021/05/17/sex-gender-and-vaccines-considerations-for-covid-19-vaccine-immunity, accessed 18 June 2021.
[24] First Month of COVID-19 Vaccine Safety Monitoring - United States, December 14, 2020-January 13, 2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7008e3.htm, accessed 18 June 2021.

Women's rights and vaccine roll out

The disproportionate effects of the pandemic, if not addressed, will continue to hamper the vaccine roll out process, further exacerbating gender inequalities. While women comprise 70% of the global health workforce, they only comprise 25% of those in leadership positions.[25] The World Health Organisation (WHO) identified this gap, noting that women's equal and meaningful participation in leadership and decision-making, as well as vaccine roll out, is critical.[26]

Vaccine roll out plans must take into account all of these disparities. Some key considerations include:

- Access to mobility: What challenges will women face in reaching designated health facilities? What are the travelling distances? What is the cost? How many times do they need to get to a facility?
- Access to technology: If access to information or registration is largely online, it will exclude large proportions of the population. Thus, plans should include a range of ways to share information about vaccine access and safety to ensure equal access to information.
- The limited decision-making power of women in seeking healthcare and their limited access to health resources.
- Documentation: Will requirements for documentation such as passports or other forms of identification prevent women, especially non-citizens such as migrants and refugees, from receiving vaccinations?
- Safety of women should be a key consideration, particularly sex workers, gender non-conforming people and migrants and refugees at risk of experiencing sexual harassment, exploitation, disrespect and other forms of GBV when seeking health services.

Gender activists and leaders raised the issue at the Commission on the Status of Women 65 (CSW-65) in March 2021, with Canada's international development minister noting that countries must employ a gender lens to tackle COVID-19. "Women are on the frontlines being exposed to the virus," said Karina Gould. "Women need vaccines to prevent COVID-19 but they also need access to tests and treatments. We need to listen to women about how their interrelated vulnerabilities could become barriers. A gender lens can help us respond to all of their needs as the essential workers in the fight against COVID-19." Gould also noted that ensuring women provide vaccinations is important.



Choolwe Jacobs, founder of the Zambia chapter of Women in Global Health, told CSW-65 that grassroots women's movements could help counter vaccine hesitancy and ensure equity in testing and vaccine access. "Women, particularly in lower and middle income countries, including in Zambia, do not have access to tests and many of them lack knowledge and awareness of testing. This is particularly the case in remote and rural areas. Empowered women community health workers can play a huge role in scaling testing to ensure it is available to everyone," Jacobs said.[27]

[25] WHO (2021) Expanding reach: Addressing gender barriers in COVID-19 vaccine roll out, https://www.who.int/news/item/03-05-2021-expanding-reach-addressing-gender-barriers-in-covid-19-vaccine-roll out, accessed 16 June 2021.
[26] WHO (2021) Expanding reach: Addressing gender barriers in COVID-19 vaccine roll out, https://www.who.int/news/item/03-05-2021-expanding-reach-addressing-gender-barriers-in-covid-19-vaccine-roll out, accessed 16 June 2021.
[27] WHO (2021), Expanding reach: Addressing gender barriers in COVID-19 vaccine roll out, 3 May 2021, https://www.who.int/news/item/03-05-2021-expanding-reach-addressing-gender-barriers-in-covid-19-vaccine-roll out, accessed 2 July 2021.

South Africa: Women, violence and vaccine roll out

In July 2021 Women's Voice and Leadership South Africa (WVLSA) condemned the violence and criminal looting ravaging South Africa amid the third wave of the COVID-19 pandemic. WVLSA called on President Cyril Ramaphosa to ensure that law and order are restored and that the vaccine roll out crucial for defending women's hard-earned rights is resumed as a matter of urgency.

WVL is a fund created and funded by Global Affairs Canada as part of its feminist foreign assistance policy. In South Africa, where the fund is managed by Gender Links (GL), WVL brings together 51 Women's Rights Organisations (WRO) across the country, especially in Gauteng, KwaZulu-Natal, the Western Cape and Limpopo provinces.

"There can be no justification for a breakdown of the rule of law on account of a Constitutional Court ruling to jail a former president for contempt of court," noted Colleen Lowe Morna, Special Adviser to Gender Links. "The fact that this violence is jeopardising vaccine roll out - the only real hope for emerging from the COVID-19 crisis which has a disproportionate effect on women - makes such behaviour particularly painful and unacceptable."

WVLSA, a member of the Peoples Vaccine Alliance, has initiated a #VaccineGenderJustice campaign. The coalition of WRO "calls on the government to ensure that the vaccine roll out is fair, equitable and does not discriminate against any segment of society, including women living in rural areas; People Living with Disability; sex workers, migrants, and the LGBTIQ community," said Grants Manager Tinashe Chipwanya.



Participants viewing products at an Entrepreneurship Trade show at Maseru Mall in Lesotho. Photo: Ntolo Lekau

The mindless and ongoing violence following the incarceration of former President Jacob Zuma on 9 July led to vaccine sites bolting their doors just days after the acting Health Minister Mmamoloko Kubayi-Ngubane announced that the country would be accelerating the roll out to include weekends. On 9 July Kubayi-Ngubane announced that eligible age groups would be extended from 50 and over to 35 to 49 year-olds from mid-July, with the roll out set to begin in August.

In his address to the nation on 11 July extending Level Four COVID-19 lock down by another two weeks, President Cyril Ramaphosa said that requirements to register online and present identification for vaccinations would be waived to accelerate roll out.

To date, despite procuring enough vaccinations to service all 60 million South Africans, the country has vaccinated less than one percent of its population. This stands in stark contrast to the billions of rands syphoned out of the country in countless corruption cases during Zuma's presidency, not to mention the costly investigation into these cases.

In 2021, WVL SA is focusing on equitable access, public education and awareness on vaccine roll out. Eleven grantees are conducting door to door campaigns in far flung rural areas to ensure equitable access. These are the MT Foundation, Free State; Coastal Resources Centre, Eastern Cape; Sinqobile Kingdom Empowerment, Mpumalanga; Community Carers Agency and Voice for the Voiceless, Western Cape; KwaZulu Development and Business Information Centre and Trans Hope (KwaZulu-Natal); Lithsani Vhana-De Foundation,

Mara Victim Empowerment Centre, Limpopo; Mankweng Community Law Advice office, Limpopo and the Dorcas Page Foundation, Gauteng.

Their work includes dispelling myths around taking vaccinations; lobbying to ensure that documentation required will not prevent women, especially migrants and refugees; sex workers and gender non-conforming people from being vaccinated; upskilling community workers and including them in healthcare campaigns, and ensuring the safety of all those seeking health services.

"WVL-SA calls on the government to generate and share sex disaggregated data on the vaccine roll out; ensure that there is a constant supply of the vaccines; prioritise care givers and ensure that vaccinations reach the most marginalised communities, especially migrant women and women living in rural areas," said WVL Grants Coordinator Nomthandazo Mankazana Mokoa. *Source: Women Voice and Leadership press release, 14 July 2021.*[28]

Data collection and the extent of GBV

During the GBV prevention workshop hosted by the SADC Gender Secretariat in March 2021, member states shared their experiences in GBV data collection, including whether they conduct dedicated GBV surveys. The SADC Gender Secretariat notes that, although the SADC region has made significant progress in formulating GBV laws and policies, there remains a huge challenge in measuring and monitoring GBV. The 2018 SADC GBV study covering seven countries (Angola, DRC, Mozambique, Namibia, Tanzania, Zambia, and Zimbabwe) with Demographic and Health Survey (DHS) data from 2010-2018 reveals serious gaps. The Secretariat notes that these hamper progress in GBV prevention and response by:

- A lack of timely data submissions by member states;
- Insufficient disaggregation of data;
- Lack of national surveys on GBV;
- Inadequate knowledge of GBV at all levels, including by some service providers;
- Weak coordination mechanisms;
- Low levels of reporting of GBV;
- Weak data collection tools and systems;
- Inadequate in-country capacity for the development of comprehensive GBV data; and
- Absence of a common regional GBV surveillance system that would facilitate data collection.

In addition, the Secretariat notes that some of the GBV indicators in the current SADC Gender Protocol Monitoring and Evaluation Framework (MERF) need review to ensure effective monitoring and reporting at least annually at the SADC Council of Ministers and SADC Summit of Heads of States. These include legal, social, economic, cultural and political practices, sexual harassment, support services, training of service providers, and integrated approaches.

The SADC region lacks a common GBV surveillance system

[28] Women Voice and Leadership press release, 14 July 2021.

The SADC Secretariat revealed these concerns following the 2020 UNiTE campaign, with its theme: *Orange the World: Fund, Respond, Prevent and Collect!* This lack of data strongly affects how agencies and countries monitor GBV as part of efforts to achieve the SDGs and other regional targets. Researchers and activists note that collecting data for all SADC countries is even more important now, as the region grapples with the COVID-19 crisis, which has increased the vulnerability of women and girls to abuse. It is important to note that some other countries depend on the DHS data, utilising the module on Domestic Violence (DV).

For more than a decade, Gender Links has represented a leading voice in the fight against GBV in SADC, spearheading seven comprehensive VAWG and/or GBV baseline studies completed in Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia, and Zimbabwe (2010 to 2016) and a comprehensive follow-up study in Botswana in 2018.[29]

Table 6.3: 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 strangers	The Violence Against Women (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.

[29] The studies can be accessed on the GL website: https://genderlinks.org.za/what-we-do/justice/research/violence-against-women-baseline-research/

Table 6.3 illustrates the differences and similarities between the DHS and GBV baseline studies. This chapter features data from both. The latter studies tend to be more in depth than DHS research on this topic, which falls into existing larger surveys measuring various health indicators. Most countries show gaps[30] on critical indicators. Other research has uncovered extremely high rates of violence in Southern African countries, with IPV particularly widespread.[31] Measuring GBV indicators through dedicated surveys gives comprehensive information on the various forms of GBV, which is why GL continues to collaborate with multiple stakeholders to collect robust data, track GBV indicators, and encourage evidence-based action.



Youth participate in a drama depicting the harms of GBV during the campaign *Towards a GBV free Eswatini* in 2019. Photo: Thandokuhle Dlamini

[30] Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/, accessed 18 June 2021.
[31] García-Moreno, C. et al. (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: World Health Organization.

Table 6.4: Status of GBV data, analysis and use: national surveys and administrative data sources by country

Country	Last DHS	Next ongoing DHS	GL survey date	Status of GBV data, analysis and use; national surveys and admin data sources
Angola	2015-2016	2021-22	n/a	• Current study on GBV ongoing in collaboration with the Catholic University of Angola. • National police and churches submit to the gender ministry for aggregation. • Review of criminal law and penal code underway.
Botswana	1988	n/a	2011 and 2018	• The country has conducted two dedicated GBV surveys at five-year intervals in partnership with GL, in 2011 and 2018. The next survey to occur in 2023. • Relies on administrative data (obtained from police, health, courts and other government agencies) in between surveys. • GBV statistics from Botswana Police Service (BPS) do not give incidences but gender ministry working with BPS to close the gap. • Gender ministry hopes to get even more data from the GBV referral system now in place.
Comoros	2012	n/a	n/a	• Island authorities work in close collaboration with United Nations Children's Fund (UNICEF) to gather data. • No dedicated GBV survey yet. • Civil society sensitising citizens in rural areas on GBV since 2011 as many people did not report or voice abuse due to cultural practices. Normalising acceptance of physical violence needs to change. • Civil society not authorised to give out information on GBV.
DRC	2013-2014	n/a	n/a	• No survey yet for GBV but has statistics for domestic violence in some post-conflict provinces. • Gender ministry, in partnership with some CSOs, to collect and compile information on GBV. • Some CSOs provide technical assistance in collecting GBV data. • Gender ministry has the responsibility to publish GBV data.
Eswatini	2006-2007	n/a	n/a	• No dedicated GBV surveys due to funding constraints. • Relies on administrative data from relevant service ministries. • Planning to collect data on physical and sexual violence as part of the Multiple Indicator Cluster Survey (MICS) in late 2021. However, researchers will only collect data from female respondents. MICS are household surveys implemented by countries under the programme developed by UNICEF to provide internationally comparable, statistically rigorous data on the situation of children and women.[32]
Lesotho	2014	2021	2014	• Draft Domestic Violence Act is now ready for cabinet approval. • As a guiding legal framework, Lesotho has come up with an Anti-GBV coordination forum backed by the Sexual Offences Act and the National Action Plan. The forum is chaired by the gender ministry and has 6 technical working groups (TWGs) that include the government, development partners, media, civil society, academia and religious sectors. The TWGs meet quarterly to evaluate progress on GBV prevention and response in the country.
Malawi	2015-2016	2021	n/a	• Relies on DHS surveys, with the last one conducted in 2015. Next DHS expected in 2021. • Conducted a rapid study on child marriage in 2020. • Administrative data accessed from police, gender ministry, one stop centres, the health ministry, and helpline services (child line services and GBV crisis line for adults). • No standardised protocols for sharing data. Access to administrative data largely depends on cordial relations between service providers. • GBV national surveillance under review. • Malawi, recently launched GBV referral pathways that include key players from community level to national level as essential data sources within the GBV data reporting and management process.

Country	Last DHS	Next ongoing DHS	GL survey date	Status of GBV data, analysis and use; national surveys and admin data sources
Mauritius	n/a	n/a	2010	• A 2008-9 study on the economic and social effects of GBV estimated costs to be 1.4 billion rupees (US $46,666,667) per annum between 2008 and 2009. • A 2014 study shows GBV costs have risen to two billion rupees per annum. • Prime Minister launched a National Action Plan on GBV in November 2020. • Currently setting up GBV observatory (surveillance) system.
Mozambique	2011	2021	n/a	• National Institute of Statistics/Nacional de Estatística (INE) collects this data. • A specific GBV survey remains a challenge but a 2014 survey in only five out of ten provinces included indicators on IPV. • In addition to the DHS 2011, Mozambique has the 2015 AIDS Indicator Survey (AIS) with GBV indicators on physical and sexual violence. The DHS 2021 (in process) will also provide an update.
Namibia	2013	n/a	n/a	• GBV data collected through the Namibia Demographic and Health Survey of 2013. • The Namibian Police have a database for GBV data.
Seychelles	n/a	n/a	2016	• GBV study carried out in 2016 in collaboration with GL. • A 2018 study on the economic costs of GBV conducted by the Commonwealth. • Focal persons regularly meet to ensure timely data collection.
South Africa	2016	n/a	Gauteng (2010); Limpopo (2013); Western Cape (2014); KwaZulu-Natal (2014)	• GBV and femicide identified as a priority. • Various departments collect administrative data. • Last DHS in 2016. Women younger than 18 and older than 49, however, not included in the survey. Various surveys are conducted by academia, GL, shelters, etc. • Public safety and justice survey only a proxy for violence data. • There is no GBV surveillance system in South Africa. • Implementation of a two-year national GBV survey is underway, targeting a sample of 23 318 participants led by the Human Sciences Research Council (HSRC) and funded by the UN, Ford Foundation, Bill and Melinda Gates Foundation. The survey will include a module on the experiences of GBV during COVID-19. Researchers expect results around December 2022.
Zambia	2018	n/a	2014	• Last dedicated GBV survey conducted by GL in 2014.
Zimbabwe	2015	2022	2012	• Last dedicated GBV survey conducted by GL and the Ministry of Women Affairs, Community, Small and Medium Enterprises in 2012. • Most recent DHS publication is the 2015 edition. The Multiple Indicator Survey for 2019 used the same domestic violence module as in the DHS. • The crime department of the police obtains and publishes administrative data in the Zimbabwe Statistical Agency (ZimStat) quarterly reports. • Government works with other partners like the United Nations Population Fund (UNFPA) to gather GBV data and respond to GBV.

Source: Compiled from SADC GBV Virtual Workshop, March 2021.

[32] Multiple Indicator Cluster Surveys', Wikipedia, https://en.wikipedia.org/w/index.php?title=Multiple_Indicator_Cluster_Surveys&oldid=999116957, accessed 30 June 2021.
[33] UN Women (2014) The Victim Empowerment and Abuser Rehabilitation Policy, https://evaw-global-database.unwomen.org/en/countries/africa/mauritius/2014/the-victim-empowerment-and-abuser-rehabilitation-policy, accessed 30 June 2021.
[34] Cruz, G. V., Domingos, L. and Sabune, A. (2014) 'The Characteristics of the Violence against Women in Mozambique', Health, 6(13), pp. 1589-1601. doi: 10.4236/health.2014.613192.
[35] The Demographic and Health Survey (DHS) Program country pages, https://dhsprogram.com/Countries/Country-Main.cfm?ctry_id=61&c=Mozambique&Country=Mozambique&cn=&r=1, accessed 1 July 2021.

Table 6.4 maps what GBV surveys have taken place and when in each SADC country. It shows that while most SADC countries have had DHS surveys, these are quite dated. Some countries (e.g. Zimbabwe) have had both DHS and dedicated GBV prevalence studies in partnership with GL. Table 6.5 maps the findings for one important parameter - women subjected to physical and/or sexual violence in the last 12 months, 2010-2019 from both the DHS and GL studies. The figures from the DHS are in black and from GL studies in purple.

Table 6.5: Women subjected to physical and/or sexual violence in the last 12 months, 2010-2019

Country	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	%	%	%	%	%	%	%	%	%	%
Angola							25.9			
Botswana									**26**	
Comoros			6.4							
DRC					36.8					
Eswatini										
Lesotho				**28**						
Madagascar										
Malawi	22.1						24.3			
Mauritius	**5**									
Mozambique		27.7				25.3				
Namibia				20.2						
Seychelles										
South Africa (all provinces)							13			
South Africa - Gauteng	**18**									
South Africa - Western Cape					**12**					
South Africa - Limpopo				**13**						
South Africa - KwaZulu-Natal (KZN)					**16**					
Tanzania							29.6	29.6	29.6	29.6
Zambia					26.7					
Zimbabwe			**26**			19.9				

Source: Adapted from SADC Gender Secretariat Statistics Unit, March 2021, and Gender Links. NB: Figures in bold purple are from GL studies and all others are DHS figures available for countries from 2010-2019.

The SADC region over the last decade shows GBV prevalence over the last 12 months ranging from 5% in Mauritius to nearly 37% in the DRC

As shown in Table 6.5, available data in the SADC region over the last decade shows GBV prevalence over the last twelve months ranging from 5% in Mauritius to nearly 37% in the DRC. Statistics from these dedicated studies in four provinces of South Africa sit at 12-18%, similar to the 2016 DHS (13%) for the whole country. From the GL studies, Botswana, Lesotho and Zimbabwe have prevalence statistics in the range 20-30% comparable to all other countries with DHS data. Overall, the findings support the often quoted (generalised) statistic that at least one in every three women have experienced physical and or sexual violence in the past year. The only exceptions are Mauritius at 5% and Comoros at 6.4%.

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 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 exist 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, sexual, and other types of exploitation; and **16.1** Significantly reduce all forms of violence and related death rates everywhere.

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The SADC region remains a fertile ground for human trafficking. The US State Department 2020 report on Trafficking in Persons[36] notes that, with the exception of Namibia, which has been elevated to Tier 1, 15 out of 16 countries in the region fail to meet the minimum standards for the elimination of trafficking. According to the report, most countries in the region lack adequate victim identification, protection efforts, and show low conviction rates of traffickers. The same report notes that several countries have laws on trafficking that do not align with the 2000 UN Trafficking In Persons Protocol and are therefore missing out on investigating other trafficking crimes. As reported in the previous edition of the Barometer, porous borders, poverty and increasing reports on corruption hinder state efforts to eliminate human trafficking. Despite this, some governments have taken significant steps to meet the required standards.



A guide to the US Department Trafficking in Persons tier system

Tier 1
Countries whose governments fully meet the Trafficking Victims Protection Act (TVPA) minimum standards for the elimination of trafficking.

Tier 2
Countries whose governments do not fully meet the TVPA's minimum standards but are making significant efforts to bring themselves into compliance with those standards.

Tier 2 Watch List
Countries whose governments do not fully meet the TVPA's minimum standards but are making significant efforts to bring themselves into compliance with those standards, and for which:

- The estimated number of victims of severe forms of trafficking is very significant or is significantly increasing and the country is not taking proportional concrete actions; and
- There is a failure to provide evidence of increasing efforts to combat severe forms of trafficking in persons from the previous year, including increased investigations, prosecution, and convictions of trafficking crimes, increased assistance to victims, and decreasing evidence of complicity in severe forms of trafficking by government officials.

Several SADC countries have trafficking laws that do not align with the 2000 UN Trafficking In Persons Protocol

Tier 3
Countries whose governments do not fully meet the TVPA's minimum standards and are not making significant efforts to do so. The TVPA, as amended, lists additional factors to determine whether a country should be on Tier 2 (or Tier 2 Watch List) versus Tier 3:

- The extent to which the country is a country of origin, transit, or destination for severe forms of trafficking;
- The extent to which the country's government does not meet the TVPA's minimum standards and, in particular, the extent to which officials or government employees have been complicit in severe forms of trafficking;
- Reasonable measures that the government would need to undertake to be in compliance with the minimum standards in light of the government's resources and capabilities to address and eliminate severe forms of trafficking in persons;
- The extent to which the government is devoting sufficient budgetary resources to investigate and prosecute human trafficking, convict and sentence traffickers; and obtain restitution for victims of human trafficking; and
- The extent to which the government is devoting sufficient budgetary resources to protect victims and prevent the crime from occurring.[37]

[36] United States Department of State (2020),Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.
[37] United States Department of State (2020),Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.

Namibia leads SADC region in push to confront trafficking

The US 2020 Trafficking in Persons (TIP) report shows that Namibia fully meets the minimum standards for the elimination of trafficking; the only country in Africa to do so. The government made key achievements that include finalising implementation of regulations for the Trafficking in Persons Act of 2018, significantly increasing the number of prosecutions, convicting and sentencing one trafficker, and training front-line responders. The government also identified more victims, referred to care a higher percentage of identified victims, and partially funded two NGO shelters that provided protective services for victims.

The State Department bases its rankings on the extent of government efforts to meet the TVPA's minimum standards for the elimination of human trafficking, which align with the Palermo Protocol, a UN protocol to prevent, suppress, and punish trafficking in human beings especially women and children. Tier 1 is the highest ranking, and it means countries fully meet the Trafficking Victims Protection Act (TVPA). However, it does not mean that a Tier 1 country does not have a human trafficking problem. According to the Trafficking in Persons report,[38] Tier 1 countries fully meet the minimum standards for the elimination of human trafficking. While other SADC countries have made progress curbing trafficking, none fully meets these required minimum standards. The report includes specific recommendations for each country.



The 2020 SADC Gender Protocol Barometer launch in Namibia.
Photo: Fabian Sampaya

Additionally, more victims voluntarily participated with law enforcement investigations and the government provided victim witnesses with protective services. The national anti-trafficking coordination body met quarterly; the government launched a nationwide awareness campaign in collaboration with an international organisation, increased training of front-line responders to prevent trafficking and continued to utilise the SADC regional data collection tool to gather and organise clear trafficking data.

Several of these successes formed part of the recommendations put forward by the United Nations Office on Drugs and Crime (UNODC) in a June 2020 report, *Impact of the COVID-19 Pandemic on Trafficking in Persons*, released in the first months of the pandemic and captured in the 2020 Barometer.

Although the government meets the minimum standards, it did not adequately train frontline officials on the National Referral Mechanism (NRM) or Standard Operating Procedures (SOPs), and observers reported some frontline responders did not fully understand their roles with regard to the provision of services to trafficking victims. Occasional breakdowns in communication between government officials and civil society and within government ministries also led to a lack of coordination among members of the National Coordinating Body (NCB). Although some officials took part in training, the government did not provide clarity on how they could be mobilised to share their knowledge and build capacity.

[38] United States Department of State (2020),Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.

The report noted several recommendations for improvement, including:

- Train officials on the Trafficking in Persons Act of 2018;
- Train officials on implementation of the NRM and SOPs;
- Strengthen coordination among government ministries to ensure roles and responsibilities are clear and anti-trafficking policies are increasingly effective;
- Improve communication between government ministries and civil society;
- Continue to ensure all identified victims get referrals to protective and rehabilitative services;
- Increase funding to civil society partners that provide accommodation and care to trafficking victims to ensure they have adequate resources;
- Increase efforts to investigate, prosecute, and convict traffickers; and
- Increase efforts to raise public awareness, especially in rural areas.

Source: US 2020 Trafficking in Persons report.

Sexual harassment



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 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 exist 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, sexual, and other types of exploitation; and **16.1** Significantly reduce all forms of violence and related death rates everywhere.

Sexual harassment in both the private and public spheres remains a significant challenge in the region. Sexual harassment exists in many traditional contexts and workplaces and perpetration now increasingly manifests in cyber misogyny, including stalking and revenge pornography, among others. Researchers believe that cyber misogyny is a new spin to an old problem: the long-standing issue of violence against women.[39]

[39] GISWatch, Canada Global Information Society Watch, https://www.giswatch.org/en/country-report/sexual-rights/canada, accessed 9 June 2021.

Despite the existence of sexual harassment legislation in 15 out of 16 SADC countries, the scope of the various pieces of legislation is limited when considering the extent and forms of online sexual harassment. Countries need to urgently develop, adopt and implement sufficiently stringent sexual harassment laws that include all the many settings where abuse takes place.

Additionally, there are growing fears that sexual harassment has been normalised in workplace settings as well as in institutions of higher learning to the extent that many victims shun calls to report abuse. However, hope is not lost, as several countries have begun to review legislation linked to sexual abuse and harassment.



Zimbabwe activists seek to address workplace harassment

Zimbabwe's workplaces may soon be safer for women who have long complained about sexual harassment on the job. At the time of writing, Zimbabwe civil society organisations were engaged in nationwide consultations to review the country's Labour Act following a petition submitted to the Parliament of Zimbabwe in October 2020 by the Emthonjeni Women's Forum (EWF).

The petition called on lawmakers to undertake a comprehensive analysis of the Labour Act to address the scourge of sexual harassment in the world of work. The Southern African Parliamentary Support Trust (SAPST) is leading the hearings, with support from the joint parliamentary portfolio committees on public service, labour and social welfare and women affairs, gender, and community and enterprises development.

EWF Programs Manager Melissa Ndlovu said parliamentary action on sexual harassment would protect women across the country. "I am really hoping that the Parliament of Zimbabwe recognises the need to address sexual harassment within the Labour Act," she said. "This will go a long way in protecting women in their various spheres of life and within the workspace."



The Emthonjeni Women's Forum has called for a comprehensive Labour Act that addresses sexual harassment at work. Photo courtesy of EWF

The petition to review the Labour Act comes hard on the heels of a 2019 Transparency International report on gender and corruption in Zimbabwe which found that 57% of women surveyed said men had forced them to offer sexual favours in exchange for jobs, medical care, and even when seeking placements at schools for their children.[40]

Zimbabwean gender activists hope the consultations represent the first step toward a comprehensive review of the Labour Act to facilitate inclusive and protective outcomes for women in all sectors of the country's economy.

[40] Transparency International Zimbabwe (ed.) (2019) Gender & corruption in Zimbabwe. Harare: Transparency International Zimbabwe.

Zimbabwe's Labour Act needs to protect women in both the formal and informal sectors

Some initial remarks shared by participants in the consultations include:

- "The Labour Act should be clear on the sentence for sexual harassment crimes. I want a place where I can report sexual harassment safely and feel protected by the law."
- "There should be a clause that clarifies what should happen when an employee is sexually harassed."
- "Employers should be fined for ignoring the whistle-blowers of sexual harassment."
- "There is need for confidential channels to report sexual harassment cases such as toll free lines to enable victims to report their cases."

Other participants suggested the need for sentencing of ten years or more for those who commit acts of sexual harassment in the workplace. "Sexual harassment should be clearly defined in the Labour Act and the definition of workplace should include the informal sector," said one participant during consultations in Bulawayo.

Women and Law in Southern Africa (WLSA) observed that some participants advocated for the creation of an independent complaint body that will monitor and regulate media to protect victims of sexual harassment.

Another organisation called for a standalone bill on sexual harassment that addresses all social aspects. Many Zimbabwean women work in the informal sector, which underscores the need for a comprehensive bill that offers protection to all women.

Sources: Emthonjeni Women's Forum (EWF) and Musasa

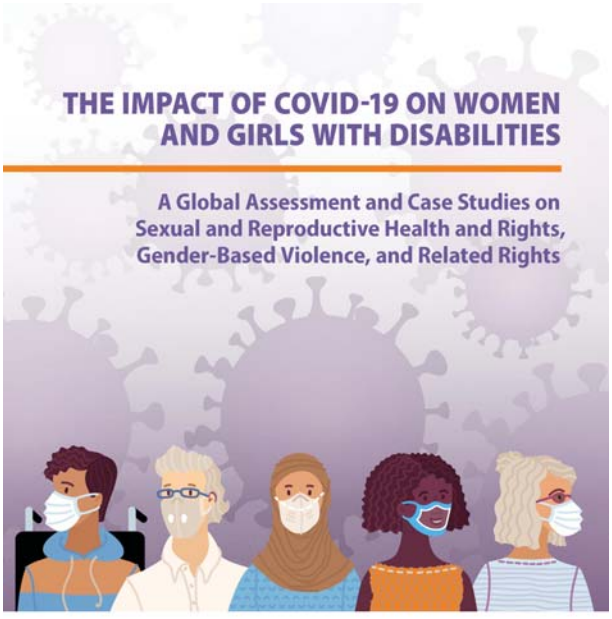
Efforts to review sexual harassment laws such as those underway in Zimbabwe represent a crucial step to stop sexual harassment, which has become endemic and normalised in many parts of the region. Related to this is the challenge of confronting workplace power dynamics. An analysis of social media discussions following allegations of a sex scandal that implicated Zimbabwe's second vice president in February 2021 shows the impact of power dynamics in perpetuating sextortion at workplaces and in institutions of higher learning. Gender activists worry about the deafening silence[41] around these issues and the lack of adequate reporting mechanisms.

"Sexual harassment has been normalised [in Zimbabwe]. I have seen two scenarios during attachment (work based learning) and at university. During attachment *waivingwa nemaDirector chaivo*, ana *sekuru* (company directors as old as my grandfather would come) asking you out, offering to pay your bills for sex and *ukaramba* (if you deny) there is always a new crop of "fresh" lady attaches coming so the cycle continues. *Ndakaramba* (I refused) and I was excluded from assignments and important projects but thank god a female engineer took me under her wing till I finished. I worked for this big organisation in Bulawayo and the old man would have a meeting *ku* (at the) bar *kuti uyu ndewanhingi* (to assign ladies for men) and it would go on *zvichitozivikanwa necompany* yese (this practice would be known throughout the company)." - *Hie Fadzie (not her real name)

Source: iHarare.com[42]

[41] Transparency International (2020) The deafening silence around sextortion - News, Transparency.org, https://www.transparency.org/en/news/the-deafening-silence-around-sextortion, accessed 13 June 2021.
[42] iHarare (2021) Zimbabwean Women Open Up On Sexual Harassment At Work As VP Mohadi's Shenanigans Make Headlines - iHarare News, https://iharare.com/zimbabwean-women-open-up-on-sexual-harassment-at-work-as-vp-mohadis-shenanigans-make-headlines/, accessed 13 June 2021.

Impact of COVID-19 on women and girls with disabilities



Findings from a 2021 global study commissioned by UNFPA and Women Enabled International (WEI) revealed that women and girls with disabilities experience disproportionately high rates of violence from partners and family members - at least three times the rate experienced by other women. The report, titled *The Impact of COVID-19 on Women and Girls with Disabilities*, further noted that women and girls with disabilities face several unique forms of violence. These include violence at the hands of caregivers, withholding of medications or assistive devices, forced institutionalisation, and forced medical interventions.

Women and girls with disabilities experience forced reproductive health interventions (including forced sterilisation, contraception, and abortion) at disproportionate rates.[43] This group also has heightened vulnerability because they often have limited awareness about sexual and reproductive health and rights (SRHR), low educational attainment, lack of resources, and dependence on others.

Research shows that during lockdowns women and girls with disabilities sometimes could not escape and seek redress for GBV, leaving this group without protection from abuse. The following extracts from the report illustrate the vulnerability of women and girls from Malawi and Zambia:

> *"One girl [with a disability] who was forced to marry, got pregnant, and because it was a forced marriage, she was being abused. Because of COVID-19, she was trapped and there were fears in that family."* - *Stella, a woman with a disability and advocate for persons with disabilities in Malawi.

> *"COVID-19 has also affected my access to sanitary and health materials. For example, I used CIC [clean intermittent catheterization], the amount they're costing now is double the price I used to buy before COVID-19, for some, and the price has even tripled. It's difficult for me to buy those materials because of the money that I have. It's not enough for those things."* - *Soneni, a 35-year-old woman with a physical disability in Zambia.[44]

In addition, the study revealed the disproportionate impact of GBV during COVID-19 for women with disabilities, including:

- Increased risk of violence from tensions within households when everyone had to stay inside for prolonged periods;
- Increased prevalence of violence, including sexual, psychological, physical, and emotional, which impacted women of diverse ages and diverse disability groups;

[43] 'UNPRPD,UNFPA,WEI, (2021) The Impact of COVID-19 on Women and Girls with Disabilities FINAL.pdf', https://www.unfpa.org/sites/default/files/pub-pdf/UNPRPD_UNFPA_WEI_-_The_Impact_of_COVID-19_on_Women_and_Girls_with_Disabilities_FINAL.pdf, accessed 14 June 2021.
[44] "UNPRPD,UNFPA,WEI, (2021) The Impact of COVID-19 on Women and Girls with Disabilities FINAL.pdf', https://www.unfpa.org/sites/default/files/pub-pdf/UNPRPD_UNFPA_WEI_-_The_Impact_of_COVID-19_on_Women_and_Girls_with_Disabilities_FINAL.pdf, accessed 14 June 2021.

- Barriers to accessing GBV services and other systems of support. For instance, shelters became, or continued to be, inaccessible or not inclusive for women with disabilities, while alternative housing arrangements through other kinds of support services simultaneously became unavailable for women and girls with disabilities due to the pandemic;
- Barriers to accessing police and justice mechanisms; and
- Lack of data on prevalence of GBV against women and girls with disabilities.

To provide guidelines for inclusion and accessibility, the UNFPA and WEI also published a COVID-19 Gender and Disability SRHR checklist[45] to encourage the provision of rights-based and gender- and disability-responsive SRHR for women, girls, and gender non-conforming persons with disabilities during and after the COVID-19 pandemic and other emergencies. It recommends the creation of a robust legal framework to ensure the respect, protection, and fulfilment of SRHR and disability rights. Additionally, it calls for removal of barriers faced by women, girls, and gender non-conforming persons with disabilities in accessing available, acceptable, and quality SRH information, goods, and services. Further, it notes that women, girls, and gender non-conforming persons with disabilities must be able to participate in SRH programme development, implementation, and monitoring.

Women and girls with disabilities experience disproportionately high rates of violence from partners and family members

Effects of GBV

Gender activists have long known that exposure to GBV leads to adverse health outcomes.[46] This includes HIV and other STI infections, induced abortion, low birth weight and prematurity, harmful alcohol use, depression and suicidal tendencies, non-fatal injuries, and fatal injuries (intimate partner homicides). Recent studies have shown the links between IPV and poor reproductive health outcomes for women, including adolescents and young women in intimate relationships.[47]



Mateboho Mokoma speaks during a 16 Days of Activism gathering at Kanana Council in Lesotho in 2018. Photo: Ntolo Lekau

[45] UNFPA and Women Enabled International 'COVID-19, Gender, and Disability Checklist: Ensuring Human Rights-Based Sexual and Reproductive Health for Women, Girls, and Gender Non-Conforming Persons with Disabilities during the COVID-19 Pandemic', p. 11.
[46] García-Moreno, C. et al. (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: World Health Organization.
[47] 'IPV and Reproductive Coercion Fact Sheet (2012)', https://www.plannedparenthood.org/uploads/filer_public/fb/70/fb70f966-e4a2-46e8-900c-9137fed3e636/ipv_and_reproductive_coercion_fact_sheet_2012_final.pdf, accessed 14 June 2021.

Intersections between IPV and reproductive coercion



A public gathering to call attention to the scourge of GBV, HIV and AIDS at Kanana Council in Lesotho in 2018. Photo: Ntolo Lekau

Reproductive coercion is any behaviour limiting a person's ability to decide when and under which conditions they will parent a child. The study into the link between IPV and reproductive coercion is of particular importance in developing country contexts such as in the SADC, where women and adolescents lack comprehensive knowledge of reproductive health. Perpetration of reproductive coercion may take various forms, including disruption of birth control or damaging a condom, coercing a partner to get pregnant, or controlling the outcome of a pregnancy through pressure to continue it or terminate it.[48] The issues of power and control are central to understanding reproductive coercion. Women's lack of control in relationships elevate men's intrusive efforts to manage their partners' fertility by pressuring them to become pregnant or sabotaging their attempts to use contraception.[49]

In the SADC region, progress on sexual and reproductive health and rights (SRHR) priorities remains patchy and insufficient. Higher rates of HIV infection align with other SRHR trends, such as unintended pregnancies and poor access to contraception services, including abortion services. The region also has high rates of GBV and harmful practices based on discriminatory cultural and gender norms. Several highly vulnerable groups, including adolescents, remain poorly served largely because of discriminatory laws and policies, which are often based on deeply held social and cultural prejudices. Reproductive coercion represents a key factor that sexual and reproductive rights discourse and intervention programmes largely misunderstand and ignore.

> Reproductive coercion threatens the reproductive health rights of many SADC women

Reproductive coercion disproportionately affects women experiencing concurrent IPV. An extensive body of literature has documented a range of negative reproductive health consequences arising from women's experiences with IPV, which include unintended pregnancies, maternal morbidity, and increased vulnerability to sexually-transmitted infections (STIs), including HIV. A study commissioned in South Africa's Gauteng province has demonstrated the role of reproductive coercion and women's risk of HIV. The study shows that where one in five women from rural Mpumalanga disclose partner abuse, HIV has surged by more than 22% among women aged 22 years and younger.[50] Reproductive coercion threatens the reproductive health rights of many women, setting back progress toward SDG 16.1, which urges all countries to significantly reduce all forms of violence and related death rates.

[48] Grace, K. T. and Anderson, J. C. (2018) 'Reproductive Coercion: A Systematic Review', Trauma, Violence & Abuse, 19(4), pp. 371-390. doi: 10.1177/1524838016663935.
[49] Miller, E. et al. (2010) 'Pregnancy coercion, intimate partner violence, and unintended pregnancy', Contraception, 81(4), pp. 316-322. doi: 10.1016/j.contraception.2009.12.004.
[50] McCloskey (2020) 'The role of reproductive coercion in women's risk for HIV: A case_control study of outpatients in Gauteng, South Africa.', https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.13373, accessed 14 June 2021.

Measuring the costs of violence in SADC

As mentioned in the previous edition of the Barometer, the World Bank estimates that GBV costs amount to 1.2%-3.7% of GDP in some countries due to lost productivity. This is equivalent to the average spending of low- and middle-income countries on primary education.[51] These costs could make fighting the COVID-19 pandemic even harder as countries struggle and need to spread resources between the two pandemics. Thus, member states should consider investing in the primary prevention of GBV.

Several ongoing Commonwealth studies are casting a spotlight on the costs of GBV in the SADC region. The latest study in Lesotho reflects similar results to studies carried out in the region, including by the Swedish International Development Cooperation Agency (SIDA) in Zimbabwe (2009); Klynveld Peat Marwick Goerdeler (KPMG) an accounting organisation in South Africa (2014); and by the Commonwealth in Seychelles 2018. The study in Lesotho makes the case that GBV presents a significant barrier to national development and to the achievement of the SDGs.[52]



A 2020 Commonwealth study estimates that VAW costs **Lesotho** $113 million annually: approximately 5.5% of the country's GDP. The key drivers of these costs include medical, legal and police support expenses. The most revealing finding is that about $45 million goes to healthcare, legal care, social protection, and learning loss. This is twice the amount of money - $21 million - spent by the Lesotho government in the 2019/2020 budget on health, education and energy.[53] Additionally, Lesotho loses about $22 million of the total amount annually due to the non-productivity of women who experience violence and fail to report to work.[54] This deprives women of earning an income and their economic independence.

To encourage the Lesotho government and private sector to consider the needs of the victims, the Commonwealth suggested several policy recommendations. These include updating the forms used for collecting data on violence against women and girls; using digital services to collect and share the data with stakeholders; training staff responsible for recording, analysing and sharing data; developing a broad approach involving all sectors to prevent the abuse; and making strategic shifts to allocate resources to carry out these recommendations.

Response

SADC Gender Protocol Article 20.1: States parties shall:
(a) Enact and enforce legislation prohibiting all forms of GBV;
(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.

[52] UN Women (2016) The economic costs of violence against women, UN Women, https://www.unwomen.org/en/news/stories/2016/9/speech-by-lakshmi-puri-on-economic-costs-of-violence-against-women, accessed 14 June 2021.
[53] 'Lesotho 2019-2020 Budget Book', https://www.gov.ls/wp-content/uploads/2019/07/2019-2020-Budget-Book-1.pdf, accessed 12 June 2021.
[54] Violence against women costs Lesotho economy $113 million annually, The Commonwealth, https://thecommonwealth.org/media/news/report-violence-against-women-costs-lesotho-economy, accessed 1 June 2021.

(d) **SADC Gender Protocol Article 20.6**: State parties shall ensure that cases of GBV are conducted in a gender sensitive environment.
(e) **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 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 realisation 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.

SADC must expand legislation to respond to emerging and evolving forms of GBV

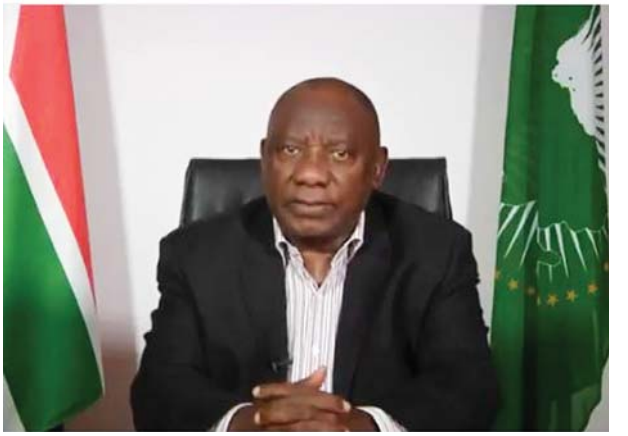
The SADC regional strategy and 2018-2030 Framework of Action for Addressing Gender Based Violence confirms that the region has made progress around legislation dealing with GBV, through specific laws and penal codes. However, activists have been calling for more reviews to expand the scope of legislation to respond to emerging and evolving forms of GBV. Legislation cannot overlook growing evidence of online violence including sexual harassment, stalking, and controlling behaviours.

South Africa amends key legislation to fight violence



Levels of GBV and Femicide (GBVF) in **South Africa** rank among the highest in the world and were widely seen as a second pandemic over the past year as South Africans grappled with both COVID-19 and escalating gender violence. Thus, a major review of the country's laws to respond to this issue represented a progressive and welcome move in 2021, according to gender activists in the region.

In 2020, President Cyril Ramaphosa first announced that the government had set aside R1.6 billion to fight GBVF in the country.



South African President Cyril Ramaphosa supported Parliament's decision to push for the adoption of three key bills to fight GBV. Photo: Twitter

By January 2021, and in line with the SADC Gender Protocol Article 20.3, the president had signed into law the Social Assistance Amendment Bill and Prescription in Civil and Criminal Matters (Sexual Offences) Amendment Bill.

The Social Assistance Amendment Bill will see the expansion of social grants to child headed households while the Prescription in Civil and Criminal Matters (Sexual Offences) Amendment Bill lifts the prescription that a victim cannot institute a civil claim or a criminal prosecution after a particular period of time.[55]

Additionally, in May 2020, the South African Parliament's portfolio committee on Justice and Correctional Services adopted The Criminal Law (Sexual Offences and Related Matters) Amendment Bill and the Domestic Violence Amendment Bill.

According to the Committee chairperson Bulelani Magwanishe[56], the amendments aimed to:

- Expand the scope of the National Register for Sex Offenders (NRSO) to include the particulars of sex offenders, and not only sex offenders against children and persons who are mentally disabled;[57]
- Expand the list of protected persons to include other vulnerable persons, namely, certain young women; persons with physical, mental, sensory or intellectual disabilities; and persons older than 60 years of age who, for example, receive community-based care and support services;[58] and
- Increase the periods for which a sex offender's particulars must remain on the NRSO before removal from the register.[59]

"I wish to commend Parliament for prioritising these bills," President Ramaphosa said in June 2021. "The passage of these amendments will be a major victory that will strengthen the fight against gender-based violence." *Source: IOL*[60]

Levels of GBVF in South Africa rank among the highest in the world



Because of a spike in GBV cases due to the COVID-19 lockdown, **Botswana** set up specialised courts to speed up justice delivery to abuse survivors. According to the Practice Directive no 9 of 2020, cited in the *Justice Roundup* newsletter,[61] the courts - which legislators housed in all Chief Magistrate stations - could treat all GBV cases as urgent applications that required expedited management, set down and disposal. The justice system prioritised GBV cases that come through the courts and removed them from the normal track of all other cases upon registration. Reflecting on the government's decision to set up the special courts, women's rights advocates said they hoped the courts would bring swifter justice to survivors of domestic and sexual abuse. Gender activists expect the move, which is in line with SADC Gender Protocol Article 20.7, to influence survivors to maintain charges and spur brisker police work.[62]

[55] Independent Online (IOL), Grants and sexual abuse bills signed into law by President Ramaphosa, https://www.iol.co.za/capeargus/news/grants-and-sexual-abuse-bills-signed-into-law-by-president-ramaphosa-fd4daddd-9634-4e3b-aaf9-f103877cd112, accessed 14 June 2021.
[56] Adoption of two bills to curb gender-based violence in SA welcomed, https://www.iol.co.za/capeargus/news/adoption-of-two-bills-to-curb-gender-based-violence-in-sa-welcomed-c33b77d5-9b9e-4881-9ff1-a0e3b650ce15, accessed 14 June 2021.
[57] Adoption of two bills to curb gender-based violence in SA welcomed, https://www.iol.co.za/capeargus/news/adoption-of-two-bills-to-curb-gender-based-violence-in-sa-welcomed-c33b77d5-9b9e-4881-9ff1-a0e3b650ce15, accessed 14 June 2021.
[58] Adoption of two bills to curb gender-based violence in SA welcomed, https://www.iol.co.za/capeargus/news/adoption-of-two-bills-to-curb-gender-based-violence-in-sa-welcomed-c33b77d5-9b9e-4881-9ff1-a0e3b650ce15, accessed 14 June 2021.
[59] Adoption of two bills to curb gender-based violence in SA welcomed, https://www.iol.co.za/capeargus/news/adoption-of-two-bills-to-curb-gender-based-violence-in-sa-welcomed-c33b77d5-9b9e-4881-9ff1-a0e3b650ce15, accessed 14 June 2021.
[60] Independent Online (IOL), '3 key bills to fight gender-based violence expected to be passed on Thursday', https://www.iol.co.za/news/politics/3-keys-bills-to-fight-gender-based-violence-expected-to-be-passed-on-thursday-09203fbe-0177-4907-8a53-f504f320169c, accessed 14 June 2021.
[61] 'Botswana Justice Round Up Newsletter', https://www.justice.gov.bw/sites/default/files/Justice%20Round%20Up-compressed.pdf, accessed 15 June 2021.
[62] Thobega, K. (2020) 'Botswana sets up gender violence courts to tackle pandemic backlog', Reuters, 30 November, https://www.reuters.com/article/botswana-rape-court-idINL8N2IG3BE, accessed 15 June 2021.

Support

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 GBV.

SADC Gender Protocol Article 23.3: State parties shall provide accessible, affordable, and specialised legal services, including legal aid, to survivors of GBV.

SADC Gender Protocol Article 23.4: State parties shall provide specialised facilities including support mechanisms for survivors of GBV.

Research shows that women survivors of GBV face a wide array of barriers that deny, and delay them access to, justice. These include legal costs and subjective costs that link to religion, stigma, and tradition. Survivor-centred approaches that seek to empower the survivor by prioritising her rights, needs and wishes represent best practices of working with survivors. This means ensuring that survivors have access to appropriate, accessible and good quality services.[63]



Politicians and gender activists attend the launch of Harare's 24-hour GBV clinic in 2016. Photo: VOA Zimbabwe

Harare opens 24-hour clinic for GBV survivors

The Harare City Council in Zimbabwe has found an innovative way to assist GBV survivors: a clinic that ensures free emergency care 24 hours of the day, including on weekends.

Most other clinics operate during business hours, which leaves a large time gap, especially because many violations occur outside of work hours and in the evening. This means that those affected usually have to wait hours for critical services or go to busy emergency rooms at regular hospitals.

The innovative clinic provides specialist and comprehensive medical care. It removes barriers to accessing healthcare often faced by survivors and provides HIV services such as testing and counselling.

[63] UN Women (2013) Survivor-centred approach, https://www.endvawnow.org/en/articles/1499-survivor-centred-approach.html, accessed 17 June 2021.

The first step to getting the project approved involved formative research showing that VAW is a major public health and human rights challenge in the city. The second step entailed sourcing a suitable site for the clinic.

Research showed that the city could use existing facilities to house the GBV clinic. Council chose Wilkins Hospital as the most ideal site due to the availability of other facilities there, especially the sexual and reproductive health centres, counselling, testing facilities and wards for the admission of survivors.

The council renovated some buildings with assistance and expertise from the Department of Works, which outlined the scope of work and costs of the project. Training of staff soon followed and the City officially opened the clinic in October 2016. Since then, the clinic has opened its doors to the public. Gender activists and councillors in Harare now hope other cities and countries will soon consider replicating their successful 24-hour model.

Source: SADC Gender Protocol @Work Summits.

Economic justice

Lack of economic independence is one of the many factors that derails progress on women economic empowerment efforts in the region. Yet economic empowerment is a sustainable solution to gender violence. It ensures access and participation of women in various economic sectors. According to the UN Women, investing in women's economic empowerment sets a direct path towards gender equality,[64] poverty eradication and inclusive economic growth.

To ensure economic justice, governments must adopt gender-responsive laws, especially as the region recover from the COVID-19 pandemic, which has crippled women's economic activities, increased unemployment and the burden of unpaid work. In the region, South Africa is the first to adopt economic justice as one of the four pillars of its National Strategic Plan on Gender Based violence and Femicide 2018-2030[65]. This is in response to the historical economic injustices that have resulted in increasing women's risk of experiencing violence. In addition, having economic power as a pillar paves the way to intentionally transform structural inequality and dramatically changes the social position of women.

Since its founding in 2001, GL has worked with more than 2000 women to document their experiences of GBV as part of its "I" Stories series.[66] These first-hand accounts of physical, sexual, verbal and emotional abuse provide glimpses into the lives, challenges and triumphs of survivors from across the SADC region. A common theme in the series involves women who speak about staying in - or returning to - abusive relationships because they lack economic independence or experience financial control as a form of abuse.



[64] UN Women, What we do: Economic empowerment, UN Women, https://www.unwomen.org/what-we-do/economic-empowerment, accessed 12 July 2021.
[65] 'South Africa National Strategic Plan Gender Based Violence and Femicide 2018-2030', https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf, accessed 12 July 2021.
[66] 'I' Stories - Gender Links, https://genderlinks.org.za/what-we-do/justice/i-stories/, accessed 1 July 2021.

The Sunrise Campaign - empowering women to end violence



In 2013, GL piloted a programme entitled *Empower Women: End Violence*. The Sunrise Campaign, as it is popularly known, tested the hypothesis that increasing women's agency, confidence and economic power would result in less violence for women in abusive relationships and more control over their lives. Results to date show a strong positive correlation between women's economic independence and sustainable solutions to GBV.

The entrepreneurship course for survivors of GBV combines life skills to enhance confidence and agency with basic business skills. While GBV debilitates and destroys self-worth, business builds confidence, negotiation skills, innovation, and resilience. The two forms of training thus complement each other. A unique feature is that local councils that have undergone a ten-stage process to become Centres of Excellence (COE) for gender in local government anchor the course. The council's include support for survivors of gender violence as part of their GBV and local economic development action plans.

The programme has evolved over the years to include handing over primary management to the COEs; a mentorship component and working with men. The programme pivoted once again in 2020 to conduct business revival training to mitigate the impacts of COVID-19. In all, GL has worked with 1129 women (28% young women aged between 18 and 30 years) located in 74 local councils in Botswana, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, eSwatini, Zambia and Zimbabwe. In all cases GL provides standard setting, quality assurance, and backstopping.

An analysis of phase two of the project focuses on five countries where all the stages of the *Sunrise Campaign* are complete and where participants had sufficient time to implement their plans. The five countries include: Botswana, Lesotho, Madagascar, Mauritius and Zimbabwe.

Table 6.6 Key Sunrise campaign 2015 and 2019 indicators

Sunrise campaign indicators	2015 End line data for 5 countries	2019 End line data for 5 countries
Number of women that completed the course	623	603
% women completed a business plan	91%	82%
% women implemented a business plan	79%	80%
Monthly income in USD	106	170
Relationship control score (%)	52%	57%
% women experiencing less or much less violence	97%	87%

Source: Source: Gender Links, Gender@Work in Local Government (unpublished).

Table 6.6 compares the endline results of each phase for each of the key indicators. The monthly income average increased from USD 106 in the first phase to USD 170 when run by the COEs. The relationship control index increased five percentage points from 52% to 57%. The percentage of participants who said they were experiencing less or much less violence in the second phase dropped from 97% to 87%. However, in both phases the most

important outcome is that the programme has increased women's agency and reduced their experience of violence. Furthermore the second phase demonstrates that this programme can be run sustainably by local authorities.

First-hand accounts or "I" Stories from participants in the programme complement quantitative data by illustrating some of the changes in participant businesses and in their lives. Many of the women said they had more self-confidence following the programme and many indicated positive changes in their relationships due to increased personal agency.

"I benefited a lot from the training as I learnt how to manage my little business, to keep some savings and to always be self-confident," said Marie Augustine Ravaorimanana from Madagascar. "I put the teachings into practice by extending my business and not sticking to just one activity; by investing my savings in another activity like brickworks in order to increase it so that I wouldn't need to borrow money for starting funds but to use my own. Thanks to GL's training on personal development, I could also set up an association called Tsinjoaina Ramba, which helps orphans and women survivors of violence to have regular papers such as identification cards. I allocate 10% of my earnings to that association."

Another participant, Itai Makara in Zimbabwe, said, "I learnt about gender equality. Women can also be successful entrepreneurs. I learnt about business planning, record keeping and market research. I have been using these concepts in my business and I intend to continue using them because my business is doing well. I will not be deterred from venturing into other businesses because of my sex.

"My plans are to finish building our house with my husband, buy a farm and send all of my children to school. I will venture into farming after buying our own farm. By the year 2030, I ought to have a big supermarket and employ many people. I thank GL for the knowledge they gave us. I thank them for their courage and love. Our lives are better than before and we are optimistic of brighter future. I wish they continue doing the good work and be able to reach out to others who are experiencing domestic violence."

Source: Gender Links, Gender@Work in Local Government (unpublished)

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 GBV including the police, the judiciary, health, and social workers;
(b) Community sensitisation programmes regarding available services and resources for survivors of GBV; 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 SADC Secretariat is on course to achieve the SADC Gender Protocol Article 24 and the BPFA +20 Africa Declaration targets through the development of tools to enable the training of service providers to have a positive and caring attitude, and offer quality service.



Zambian youth participate in the Lusaka City Council campaign against child marriage in 2020. Photo: Albert Ngosa

The SADC Secretariat, with the support of the European Union, is implementing the Support to Peace and Security in the SADC Region Programme (SPSS). Among other issues, the programme aims to enhance capacity in SADC for gender-sensitive conflict prevention, management and resolution and for addressing the prevalence of sexual and GBV.

The SADC Executive Secretary's report for the 2019/2020 financial year notes that GBV continues to be a challenge for the SADC region in its efforts towards achieving gender equality and promoting peace and security within the regional integration agenda. In the report, Executive Secretary Stergomena Lawrence Tax said the Secretariat is developing tools to guide the regional response to GBV through the SPSS programme.

These include the Regional Sexual and Gender-based Violence Training Guidelines, which will support capacity strengthening of frontline officers, especially law enforcement officers, at national level to ensure effective and efficient prevention and provision of comprehensive GBV services. The Training Guidelines will also build awareness among key service providers on GBV, its impacts and consequences.

The second instrument under development is a Regional Guideline on Developing GBV Standard Operating Procedures (SOPs) and Referral Mechanisms. This Guideline aims to provide member states with steps to follow in the development and implementation of GBV SOPs and referral mechanisms to facilitate access to quality, timely and appropriate services for GBV victims/survivors. The Regional Guidelines describe essential services for GBV victims by the health, social services, police, and justice sectors and provide overall guidance on coordination of essential GBV services at national level.

In addition, the Secretariat will create a regional inventory of Sexual and Gender Based Violence (SGBV) legislation. This exercise also includes conducting a rapid assessment of GBV laws and policies with recommendations to member states for addressing existing gaps.

The SPSS programme continues to support the wide dissemination of the SADC Strategy and Framework of Action for Addressing GBV (2018-2030) across the region and public education and awareness-raising interventions. Another of the key result areas of the SPSS programme involves strengthening SADC's capacity to address issues of SGBV by training service providers, in particular law enforcement officers, on effective response to GBV.

The SADC Secretariat is developing tools to guide a regional response to GBV



Members of Mazenod Council march as part of the 16 Days of Activism in 2020.
Photo: Ntolo Lekau

It also supports member states, based upon requests, to review or develop national GBV action plans. For example, it supported Malawi to conduct a national consultative forum to aid the review of the Malawi Action Plan on Ending Gender-Based Violence and to create a platform for discussing recommendations for review of GBV-related legislation.

The programme also specifically targets parliamentary engagement, encouraging policymakers to be advocates for change in the response to GBV. In particular, this occurs through creation of platforms for engaging parliamentarians in understanding GBV and the related regional policy instruments, including their participation in the development of the SADC GBV Model Law.[67]

Prevention

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 GBV.

Attitudes

Psychologists define an attitude as a set of emotions, beliefs, and behaviours toward a particular object, person, thing, or event. Attitudes are often the result of experience or upbringing, and they can have a powerful influence over behaviour.[68] One factor that affects attitude formation is the influence of social roles and norms. Social roles relate to how people are expected to behave in a particular role or context. Social norms involve society's rules for what behaviours are considered appropriate. Social norms that promote gender inequality can increase violence and compromise women's sexual and reproductive health.

While attitudes are enduring, they are not cast in stone, they can change. Theorists suggests that the same influencers to attitude formation can also lead to attitude change in individuals[69]. Indeed, work by GL through the Centres of Excellence (COE) in gender mainstreaming programme in local councils throughout the region has identified gender champions who are useful in challenging patriarchal mind-sets and promoting gender equitable attitudes.

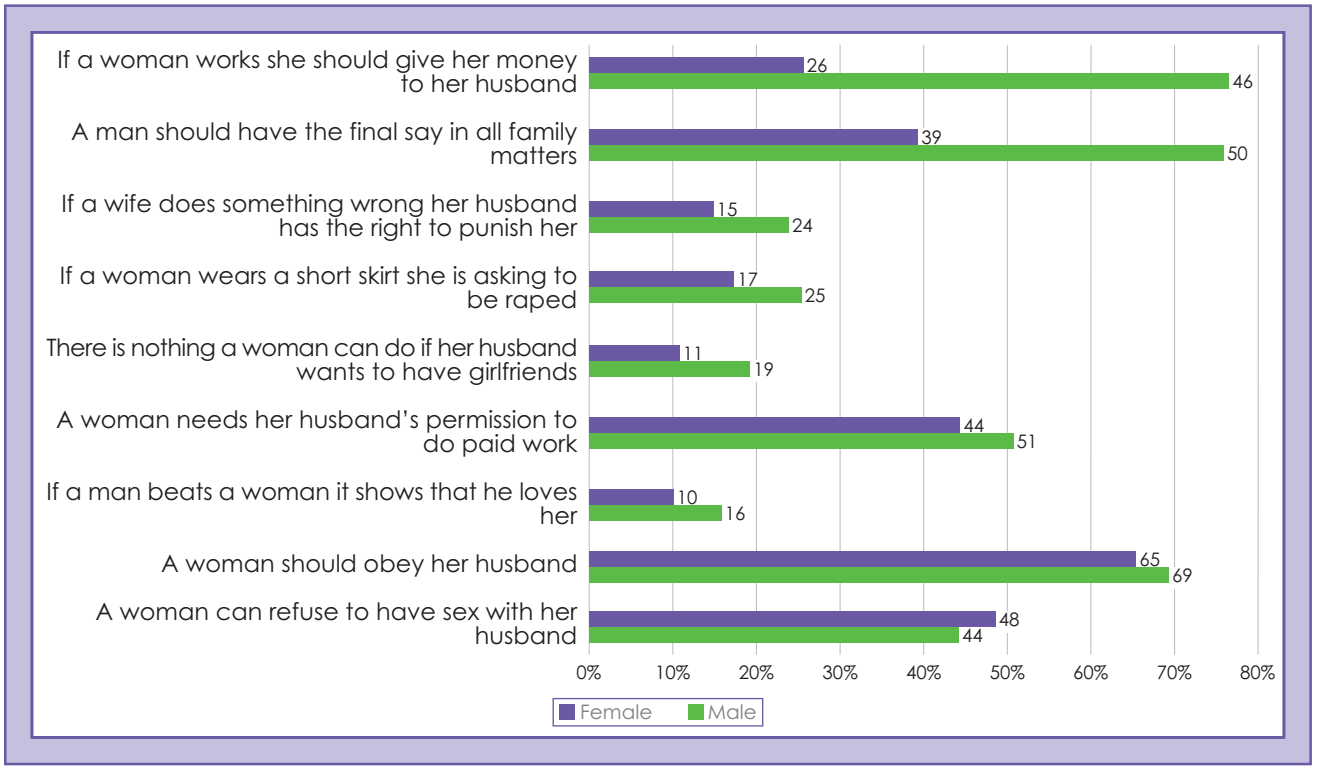
[67] Southern African Development Community (SADC) Secretariat develop tools to guide the Region's response to Gender-based Violence, https://www.sadc.int/news-events/news/sadc-secretariat-develop-tools-guide-regions-response-gender-based-violence/, accessed 17 June 2021.
[68] Cherry, K. (2021) How Can Our Attitudes Change and Influence Behaviors?, Verywell Mind, https://www.verywellmind.com/attitudes-how-they-form-change-shape-behavior-2795897, accessed 12 July 2021.
[69] Bowleg, L. (2009) Teaching Tip Sheet: Attitudes and Behavior Change, https://www.apa.org/pi/aids/resources/education/attitude-change, accessed 12 July 2021.

However, one debilitating factor is the tolerance of violence in the region which appears to be a persistent challenge in shaping positive gender norms and attitudes in men and boys in the SADC. It is important to note that where violence against women is tolerated and accepted in a society, its eradication is made more difficult.

Given the negative consequences of GBV on individuals and communities, the issue of how peoples' attitudes about GBV relate to their behaviours is an especially important topic in gender attitude transformation. In line with the SADC protocol on Gender and Development to eliminate GBV by 2030, the promotion of gender attitudes transformation particularly within the male population is an important pathway towards the eradication of GBV in SADC.

An important first step in influencing attitudes and behaviour change is to understand gender attitudes in SADC. Over the years, GL has tested the patriarchal attitudes of women and men on several provocative statements and questions that form part of GL's Gender Progress Score (GPS). Nine questions have a strong bearing on gender-based violence theme. Responses to these questions between 2019-2021 show that deep patriarchal and sexist attitudes persist.

Figure 6.1: Regional gender attitudes by sex on key GBV questions



Source: Gender Links Attitude Survey 2019-2021.

Figure 6.1 shows differences in perceptions by sex. Overall, male respondents held more negative gender attitudes in relation to gender-based violence questions than female respondents. A significantly higher proportion of male respondents agreed or strongly agreed with the following statements:

- If a woman works she should give her money to her husband (20% more male respondents agreeing or strongly agreeing than female respondents). Participation in decision-making is a measure of women's empowerment. This often links to important issues like healthcare and major household purchases.

- A man should have the final say in all family matters (11% more male respondents agreeing or strongly agreeing than female respondents). This finding demonstrate attitudes endorsing men's continued dominance in decision-making.
- If a wife does something wrong her husband has the right to punish her (9% more male respondents agreeing or strongly agreeing than female respondents).
- There is nothing a woman can do if her husband wants to have girlfriends (8% more male respondents agreeing or strongly agreeing than female respondents). The evidence here provides information on women's vulnerability and risk of exposure to multiple concurrent sexual relationships, a factor that negatively affects women's sexual and reproductive health.
- If a woman wears a short skirt she is asking to be raped (8% more male respondents agreeing or strongly agreeing than female respondents). This indicator illustrates the perennial problem linked to victim blaming when it comes to rape and sexual assault. Gender activists in SADC have frequently taken to the streets and social media using the hashtag #IWearWhatIWant to combat attitudes like those expressed here. Addressing these harmful attitudes requires the collective efforts of many stakeholders, including the media and lawmakers.
- A woman needs her husband's permission to do paid work (7% more male respondents agreeing or strongly agreeing than female respondents).
- If a man beats a woman it shows that he loves her (6% more male respondents agreeing or strongly agreeing than female respondents). Physical intimate partner violence is one of the most common forms of GBV in the region, often leading to loss of productive capacity, injuries, disability, and sometimes death. This finding speaks to women's participation in decision making as it relates to access to economic resources. Expanding women's economic independence is critical to reducing GBV.
- A woman should obey her husband (4% more male respondents agreeing or strongly agreeing than female respondents). This reflects the region's deeply held cultural belief that women should be submissive to men.

On the positive side, more women (48%) than men (44%) agreed or strongly agreed with the statement "A woman can refuse to have sex with her husband". This suggests that women in could suggest that women agency for women in negotiate for safer sex in their relationships. Of concern is the high proportion of women who agreed or strongly agreed with the following statements:

- A woman should obey her husband (65%).
- A woman needs her husband's permission to do paid work (44%).
- A man should have the final say in all family matters (39%).
- If a woman works she should give her money to her husband (26%).

The findings show that transforming gender attitudes is a priority if SADC is to achieve wide-spread prevention of GBV. The need for primary prevention of GBV came into sharper focus during the COVID-19 crisis. The inexcusable lack of urgency to prioritise prevention of GBV has haunted leaders across the region as they grappled over the past year with escalating gender violence during a global pandemic and the simmering existential global crisis presented by climate change.

As highlighted earlier in the analysis of costs of GBV to SADC, it is imperative for SADC member states to put more focus on addressing the social norms, structures of gender inequality, and the general acceptance of Violence Against Women and Girls (VAWG) that contribute to the high rates of GBV in the region. These must comprise integral components in all national and regional actions to prevent VAW. The pandemic once again underscored that primary prevention initiatives play a critical role in response and care services for survivors.[70]

[70] Jewkes, R. and Abrahams, N. (2002) 'The epidemiology of rape and sexual coercion in South Africa: an overview', Social Science & Medicine (1982), 55(7), pp. 1231-1244. doi: 10.1016/s0277-9536(01)00242-8.

GBV campaigns

Despite the challenges, all SADC countries now have campaigns to end GBV and strategies to raise awareness and advocate for GBV prevention. Annually, the 16 Days of Activism against GBV stands out as a major regional activity. The advent of digital technologies has expanded the reach of these campaigns through platforms such as Twitter, Facebook, WhatsApp, and Instagram.



In **South Africa**, *#AMillionVoices AgainstGBV*, provides an example of the type of powerful social media app used to empower young women and girls to combat GBV. Developed by Sinqobile Kingdom Empowerment Centre, it offers a broader platform to reach out to young women and men to discuss GBV daily and share practical and realistic solutions to stop GBV and to connect to GBV news and information. The app has six groups for young women and girls looking to access much needed assistance and information.[71]



In **Zimbabwe**, the Spotlight Initiative to end GBV launched the *#WithHer campaign* as part of the 2020 16 Days of Activism. The campaign aims to mobilise the public and communities to prompt action to end SGBV and harmful practices with a specific focus on early marriage. The Spotlight Initiative, a four-year programme, targets 11 million beneficiaries, particularly rural women and girls, women and girls with disabilities, and women living with HIV. The UN-led initiative aims to ensure that all women and girls benefit from adequate legislation and policies, gender-responsive institutions, violence prevention programmes, essential services, comparable and reliable data, and a strong social movement against violence and harmful practices at the national and sub-national levels.



Lobatse Town Council in **Botswana** adopted a new method to combat GBV, dubbed the P.E.P approach. It stands for: *Prevention* by means of raising awareness and free contraception to public areas; *Empowerment* through psychosocial support and a financial project; and *Protection* by referral of survivors to appropriate shelters and safe environments and through strengthening stakeholder collaborations. Through the programme, the council aims to raise awareness and increase knowledge and understanding of GBV. They also want to discuss strategies and support mechanisms to reduce and respond to incidents of GBV. Additionally, the council sought to commemorate the achievements, efforts and struggles of women towards the entire development process and link survivors with financial institutions and government funding. Activities conducted include commemoration of the 16 Days of Activism and Women's Day. The council also established a support group with 21 GBV survivors and hosted a workshop for committee members to gain skills on how to sensitise the community on GBV issues.[72]

Member states must ensure gender sensitive vaccine roll out plans

[71] Girl, Talk Forum: StopGBVapp, Facebook, https://www.facebook.com/Girl-Talk-Forum-StopGBVapp-103556948114357/, accessed 16 June 2021.
[72] Gender Links, 'Summit 2019: Una Zomba Lobatse Town Council', Una Zomba Lobatse Town Council, https://genderlinks.org.za/casestudies/botswana-lobatse-town-council-una-zomba/, accessed 1 July 2021.

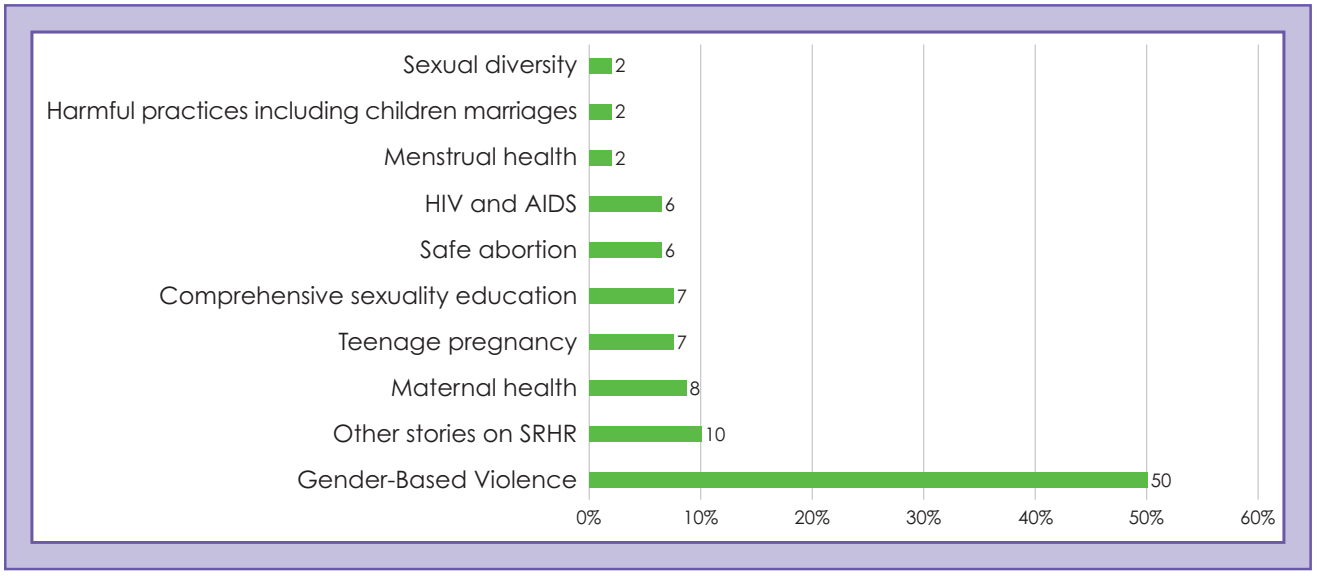
Role of the media

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 GBV 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.[73]

In today's world, the media wields significant social influence. After many years of contributing to the problem, SADC media has recently become more proactive in raising public awareness on GBV prevention, response, and support activities.[74] The findings from the 2020 *Gender and Media Progress Study* (GMPS) show the extent of reporting SRHR and GBV in SADC. The 2020 GMPS found that SRHR constituted just 2% of all stories covered in the media during the monitoring period.

Figure 6.2: SRHR topic breakdown in SADC



Source: Highlights from the Gender and Media Progress study (2020).

Figure 6.2 shows that GBV makes up half of all SRHR news. At 2% each, menstrual health, harmful practices, and sexual diversity represent the least covered topics.[75]

[73] SADC Protocol on Gender and Development Article 29 (1-7).
[74] Chiramba, K. Musariri, L and Rasesigo G, (2018). Botswana Relationship Study. MNIGA.
[75] 'Oronje et al. - 2011 - Engaging media in communicating research on sexual.pdf', https://genderlinks.org.za/wp-content/uploads/2020/11/GMPS-2020-VCfin.pdf, accessed 17 June 2021.

In this time of expanding digital technologies, social media has emerged as an indispensable tool for information dissemination, both accurate and false. Digital and social media has played an outsized role in propagating myths and negative attitudes about the COVID-19 pandemic, including vaccine hesitancy that continues to take root amongst many citizens across SADC. As the world continues to move in the digital direction, organisations and activists must devise innovative and positive ways of tapping into digital technology approaches to protect women and girls at risk of GBV.

GBV is the most covered SRHR news topic, making up 50% of all SRHR news in the region

Social media



Social media proved both harmful and useful during COVID-19 lockdowns. While many used it to promote false news about the pandemic and vaccines, others used it to share materials on a broad array of GBV topics and inform men and women about service availability across the region. Recognising the power of social media, the Alliance for Advancing Health Online uses social media to enhance the health and resilience of communities worldwide. Through the Vaccine Confidence Fund (VCF), it supports targeted research on using social media to increase vaccination confidence and uptake, particularly among historically marginalised or excluded communities.[76]

In the public sphere, many people continue to take to social media to perpetuate harmful gender stereotypes and cyber misogyny; men use it to share derogatory comments and content that perpetuate ideas of women as sex objects. Within the private spheres, too, cyber insecurities linked to the contemporary "smart home" have exposed women to abuses, which include access control, phishing, and other social engineering behaviours.

Conversely, many opportunities also exist to ensure social media can be a valuable tool for activists to transform negative perceptions.[77] The scale of social media makes it an effective campaign tool in raising awareness about GBV laws and GBV in general. Activists in the region increasingly use both Twitter and Facebook to share country-specific and global campaigns such as #WithHer, #24Demands, #AmINext (triggered by the rape and brutal murder of Uyinene Mrwetyana in August 2019), #MeToo, #TotalShutDown, #NotInMyName, and #NotOurLeaders. The momentum towards a change in thinking and attitudes, from response to prevention, has intensified as more voices speak out at various levels and on various platforms.



The Stop GBV App offers an online platform for discussions about preventing GBV in South Africa. Photo: Sinqobbile

[76] Alliance for Advancing Health Online, 'Promoting vaccination confidence and uptake', https://vaccineconfidencefund.org/ accessed 30 June 2021.
[77] Are you ready for change? Gender equality attitudes study 2019 | Digital library: Publications | UN Women - Headquarters, https://www.unwomen.org/en/digital-library/publications/2020/06/gender-equality-attitudes-study-2019, accessed 17 June 2021.

Harnessing social media to increase COVID-19 vaccine confidence



Social media has changed our daily lives in almost every way, according to the Alliance for Advancing Health Online, an organisation that seeks to expand social media use to enhance the health and resilience of global communities.

The organisation notes that social media impacts how we live, work, and engage with key public information. This includes COVID-19 vaccines, which will continue to play a critical role in helping to end the pandemic and bring back a sense of normalcy. As vaccines become available in all countries, the public health priority will shift from addressing concerns around vaccine access and supply to better understanding the dynamics of vaccine demand, hesitancy, and confidence.

With more and more communities relying on social media as a significant source of information related to COVID-19 vaccines, it is vital that citizens understand the role these platforms can play and effectively harness their capabilities to increase vaccination confidence and contribute to vaccine decision-making.[78]

Restorative justice

SADC Gender Protocol Article 20.4: State parties shall put in place mechanisms for the social and psychological rehabilitation of perpetrators of GBV.

SADC Gender Protocol Article 23.5: State parties shall provide effective rehabilitation and re-integration programmes for perpetrators of GBV.

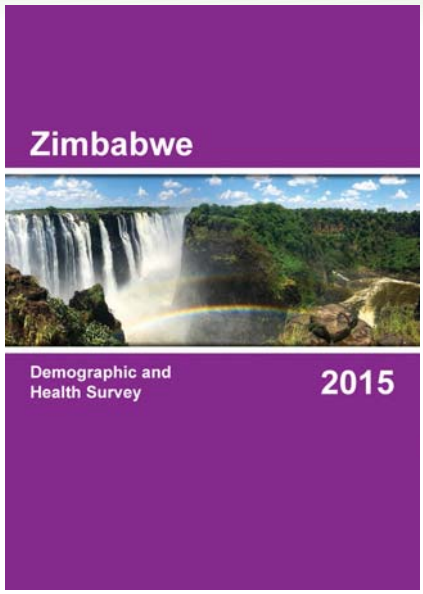
Across SADC, progress in engaging men to stop or prevent violence against women and girls remains slow. Men represent the main perpetrators of violence due to many factors, prominent among them negative social constructions of masculinity across the region.

> Progress in engaging men to stop or prevent violence against women and girls remains slow

[78] Alliance for Advancing Health Online, 'Promoting vaccination confidence and uptake', https://vaccineconfidencefund.org/, accessed 30 June 2021.



A multi-stakeholder approach to ending violence in Zimbabwe



The 2015 Zimbabwe Demographic Health Survey found that 14% of women experience sexual violence at least once in their lifetimes.

High rates of child marriage, teenage pregnancy, and GBV persist across Zimbabwe's Nkayi Rural District Council. Because of these challenges, the council has conducted GBV awareness campaigns by working with multiple community stakeholders and with a strong focus on raising awareness on ending child marriages. Campaigns targeted youth and the council worked with multiple partners, including the ministries of women affairs, community, small and medium enterprises and health, as well as the Police Victim Friendly Unit, social welfare, and other civil society groups.

According to the 2015 Zimbabwe Demographic Health Survey, 14% of women aged 15-49 experienced sexual violence at least once in their lifetimes. Thus, the council and partners have been teaching communities about the scourge of GBV and the dangers of child marriage. The trainings encourage youth and their parents to report sexual violence and child marriages.

Communities have also been educated on other health issues related to child marriage and GBV, particularly HIV and AIDS and other STIs.

In a bid to counter the socio-cultural beliefs that perpetuate GBV, the council has engaged traditional leaders to speak out against child marriage and GBV in the district as well as encourage survivors of violence to report it. The work with traditional leaders represents the most innovative part of the project, as so much violence links to traditional views that portray women as objects and possessions.

Source: Zimbabwe SADC Protocol@Work Summit 2020

Integrated approaches



SADC Gender Protocol Article 25: State parties shall adopt integrated approaches, including institutional cross-sector structures, with the aim of eliminating GBV.

All SADC countries have created national action plans (NAPs) to end GBV, but some have become outdated while others await approval, with only some marginal action accomplished in recent months due to resource constraints.



In **Comoros**, the government has collaborated with UNFPA to set up six pilot monitoring and alert committees against GBV throughout the archipelago since 2020. The programme aims to support prevention and the management of GBV cases.[79] In addition, the UNFPA supports the government, through the National Commission for Gender and Civil Society, to work to end all forms of violence against women.[80]

Strengthening GBV coordination

Identifying useful and innovative processes for effective GBV coordination in SADC remains critically important. Gender activists know that GBV prevention succeeds most often when it involves a multi-sectoral approach. This has been especially true during the COVID-19 pandemic, as activists aimed to include GBV coordination and outreach alongside public health efforts.

The SADC Gender Secretariat notes the importance of reduction of GBV as a catalyst to peace and security in the region. In line with the SADC Gender Protocol, the Secretariat works in collaboration with the Ford Foundation and GIZ to promote partnerships that help to increase coordination at national and sub-national level.

UN Women's Caroline Meenagh recently provided an overview of how her organisation works collaboratively with other UN agencies to promote GBV prevention guided by the RESPECT Framework (2019),[81] developed by WHO and endorsed by the 12 UN agencies.

Figure 6.3: UN Women RESPECT framework

R	**Relationship skills strengthened:** strategies to improve skills in interpersonal communication, conflict management and shared decision making.
E	**Empowerment of women:** economic and social empowerment strategies including those that build skills in self-efficacy, assertiveness, negotiations, and self-confidence.
S	**Services ensured:** ensuring a range of services including health, police, legal, and social services for survivors of violence.
P	**Poverty reduced:** strategies targeted at women or the household, whose primary aim is to alleviate poverty.
E	**Environments made safe:** efforts to create safe schools, public spaces and work environments, among others.
C	**Child and adolescent abuse prevented:** strategies that establish gender equitable and nurturing relationships by parents, educators and others working with children. This strategy demonstrates the overlap between violence against children and violence against women.
T	**Transformed attitudes, beliefs and norms:** strategies that challenge harmful gender attitudes, beliefs, norms and stereotypes.

Source: UN Women RESPECT Framework Implementation guide overview.

[79] UNFPA Comoros (2021) VBG_: L'UNFPA remet de matériels informatiques et de mobiliers aux comités de veille de Mohéli et d'Anjouan, UNFPA Comoros, https://comoros.unfpa.org/fr/news/vbg-lunfpa-remet-de-mat%C3%A9riels-informatiques-et-de-mobiliers-aux-comit%C3%A9s-de-veille-de-moh%C3%A9li-et, accessed 18 June 2021.
[80] UNFPA ESARO (2017) Reducing violence against women, UNFPA ESARO, https://esaro.unfpa.org/en/news/reducing-violence-against-women, accessed 18 June 2021.
[81] UN Women (2020) RESPECT Women: Preventing violence against women - Implementation package, https://www.unwomen.org/en/digital-library/publications/2020/07/respect-women-implementation-package, accessed 16 June 2021.

As illustrated in Figure 6.3, the framework builds on the 2015 Prevention of VAW Framework to guide policy and programming interventions on GBV using seven strategies represented by each letter.

Drawing lessons from the management and resourcing of HIV and AIDS programmes could assist in finding lasting solutions to GBV prevention in the region. For this, the Southern Africa AIDS Dissemination Service (SAfAIDS) highlighted the following key lessons from its work on HIV in the region:

- The need for costed SGBV action plans;
- Reliable and consistent SGBV data to enable stakeholders to work and respond better; and
- Importance of a multi-sectoral approach with a clear coordination framework at country and regional levels. With the emergence of COVID-19, GBV coordination has become more important than ever before.

Work by GIZ's Partnership for Prevention (PfP) programme, which identifies and supports flagship GBV projects, has been gaining momentum in the region. Strengthening stakeholder partnerships underpins the programme and SADC leaders should harness the knowledge from PfP case studies from Lesotho, South Africa and Zambia. Agencies can scale up these best practices to strengthen GBV coordination work at country level.



Despite the absence of a Domestic Violence Act (a draft is now before cabinet) as a guiding legal framework, **Lesotho** has come up with an Anti-GBV coordination forum backed by the Sexual Offences Act and the National Action Plan. The gender ministry chairs the forum, which has six technical working groups that include the government, development partners, media, civil society, academia and religious sectors. The groups meet quarterly to evaluate progress on GBV prevention and response in the country.



Representatives from **South Africa**'s Department of Social Development recently presented the country's long journey through the development and now implementation of the National Strategic Plan on GBV and Femicide. The unacceptably high levels of GBV leading to the 2018 landmark presidential summit provided impetus for the development of the NSP on GBVF. According to the Department of Social Development, the NSP has high ownership across the country and the Office of the Presidency ensures that government allocates resources for the optimal functioning of the coordination structure set.



Realising the need for harmonised data collection in **Zambia**, the Young Women Christian Association (YWCA) made presentations about how the gender sub-committees created a standardised reporting format for data on GBV. The National Development Plan 7 informs the process, which GIZ supports. Gender sub-committees support a multi-sectoral engagement and effort by various stakeholders in the GBV sector. CSOs, government departments, people with disabilities, traditional leaders and chiefs also sit in the committees. However, the composition of the committees depends on the active stakeholders in particular provinces and districts. Standardised data collection makes GBV planning, implementation, reporting, and evaluation efficient.



Kapoche secondary School, youths stand against GBV, Zambia.
Photo: Albert Ngosa

Next steps

- **GBV during COVID-19:** Vaccine rollout plans should consider equal access in terms of mobility and access to information. They must also consider the limited decision-making power of women and the challenges facing migrant and refugee women.
- **GBV data collection and information management:** Ensure timely data collection through robust collection tools and systems. This includes harmonising indicators to feed into the regional GBV surveillance system and strengthening coordination and collaboration among administrative data stakeholders (police, gender, health, social welfare, etc.).
- **Prevention:** Member countries need to invest in the primary prevention of GBV. This means addressing social norms, structures of gender inequality, and the general acceptance of VAWG as integral components in all national and regional actions to prevent VAW. Legislators must embrace the critical role of communities in preventing GBV at the local level. Community members should be mobilised and sensitised about the important role they play in preventing GBV.
- **Media coverage:** As the world continues to move in the digital direction, there is a need for member states to consolidate gains made to improve traditional media and use these and other innovative ways to tap into the many advantages of digital technology to protect women and girls at risk of GBV. This includes expanding the scale of digital advocacy campaigns and employing communication strategies that amplify solutions for the most common forms of GBV per country.
- **Legal:** Member states should urgently review legislation to expand its scope to respond to emerging and evolving forms of GBV, including online sexual harassment, stalking, and controlling behaviours. This should include a review of the legal barriers to accessing COVID-19 vaccinations and testing.
- **Support:** There is need for member states to embrace survivor-centred approaches in GBV service provision. States should adopt and expand perpetrator rehabilitation programmes and ensure support facilities can also serve male victims of violence.
- **Integrated approaches:** Member states must strengthen GBV coordination through clear frameworks at country and regional levels, including by strengthening stakeholder partnerships and developing and implementing costed SGBV action plans.
- **Diverse groups:** The region urgently needs specific guidelines for inclusion and accessibility to clarify how to provide access to SRHR, HIV, and GBV services for diverse groups, including women with disabilities.

With the emergence of COVID-19, GBV coordination has become more important than ever

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Harmful Practices 7



Amanzimtoti Trauma Centre March during the 16 days activism 2020, Amanzimtoti, South Africa. Photo: Loraine Odendaal

KEY POINTS

- The COVID-19 pandemic coupled with slow vaccination roll out programmes could further expose women and girls to harmful practices especially child marriages and Female Genital Mutilation (FGM). Vaccine hesitance is itself emerging as a harmful practise.
- To enhance the protection of civilians without invoking state of emergency measures during COVID-19 pandemic, Angola amended the Civil Protection Law.
- In December 2020, the Mauritian government gazetted the Children's Act of 2020.[1] The Act, which now awaits proclamation, seeks to address the issue of child marriages in the country and establishes the Children Coordinating Panel, a body to oversee the implementation of the Act.
- South Africa has the lowest percentage of women married by age 18 (4%) and Mozambique has the highest (53%).[2]
- The Zambian parliament is amending Article 47.2 of the of Constitutional Amendment Bill number 10 of 2019 to enhance the participation of women with disabilities in politics.
- Zimbabwe launched a National Disability Policy which seeks to address the marginalization and discrimination of Persons with Disabilities (PWDs).
- Medical practitioners performed 52 million of the Female Genital Mutilation (FGM) procedures globally.[3]
- Besides FGM and child marriages, women and girls in parts of Zimbabwe and South Africa could be experiencing other less common harmful practices like breast ironing.

[1] Government of Mauritius, 'The Children's Act No 13 of 2020', https://mauritiusassembly.govmu.org/Pages/Acts/Acts2020.aspx, accessed 24 June 2021
[2] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.
[3] UNICEF (2020) Approximately 1 in 4 survivors of female genital mutilation were cut by a health care provider, https://www.unicef.org/press-releases/approximately-1-4-fgm-survivors-were-cut-health-care-provider, accessed 25 June 2021.

Table 7.1: Key Indicators on harmful practices

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Constitution																
Constitution has claw back clauses	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No	No	No Yes	No	No
Constitution addresses contradictions between the constitution, laws and practices	Yes	No	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes		Yes	Yes
Early child marriages																
Minimum legal age of consent to marriage for women	15	21	18	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	18	21	18
Exceptions for women	15	18	A judge can authorise marriage younger than 18 in certain cases and if both parties consent	None	Possible no age	Possible no age	Possible no age	None	16	None	Possible no age	Possible no age	None	Country's Supreme Court ordered government to ban marriage of children under 18 years	16	None
Exceptions for men	16	18	A judge can authorise marriage younger than 18 in certain cases and if both parties consent	None	Possible no age	Possible no age	Possible no age	None	16	None	Possible no age	Possible no age	None	Legislation under appeal	16	None
Percentage young women married by age 18[4]	30	10	32	37	5	16	40	42	n/d	53	7	n/d	4	31	29	34
Percentage young women married by age 15	8	n/d	10	10	1	1	12	9	n/d	14	2	n/d	1	5	6	4

Source: Gender Links (2019) and Girls Not Brides; https://data.unicef.org/country/ accessed 27 June 2021.

Introduction

Deep rooted patriarchal beliefs fuel harmful practices including child marriage, marital rape, witchcraft accusations, widow inheritance, breast ironing, virginity testing, and female genital mutilation (FGM). These practices compromise women and girls' sexual and reproductive health and rights (SRHR) and increase exposure to HIV and AIDS. Despite their harmful nature, such practices persist across countries because they have been normalised by the perpetrators and by the victims who have been socialised to follow tradition passively.

[4] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.



Gaabomotho theatre group perform a drama on GBV and Human rights during the 2020 Women's Day commemmorations, Otse, Botswana.
Photo: Mboy Maswabi

Over the years, many SADC governments have made provisions in Constitutions and acts of parliament to provide protections for women and girls as illustrated in Table 7.1 which show that:

- The Constitutions of six SADC countries (Botswana, Comoros, Eswatini, Lesotho, Malawi, and Mauritius) have clawback clauses. This means they provide for gender equality on one hand but make other guarantees that undermine its provision.
- Four Constitutions (Botswana, Comoros, DRC, and Mauritius) have not addressed contradictions between their constitutions and customary laws and practices.
- Ten SADC countries have a minimum legal age of consent to marriage for women set at 18 or older. All SADC countries have set the minimum legal age of consent to marriage for men at 18 or older.
- South Africa has the lowest percentage of women married by age 18 (4%) and Mozambique has the highest (53%).

The disproportionate impact of the COVID-19 pandemic on women and girls in the region is rooted in gender inequalities. Reports show that the closure of schools due to the pandemic has increased the exposure of women and girls to the risk of child marriage in Malawi, Zimbabwe, and South Africa. Malawi witnessed over 13,000 new child marriages in 2020.[5] According to UNICEF the main drivers of child marriage are poverty, cultural and religious traditions, and peer pressure[6]. Child marriage is often associated with limited education and employment opportunities, forcing many girls and women into transactional sex in order to buy food.[7] Growing poverty in the region fuels harmful practices even more.

With the COVID-19 vaccine roll out, vaccine hesitancy has added itself to the list of harmful practices, fuelled by the misinformation, fake news, political figures and faith leaders who are discouraging their followers from taking the vaccine. The University of Johannesburg's Centre for Social Change and Human Sciences Research Council's (HSRC) Developmental, Capable and Ethical State (DCES) division recently conducted an online survey[8] among South Africans to determine public perceptions of the economic, social and political impact of Coronavirus. Findings from the study show that men are less trusting of the vaccine but more willing to be vaccinated than women are.

The prevalence of FGM among women aged 15-49 in Tanzania dropped from 18% in 1996 to 10% in 2016. Only 3% of women aged 15-49 report that they think the practice should continue.[9] The declining trends and shifting attitudes bode well for Sustainable Development Goal (SDG) 5.3 that seeks to eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation.

Breast ironing or flattening prevalent in West African countries requires further research. Zimbabwe and South Africa have reported the practice but there is still insufficient data about its impact. The United Nations estimates that 3.8 million teenagers are affected by breast ironing globally.[10]

[5] Macho, M. J. T. (2021) 'Gender Equality: A Catalytic Accelerator for Agenda 2030', Spotlight Initiative Bulletin, 2, p. 20.
[6] UNICEF Malawi 'Child Marriage in Malawi', p. 2, https://www.unicef.org/malawi/media/526/file/Child%20Marriage%20Factsheet%202018.pdf, accessed 27 June 2021
[7] 'Children in southern Africa are being forced into prostitution due to drought', Newshub, https://www.newshub.co.nz/home/world/2020/01/children-in-southern-africa-are-being-forced-into-prostitution-due-to-drought.html, accessed 27 June 2021.
[8] 'COVID-19 Vaccine hesitancy South Africa studies 2021',https://sacoronavirus.co.za/wp-content/uploads/2021/04/Report_COVID-19-vaccine-hesitancy_SA-studies_1April2021.pdf, accessed 8 July 2021.
[9] Tanzania Demographic and Health Survey 2016, https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf, accessed 17 June 2021.
[10] Breast ironing: a harmful practice that doesn't get sufficient attention, The Conversation, available at: http://theconversation.com/breast-ironing-a-harmful-practice-that-doesnt-get-sufficient-attention-116206, accessed 25 June 2021.

Despite what often appears to be slow action, there are ongoing law and policy reforms within countries to prevent and mitigate the harrowing effects of harmful practices. There is progress by countries to conform with international and regional norms and standards. Mauritius is the only country not to sign the SADC Protocol on Gender and Development because of its objection to 18 as the minimum age for marriage. During this period the island gazetted the Child Protection Act that prohibits marriage under 18 years. This could open the door for Mauritius to sign the Protocol. The Supreme Court of Tanzania upheld a high court decision to ban marriages of children below 18 years.

Botswana opened 25 specialised courts to expedite cases of GBV and harmful practices. Zimbabwe launched its National Disability Policy in June 2021. The policy seeks to address the marginalisation and discrimination of Persons with Disabilities (PWDs), empower them to improve their quality of life and contribute to national development. Similarly, in the DRC, activists expect a new Disability Rights Bill to bring significant change towards addressing the discrimination and harmful cultural practices directed specifically at women and children with disabilities.

The International Widows Day set aside by the United Nations[11] in 2011 and commemorated annually on 23 June, is a global awareness day that seeks to illuminate the injustices that widows face. The 2021 slogan, "Invisible Women, Invisible Problems,"[12] should help to raise awareness on the issue of widowhood in Southern Africa. Widows, both young and old, face a myriad of challenges ranging from legal, financial and social including property grabbing, and elder abuse. A University of South Africa (UNISA) Senior Lecturer in Adult Education Dr Sizakele Matlabe[13] notes, "Widows are stigmatised for life, shunned and shamed. Yet, many of these abuses go unnoticed and are even normalised."[14] The rights of widows and widowers are even harder to realise for the widowed women living in rural areas with limited service provision especially during pandemics like COVID-19.

The SADC Protocol on Gender and Development requires state parties to end harmful cultural practices and protect women, girls, and children from them and the attendant gender-based violence (GBV). Article 21 (1) states that they must take measures, including legislative measures, to discourage cultural and traditional norms that exacerbate the persistence and tolerance of GBV so as to eliminate such practices. In addition, the Protocol urges "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."[15]

This chapter examines the source and impact of harmful cultural practices on the rights of women, girls, and children including people with disabilities in Southern Africa. The chapter explores Constitutional and legal provisions; access to justice; marriage and family rights; child marriages; disability; the rights of widows and widowers and other harmful practices.

Between 2019 and 2021, Gender links administered a gender attitudes survey to measure the perception of men and women on key gender attitudes. Some of these questions give pointers on the patriarchal attitudes that fuel harmful practices. Relevant results are cited in different parts of the chapter. The chapter identifies efforts made by governments, civil society, and communities to end harmful practices. The chapter is framed in the context of the COVID-19 pandemic, the likely impact of the ongoing vaccine rollout, and mitigation strategies.

[11] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.
[12] International Widows' Day 2021: Theme, Importance, History, Activities, Quotes, https://internationaleventday.com/event/international-widows-day/, accessed 22 June 2021.
[13] UNISA, Advocating for widows' rights and recognition, available, https://www.unisa.ac.za/sites/corporate/default/News-&-Media/Articles/Advocating-for-widows%E2%80%99-rights-and-recognition, accessed 22 June 2021.
[14] UNISA, Advocating for widows' rights and recognition, available, https://www.unisa.ac.za/sites/corporate/default/News-&-Media/Articles/Advocating-for-widows%E2%80%99-rights-and-recognition, accessed 22 June 2021.
[15] Article 27 (2), SADC Protocol on Gender and Development

COVID-19, vaccine roll out and ending harmful cultural practices



State of vaccine roll-out in SADC is very low and could hinder progress in ending harmful practices in the region

As countries shift between harsher and less strict COVID-19 lockdowns, many women and girls are still confined within their homes and prone to poverty and abuse by perpetrators. The confinement has given perpetrators of harmful practices like child marriages a shield to commit the offenses away from the spotlight of neighbours, schools, and law enforcement agencies. For instance, in Malawi some parents and guardians have resorted to marrying off girls to reduce the financial pressure on their households.[16] Deutsche Welle (DW) the Germany international broadcaster cites the case of Memory Danifolo a Malawian woman who married off her 16-year-old daughter to alleviate financial stress.[17]

The repeated closure of schools which started in March 2020 and is still happening now during the third wave means that the exposure of children especially girls to risky environments continues. Teachers and parents have raised red flags against the repeated closure of schools as idleness is becoming a fertile ground for promoting sexual activity leading to sex with peers and early marriages. The layer of protection offered by schools has been eroded. Appropriate and meaningful assistance for children suffering, or recovering, from harmful cultural practices may be minimal or unavailable.

With the exception of Seychelles, the current state of vaccinations in SADC is very low and could hinder progress in ending harmful practices in the region.

With a handful of COVID-19 vaccines now authorised for distribution, questions are arising over their efficacy. Social media is also awash with myths and facts on these vaccines leading to women and men reacting differently to vaccine information. Some, for religious reasons think that, "vaccines are dangerous", "vaccines are a mark of the beast".[18] The myths and misinformation about vaccines are themselves a harmful practice as they delay the roll out of vaccines. The South African government makes it clear that vaccines have no connection with any religious organisations and cannot be infused with spirits, demons or other abstract ingredients. There is no conspiracy to possess, bewitch or control anybody.[19] Without proper vaccine information, there is a danger that people get vaccinated without adequately weighing information and also carry the risk to themselves and to others if they decide to opt out.

An efficient roll out programme has several implications for reducing harmful practices. The World Health Organisations (WHO) Immunization Agenda (IA) 2030 positions immunization as a "key contributor to people's fundamental right to the enjoyment of the highest attainable physical and mental health and

[16] Deutsche Welle (2020) Fears grow of a surge in child marriages in Malawi, https://www.dw.com/en/fears-grow-of-a-surge-in-child-marriages-in-malawi/a-54009682, accessed 26 June 2021.
[17] Deutsche Welle (2020) Fears grow of a surge in child marriages in Malawi, https://www.dw.com/en/fears-grow-of-a-surge-in-child-marriages-in-malawi/a-54009682, accessed 26 June 2021.
[18] No, the COVID-19 vaccine is not linked to the mark of the beast - but a first-century Roman tyrant probably is, The Conversation, http://theconversation.com/no-the-COVID-19-vaccine-is-not-linked-to-the-mark-of-the-beast-but-a-first-century-roman-tyrant-probably-is-158288, accessed 16 July 2021.
[19] COVID-19 Coronavirus vaccine myths and facts, https://www.gov.za/COVID-19/vaccine/myths, accessed 7 July 2021.

also as an investment in the future, creating a healthier, safer, more prosperous world for all."[20]



The Dorcas Page Foundation is debunking myths on vaccines in Gauteng, South Africa. Photo courtesy of Dorcas Page Foundation

Vaccine roll out assures a gradual return to normalcy in line with Sustainable Development Goals (SDG) Goal 3 target 8 to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". Economic activities can resume at pre-COVID-19 scales. This reduces poverty levels and reduces the burden on parents who might otherwise would have send their daughters for early marriages.

An efficient roll out strategy could result in children that are already in child marriages getting vaccinated so that they can become economically productive. If teachers are prioritised in roll out campaigns, and other protective measures are put in place, schools can re-open. This would give girls and women a chance to be in school and continue with their education: critical for women's economic empowerment. The continued closure for schools has already seen a surge in early pregnancies and child marriages in Malawi, Zimbabwe and South Africa.

An efficient vaccine roll-out means countries can gradually re-focus their energies away from COVID-19 and vaccine management to meeting regional and global targets on gender equality. Presently almost all countries are focused on procuring vaccines, and strategising on increasing vaccine take up within countries. Gains made on ending harmful practices could be lost if countries remain much longer in the vaccination mode.

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. **Article 6:** State parties shall review, amend, or repeal all discriminatory laws and specifically abolish the minority status of women.

To give effect to the SADC Protocol on Gender and Development, member states need to ensure that key gender provisions are not compromised within their constitutions. Constitutions, being the supreme law of a country, should generally reflect accepted principles of equality and democracy. These include provisions for non-discrimination based on sex, marital status, promotion of gender equality, removal of claw back clauses, and addressing contradictions between the constitutions, laws and practices.

[20] WHO, Immunization Agenda 2030, https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030, accessed 7 July 2021.

Table 7.2 overleaf provides a synopsis of some of the key constitutional provisions on gender in all SADC countries. Of particular note:

- All SADC constitutions provide for non-discrimination generally.
- All SADC constitutions (except Seychelles) provide for non-discrimination based on sex, specifically. They also (including Seychelles) provide for non-discrimination on the basis of sex and others, e.g. marital status and pregnancy.
- The constitutions of Botswana and Seychelles do not provide for the promotion of gender equality.

Despite the lack of major constitutional reforms in the period under review, there have been notable law reforms aimed at promoting gender quality and equity.



Angola amended the Civil Protection Law, to enable measures to respond to the COVID-19 pandemic, without invoking a state of emergency. The amendments seek to ensure that any measures to deal with emergencies like COVID-19 do not compromise citizen's fundamental rights.



In **Zambia**, the women's movement is rallying support for the enactment of Article 47.2 of Bill 10. The bill seeks to enhance women's participation in parliament by transforming the electoral system from the first-past-the-post (FPTP) to a mixed-member electoral system (MMS). According to experts in the country, the FPTP does not encourage equal and fair representation of women in parliament (presently 19 out of 158 members). Citing similar electoral reforms that improved women's participation in politics in Rwanda, South Africa, Namibia, Uganda, Mozambique and Angola, Gladys Mutukwa suggests that the MMS system will also improve representation of youth and people with disabilities in parliament.[21]



In April 2021, **Zimbabwe** parliament approved Constitutional Amendment Bill Number 2, amid concerns of the rushed process to amend the constitution.[22] Positive measures include the extension a quota that ensures at least 60 women MPs in the National Assembly for another 10 years. Women MPs in the country, including those who take part thanks to this quota, have been instrumental in fighting for the rights of women and girls.[23] A positive gain for local government is that the constitutional amendments seek to extend the system in place at the national level to the local level with 30% seats reserved for women and distributed on a Proportional Representation (PR) basis. The move, which enhances gender parity in all areas of political decision-making came after Zimbabwe President Emmerson Mnangagwa and his cabinet offered their full support and approval of a 30% women's quota at the local level. This follows the first ever Women Councillors Indaba convened by Zimbabwe Local Government Authority (ZiLGA), Women in Local Government Forum (WILGF) in partnership with Gender Links (GL) in December 2020.[24]

Another positive gain from the amendments is the support for the representation of women with disabilities in parliament. Coupled with the new National Disability Policy launched in June 2021, the move to increase representation of women with disabilities in parliament is progressive.

[21] Zambia Daily Mail, Women's movement nods support for Article 47.2 of Bill 10,http://www.daily-mail.co.zm/womens-movement-nods-support-for-article-47-2-of-bill-10/, accessed 28 June 2021.
[22] Veritas, Constitution Watch 1/2021 -Constitution Amendment No. 2 Fast-tracked with Unconstitutional Amendments, http://www.veritaszim.net/node/4929, accessed 28 June 2021.
[23] 'SADC Gender Protocol 2020 Barometer Chapter 7 Harmful Practices', https://genderlinks.org.za/wp-content/uploads/2020/08/Chap7-Baro2020-HARMPRACrev2.pdf, accessed 24 June 2021.
[24] 'Zimbabwe: Local quota for women now in parliament', Gender Links, https://genderlinks.org.za/news/zimbabwe-local-quota-for-women-now-in-parliament/, accessed 7 July 2021.

Table 7.2: Key gender provisions of SADC Constitutions

Country/Constitution	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar
Provides for non-discrimination generally	Yes, Article 23	Yes, Section 15	Yes, Article 2	Yes, Articles 11, 12 and 13	Yes, Section 20	Yes, Chapter II, Sections 1 and 18	Yes, Article 8
Provides for non-discrimination based on sex specifically	Yes, Article 21	Yes, Section 3	Yes, Article 2	Yes, Articles 14, 36 and 45	Yes, Section 20	Yes, Section 18	Yes
Provides for non-discrimination on the basis of sex and others e.g. marital status, pregnancy	Yes, Article 21	Yes, Section 15	Yes, Article 2 (sex only)	Yes, Articles 40	Yes, Section 20 (2)	Yes, Section 18	Yes, Article 8
Provides for the promotion of gender equality	Yes, Articles 21 and 35	No	Yes, Articles 3, 34, 38, 61	Yes, Article 14	Yes, Section 28	Yes, Chapter III, Sections 26 and 30	Yes
Has other provisions that relate to gender equality	Yes, Articles 36 and 77	No	Yes, Articles 34, 38, 61	Yes, Article 16	Yes, Section 28	Yes, Section 26	Yes, Article 17
Has claw back clauses	No	Yes, Section 15	No	No	Yes, Section 20	Yes, Section 18	No
Addresses contradictions between the constitution, laws and practices	Yes, Article 239	No	No	No	Yes, Section 2 and Article 20	Yes, Section 18	Yes, Article 160

Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Yes, Section 20	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, Article 20	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, Sections 13 and 20	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 13	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
Yes, Sections 19 and 18	No	Yes, decrimina-lisation of homo-sexuality 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 26	Yes, Section 16	No	No	No	No	No	No	The new Constitution invalidates customary law and practices that infringe on women's rights
Yes, Article 5	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.

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.

African experts define access to justice 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."[25] For most women in the region and especially those living in the rural areas, access to the courts remains a challenge. A 2015 report in Malawi for example, observed that the courts that are near the poor are often poorly resourced, poorly managed and offer a limited range of services.[26] For access to justice to be meaningful, availability of courts is not sufficient. The quality of service rendered at the courts is of paramount importance. This ensures that the law can enforce people's rights and responsibilities.

Despite customary courts being closer and more accessible, many women still face challenges in utilising these courts owing to their discriminatory customary laws and practices. In some instances, women are required to be accompanied by a man for a hearing. This makes it difficult for women and girls to testify in cases such as marital rape or sexual assault. To ensure that women get a fair deal these courts require remodelling. The South African National Assembly

Access to courts remains a persistent challenge, especially for those women living in the rural areas

[25] Justice in Transition and the Complexities of Access, ACCORD, https://www.accord.org.za/conflict-trends/justice-transition-complexities-access/, accessed 28 June 2021.
[26] Sustainable Development Goal 16 and access to justice: The case of lay magistrates in Malawi, available at: https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/GOAL-16-Book-Ntaba2.pdf accessed 24 July 2021.

has paused on passing the 2017 Traditional Courts Bill to obtain legal opinion on the constitutionality of failing to provide people with a right to opt out of proceedings in traditional courts.[27]



Amanzimtoti participate in a march during the 16 days activism campaign in 2020, Amanzimtoti, South Africa..
Photo: Loraine Odendaal

COVID-19 has resulted in some courts closing or reducing times of hearings compromising fairness. This has left many women facing enormous challenges in accessing justice. To improve access to justice, Botswana has responded by creating specialised courts to expedite gender based violence cases.

Justice and women

Justice and Women (JAW) is a non-governmental organisation working in the rural parts of KwaZulu-Natal (KZN), South Africa. It started in Pietermaritzburg as a project run in partnership by two non-governmental organisations, Family and Marriage Society of South Africa (FAMSA) and Black Sash.

JAW works to support women to access justice particularly for maintenance and domestic violence orders through the Pietermaritzburg Magistrates Court. In 2011, in response to funding constraints, JAW set up a project in Mthonjaneni/Melmoth in the King Cetshwayo District of KZN. The rural area around Melmoth is part of the Ingonyama Trust and King Zwelithini is the sole beneficiary. He entrusts the land to Traditional leaders, who manage communities according to customary values and practices. The JAW project sought to empower women in these areas to access their rights to equality, freedom from violence and bodily integrity.

As a grantee of the Women's Voice and Leadership South Africa (WVLSA), JAW uses an evidence based model to create awareness of the root causes and consequences of power imbalances between men and women. This project takes on board community members, and equips them with knowledge and skills to identify their own gendered attitudes, abusive behaviors and work towards changing these. The process motivates them to reach out to others within their circle of influence and support them to undergo the same journey. The model builds capacity to address any imbalances of power in traditional communities surrounding KZN.

Source: Women's Voice and Leadership South Africa[28]

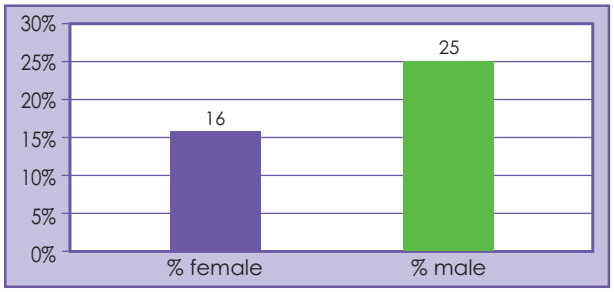
[27] South Africa's efforts to fix traditional courts hit a snag, The Conversation, http://theconversation.com/south-africas-efforts-to-fix-traditional-courts-hit-a-snag-162356, accessed 28 June 2021.
[28] 'Justice and Women', Women's Voice and Leadership SA, http://www.wvlsa.org.za/our-grantees/my-core-grantees/justice-and-women/, accessed 7 July 2021.

Marriage and family rights

Article 8: Marriage and family rights
1. State parties enact and adopt 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.
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.

Laws and practices relating to marriage in SADC are heavily influenced by patriarchal norms that view the man as the head of the family, with everything within that family, including children, belonging to the man. The Gender Attitude Survey asked how respondents reacted to the statement: "*Children belong to a man and his family.*"

Figure 7.1: Children belong to a man and his family



Source: Gender Links Attitudes Survey 2019-2021.

Figure 7.1 shows that a quarter of men and 16% of women in SADC agree or strongly agree that children belong to a man and his family. This has profound implications for household decision-making and the dissolution of marriages despite Article 8 of the SADC Protocol on Gender and Development requiring that both women and men to have reciprocal rights and duties towards their children with the best interest of the children always being paramount.



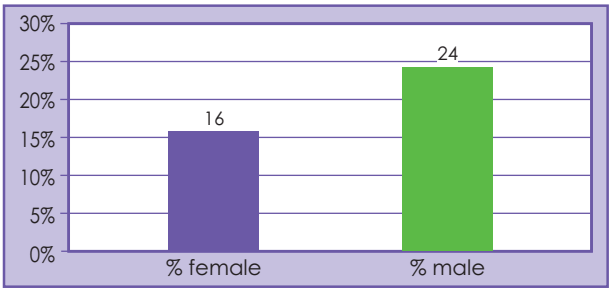
The proposed **Zimbabwe** Marriages Bill 2019 seeks to harmonise all types of marriages under one Act. There are currently three types of marriages in Zimbabwe: civil marriages, registered customary marriages, and unregistered customary law unions. The regimes come with different hierarchical and often

discriminatory rights during a marriage, at divorce, and in terms of inheritance.

Civil marriage has the most rights and unregistered customary law union the least rights. The proposed Marriage Bill 2019 has now gone through its third reading in parliament amid stormy debates. The recognition of civil partnerships as a type of union for realising justice between the parties upon the dissolution of the relationship has re-ignited the issue of property rights: a central issue in any marriage whether civil or customary. The proposed Marriages Bill bans same-sex marriages excluding the LGBTIQ community from this harmonisation of laws to remove discrimination in marriage.

An unintended consequence of recognising civil partnerships is the potential increase in formalised polygamous unions, which could undercut women's rights. Traditional leaders opposed a clause stating that the payment of bride price could not prevent marriage between two consenting adults, if they satisfy other requirements of the law. The chiefs maintain that the payment of lobola is a cornerstone of marriage in customary unions in Zimbabwe.

Figure 7.2: If a man has paid Lobola (bride price) for his wife, he owns her



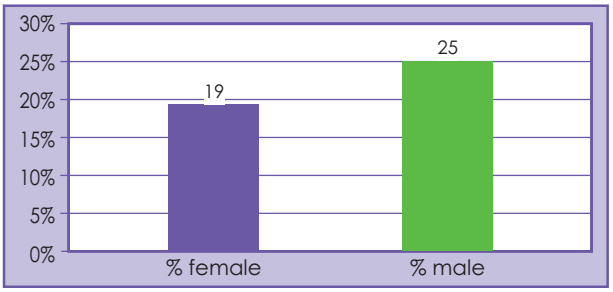
Source: Gender Links Attitudes Survey 2019-2021.

Figure 7.2 shows that in response to the statement: "*If a man has paid Lobola (bride price) for his wife, he owns her*" nearly one quarter of the men in the sample supported the statement, compared to 16% of women. This shows that although attitudes towards practices such as bride price are changing, a significant proportion of the population still support such practices in the SADC region.

Polygamy

Although polygamy is slowly dying out in Southern Africa, it is still practiced in some traditional settings. Polygamy became highly visible during the tenure of the openly polygamous President Jacob Zuma in South Africa from 2009 to 2018. Polygamy is self-evidently discriminatory against women because while a man can marry many wives, a woman cannot marry many husbands. Critics of polygamy point out that women in such relationships are at increased risk of exposure to HIV and AIDS. Polygynous relationships have also been associated with relatively poor child health and poor economic independence for the women. Wives in such settings often have very little access to their husbands' estate with the possible exception of the first wife.

Figure 7.3: A man can marry as many wives as he wants but a woman can only marry one man



Source: Gender Links Attitudes Survey 2019-2021.

Figure 7.3 from the regional Gender Attitude Survey shows that 25% men (compared to 19% women) agree or strongly agree with the statement that "a man can marry as many wives as he wants but a woman can only marry one man."

In a controversial move, the **South Africa**n Department of Home Affairs (DHA) has put forward a green paper[29] that details proposed alignment of the country's marriage laws to the constitution. Section 4 of the green paper addresses polygamous marriages. The Recognition of Customary Marriages Act 120 of 1998 (RCMA) provides for the conclusion of polygamous marriages between a man and more than one women. South Africa is seeking to make this "fair" by providing for women to be able to marry several husbands. The obvious flaw in the argument is that polyandry is highly unlikely to ever happen in reality, even if this may appear to be "fair" on paper.

Speaking on Newzroom Afrika, a television news channel in South Africa, the Chief Director of Policy at the Department of Home Affairs, Sihle Mithiyane said the government is still to consider the green paper. He added that it is an opportune time for the nation to debate the matter. Mithiyane noted that traditional leaders in the country overwhelmingly agree that polygamy is for men. He added that some religious leaders support polygamy while others reject it totally.

According to the DHA, the South African law does not recognise the right of a woman to take more than one husband, otherwise known as Polyandry, therefore in this view, the Marriage Act is discriminatory and does not promote gender equality. The department argues that to protect the rights of women in polyandrous relationships, there is need to align the Marriages Act with Section 9 of the Constitution. Since the publication of the Green paper, there has been intense debate around whether South Africa is ready for polyandry.

Polyamory activists (those that advocate for open and non-monogamous relationships) argue that the proposals by the DHA are progressive. Elizabeth Reitif a member of Polyamory South Africa says: "it's high time this happened... and maybe eventually this will come around to polyamorous marriages because polygamy and polyamory are actually quite contradictory ways of life, while it actually might seem the same on the surface."[30] In her view also, the reason why most men are vocal on the issue is that polyandry challenges tenets that are at the heart of patriarchy namely male dominance and control over women's sexuality. Protagonists argue that women's agency and the ownership of property are also improved.

Most gender activists regard the move as retrogressive and suggest that it affects the fragile gains made in championing women's rights in the country. Speaking on the South African Broadcasting Corporation (SABC) News, GL Policy and Movement Building manager Shamiso Chigorimbo said polyandrous relationships do not give agency to women in a patriarchal society where practices like lobola still occur. She argues that polygamous marriages should be abolished.

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,

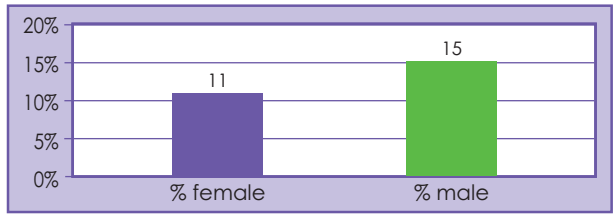
[29] Department of Home Affairs - Know Your Green Paper on Marriages in South Africa, http://www.dha.gov.za/index.php/notices/1449-know-your-green-paper-on-marriages-in-south-africa, accessed 21 June 2021.
[30] South Africa government considers new marriage law that recognises women with multiple husbands, CapeTalk, https://www.capetalk.co.za/articles/416021/sa-govt-considers-new-marriage-law-that-could-see-women-have-multiple-husbands, accessed 21 June 2021.

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 6(a) no marriage shall take place without the free and full consent of both parties; Article 6(b) 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.[31] The same Model Law defines a child as any person under the age of 18 years in line with other international human rights instruments.[32]

Poverty and religion are the main drivers of child marriage

Child marriage, defined as marriage of children under 18 years of age is a global problem and a human rights violation affecting millions of children and especially girls.[33] Statistics show that levels of child marriage are high in Sub -Saharan Africa where 35% of young women are married before the age of 18.[34] Poverty and religion are the main drivers of child marriage. Many families marry off their girl children early to avoid poverty. Feeding, clothing, and educating girls is often considered expensive. However, research shows that the social and health consequences of child marriage are devastating. It affects children's sexual and reproductive health and rights, exposing them to STI and HIV infection because hymeneal, vaginal, or cervical lacerations increase the transmission rate. Many of these young girls lose their virginity to HIV-infected husbands.[35]

Figure 7.4: Families should spend less money on the education of daughters as on the education of sons



Source: Gender Links Attitudes Survey 2019-2021.

Figure 7.4 shows that 15% of men and 11% of women in SADC believe that families should spend less money on the education of girls than that of the boy child. It is encouraging that the majority of respondents did not subscribe to this view. However, the preference for boys' education over girls is an indicator of the kinds of attitudes that fuel early marriages of the girl child. Child marriage also results in girl children abandoning school to assume new roles as wives and mothers. This has dire health and financial consequences.

[31] 'SADC Model Law on eradicating Child Marriage and Protecting Children already in Marriage', https://www.girlsnotbrides.org/documents/484/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf, accessed 28 June 2021.
[32] Article 1 of the Convention on the Rights of the Child defines a child as every human being below the age of 18 years
[33] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.
[34] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.
[35] Nour, N. M. (2006) 'Health Consequences of Child Marriage in Africa', Emerging Infectious Diseases, 12(11), pp. 1644-1649. doi: 10.3201/eid1211.060510.

COVID-19 and child marriages

Child rights experts at Plan International and the United Nations Education Scientific and Cultural Organisation (UNESCO) say COVID-19 forced school closures in 185 countries. This has the potential for increased drop-out rates which will "disproportionately affect adolescent girls, further entrench gender gaps in education and lead to increased risk of sexual exploitation, early pregnancy and early and forced marriage'[36].

"While many girls will continue with their education once the school gates re-open, others will never return to school. Education responses must prioritise the needs of adolescent girls' at the risk of reversing 20 years of gains made for girls' education," writes Stefania Giannini, UNESCO Assistant Director-General for Education, and Anne-Birgitte Albrectsen, Chief Executive Officer, Plan International[37].



COVID-19 and child marriages in Malawi

Malawi closed schools in 2020 as the pandemic raged through the country. In some cases, parents and guardians have resorted to marrying off girls to reduce financial pressure on their own households. Many families are struggling to make ends meet after losing their incomes because of the COVID-19 lockdown.

In Katchitsa village, the elders worry the school closures are affecting efforts to end child marriage. They want the Malawian government to implement working measures to re-open schools and protect young women from entering marriages too soon. "About thirteen girls from my area have married during this period," village representative Samuel Mtenje said. "Stakeholders should lobby the government to put up these measures as a way of serving the girls."[38]

According to Henderson Nazombe, a teacher at Ntepuwa Primary School in Mulanje, most learners in the area get married because of culture and lack of motivation. He says the closure of schools has worsened the situation.

"Most young people are married off just after writing their end of primary examination and now that schools have closed, they have just taken advantage. Maybe there should have had something to keep them busy," said Nazombe, whose youngest students are aged 13. "In my school, there haven't been any initiatives to help or engage the students during the closure. It might be too late but charities and government need to hold awareness campaigns and instil hope in the students. Some of them think that it has closed forever," he said adding that even some boy students are also marrying. He ruled out an option of online teaching, or using radio lessons to reach the students saying that most of the families are too poor to afford and maintain a radio receiver. Moreover, some parents are not literate to take the learners through the lessons, he said.

Maggie Kathewera Banda, Director for Women Legal Resource Centre (WOLREC), a local charity, has received reports of the increase of pregnancies and child marriages across the country after the schools were closed in March this year. She added that there has been an increase in gender based violence targeting young girls.

"Girls who were in boarding schools were protected from would-be-perpetrators. Since

[38] Deutsche Welle (2020) Fears grow of a surge in child marriages in Malawi, https://www.dw.com/en/fears-grow-of-a-surge-in-child-marriages-in-malawi/a-54009682, accessed 26 June 2021.

they are now confined they have become more vulnerable," she said adding: "And on the economic side, you find that most families that were doing business have lost income and because of that they can't cater for their families and this is forcing some girls to get into relationships to get support."

Stephano Akuzike Joseth, Blantyre District Social Welfare Officer said apart from child marriages and pregnancies, young people have adopted some bad habits including gambling and patronising video shows, whose content of the movies may not befit their age. "We're seeing an increase in cases of child marriages, defilement and pregnancies. We get reports on monthly basis and we're able to measure through our Child Protection Case Management. Starting from March this year, we have seen a significant rise of these cases which can be attributed to closure of schools due to COVID-19," Joseth said.

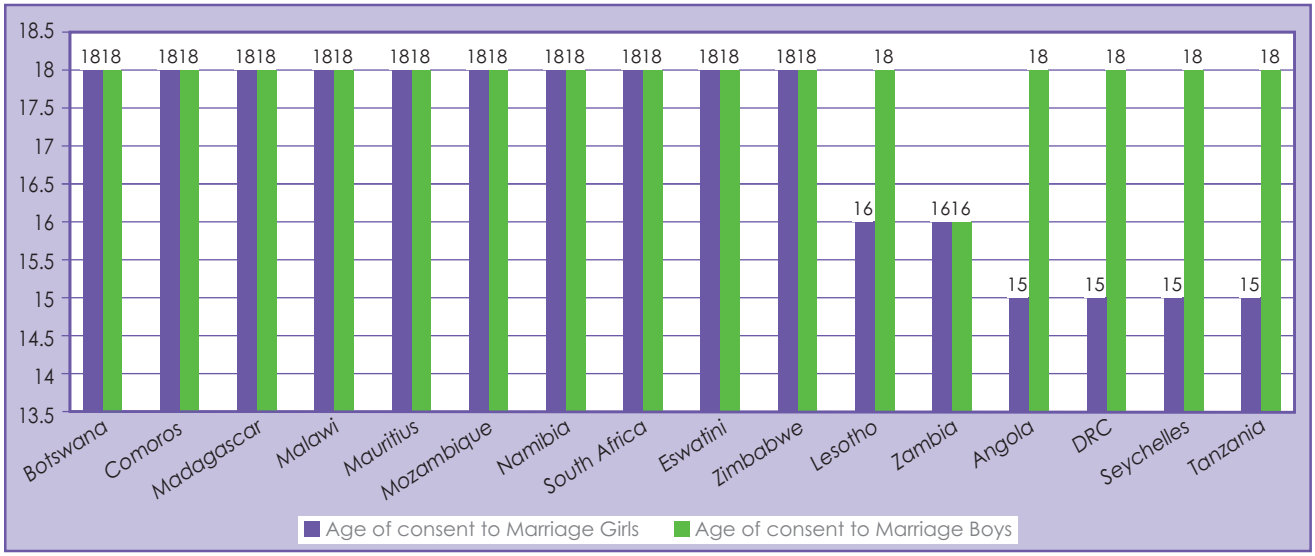
His office is conducting awareness campaigns through child protection workers. They are trying to reach out to community leaders who play a significant role in protecting the children. "I think most of the awareness that we've had was to do with corona virus and social distancing but we also need to look at how the community can protect children in this atmosphere and that's where our focus is right now."

Source: Charles Pensulo, Gender Links News Service Gender and COVID-19 series[39]

Minimum age of marriage

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."[40] The same model Law defines a child as any person under the age of 18 years in line with other international human rights instruments. In line with the SDG 5.3, The Maputo declaration, SADC Protocol Article 8.2a, and the SADC Model law on Child Marriage, most SADC countries have set the minimum age of consent to marriage at 18 years but some are yet to review the minimum age limits.

Figure 7.5: Age of consent to marriage for girls and boys by country



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

[39] Pensulo, C. (2020) 'School closure exposing girls to child marriage', Gender Links, https://genderlinks.org.za/news/girls-exposed-to-child-marriages-as-schools-remain-closed/, accessed 26 June 2021.
[40] 'SADC Model Law on eradicating Child Marriage and Protecting Children already in Marriage', https://www.girlsnotbrides.org/documents/484/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf, accessed 28 June 2021.

Figure 7.5 shows that most SADC countries have set the age of consent to marriage at 18. Six countries - Angola, DRC, Lesotho, Seychelles, Tanzania, and Zambia - have lower ages of consent to marriage for girls, boys, or both. The lower ages of consent are not in line with regional expectations for countries to domesticate the SADC Model Law on Child Marriages that seeks to end all forms of child marriage.



Article 24 of the **Angola**n Family Code[41] is an example of the exceptions found in some SADC laws. It states that "Only those over 18 years old can marry." However, the law goes on to say that, "Exceptionally, a man who has completed 16 years and a woman who has completed 15 years may be authorised to marry when, considering the circumstances of the case and taking into account the interests of minors, marriage is the best solution." Such authorisation "will be granted by the parents, guardians or whoever holds the responsibility, and may be supplied by the Court, after hearing the opinion of the Family Council, when the non-authorization proves unjustified".



Mauritius: Legislation bolsters long-standing fight to end child marriage

In December 2020, the Mauritian government gazetted the Children's Act of 2020.[42] This will increase the legal age of marriage from 16 to 18 years old, effectively ending child marriages.

The Act is a victory for the movement 'Sitwayin Angaze', including GL Mauritius, Young Queer Alliance, Media Watch Organisation and SOS Femmes, all operating under the umbrella of the SADC Gender Protocol Alliance.

Mauritius did not sign the SADC Protocol on Gender and Development because the civil code of the country allows children to marry below the age 18. The 2020 Voice and Choice SRHR Barometer found that Mauritius is among eight SADC countries in which "more than half of women between ages 15 and 49 do not have a say in decision-making about contraceptive use".[43]

Section two of the Children's Bill prohibits the marriage of children under the age of 18. As part of consequential amendments, Section 73(1)(b)(ii) of the same Act also stipulates that "no religious marriage shall be celebrated unless the parties to the religious marriage are aged 18 or above". Part III of the Act prohibits any person to marry or cause a child to marry civilly or religiously.



Ending child marriage represents a key component of SRHR in Africa, Mauritius.

Since the Act aims to protect all children, child or early marriages will be monitored more closely as it will constitute a legal offence. According to official statistics, 705 girls, aged 15 to 19 years, were married between the years 2015 to 2017 in Mauritius. The Children's Bill is a huge step towards the protection and safeguarding of children in Mauritius.

[41] 'Angola National Legislation', https://www.icmec.org/wp-content/uploads/2018/07/ICMEC-Angola-National-Legislation.pdf, accessed 23 June 2021.
[42] Government of Mauritius, 'The Children's Act No 13 of 2020', https://mauritiusassembly.govmu.org/Pages/Acts/Acts2020.aspx, accessed 24 June 2021
[43] Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links. Available at: https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/, accessed 18 June 2021

Key changes include the protection of young children from early child marriage based on parental consent due to harmful religious and cultural customs. In 2018, Gender Links and the Southern African Gender Protocol Alliance went to CEDAW with a shadow report[44] emphasising that the age of marriages both civil and religious should be 18.[45]

The Act establishes the Children Coordinating Panel, a body to oversee the implementation of the Act and deter the public from forcing children into marrying early. Furthermore, advocacy and awareness campaigns on child marriage can change patriarchal ideologies and cultural or religious beliefs.

According to statistics from the Ministry of Health, the infant mortality rate has risen to 14.3 per 1000 live births while maternal deaths stood at 0.66 per 1000 live births. Extensive discussions of the Children's Bill aim to make parents and children aware of the adverse impacts of early marriage. A legal ban on child marriage will ultimately aim to protect every child under the age of 18. The Children's Act will create awareness about child marriages in general.

With governmental priorities shifting towards alleviating the toll on the healthcare system and immediate COVID-19 relief, the vaccination programme and COVID-19 related Bills are taking precedence. Sustained efforts to end child marriage through awareness campaigns and advocacy need to be sustained. As noted in the 2020 SADC Gender Protocol Barometer, often the same patriarchal systems and individuals that drive traditional harmful practices such as child marriage are key decision-makers in religious settings and therefore make similar decisions and dictations in both settings.[46]

Source: Anushka Virahsawmy, Mauritius Alliance and COE, SRHR Most Significant Result 2021[47]



Key proposals put forward by the **South Africa**n Department of Home Affairs in a Green paper[48] submitted to cabinet seek to remove the inconsistencies and exceptions that exist regarding the legal age of marriage. Currently, whilst the legal age of marriage is 18, a minor can get married with the consent of his or her parents. The Green paper proposes that no person under the age of 18 be allowed to marry. In addition, where the presence of both spouses is not required for religious marriages such as Hindu and Muslim marriages, the new proposal suggests that no marriage take place without the full and free consent of the intending spouses. The envisaged reforms are in line with global and regional child marriage laws that seek to have a uniform age of marriage at 18 without any exceptions. This provision will give protection to minors under the age of 18 and women in religious marriages.[49]



There is little progress in amending the Law of Marriage Act in **Tanzania**.[50] It is now two years since the Court of Appeal upheld a 2016 High Court judgment that outlawed child marriage and declared it unconstitutional.[51] Specifically, the upper court gave the government a one year ultimatum to amend sections 13 and 17 of the Marriage Act that allows a girl as young as 15 to be married with parental consent and a 14 year old girl to marry with court consent. Child rights activists in Tanzania worry that continued delays in closing the legal loophole leaves room for discrimination and marginalisation of girls and women.

[44] Treaty bodies Sessions, Office of the United Nations High Commissioner for Human Rights (OHCHR), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/SessionDetails1.aspx?Lang=en&SessionID=1172, accessed 24 July 2021
[45] Mauritius : #ChildnotBride - The fight is on to end Child Marriage in Mauritius, Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/mauritius/mauritius-childnotbride-the-fight-is-on-to-end-child-marriage-in-mauritius/, accessed 24 July 2021
[46] 'SADC Gender Protocol 2020 Barometer Chapter 7 Harmful Practices', https://genderlinks.org.za/wp-content/uploads/2020/08/Chap7-Baro2020-HARMPRACrev2.pdf, accessed 24 June 2021.
[47] Mauritius Alliance and COE SRHR Most Significant Result 2021, Gender Links, https://genderlinks.sharepoint.com/:w:/r/programmes/alliance/_layouts/15/Doc.aspx?sourcedoc=%7B268E2579-884C-4773-B5CC-0D05C8CBE702%7D&file=Mauritius_ALLIANCEANDCOEMSR_Preetima072021.docx&action=default&mobileredirect=true, accessed 8 July 2021.
[48] Government of Mauritius, 'The Children's Act No 13 of 2020', https://mauritiusassembly.govmu.org/Pages/Acts/Acts2020.aspx, accessed 24 June 2021
[49] Department of Home Affairs - Know Your Green Paper on Marriages in South Africa, http://www.dha.gov.za/index.php/notices/1449-know-your-green-paper-on-marriages-in-south-africa, accessed 21 June 2021.
[50] Msichana Initiative (2021) 'Ending child marriage: Stakeholders' collective efforts in reviewing of the Law of the Marriage Act.', February, https://msichana.or.tz/ending-child-marriage-stakeholders-collective-efforts-in-reviewing-of-the-law-of-the-marriage-act/, accessed 23 June 2021.
[51] The Attorney General v Rebeca Z, Gyumi, Civil Appeal Number 204 of 2017, October 2019.

Advocacy on ending child marriages

The SADC Gender Protocol obliges state parties to introduce and support gender sensitisation and public awareness programmes aimed at changing behaviours and eradicating GBV.[52]

Various stakeholders are working in Malawi to end child marriages. As the cases study below will show, there is progress in challenging gender norms that perpetuate harmful practices.



Malawi: Local youth organization saves girls from early marriages

Sifati Mustafa, 15, an orphan in Machinga district is a victim of COVID-19 induced early marriage as her uncle married her off and her three siblings all under-aged. "My uncle found men and married us off. I could not believe it. Perhaps he had problems taking care of all of us. Since he depends on rain-fed agriculture, life was tough; he struggles to harvest enough food for the whole year. We had no choice but to comply with his idea of marrying us off. It seems he collected some money from these men," says Mustafa.

COVID-19 shattered the school calendar, isolating learners from friends, denying them network support. Pandemic-related travels restrictions and physical distancing have also made it difficult for girls to access health care, social services and community support that protect them from child marriages, unwanted pregnancies and Gender Based Violence (GBV).

Through the UN Spotlight Initiative, Forum for Youth and Development (FOYODE) is implementing a project aimed at eliminating violence among women with an emphasis of transforming the social norms that perpetuate this violence. FOYODE is also implementing a programme to bring back school girls from early and child marriages.

To date, FOYODE has annulled 108 chid marriages in three Traditional Authorities (T/As), Ngokwe, Nkoola and Nyambi in Machinga district. Out of these annulled marriages, 68 girls are now back in school. The other girls are expected to go back to school next term. This initiative has been done in conjunction with chiefs in all the T/As, community facilitators and other stakeholders working for the betterment of women and girls.[53]

The programme is already making an impact by engaging community influencers such as chiefs, legislators and religious leaders to take a leading role in ending child and early marriages. Chiefs and faith leaders are taking active role in ending harmful practices. Group Village Headman Kwacha in the district managed to rescue three girls who were married off.

"When I heard that Sifati and her sister`s marriages, I immediately reported the matter to the police. The Police Victim Support Unit (VSU) investigated the matter and arrested the uncle", says Kwacha.

According to UNICEF (2013) roughly 700 million women alive today were married before the age 18. Sadly, Malawi is among the top 20 countries with the highest percentages of

[52] SADC Protocol on Gender and Development, Article 21 (2)
[53] Macho, M. J. T. (2021) 'Gender Equality: A Catalytic Accelerator for Agenda 2030', Spotlight Initiative Bulletin, 2, p. 20.

women aged 20-24 married before they reached ages of 15 and 18. Poverty, patriarchal ideals of society, long distances to and from school and harmful cultural practices (that regard menstruation as a sign of womanhood), are major contributors to child marriages.

These barriers prevent young girls from attaining their goals and dreams. This also retards national development as the country spends resources to mitigate impacts of child marriages such as high population growth, fistula, HIV/AIDS and Violence Against Women and Girls (VAWG).

COVID-19 has pushed these figures higher in Malawi. Lockdown has forced even more girls into early marriages to cope with economic hardships of the pandemic. According to the Ministry of Education, during the 2019/20 academic year, 4,092 learners (3, 923 girls and 169 boys) dropped out of school due to early pregnancies and marriages. Over one quarter (1,106) of the girls got married.

FOYODE uses the "barbershop toolkit" which puts men and boys at the centre stage by creating a space for them to participate in the conversation of ending inequalities and be part of the solution. Barbershop events encourage men and boys to become actively engaged in promoting gender equality by better understanding how inequality limits the ability of individuals, businesses and communities to reach their full human, economic and social potential.

The long-term goal is to have more girls in school and ensure that communities appreciate the need for more girls to complete their education and become active citizens at family, community and national levels. By engaging community leaders to take ownership of social change and become part of the solution a lot of people will comply hence long-term impact.

Source: Joseph Kayira, Malawi Alliance and COE, SRHR Most Significant Result 2021[54]

Persons with disabilities





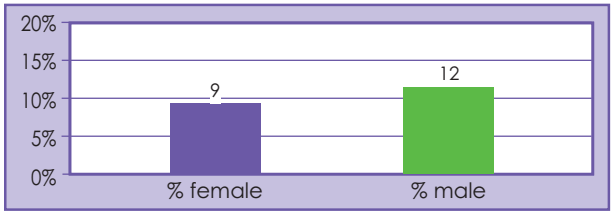
Article 9: Persons with disabilities: State parties shall, in accordance with the SADC Protocol on Health and other regional and international instruments relating to the protection and welfare of people with disabilities to which member states are party, adopt legislation and related measures to protect 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).[55]

People with disabilities face a myriad of challenges including lack of access to SRHR information, goods, and services. Additionally, the ability to make decisions about one's own body and life, are rights often overlooked for women and girls with disabilities as compared to other groups. Many are without sufficient government support as they face exclusion from programmes that are relevant for them.

[54] Malawi Alliance and COE SRHR Most Significant Result 2021, Gender Links, https://genderlinks.sharepoint.com/:w:/r/programmes/alliance/_layouts/15/Doc.aspx?sourcedoc=%7B2F53F6CE-7D30-4B0C-8FD2-5C79B888A2D9%7D&file=Malawi_KAYIRA_JOSEPH_ALLIANCEMSRHarmfulPractices.docx&action=default&mobileredirect=true, accessed 8 July 2021.
[55] United Nations Convention on the Rights of Persons with Disabilities.

Figure 7.6: Disabled boys should have priority over disabled girls to special needs facilities and services



Source: Gender Links Attitudes Survey 2019-2021.

Figure 7.6 shows regional gender differences regarding the welfare of children living with disabilities. Twelve percent of male respondents, compared to 9% female respondents agree or strongly agree with the statement that "disabled boys should have priority over disabled girls to special needs facilities and services". While it is heartening that the majority of respondents disagreed with the statement, the findings show the attitudinal barriers that affect the inclusion of children especially girls with disabilities in accessing special needs facilities and services. According to UNICEF widespread under-estimation of the abilities and potential of children with disabilities creates a vicious cycle of under expectation, under-achievement and low priority in the allocation of resources.[56]

A 2021 study by the UNFPA, and Women Enabled International (WEI) on the Impact of COVID-19 on people with disabilities notes that the COVID-19 pandemic brought harrowing experiences for many people with disabilities who required special care during the pandemic and in lockdown. For instance, interpreters were barred due to social distancing restrictions.[57] Such experiences limit the ability of women and girls with disabilities to access justice.



South Africa: Concerns over the plight of people living with disabilities

The topic of coronavirus vaccines is dominating almost every conversation at the moment. Anti-vaxxers and COVID-19 denialists have been disputing basic vaccine science, disseminating damaging fake information on social media platforms. Others, among them healthy older people who qualify for immediate access, are postponing vaccination to "wait and see", stating they are "undecided".

Those living with disabilities and serious underlying conditions do not have such luxury of choice, and for many it is much more of a life-and-death matter. Since April 2021, people over 60 in South Africa have been permitted to register for COVID-19 vaccinations, and yet, only half of the estimated number of senior citizens have registered[58], and fewer have received the vaccine. From 1 July 2021, those over 50 have also been invited and earlier in June, the government approved the vaccination roll-out to be extended to journalists[59] next, while higher education minister Blade Nzimande announced that the vaccination of university staff[60] might also start soon.

But what of that most marginalised sector of the global population and our country, people with disabilities?

[56] UNICEF (2007) Promoting the rights of children with disabilities (2007). Florence: Innocenti Research Centre (Innocenti digest, 13), https://www.un.org/esa/socdev/unyin/documents/children_disability_rights.pdf, accessed 15 July 2021
[57] UNFPA and Women Enabled International (2021) The Impact of COVID-19 on Women and Girls with disabilities, https://www.unfpa.org/featured-publication/impact-COVID-19-women-and-girls-disabilities, accessed 14 June 2021.
[58] Two months later, only half of over-60s have registered for their COVID-19 vaccinations, available at: https://www.businessinsider.co.za/only-half-of-south-africa-elderly-registered-for-vaccines-on-the-evds-2021-6, accessed 16 July 2021.
[59] Sanef welcomes government decision to vaccinate journalists, available at: https://www.polity.org.za/article/sanef-welcomes-govt-decision-to-vaccinate-journalists-2021-06-29, accessed 16 July 2021.
[60] 'Vaccination of university staff to start "soon" in South Africa' (2021) Research Professional News, 1 July. Available at: https://www.researchprofessionalnews.com/rr-news-africa-south-2021-7-vaccination-of-university-staff-to-start-soon-in-south-africa/, accessed 16 July 2021.

At least 12% and possibly as much as 20% of South Africa's population experience activity limitations[61]. Limitations include a spectrum of disabilities, such as complete or partial immobility, restricted communication, sensory deprivation, and psychosocial and neurological complications.

Some people have more than one impairment, increasing their inability to function optimally in society or even attend to their own basic needs. Many people with disabilities have weak immune systems and comorbidities, making them more susceptible to the coronavirus. In his monthly televised speeches to the nation during the pandemic, President Cyril Ramaphosa rarely acknowledges the plight of people with disabilities or shows compassion for their circumstances. He has voiced concern about gender-based violence, but not a word about those living with disabilities during COVID-19[62].

In his closing remarks to the Presidential Working Group on Disability (PWGD) on the International Day of Persons with Disabilities in 2020[63], Ramaphosa made statements about empowerment, employment, inclusion and protection of people with disabilities in South Africa. Yet, he failed to mention how best to serve them and address specific needs and challenges during the COVID-19 pandemic. He further failed to report on how the government was implementing the 2015-2030 Implementation Matrix[64] of the white paper on the rights of persons with disabilities, specifically Section 3.5 covering "protection during situations of risk and disaster". Subsection 3.5.3 is particularly relevant during a pandemic:

> *"Provide accessible emergency services: Municipal emergency services must put in place reasonable accommodation, support systems and trained emergency personnel to ensure equitable and immediate access to these services for persons with disabilities."*

But Section 3 has been neglected by the Department of Cooperative Governance and Traditional Affairs (COGTA) and its Minister Nkosazana Dlamini-Zuma, responsible for the Disaster Management Council and disaster regulations. COGTA documents state that people with disabilities are part of the population and, therefore, covered by all disaster regulations, implying that they don't need any special treatment.

However, many people with disabilities experience weakened immune systems and respiratory conditions. Such comorbidities profoundly affect those with conditions such as spinal injuries, congenital heart defects, osteogenesis imperfecta (a bone disorder), and Friedreich's ataxia (a movement disorder). They also negatively impact many other disabled people, making them, like the elderly, more vulnerable to COVID-19 infection and complications.

Disabled children do not escape the virus, and parents have a real fear of children contracting the virus.

Within months after the start of the 2020 lockdown, several reports highlighted how ill-prepared the National COVID-19 Command Council and its provincial agencies were to accommodate the diverse and specific needs of people with disabilities in our country.

A Stellenbosch University 2020 study[65] found that many disabled people could not access food parcels because of their immobility or the expenses of getting to the distribution points. There is still no official or sustained plan to distribute food parcels, medical supplies and other COVID-19 essentials to the homes of people with disabilities.

[61] Disability Analysis of the National Development Plan 2030, available at: http://www.women.gov.za/images/Disability-Analysis-of-the-National-Development-Plan-2030.pdf, accessed 15 July 2021
[62] Pandemic Takes Unique Toll on South Africa's Disabled, available at: https://www.voanews.com/COVID-19-pandemic/pandemic-takes-unique-toll-south-africas-disabled, accessed 16 July 2021.
[63] President Cyril Ramaphosa: International Day of Persons with Disabilities 2020. available at: https://www.gov.za/speeches/working-group-disability-3-dec-2020-0000, accessed 16 July 2021).
[64] White paper on the rights of persons with disabilities Implementation matrix 2015 - 2030, available at: https://www.sada.org.za/wp-content/uploads/2020/08/WPRPD-Implementation-Matrix-Cabinet-Approved.pdf, accessed 16 July 2021.
[65] Swartz, L., McKinney, D. E. L. and McKinney, D. V. (2020) 'COVID-19 and disability considerations: report on the experiences of people with disabilities in South Africa', p. 30. http://www.sun.ac.za/english/faculty/healthsciences/centre%20for%20rehabilitation%20studies/documents/report%20-%20covid%2019%20and%20disability%20considerations_edited_13%20october%202020%20(2).docx.pdf, accessed 16 July 2021.

House visits become the responsibility of the various non-profit disability sector organisations (DSOs), funded almost exclusively by philanthropists. Such a situation gives little credence to the government's claims to foster public and private partnerships during the crisis.

The Stellenbosch study highlights the dependency and abuse experienced by people with disabilities during the first months of the lockdown. A recent Daily Maverick article by An Wentzel highlights the psychosocial impact[66] of COVID-19 on people with disabilities and their caregivers, namely the genuine fear, anxiety and emotional distress about possible exposure to the virus. This distress can only add to the mental health services burden in a country where 30% of the population experience common mental health[67] problems during their lifetime.

Source: Daily Maverick[68]



Despite the challenges, governments in SADC have been responsive in reforming legislation and policies around disability. In the **DRC** where approximately 10 million people or close to one in eight persons are disabled[69] the new Disability Rights Bill is expected to bring significant change. It will address the discrimination and harmful cultural practices directed specifically at women and children with disabilities. Children with disabilities in the DRC are often accused of witchcraft.[70] The new law is a critical piece of legislation aimed at addressing this issue and providing these children with protection. However, more needs to be done to reduce preventable diseases such as polio, road accidents and violent conflict that are among the main causes of disability in the country.

New disability policy for Zimbabwe sets standards for the inclusion of Persons with Disabilities in all facets of life



Launch of the National Disability Policy, June 2021, Harare, Zimbawe.
Photo courtesy of UNESCO



The new National Disability Policy for **Zimbabwe** launched in June 2021 is set to reform the lives of many people living with disabilities in the country. The policy seeks to address the marginalization and discrimination of Persons with Disabilities (PWDs), empower them to improve their quality of life and enable them to contribute towards national development. It sets standards for the gender and disability responsive policy framework on disability across all sectors, including the public, private and development sectors[71]. The policy aims to end harmful discrimination, marginalisation and exclusion of PWDs from participating in different sectors of the economy. During the launch President Emmerson Mnangagwa said: "The reality is that no one plans to be born with a disability or desire to acquire a disability. Hence, everyone has an

[66] Wentzel, A. (2021) CORONAVIRUS: People living with disabilities struggle to overcome severe disruptions to life and health caused by the pandemic, Daily Maverick, available at: https://www.dailymaverick.co.za/article/2021-06-20-people-living-with-disabilities-struggle-to-overcome-severe-disruptions-to-life-and-health-caused-by-the-pandemic/, accessed 16 July 2021.
[67] Mental Health Information Network: Analysis of Mental Health Campaigning and Advocacy in South Africa, available at: https://gospeakyourmind.org/sites/default/files/2020-10/SouthAfrica_1_0.pdf, accessed 15 July 2020
[68] Wentzel, T. H., Narnia Bohler-Muller and Therina (2021) Vulnerable but overlooked: The COVID-19 vaccine plight of people with disabilities in South Africa, Daily Maverick, https://www.dailymaverick.co.za/article/2021-07-05-vulnerable-but-overlooked-the-COVID-19-vaccine-plight-of-people-with-disabilities-in-south-africa/, accessed 14 July 2021.
[69] New bill offers hope to people with disabilities in DR Congo, France 24, https://www.france24.com/en/africa/20201203-new-bill-offers-hope-to-people-with-disabilities-in-dr-congo, accessed 24 June 2021.
[70] 'SADC Gender Protocol 2020 Barometer Chapter 7 Harmful Practices', https://genderlinks.org.za/wp-content/uploads/2020/08/Chap7-Baro2020-HARMPRACrev2.pdf, accessed 24 June 2021.
[71] UNESCO (2021) Zimbabwe launches National Disability Policy, UNESCO, https://en.unesco.org/news/zimbabwe-launches-national-disability-policy, accessed 24 June 2021.

equal chance of becoming a person with some kind of disability at any time. Guided by the values of Ubuntu, Hunhu and the legislative obligations, both state and non-state actors have the collective obligation to do all which is possible for the fulfilment of the aspirations of this sector."[72]

As countries roll out vaccines in their jurisdictions, it is important that roll out plans are all inclusive. To ensure SRHR for women, girls, gender non-conforming persons and persons with disabilities in the recovery from COVID-19, the UNFPA, WEI, (2021) suggest the following checklist and key actions for countries.

Create an enabling legislative and policy framework

There is a robust legal framework in place to ensure the respect, protection, and fulfilment of SRHR and disability rights:

- The full range of international human rights treaties and any relevant regional human rights treaties have been ratified.
- Reports to U.N. and regional treaty monitoring bodies contain specific information about women, girls, and gender non-conforming persons with disabilities, including their SRHR, and have been developed in consultation with these groups.
- There is a law, policy, or national action plan on SRHR that:
  - Provides for access to the full range of SRH information, goods, and services in line with international human rights obligations.
  - Specifically recognizes the intersection of gender and disability and enumerates specific steps to ensure access to SRH for women, girls, and gender non-conforming persons with disabilities.
  - Has a specific and sufficient budget allocated for implementation, including for disability inclusion.
- There is a law on disability rights modelled on the Convention on the Rights of Persons with Disabilities that:
  - Specifically addresses gender, including as related to SRH.
  - Has a specific budget allocated to implementing this law and resulting policies?

Ensure access to disability inclusive services

- Barriers that women, girls, and gender non-conforming persons with disabilities face to available, accessible, acceptable, and quality SRH information, goods, and services have been identified and addressed.
- Guidance has been provided to SRH facilities on how to ensure that SRH facilities and equipment are physically accessible, services and goods are economically accessible, patients are provided with information in accessible formats, and sign language interpreters or other trained support people are provided.
- A nationwide accessibility audit has been conducted to assess the full range of accessibility measures in SRH facilities.
- An action plan has been put in place to address gaps in accessibility.
- SRH providers and staff are required to undergo training on human rights, particularly gender and disability rights, including as part of medical education. This training includes:
- Information to counter the incorrect assumption that persons with disabilities are asexual or incapable of making healthcare decisions.
- Information on the diversity of disability and on providing respectful care to persons with disabilities.
- An awareness-raising programme in the community is in place about the need for SRH for persons with disabilities, including about their rights in this context, and to counter stigma and stereotypes around disability and sexuality.

Development, Implementation and Monitoring of SRH Programmes

Women, girls, and gender non-conforming persons with disabilities participate and are included in SRH programme development, implementation, and monitoring.

[72] UNESCO (2021) Zimbabwe launches National Disability Policy, UNESCO, https://en.unesco.org/news/zimbabwe-launches-national-disability-policy, accessed 24 June 2021.

- Government entities routinely work with independent, human rights-based organizations led by women, girls, and gender non-conforming persons with disabilities to develop, implement, monitor, and evaluate policies and programmes related to SRH.
- Disaggregated data is collected on women, girls, and gender non-conforming persons with disabilities surrounding SRH.
- Disaggregation includes gender, disability, age, sexual orientation, socio-economic status, and living environment, among other relevant statuses.

Source: UNFPA[73]

The rights of widows and widowers

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.

On 23 June, the global community commemorated International Widows Day under the theme, "Invisible Women, Invisible Problems."[74] Widows, young and old, face a myriad of challenges ranging from legal, financial to social. The rights of widows and widowers are even harder to realise for the widowed women living in rural areas with limited service provision. Challenges include:

- Neglect and maltreatment by society and family members;
- Struggle with witchcraft accusations;
- Lack of voice and choice after the death of the husband;

> Widows are stigmatised for life, shunned and shamed. Yet, many of these abuses go unnoticed and are even normalised

- Disinheritance by family members;
- Denied inheritance rights to their spouse's estate or forced into unwanted marriages;
- Stigma associated with being a widow;

[73] UNFPA (2021) COVID-19, Gender, and Disability Checklist: Preventing and Addressing Gender-Based Violence against Women, Girls, and Gender Non-Conforming Persons with Disabilities during the COVID-19 Pandemic, https://www.unfpa.org/resources/COVID-19-gender-and-disability-checklist-preventing-and-addressing-gender-based-violence, accessed 11 July 2021.
[74] International Widows' Day 2021: Theme, Importance, History, Activities, Quotes, https://internationaleventday.com/event/international-widows-day/, accessed 22 June 2021.

- Traumatising widowhood rituals during mourning and at burial sites;
- Lack of economic resources, jobs and markets;
- Limited access to justice, legal aid and representation;
- Vulnerability to gender based violence;
- Widows with disabilities face a higher risk of abuse and neglect.

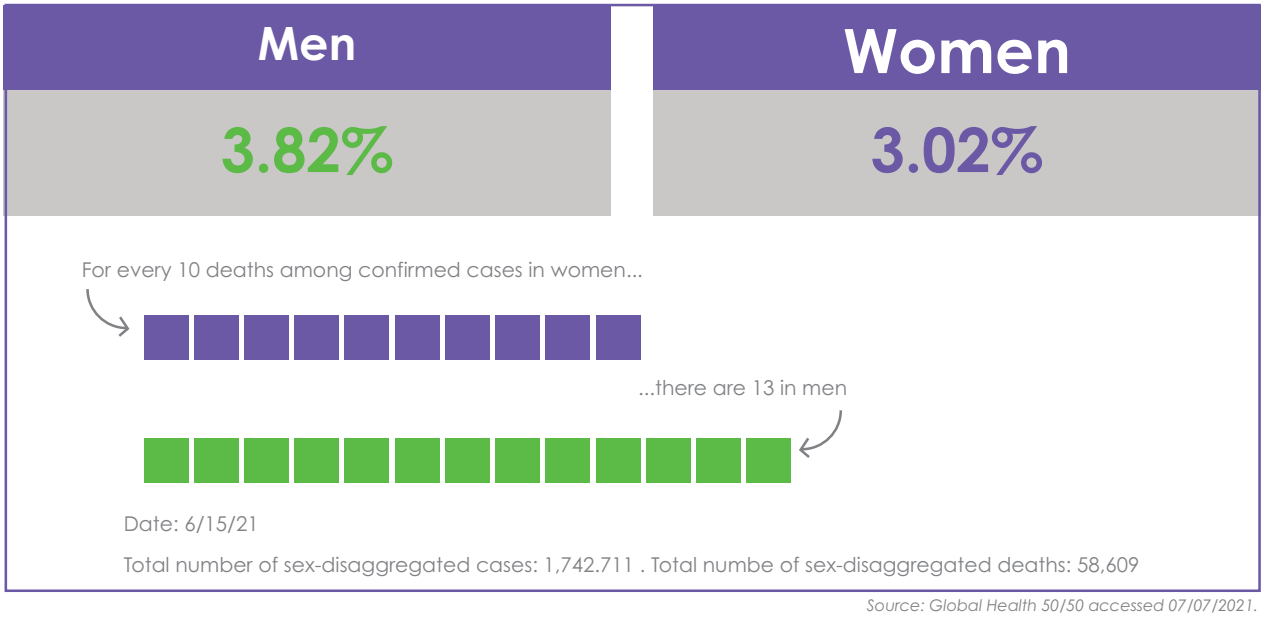
In her research that advocates for widows' rights and recognition, University of South Africa (UNISA) based Lecturer, Dr Sizakele Matlabe, notes that: "Widows are stigmatised for life, shunned and shamed. Yet, many of these abuses go unnoticed and are even normalised."[75]

Our perception of widows needs to change. They are not witches but women who have lost their partners, they are heartbroken, and in most cases they are economically disadvantaged. Society has a responsibility to support them. It is a fallacy to believe that all widows are elderly or are looked after by their children or close family members. There are young widows too who face similar challenges as the elder widowed women. Many of them have young families to look after and they need access to jobs, markets, health, and legal representation. They also need to be protected from gender based violence especially from abusive intimate partners, and family members.

Securing widows rights for example through land rights empowers widows and is critical to achieving the sustainable development goals. Society must know that widowhood contributes significantly to intergenerational poverty.[76] Due to poverty, children of widows are often denied education and economic opportunities for them to thrive. To improve strategies, as well as support and response systems, governments must encourage more research into widowhood.

The COVID-19 pandemic adds to these challenges. The Global Fund for Widows maintains that the virus will expose and exacerbate the plight of widows throughout the developing world[77] especially as men are dying at a dramatically faster rate than women.[78]

Figure 7.7: Proportion of Covid-19 deaths by gender in South Africa



Source: Global Health 50/50 accessed 07/07/2021.

[75] UNISA, Advocating for widows' rights and recognition, https://www.unisa.ac.za/sites/corporate/default/News-&-Media/Articles/Advocating-for-widows%E2%80%99-rights-and-recognition, accessed 22 June 2021.
[76] 'Widows for Peace through Democracy (WPD) Recommendations for CSW62', http://www.widowsforpeace.org/wp-content/uploads/2018/04/WPD-RECOMMENDATIONS-CSW62-1.pdf, accessed 22 June 2021.
[77] 'Covid and Widowhood', https://uploads-ssl.webflow.com/5fce889a3c0f6e35f56692ce/5fce889a3c0f6e0e0f669306_COVID-and-Widowhood-MAY-2020.pdf, accessed 7 July 2021.
[78] Including widows in the work to "build back better" from COVID-19, UN Women, https://www.unwomen.org/en/news/stories/2020/6/statement-ed-phumzile-including-widows-in-COVID-19-recovery, accessed 7 July 2021.

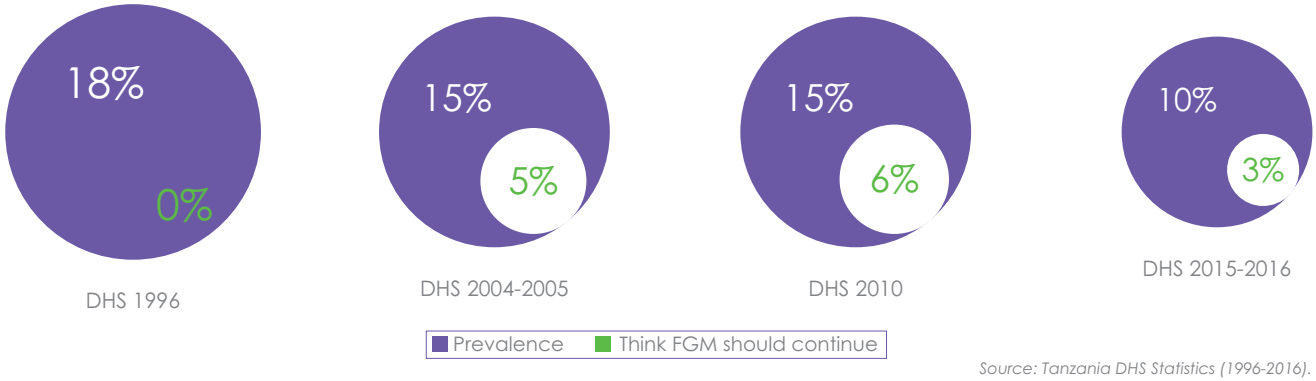
By June 2021, out of the 16 SADC countries, only South Africa had sex-disaggregated data on COVID-19 deaths.[79] Figure 7.7, illustrates the disproportionate impact of COVID-19 deaths to men which support the proposition that many women could have been widowed as a result of the corona virus outbreak.

Female Genital Mutilation (FGM)

SDGs 5.3 Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation (FGM).

Female genital mutilation (FGM) refers to, "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons." Global estimates show that at least 200 million girls and women have undergone FGM in 31 countries. These figures are based on data drawn from Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). In Africa, the practice is most prevalent in Somalia, Djibouti, and Guinea. In Southern Africa, Tanzania has the highest number of FGM cases.[80] But attitudes towards FGM in Tanzania are changing.

Figure 7.8: Prevalence of FGM and perceptions on the practice among women and girls aged 15-49 in Tanzania



Source: Tanzania DHS Statistics (1996-2016).

Figure 7.8 illustrates that the prevalence of FGM among women aged 15-49 in **Tanzania** has dropped from 18% in 1996 to 10% in 2016. Also, a declining percentage of women and girls who have heard about FGM, think that the practice should continue. This trend from 1996 is a promising one towards the achievement of SDG Goal 5.3 which seeks to eliminate all harmful practices, such as child, early, and forced marriage and female

[79] Global Health 50/50 (no date) 'The COVID-19 Sex-Disaggregated Data Tracker', https://globalhealth5050.org/the-sex-gender-and-COVID-19-project/the-data-tracker/, accessed 7 July 2021.
[80] Female Genital Mutilation (FGM) Statistics, UNICEF DATA, https://data.unicef.org/topic/child-protection/female-genital-mutilation/, accessed 25 June 2021.

genital mutilation. Advocacy and awareness-raising work by government, civil society, and development partners is commendable. More targeted interventions are needed to discourage both health personnel and traditional practitioners from performing FGM.

The growth in the medicalisation of FGM stems from a misguided belief that the dangers of FGM are medical, rather than a fundamental violation of a girl's rights. Medicalising the practice of FGM does not eliminate the danger it poses to women as it still removes and damages healthy and normal tissue and interferes with the natural functions of a girl's body. "Doctor-sanctioned mutilation is still mutilation. Trained health-care professionals who perform FGM violate girls' fundamental rights, physical integrity and health," said UNICEF Executive Director Henrietta Fore. "Medicalising the practice does not make it safe, moral, or defensible."[81] Legal and policy interventions that prohibit medical personnel from performing FGM are urgently needed.[82]

> Doctor-sanctioned female genital mutilation is still mutilation

Other harmful practices



Some girls are also made to wear an extremely tight strap around their chest.
Photo courtesy of BBC News

Breast ironing: a harmful practice that does not get sufficient attention

Breast ironing or flattening is a practice done to prevent the development of girls' breasts with the intention of reducing the sexual attention she may receive. It involves using an object to massage, pound, or press the breast flat. In her research in Cameroon, Tascott noted that the practice can include the use of grinding stones, spatulas, brooms and belts to tie or bind the breasts flat.[83] Tools include leaves believed to have medicinal or healing qualities; plantain peels; hot stones and electric irons. According to the United Nations, 3.8 million teenagers globally have experienced breast flattening. The practice is little known and often overshadowed by FGM and child marriages.

In Cameron an estimated one in three girls have been subjected to breast ironing. Several reports link the practice to some parts of Zimbabwe and South Africa.[84] However, a large scale quantitative study is required to better understand this phenomenon.

Sadly, mothers, midwives and healers carry out the practise, sometimes as a source of income (see also earlier section on FGM). Some mothers begin ironing the breasts of their daughters as a way of trying to prevent early marriage and

[81] UNICEF (2020) Approximately 1 in 4 survivors of female genital mutilation were cut by a health care provider, https://www.unicef.org/press-releases/approximately-1-4-fgm-survivors-were-cut-health-care-provider, accessed 25 June 2021.
[82] UNICEF (2020) Approximately 1 in 4 survivors of female genital mutilation were cut by a health care provider, https://www.unicef.org/press-releases/approximately-1-4-fgm-survivors-were-cut-health-care-provider, accessed 25 June 2021.
[83] 'Understanding-breast-flattening.pdf', https://fic.tufts.edu/assets/Understanding-breast-flattening.pdf, accessed 26 June 2021.
[84] Knopova, E. (2016) The breast ironing: Possible solutions to an unknown form of child abuse in Africa. doi: 10.13140/RG.2.2.11369.03689.

keep daughters in school for longer.[85] The tragedy is that a practise meant to protect girl children itself violates their rights.

Breast ironing can result in burns; scars and uneven skin including deep breast tissue injuries.[86] "One mother burned her own hand so badly that she came to the hospital. Only when she saw what happened to her own hand did she realise how painful the practice must be for her daughter, who was feeling this hot stone on her breasts, which are much more sensitive than the palm."[87] The combination of severe injuries by repeated heat and pressure can lead up to uneven breast growth, breast malformation, breast sagging, breast-feeding difficulties, tumours, cysts and even breast cancer many years after.[88] Victims may also later have trouble with breastfeeding, which may lead to stigma and social rejection.



Breasts ironing, "I" story from Zimbabwe

I remember being 11 almost 12 and I had started developing breasts. Because of my small frame and my preference for male, rather than female, friends my mother worried that I would start getting involved in sexual activities. So she invited my grandmother to come have a talk with me and take some precautions so as to preserve my womanhood as they put it. My grandmother came; spoke to me about my body changing took a cooking stick, which she used to hit my developing breasts. This was meant to slow down the rate at which my breasts would grow and let us just say I think it worked because even though I am in my 30s I still have hope they will grow. These bee stings I have cannot be my fully developed breasts!

The other version of that traditional practice and how it is practiced in other African countries (breast ironing) is horrifying. The thought of it makes me cringe. Breast Ironing is a heinous practice. This insane activity involves the flattening of little-developing breasts of young girls to "protect" them from rape or any sexual harassment.

Though many organisations are working tirelessly for the awareness amongst the people, I wonder how people can punish little girls just to accommodate the lustfulness of men. Can't they educate their men and let these girls enjoy the budding and blossoming of their bodies? Why are we constantly accepting men's ills at the expense of fellow women and children? Why don't they punish these criminals who rape and harass these little girls instead of punishing these girls? I guess I have more questions than answers but my heart bleeds for these little girls.

Source: Pakasipiti Zimbabwe[89]

[89] Dee, L. (2016) 'Breast Ironing', pakasipitizimbabwe, 21 April, https://pakasipitizimbabwe.wordpress.com/2016/04/21/breast-ironing/, accessed 26 June 2021).

Next steps

- **Scrapping discriminatory laws:** The government of Tanzania must uphold the Supreme court ruling to amend the Law of Marriage Act in line with the SADC Model Law on Child marriage. Continued delays in closing the legal loophole leaves room for discrimination and marginalisation of girls and women in the country.
- **Access to justice:** To ensure equality of women as complainants in accessing justice, remodelling of customary court structures in the region is important.
- **Campaigns and advocacy:** Innovative ways to end marriage including the role of traditional leaders and teen mothers in advocacy and campaigns against child marriages should be strengthened.
- **Enforcing child marriage laws:** As opposed to rhetoric, sufficient law enforcement and monitoring to delay marriage and protect the rights of women and girls is needed if changes in age-at-marriage laws are to achieve the desired outcomes.
- **Policy support:** Alternative policies need to be devised to ensure that girls' later-life outcomes, including their participation in higher education and society, are ensured, encouraged, and protected.
- **Evidence gathering:** More research is needed to establish the extent of breast ironing practices in the region. The few reports that mention presence of the practice are insufficient to draw scientific conclusions about the practice in the SADC region.
- **Institutional support:** Implement clear and unequivocal mandates for institutions that advance women's rights to address harmful practices, especially in the roll out of vaccines to vulnerable groups such as women with disabilities.
- **Response:** The setting up of specialised and dedicated GBV courts in Botswana during the COVID-19 lockdown is a best practice in the region which can be replicated by other governments in the region.
- **Support to People with disabilities:** To address the specific needs and challenges during the COVID-19 pandemic. Countries should put systems in place including accessible emergency services that provide protection to people with disabilities during situations of risk and disaster.



Women celebrate the launch of the 2020 SADC Gender Protocol Barometer in Tanzania. Photo: Gender Links Alliance

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Sexual Diversity 8



LGBTQ activists march in South Africa in 2021 to pressure the country's parliament to expedite a Hate Crimes Bill currently awaiting approval.
Photo courtesy of Unsplash / Tanushree Rao

KEY POINTS

- Four Southern African countries (Angola, Mozambique, Seychelles, and South Africa) have decriminalised same-sex relationships.
- Madagascar allows same-sex relationships for those older than 21, while the Government of Botswana has appealed a 2019 High Court decision to decriminalise same-sex relations.
- COVID-19 has exacerbated vulnerabilities in LGBTQ communities, especially those relating to economic survival, healthcare and gender-based violence.
- Three countries (Mauritius, Namibia, and South Africa) allow LGBTQ people to change their gender markers. The inability for transgender people to change their gender marker presents challenges in their everyday lives including in banking, accessing healthcare and in legal processes.
- Mauritius and South Africa ban conversion therapy, which experts note causes physical and psychological damage.
- Only one SADC country, Angola, has hate crimes legislation that explicitly protects LGBTQ persons from violence and discrimination.
- The UN Human Rights Office has called on all countries to outlaw sporting regulations that pressure female athletes to undergo "unnecessary" medical interventions.
- COVID-19 health efforts must include long-terms strategies towards the attainment of universal health care that incorporates inclusive and distinct care for LGBTQ people.

Introduction



Members of the LGBTQ community in Namibia commemorate the country's first Pride event in July 2017. Photo courtesy of Hildegard Titus/AFP

Lesbian, gay, bisexual, transgender and queer (LGBTQ) people in Southern Africa continue to face discrimination and violence because of their sexuality or gender identity and expression.

COVID-19 lockdowns have severely affected the rights of LGBTQ persons and compromised their access to health and essential services

To assess the depth and nature of social exclusion and the dangers faced by LGBTQ people across the region, the Other Foundation commissioned studies of ten countries in Southern Africa in 2016: Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. The studies also sought to help activists unpack the dominant narratives about sexual orientation and gender identity in the region so that LGBTQ groups can organise better to advocate for change.[1]

In Namibia and Botswana, the nature of the public discourse about LGBTQ people has shifted dramatically over the past decade, from what the Other Foundation refers to as the "backlash" cycle to a "progress" cycle, illustrated by a more positive or neutral stance. In Mauritius and Mozambique, the studies found public discourse on the subject to be positive or neutral.

[1] Canaries Summaries, https://theotherfoundation.org/wp-content/uploads/2016/10/Canaries_Summary_epub_Draft4_MJ6-2.pdf, 11 October 2021.

These four countries share a sympathetic or neutral media (often due to sensitisation training by LGBTQ organisations and their allies); effective strategic advocacy by LGBTQ organisations through the judicial, legislative or executive systems; and mobilisation of effective alliances with other human rights actors and with state agencies.

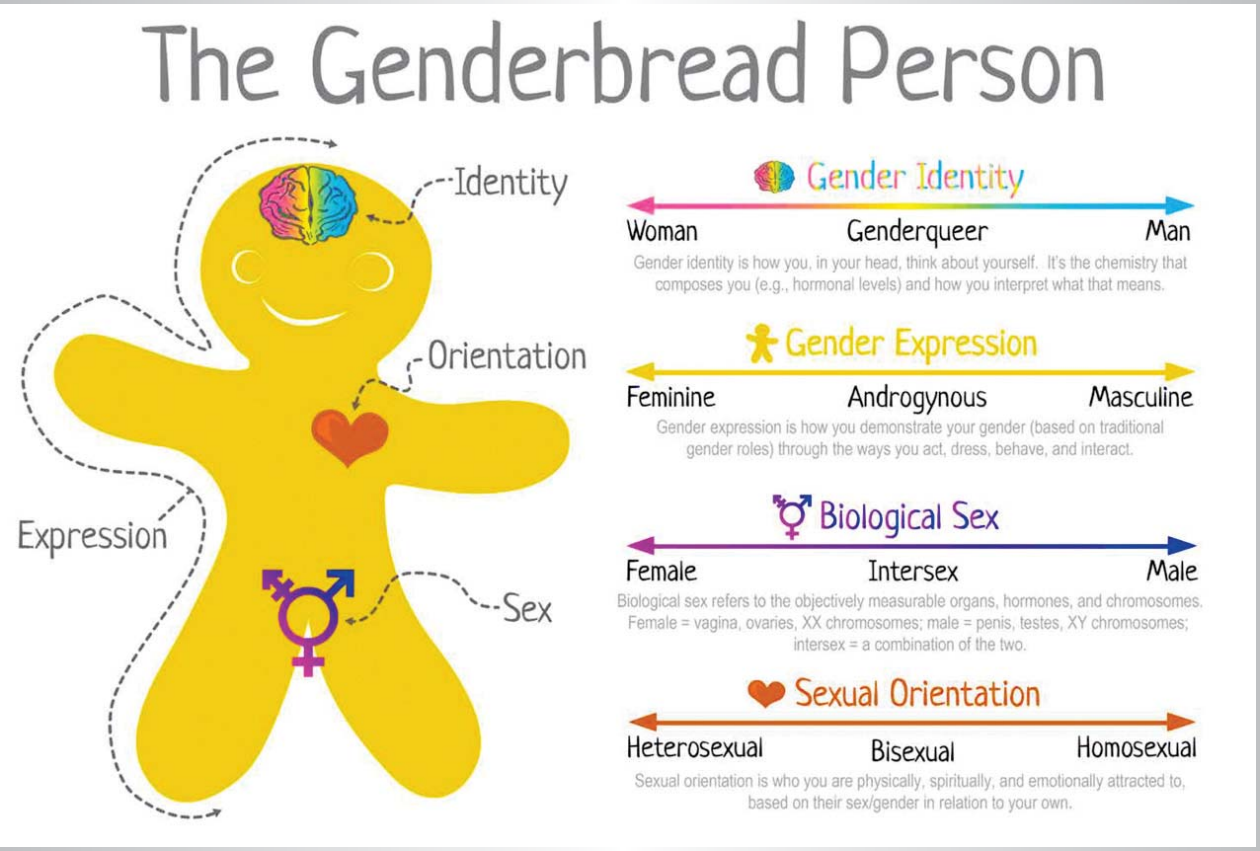
Meanwhile, Malawi, Zambia, Zimbabwe and, to a lesser extent Eswatini, have seen inflamed public discourse against LGBTQ people. In these countries, activists perceive this in part as a backlash against assertive LGBTQ rights movements or individuals.

Since March 2020, states in the Southern African Development Community (SADC) have been in varying stages of lockdown due to the COVID-19 pandemic. These have severely affected the rights of LGBTQ persons and restrictions on movement have compromised their access to health and other essential services. Additionally, the economic consequences of COVID-19 resulted in the loss of livelihoods for LGBTQ people, forcing some to move into unsafe homes.

It is imperative that governments implement sustainable strategies to address these issues and guarantee LGBTQ rights and access to services.

Key concepts

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 or non-binary - 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. A **cisgender** person is someone whose sense of personal identity and gender corresponds with their birth sex.

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 emotional, romantic or sexual attraction. Sexual orientation may include same-sex attraction (homosexuality), attraction to someone of a sex different from your own (heterosexuality), attraction to both men and women (bisexuality), to all genders (pansexual), or neither (asexuality). A person's gender identity does not predetermine their sexual orientation. It is important to understand that these orientations and identities fall on a continuum and can be fluid. 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 for boys, pink for girls; cars for boys, dolls for girls; football for boys, playing house for girls).

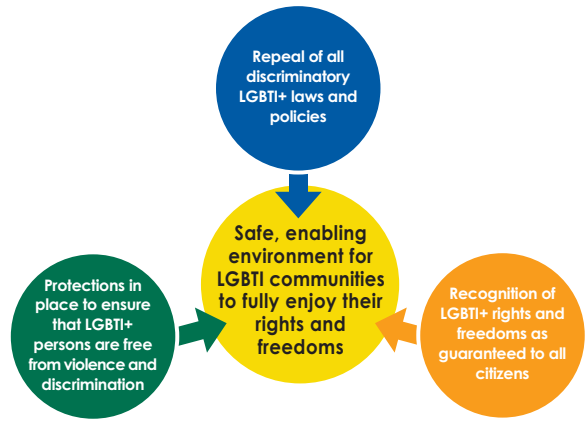
Queer is an umbrella term to refer to a person whose attraction and/or identity goes beyond the traditional definitions associated with sexual orientation and gender identity. Different people use this term to mean different things.

It is important for legislators in member states to recognise that their populations include people of diverse sexual orientations, gender identities and expressions. LGBTQ refers to all people across the sexual orientation, gender identity and expression and sex characteristics (SOGIESC) spectrum and all have a right to equal and dignified treatment and to live freely and safely.

The decriminalisation of same sex consensual acts is an important part of the struggle to advance LGBTQ rights. Decriminalisation is part of a bigger set of changes required to secure the human rights of LGBTQ communities.

In 2014, the African Union's major human rights body, the African Commission on Human and Peoples' Rights, adopted Resolution 275. It calls on state parties to the African Charter on Human and Peoples' Rights to refrain from, investigate and punish acts of violence and discrimination against people based on their sexual orientation and gender identity.[2]

Figure 8.2: Three-pronged approach to advocating for LGBTQ rights



[2] Abolition of Angola's anti-gay laws may pave the way for regional reform, The Conversation, http://theconversation.com/abolition-of-angolas-anti-gay-laws-may-pave-the-way-for-regional-reform-111432, accessed 15 July 2021.

As outlined in Figure 8.2 the *#VoiceandChoice* campaign advocates for a three-pronged lobbying and advocacy strategy. These include legal reform and policy development, social protections and the recognition of LGBTQ rights as basic human rights guaranteed to all citizens.

Successful LGBTQ lobbying and advocacy efforts must include public education on LGBTQ rights.

The Southern Africa Gender Protocol Alliance administered the 25-question Southern African Gender Progress Study (GPS) survey to 34 323 women and men of all age groups in 15 SADC countries between January 2019 and May 2021. The GPS included two questions relating to LGBTQ rights.

Table 8.1: Regional responses to questions on sexual diversity in the GPS

Question	Agreed or Strongly Agreed
Homosexuality is a psychological disease	30%
It bothers me when a girl acts like a boy	31%

Figure 8.3: Differences in responses to questions in the GPS



Table 8.1 and Figure 8.3 show that, when respondents answered questions about sexual diversity, 30% agreed or strongly agreed with the statement "Homosexuality is a psychological disease" and 31% agreed or strongly agreed with the statement, "It bothers me when a girl acts like a boy." The study also found male respondents likelier to agree with these statements.

Although researchers identified this statistical difference between male and female responses, the difference is negligible. While it is encouraging to note that about 70% of respondents did not agree to both statements, 30% explicitly stated that homosexuality and diverse gender identities bother them. These numbers point to the need for widespread public education on sexual diversity and LGBTQ rights.

Social, religious and cultural biases drive negative attitudes towards LGBTQ rights. Anti-LGBTQ groups have employed the notion that LGBTQ communities are "unchristian" to fuel opposition to the recognition of LGBTQ rights. In October 2020, Pope Francis, head of the Catholic Church, publicly declared his support for same sex civil unions, challenging these attitudes. Activists underscore the importance of working with religious, cultural and traditional leaders in lobbying and advocacy for the recognition of LGBTQ rights.

Pope Francis supports same-sex civil unions



Pope Francis speaks at an inter-religious ceremony for peace in Rome in October 2020. Photo courtesy of AP Photo/Gregorio Borgi

Pope Francis has called for the recognition of civil union laws that would provide legal protection for same-sex couples

As part of this recognition, Pope Francis emphasised that gay and lesbian people are "children of God and have a right to a family," and that "nobody should be thrown out, or be made miserable because of it."

In the past, the Vatican has publicly opposed violence and discrimination against LGBTQ people, including the criminalisation of same-sex activity.

The Pope's remarks are likely to resonate in contexts where basic legal recognition is badly needed. But they also boost support for LGBTQ families at a time when lawmakers and right-wing groups are attempting to weaken non-discrimination protections in areas like adoption and foster care, often in the name of religion.

The Pope's remarks may not immediately translate into stronger protections for LGBT people, but they offer a powerful reminder that LGBT families deserve respect and recognition at a time when that fact is too often ignored.

Source: Ryan Thoresen, Human Rights Watch, October 2020.

[3] Human Rights Watch, 'Pope Francis Supports Same-Sex Civil Unions', https://www.hrw.org/news/2020/10/21/pope-francis-supports-same-sex-civil-unions, accessed 11 October 2021

Table 8.2: Sexual diversity baseline indicators in 2024

INDICATORS	Angola	Botswana	Comoros	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	No	Never criminalised	No	Never criminalised	Yes, for those over 21	No	No	Yes	No	Yes	Yes	No	No	No
Gender/s		All genders	Male only		All genders		All genders	All genders	Male only		Male only			All genders	All genders	Male only
Years in prison/other		Seven	Up to five or a fine		Undeter-mined			14	Five		Undeter-mined			Life	Life	One
Protection																
Protection against discrimination																
Specific constitutional provisions	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Broad protections	Yes	No	No	No	No	No	No	No	No	Yes	No	No	Yes	No	No	No
Employment	Yes	Yes	No	No	No	No	No	No	Yes	Yes	No	No	Yes	No	No	No
Criminalisation of violence/discrimination against LGBTI communities																
Hate crimes/ aggra-vated circumstances	Yes	No	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	No
Ban on conversion therapy																
CT banned	No	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	No	Yes	No	No	No
Civil unions	No	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	No	No	No	No	No	Yes	No	No	No
Second parent adoption of children	No	No	No	No	No	No	No	No	No	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	Not possible	Nominally possible	Possible	Nominally possible	Possible	Not possible	Possible	Not possible	Possible	Not possible
Name change	Nominally possible	Possible	Not 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	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Able to operate freely	Yes	Yes	No	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	No	No	No

[4] ILGA, 2020. World State Sponsored Homophobia report global legislation overview update, ENG-CovArtboard 1 (ilga.org), accessed 11 October 2021.

Table 8.2 shows that:

- Four out of the 16 SADC countries have decriminalised same-sex consensual acts: Angola, Mozambique, Seychelles, and South Africa. DRC and Lesotho have not ever criminalised homosexuality, so laws in those countries require further clarity. Madagascar decriminalises homosexuality for those older than 21 but criminalises it for anyone younger than 21.
- Four countries (Comoros, Mauritius, Namibia, and Zimbabwe) criminalise homosexuality for men only.
- Only South Africa has constitutional provisions to protect LGBTQ people.
- Six countries (Angola, Botswana, Mauritius, Mozambique, Seychelles and South Africa) have employment protections for LGBTQ people.
- Only Angola criminalises hate crimes and incitement to violence against LGBTQ communities, while only Mauritius and South Africa ban 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).[5]
- Some countries, like Mauritius, have contradictory legislation, criminalising homosexual sex acts yet protecting LGBTQ people from discrimination in the workplace and banning conversion therapy.
- Only South Africa recognises same sex unions, civil unions, joint adoption of children and second parent adoption of children.
- Four countries explicitly allow people to change sex and/or gender markers[6] and their names (Mauritius, Namibia, South Africa, and Zambia), while four others nominally allow these changes (Angola, Botswana, Malawi and Mozambique).
- LGBTQ organisations can legally register in nine countries (Angola, Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa, and Zimbabwe) and operate freely in seven countries in Angola, Botswana, Lesotho, Mauritius, Namibia, Seychelles and South Africa.

This chapter includes new case studies and information on LGBTQ concerns in SADC. Sections on global, continental, and national legislative frameworks align with last year, as these remain unchanged. This is a concern because only four of 16 countries in SADC have fully decriminalised homosexuality, which activists see as an important first step towards full recognition of LGBTQ rights. Governments must accelerate this moving forward.

Governments need to develop strategies that address the unique impact of COVID-19 on the LGBTQ community

Researchers prepared this sexual diversity chapter against the backdrop of the COVID-19 pandemic. Like other communities, COVID-19 has affected LGBTQ people in fundamental ways, which this chapter highlights. The current crisis points to the need for governments and civil society to engage with the short- and long-term implications of COVID-19, development priorities, and the unique impact of both on key populations, including the LGBTQ community.

[5] 'Conversion therapy' (2021) Wikipedia, https://en.wikipedia.org/w/index.php?title=Conversion_therapy&oldid=1049182454, accessed 15 July 2021.
[6] 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.

COVID-19 and vaccine justice



COVID-19 continues to devastate large segments of the LGBTQ community. In many countries, LGBTQ people work predominantly in the informal sector, relying on daily wages and surviving without job protections. This makes them especially vulnerable to economic slowdowns and restrictions on movement.

Many LGBTQ people must choose between risking infection to earn enough money to pay for food and shelter or adhering to lockdown requirements and risk going without basic necessities.

The COVID-19 pandemic has overwhelmed health systems, which have been experiencing shortages of personal protective equipment, test kits, and specialised equipment such as ventilators. During this crisis, health systems have not prioritised LGBTQ people or their specific needs. Even in the absence of a pandemic, LGBTQ communities face discrimination, stigma, refusal of services, and confidentiality breaches when accessing health services in SADC. This may contribute to reluctance among members of the LGBTQ community to access the COVID-19 vaccine.



Zimbabwe: LGBTQ people wary of public COVID-19 vaccination sites



Healthcare workers from the Ministry of Health prepare to vaccinate LGBTQ people in Harare in July 2021 at a vaccination site championed by GALZ.
Photo: GALZ

The Gays and Lesbians Association of Zimbabwe (GALZ) says its members have avoided public COVID-19 vaccination centres because of discrimination.

In response, the sexual minority rights group has worked with government to establish safe sites at which LGBTQ people can access safe and non-discriminatory healthcare services.

A GALZ official, who requested anonymity, said the rights organisation had initiated the "private" jabbing campaign to protect sexual minorities from unwarranted attacks.

"We received information that some members felt wary of going to public health facilities to access the jabs because Zimbabwean society remains largely homophobic, using the guise of religion and culture, to discriminate and violate LGBTQ persons," said the official.

Common violations include hate speech, blackmail, unlawful arrest and detention, disownment by families, excommunication from religious institutions, eviction, forced marriage, extortion, invasion of privacy and loss of employment, the GALZ officer noted. Because of this stigma, discrimination and harassment, LGBTQ persons face hardships accessing healthcare services.

"There may be judgement from members of the public at the facility. For example, in queues, or where health professionals may not know what to do when dealing with an intersex or transgender person for the very first time."

They added, "GALZ is complementing government efforts to ensure all people are vaccinated. As a [United Nations Population Fund] UNFPA-Global Fund implementing partner under the key populations programme, we have a referral network for members in other cities and towns to access health facilities.

"Since the advent of COVID-19, GALZ has been running a weekly health services satellite clinic. This is an extension of the sexual and gender-based violence (SGBV) clinic at Wilkins Hospital."

To ensure its members access COVID-19 vaccines, GALZ and its partners mobilised resources to set up safe and non-discriminatory sites to curb the further spread of the deadly pandemic, which has not spared its membership.

"COVID-19 does not discriminate; as such members did fall ill while some sadly lost family members just like other citizens. Travel bans made it difficult for persons who were used to accessing the pre-exposure prophylaxis (PrEP) and antiretrovirals (ARVs) and other family planning services at friendly facilities."

The global pandemic also affected the livelihoods of GALZ members and LGBTQ people in Zimbabwe as successive lockdowns disrupted businesses and resulted in job losses. GALZ set up online counselling units to provide psychosocial support to affected individuals.

Source: James Muonwa for AllAfrica, August 2021.[7]



Cyril Ramaphosa, South Africa's president, referred to GBV as a parallel pandemic.
Photo courtesy of UN Women

During the initial phase of the pandemic, Cyril Ramaphosa, South Africa's president, referred to gender-based violence (GBV) as a parallel pandemic. LGBTQ people suffer from this second pandemic and they faced increased vulnerability to GBV as many returned to violent homes or environments due to job losses and homelessness. Mandatory lockdowns to curb disease transmission may also trap them in households with unsupportive families or their abusers, isolated from the people and resources that can help them.

Many LGBTQ people experience increased isolation, which leaves them cut off from chosen families and support networks. The inability to connect in person with LGBTQ communities and friends during this time of physical distancing exacerbates feelings of seclusion and even fear.

[7] Muonwa, J. (2021) Zimbabwe: LGBT People Shun Public Covid-19 Vaccination Sites, allAfrica.com, https://allafrica.com/stories/202108040573.html, accessed 10 August 2021.

Botswana: A snapshot of how COVID-19 has affected the LGBTQ community



Botswana-based activist and poet Kutlwano "Bubbly" Seladledi, died during the COVID-19 pandemic. Photo: @dilotsotlhe/LEGABIBO

In the early weeks of the lockdown, I attended a memorial service on Facebook Live to remember and celebrate the life of Kutlwano "Bubbly" Seladledi, an LGBTQ activist and spoken-word poet from Botswana, who passed away on 2 April 2020.

Bubbly, as their name suggests, was one of the nicest, warmest, most good-humoured people and welcomed me in Botswana just a few years ago. I will never forget their laugh and kind smile.

Bubbly wasn't a direct casualty of the coronavirus. Rather, their death was the result of a hard-fought struggle with depression brought on by the stigma and discrimination LGBTQ Batswana are far too familiar with.

Lesbians, Gays & Bisexuals of Botswana (LEGABIBO), Botswana's central LGBTQ organisation, understands deeply that their community's mental health challenges do not dissipate when their country shuts down. In fact, they are often amplified by sudden social isolation and increased anxieties around employment, housing, and accessing critical health services. Stuck in difficult and unsafe home situations, LGBTQ Batswana are confronted with domestic violence, suicidality, depression, anxiety, death threats, homelessness, unemployment, and hunger.

Forced to operate remotely, LEGABIBO staff are working diligently to continue to provide psychosocial support, offer sexual and reproductive health services, assist on domestic violence cases, distribute food parcels, and link persons to emergency shelter. In an already difficult and often hostile environment, LEGABIBO and LGBTQ organizations worldwide are working even harder to keep queer people safe during the COVID-19 pandemic.

Bubbly will be remembered by their friends and colleagues for, "their quest for social justice for the LGBTQ community and their involvement with many initiatives that sought to promote inclusion and connect each and every one of us to love, dignity, and Botho." I hope we can honour Bubbly by remembering that while we may be physically apart, we are not alone. Our communities need each other now more than ever.

Source: Michelle Samuels for Boston University's BU Today in June 2020.[8]

[8] A Snapshot of How COVID-19 Is Impacting the LGBTQ Community, Boston University, https://www.bu.edu/articles/2020/how-covid-19-is-impacting-the-lgbtq-community/, accessed 11 October 2021.

Legal and policy frameworks

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.

Global instruments

The UN is the sum of its member states, many of which do not tolerate LGBTQ rights. As such, the Sustainable Development Goals (SDGs) do not include any specific references to LGBTQ people or issues. Nevertheless, to ensure that the global development agenda does not leave LGBTQ communities behind, the United Nations Development Programme (UNDP) developed the lesbian, gay, bisexual, transgender and intersex (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 LGBTQ Inclusion Index comprise political and civic participation, economic well-being, personal security and violence, health, and education.[9]

The SDGs do not include any specific references to LGBTQ people

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 based on the application of international law to human rights violations based on sexual orientation and gender identity.[10] Although stakeholders first adopted these Yogyakarta Principles in 2007, and updated them in 2017, they remain non-binding. However, they provide comprehensive guidance to states, including: Rights to universal enjoyment of human rights, non-discrimination, and recognition before the law; rights to human and personal security; economic, social, and cultural rights; rights to expression, opinion, and association; freedom of movement and asylum; rights of participation in cultural and family life; rights of human rights defenders; and rights of redress and accountability.[11]

The UN has rolled out several instruments that enshrine these rights, and SADC countries have signed onto many of them.

[9] Advancing the Human Rights and Inclusion of LGBTI People: A Handbook for Parliamentarians', p. 76. https://www.pgaction.org/inclusion/pdf/handbook/en.pdf , accessed 8 October 2021.
[10] Introduction to the Yogyakarta Principles - Yogyakartaprinciples.org', http://yogyakartaprinciples.org/introduction/, accessed 11 October 2021.
[11] Advancing the Human Rights and Inclusion of LGBTI People: A Handbook for Parliamentarians', p. 76. https://www.pgaction.org/inclusion/pdf/handbook/en.pdf , accessed 8 October 2021.

Table 8.3: Overview of key UN instruments and SADC commitments

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
Comoros	S	S	SP	SP	SP	SP	SP
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, 2016.[12]

Table 8.3 provides an overview of the relevant UN instruments and the status of SADC member 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:

1. None means a state has not committed to the instrument, indicated with an "N."
2. Signatory means a state has signed an agreement but has not ratified it at national level, indicated with an "S."
3. State party means a state has ratified the instrument at national level, which means it must domesticate it, 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 Botswana, Tanzania and Zimbabwe have not signed the Convention on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

Angola has not ratified the CAT and International Convention on the Elimination of all forms of Racial Discrimination (ICERD). Meanwhile, Botswana lags in several areas as it has not committed to the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social, and Cultural rights (ICESRC) or CAT and it has only signed up to, but not domesticated, the Convention on the Rights of the Child (CRD) and ICERD.

While progress by countries in SADC to implement relevant instruments has stalled in some areas, the UN has increasingly focused on sexual diversity at the global level. The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA World) conducted an analysis of thematic reports submitted to the UN Human Rights Council and General Assembly.

[12] ILGA, 2016, Treaty Bodies SOGIESC references, https://ilga.org/downloads/Treaty_Bodies_SOGIESC_references_2016_ILGA.pdf, accessed 11 October 2021.

Table 8.4: UN thematic reports with good or strong LGBTQ references in 2020

Mandate	Report topic	References
Special Rapporteur in the Field of Cultural Rights	Cultural rights defenders January 2020 (41st Session Human Rights Council (HRC))	Good references to LGBTQ and SOGI (cultural rights includes LGBTQ rights, challenges defenders face and need for protection)
Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression	Artistic Freedom of Expression: July 2020 (44th Session HRC)	Good reference to LGBTQ, sexual minorities (suppression of LGBTQ activists, artists, and artistic events and expression)
Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association	Celebrating women in activism and civil society: the enjoyment of the rights to freedom of peaceful assembly and of association by women and girls: July 2020 (75th Session General Assembly (GA))	Good reference to LGBTQ (women with multiple and intersecting forms of marginalisation, police violence and restrictions on overseas funding)
Special Rapporteur on Freedom of Religion or Belief	Freedom of religion or belief and gender equality: August 2020 (43th Session HRC)	Very strong reference to SOGI-based violence and discrimination in the name of religion or belief
Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard Of Living, and on the Right to Non-Discrimination in this Context	COVID-19 and the right to adequate housing: July 2020 (75th Session GA)	Strong references to LGB, transgender and gender-diverse persons and SOGI (A separate section on LGBTQ persons' right to housing during the pandemic; a recommendation on data collection)
Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-Discrimination in this Context	Guidelines for the implementation of the right to adequate housing: December 2019 (43rd Session HRC)	Good references to LGBTQ and "sexual identity" (vulnerability and discrimination in housing)
Special Rapporteur on the Rights of Indigenous Peoples	The impact of COVID-19 on the rights of Indigenous peoples: July 2019 (75th Session GA)	Good references to LGBTQ and SOGI (example from Thailand; recommendation to pay attention to the situation of Indigenous LGBTQ persons; call to collect and analyse data on indigenous LGBTQ and two-spirit persons in the health-care system; no discrimination based on SOGI)
Special Rapporteur on the Right To Privacy	Summary of activities on surveillance, health data, business enterprises use of personal data and protection against gender-based privacy infringements: February 2020 (43rd Session HRC)	Good references to SOGIESC (considerations of the right to privacy of people with diverse SOGIESC in relation to treatment of persons deprived of their liberty; changing rooms and health-related data)
Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity	"Conversion therapies" practices: May 2020 (44th Session HRC)	Explores practices of so-called "conversion therapy" across the globe, including their impact on victims, their human rights implications and their connection with violence and discrimination based on sexual orientation and gender identity, as well as measures adopted to prevent them and to penalise or prosecute those who perform them and remedies provided to victims
Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity	COVID-19: July 2020 (75th Session GA)	Discusses the impact of COVID-19 on the human rights of LGBTQ and gender-diverse persons, communities and/or populations; analyses the impact of the pandemic on social exclusion and violence and the interaction with institutional drivers

Mandate	Report topic	References
		of stigma and discrimination; and analyses measures adopted in the context of the pandemic aimed at persecuting LGBTQ and gender-diverse persons or with indirect or unintended discriminatory effects and identifies good practice
Special Rapporteur on the Promotion of Truth, Justice, Reparation and Guarantees of Non-Recurrence	The gender perspective in transitional justice processes: July 2020 (75th Session GA)	Strong reference to LGBTQ and gender perspectives considered in conceptualisation, design and implementation of national transitional justice strategies and mechanisms
Special Rapporteur on Violence Against Women, its Causes and Consequences	Violence against women journalists: May 2020 (44th Session HRC)	Good references to LGBTQ people, LBTI women, LT journalists and LGBTQ issues (in the context of attacks, abuses and harassment experienced by journalists, and retaliation for covering certain issues)

Source: ILGA, 2020.[13]

In 2020, 39 reports (more than 50% of all thematic reports) mentioned some LGBTQ-related topics, with 12 of these reports - set out in Table 8.4 - including good or strong references to LGBTQ populations.

Activists welcome the ongoing attention to LGBTQ human rights issues by the UN structures and encourage mandate holders to strengthen their analysis of specific populations within LGBTQ communities and to look into the situation of LGBTQ persons who are not necessarily activists. This includes LBQ women, trans or intersex persons and LGBTQ persons with disabilities.

Continental instruments

Two binding treaties that apply at the regional level strengthen the fight to curb violence against people based on their real or imputed sexual orientation or gender identity. The African Charter on Human and Peoples' Rights (also known as the Banjul Charter), represents the principal treaty and 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.[14]

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 LGBTQ communities. Resolution 275 calls on member states to:

1. Ensure that human rights defenders work in an enabling environment free of stigma, reprisals, or criminal prosecution because of

[13] ILGA, 2020. LGBTI rights | UN experts push for better protection across a range of topics, https://ilga.org/lgbti-rights-special-procedures-UN-experts-push-for-better-protection, accessed 3 October 2021.
[14] African Commission on Human and Peoples Rights Resolution 275, http://cfnhri.org/uploads/files/resolution_275_eng.pdf , accessed 10 October 2021.

their human rights protection activities, including the rights of sexual minorities; and
2. 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.[15]

The first clause in resolution 275 commits member states to allowing LGBTQ organisations to operate freely. This is currently only possible in Angola, Botswana, Lesotho, Mauritius, Namibia, Seychelles, and South Africa. Nine SADC countries actively restrict these organisations.

The second clause commits member states to creating a legal environment that criminalises violence against LGBTQ persons in all its forms and ensures prosecution of perpetrators of such violence.

Angola is the only country in SADC that has specific hate crime legislation that protects LGBTQ people from violence and discrimination. Other countries should urgently bring in similar legislation.

During the week of 15 March 2021, the UN Human Rights Council discussed the Forum on Minority Issues' recommendations to tackle hate speech on social media. The document includes LGBTQ people among the particularly vulnerable populations to online hostility.

Hate speech on social media forces LGBTQ people back into silence

The United Nations describes hate speech as "any kind of communication that attacks or uses pejorative or discriminatory language with reference to a person or a group on the basis of who they are." This is language that has the potential to generate intolerance and hatred, and our communities are constantly confronted with it.

The online space has been revolutionary for LGBTQ people: it has helped build communities. But with more visibility, also came backlash: 84% of respondents to a survey conducted by ILGA World in 2020 said that those spaces have exposed them to hate speech and threats.

With more people forced to engage online, attacks against the LGBTQ community intensified during the COVID-19 pandemic, further disrupting what was left of any safe space.

The UN Forum on Minority Issues rightfully called on states and tech companies to "ensure an inclusive access to the digital world." However, hate speech is consciously hampering such opportunities: it is yet another form of intimidating LGBTQ and other communities back into silence.

Trans persons are currently particularly under attack, especially whenever legitimate debates on legal reforms are used as a pretext to deny trans people their right to existence.

Clearly, neither withdrawing from online spaces nor going back to the closet are viable options. But enduring constant abuse can be extremely difficult, especially when perpetrators don't seem to be sanctioned for their behaviour. It is high time for states and social media companies to take action.

[15] http://www.achpr.org/sessions/55th/resolutions/275/

The business of social media platforms depends on data analysis: they should investigate how exactly hate speech targets each community. If access to this data were open, states would have further evidence of the need to improve laws and policies on the matter.

Let us be clear: everyone is entitled to their opinions, but not to destroy others in the process. Freedom of speech is precious, but this cornerstone of the international human rights framework must never become an excuse to legitimise hatred and intolerance.

Hate speech thrives whenever inequalities rise. Change starts by fostering inclusive and just societies. It continues with empowering netizens to use social media as a space where more speech and dialogue - not less - can happen, provided that everyone is ready to recognise and reject hate. This is not a responsibility of governments and platforms alone: all of us share virtual spaces, and we all must act.

Addressing hate speech means keeping it from escalating into incitement to discrimination, hostility and violence. It is a human rights issue, and a matter of basic human decency.

Source: Daniele Paletta for ILGA, March 2021.[16]

Regional instruments

No SADC instruments currently exist specifically to address LGBTQ rights. This is indicative of the resistance amongst legislators in most SADC states to address the needs of these communities. South Africa remains the exception, with some of the most progressive laws, policies, and practices in the world. Given the policy-rich global and continental environment, activists need to continue to lobby and advocate for a regional protocol on the rights of LGBTQ people - one that includes global and continental provisions within a SADC context.

Three SADC instruments speak to improving SRHR in member states:

1. Strategy for Sexual and Reproductive Health and Rights in the SADC region, 2019-2030;
2. SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights among key populations; and
3. Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region.

The ***SADC SRHR strategy*** includes LGBTQ people in its list of beneficiaries (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, men who sleep with men (MSM) and LGBTQI, migrants, refugees, mobile populations, people living with disabilities, and victims of sexual exploitation).[17] The SRHR strategy makes no other specific reference to the needs of LGBTQ people.

The ***SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights*** does not include LGBTQ people among key populations at all. However, it does identify MSM and transgender people as key populations. All key populations named in this strategy face elevated levels of stigma and discrimination, which impede their access to health services, including HIV and SRH services. They also face stigma and discrimination in healthcare settings, the workplace, families, and within communities.[18]

The ***Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region*** takes a similar approach by referencing LGBTQ persons as a key population. It calls on

[16] ILGA, 2020. Hate speech on social media is forcing LGBTI people back into silence. It's time to take action, https://ilga.org/hate-speech-social-media-forcing-lgbti-back-silence-take-action, accessed 17 July 2021.
[17] SADC SRHR 2019-2030, https://genderlinks.org.za/wp-content/uploads/2018/11/1-Final-signed-SADC-SRHR-Strategy-2019-2030.pdf, 9 October 2021.
[18] Regional strategy for HIV prevention, treatment and care and sexual and reproductive health and rights among key populations (2018). Gaborone, Botswana: SADC Secretariat, https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf, 10 August 2021.

states to:

1. Review and revise or develop new policies that support access to integrated SRH and HIV services for key populations, especially adolescents, youth, migrant populations, LGBTQ persons, and people with disabilities; and
2. 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.[19]

All SADC states have signed up to the 2019 SADC SRHR Strategy and the 2018 SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights. However, some member states have yet to implement the provisions of these guiding instruments. Since the adoption of the 2019 SADC SRHR Strategy, none of the states has submitted reports on their performance towards achieving the stipulated targets.

This raises important questions about accountability and the enforcement of SADC instruments. Should there be sanctions for countries that do not domesticate the relevant instruments?

No SADC instruments currently exist specifically to address LGBTQ rights

Tanzania: Government attacks against LGBTQ health and rights on the rise

One of the most significant casualties of the Tanzanian government's overt hostility to LGBTQ people is the right to the highest attainable standard of health, guaranteed under international treaties that Tanzania has ratified. Even in comparison to other countries that criminalise same-sex relations, Tanzania has become an outlier in its efforts to render LGBTQ-friendly health services inaccessible.

Until 2016, although Tanzania criminalised same-sex conduct its health sector acknowledged and made some efforts to address the specific vulnerabilities of men who have sex with men and other groups considered "key populations." This means that public health initiatives should take particular efforts to address the needs of these groups as part of their national HIV prevention and treatment efforts. Government bodies included gay men and transgender people in discussions around HIV prevention and treatment. Activists considered Tanzania's overall approach to HIV and AIDS largely successful, because it was evidence-based and relatively inclusive.



An HIV-positive gay man attends a clinic in Dar es Salaam in November 2016.
Photo courtesy of HRW

In contrast, since 2016, the Ministry of Health has prohibited community-based organisations from conducting outreach on HIV prevention

[19] http://www.integrainitiative.org/wp/wp-content/uploads/2015/12/tmp-11285-SADC-Min-Stds-Eng-final-1158402048.pdf

to men who have sex with men and other key populations based on the pretext that such organisations engage in the "promotion of homosexuality." The Ministry closed drop-in centres that provided HIV testing and other services to key populations, run in many cases by international agencies, asserting that these centres, too, are involved in "homosexuality promotional activities." It banned the distribution of lubricant, an essential HIV prevention tool for key populations and for much of the wider public, including post-partum women.

The Health Ministry asserts that public health centres in Tanzania provide discrimination-free services to LGBTQ people and key populations and that there is no need for specialised services run by civil society organisations. Human Rights Watch research has found, however, that discrimination on the basis of sexual orientation and gender identity in government health centres remains common.

The authorities have also undermined the right to health through a series of police raids on meetings and workshops organised by health and rights activists and their allies, arresting participants, including foreign lawyers, in an effort to silence and instil fear within activist communities as well as service provision groups and their beneficiaries.

Police continue to conduct arbitrary arrests based on sexual orientation or gender identity. In some cases, police enlist health care providers to carry out forced anal examinations in attempts to find proof of homosexual conduct. This practice is a medical travesty and a grave violation of human rights that can amount to torture. Arrests and mistreatment of LGBTQ people not only violate rights to privacy, non-discrimination, and the right to be free from torture, they also drive vulnerable communities underground and away from health services, further undermining the right to health.

Source: Human Rights Watch, February 2020.[20]

Constitutional provisions

Only South Africa has specific provisions in its constitution recognising the rights of LGBTQ 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 protections for LGBTQ people. Fourteen SADC countries include equality and non-discrimination clauses in their constitutions, but do not include sexual orientation. A constitution provides fundamental foundational principles that apply to all citizens. Governments should not use a constitution to exclude any individuals or groups.

The Comoros Constitution of 2018 guarantees equality in Article 2 as follows: "The Union of the Comoros equally recognises the equality of all citizens before the law, without distinction of race, sex, religion, political belief, and it assures all citizens the full enjoyment of fundamental freedoms."[21]

[20] Human Rights Watch, 2020, "If We Don't Get Services, We Will Die": Tanzania's Anti-LGBT Crackdown and the Right to Health, https://www.hrw.org/report/2020/02/03/if-we-dont-get-services-we-will-die/tanzanias-anti-lgbt-crackdown-and-right, accessed 4 October 2021.
[21] Comoros Constitution 2018, https://www.constituteproject.org/constitution/Comoros_2018.pdf?lang=en , accessed 3 October 2021.

Article 3 further elaborates on these rights: "All Comorians of the two sexes enjoying their civil and political rights are electors, within the conditions determined by the law." This clause does not recognise any other genders except for female and male. This has a fundamental impact on gender non-conforming persons.

LGBTQ activists have lauded South Africa for its progressive constitution, often referred to as one of the best in the world

LGBTQ activists have lauded South Africa for its progressive constitution, often referred to as one of the best in the world. The efficacy of a constitution is only as powerful as the manner in which citizens and lawmakers leverage it in specific legislation to advance equality for all citizens. Legislators tabled the Prevention and Combatting of Hate Crimes Bill in South Africa in 2016 but they have not yet propagated it into law.

In 2008, the South African Human Rights Commission (SAHRC) took a case against the late Jon Qwelane, a journalist and former South African ambassador to Uganda, for his article "Call me names, but gay is not ok" published in the Sunday Sun in 2008. The case highlighted important gaps in the South African Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) and the role of the Constitution.

Despite the progressive Constitution in South Africa providing strong human rights foundation, the Qwelane case emphasises the need for ongoing vigilance and accountability.



Gay Pride march in Johannesburg, South Africa.

Photo courtesy of Laurie Adams



South Africa: Constitutional Court says late journalist committed hate speech



South Africa's Constitutional Court found Jon Qwelane, the late broadcaster and ambassador, guilty of hate speech. Photo courtesy of Kempton Express

The Constitutional Court on 30 July 2021 ruled that an anti-gay column penned by the late broadcaster and ambassador Jon Qwelane was hate speech.

The unanimous ruling by the apex court overturned a previous decision in the Supreme Court of Appeal (SCA). The SCA had said that although Qwelane's article, "Call me names, but gay is not ok," was strident and provocative bigotry, it still fell within the realm of freedom of expression.

The article, carried in the *Sunday Sun* in 2008, led to a flood of complaints to the South African Human Rights Commission (SAHRC), which instituted legal action, initially in the Equality Court.

"Homophobic speech is part and parcel of the broader system of homophobia and transphobia in South African society... It contributes to an environment that serves to delegitimise their very existence and their right to be treated as equals," said Justice Steven Arnold Majiedt.

Judge Majiedt said hate speech regulations ought to be grounded in the express anti-racist and anti-sexist tenets of the Constitution. He said Qwelane had "significant stature" and influence, and had clear intent to instigate hatred against the community and "it was difficult to conceive a more egregious assault" on the dignity of LGBTQ people. "There can be no question that his statements constituted hate speech."

The other issue before the court was the ruling by the Supreme Court of Appeal that the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA), generally known as the Equality Act, was "vague and over-broad." This was especially so because PEPUDA went much further than the Constitution in outlawing speech that was "hurtful."

The SAHRC had argued that while the section of the Act infringed on the right to freedom of expression, the limitation was reasonable and justifiable, in light of the right to dignity. "Sexual orientation" is not included in the Constitution under the freedom of expression section that prohibits "advocacy of hatred that is based on race, ethnicity, gender or religion, and that constitutes incitement to cause harm."

Majiedt said "sexual orientation" should be added to the list of protected groups as "it would not be possible to protect the rights of the LGBTQ community without prohibiting hate speech based on sexual orientation."

Source: Tania Broughton for GroundUp, July 2021.[22]

[22] Broughton, B.T. (2021) Constitutional Court rules that Jon Qwelane did commit hate speech, GroundUp News, https://www.groundup.org.za/article/constitutional-court-rules-ambassador-committed-hate-speech/, accessed 2 August 2021.

Status of same-sex consensual sexual relations in SADC

Most SADC countries criminalise same-sex consensual sexual acts or sodomy for men through various means. However, many variations exist in terms of the way countries enforce the legislation.

Table 8.5: Status of same-sex consensual sexual acts

Country	Current status
Angola[23]	***Decriminalised*** Sexual orientation is an aggravating factor for several crimes as discrimination (art. 212) or incitement to discrimination (art. 380), injury (art. 213) and defamation (art.214), and corpse desecration (art. 223, in conjunction with articles 221 and 222). Sexual orientation is also included as a characteristic of persecution, which constitutes a crime against humanity (art. 382), protecting sexual minorities in times of extreme violence and internal turmoil.
Botswana[24]	***Pending a government appeal*** Botswana Penal Code sections 164(a), 164(c), 165, and 167. High Court ruled unanimously that the relevant sections are unconstitutional; the attorney requested and received leave to appeal the decision. The appeal is set for 12 October 2021.
Comoros[25]	***Criminalised*** Penal Code of the Federal Islamic Republic of Comoros 138, Article 318. "(3) Without prejudice to the more serious penalties provided for in the preceding paragraphs or by articles 320 and 321 of this Code, whoever will have committed an improper or unnatural act with a person of the same sex.
Democratic Republic of the Congo[26]	***Never explicitly outlawed*** On 22 October 2010, the Congolese parliament sent the Sexual Practices Against Nature Bill to the Socio-Cultural Committee. The Bill gained widespread support both publicly and within the government, and the National Assembly considered it constitutional. Legislation had yet to be drafted.
Eswatini	***Criminalised*** Eswatini criminalises same-sex sexual activity despite no law explicitly outlining this, as Section 252(1) of the Constitution (2005) states that Roman-Dutch Common Law, as interpreted in 1907, applies to any regulations or laws in place prior to independence in 1968 and not subsequently overturned. As such, "sodomy" remains a crime. In 2005, media reported that the government had plans to include prohibitions of all male homosexual acts and lesbian acts in its revision of the Sexual Offences laws with proposed penalties of imprisonment for a minimum period of two years.[27]
Lesotho	***Not criminalised*** Under Article 52 of the Penal Code Act (effective 2012), "sodomy" is not mentioned among the unlawful sexual acts. Furthermore, the Code does not have any provisions criminalising same-sex consensual relations, therefore revoking the previous common law crime of "sodomy." In this sense, Section 2(2) of the Code states, "no person shall be tried, convicted or punished for an offence other than an offence specified in this Code or in any other written law or statute in force in Lesotho."[28]
Madagascar	***Criminal for those younger than 21*** Prior to and following its independence from France in 1960, the Criminal Code (2005) has not prohibited consensual same-sex sexual acts between adults in Madagascar. However, article 331 sets the age of consent at 14 for heterosexual sexual acts and 21 for same-sex sexual acts.
Malawi	***Criminalised*** Section 153 of the Penal Code states that anyone who has had "carnal knowledge of any person against the order of nature" is guilty of a felony and is liable to face imprisonment for up to 14 years. Additionally, Section 156 criminalises "indecent practices between males," whether in public or private, imposing a penalty of imprisonment for five years and/or corporal punishment. In December 2010, the parliament passed a bill amending the Penal Code (effective in January 2011), which introduced Section 137A to criminalise "indecent practices between females," imposing a penalty of imprisonment of five years.

[23] Law, I.-W.N. in P. (2021) 'Decriminalisation of consensual same-sex acts in Angola and the progress of LGBTI human rights in Lusophone Africa', Africa Law, 5 March, https://africlaw.com/2021/03/05/decriminalisation-of-consensual-same-sex-acts-in-angola-and-the-progress-of-lgbti-human-rights-in-lusophone-africa/, accessed 17 July 2021.
[24] 'Decriminalising Homosexuality: Reshaping the Landscape in Botswana and a Missed Opportunity in Kenya', https://harvardhrj.com/2020/03/decriminalising-homosexuality-reshaping-the-landscape-in-botswana-and-a-missed-opportunity-in-kenya/, accessed 17 July 2021.
[25] Human Rights Watch Country Profiles: Sexual Orientation and Gender Identity, https://www.hrw.org/video-photos/interactive/2020/06/22/human-rights-watch-country-profiles-sexual-orientation-and, accessed 6 October 2021.
[27] ILGA World: Eddie Bruce-Jones Lucas Paoli Itaborahy, State-sponsored Homophobia: A world survey of laws prohibiting same sex activity between consenting adults (2012), 36.
[28] Southern Africa Litigation Centre, Laws and Policies Affecting Transgender Persons in Southern Africa: Lesotho (Johannesburg: SALC, 2017), 92

Country	Current status
Mauritius	***Criminalised*** The Criminal Code (1838) Article 250 (1) states that any person found guilty of "sodomy or bestiality" shall be liable to up to five years' "penal servitude." In 2007, the government introduced the Sexual Offences Bill, which would have deleted the crime of sodomy (see Section 24), and set an equal age limit of 16 years for sexual acts (Sections 11 to 14). However, parliament never passed the bill.[29] In June 2020, the Supreme Court of Mauritius authorised four young activists to challenge the constitutionality of Section 250(1) of the penal code.[30]
Mozambique	***Decriminalised*** In July 2014, the parliament approved Law 35/2014 repealing earlier criminalising provisions, namely articles 70 and 71 of the 1886 Penal Code, as modified by Law No. 177 (1912) and Executive Order-Law No. 39688 of 1954. These colonial provisions imposed penalties on people who "habitually practiced vices against nature." The revised Penal Code came into force in June 2015.
Namibia	***Criminalised*** No codified legislation in Namibia directly criminalises same-sex sexual activity; as such, lawmakers derive criminalisation from interpretations of Roman-Dutch Common Law. However, the Criminal Procedure Act 25 (2004) outlines in Article 299 the need for verifiable evidence that an accused person committed the "offence of sodomy or attempted sodomy," providing clear evidence of *de jure* criminalisation.
Seychelles	***Decriminalised*** In July 2016, an amendment to the country's Penal Code (1955) repealed Sections 151(a and c), removing them from the updated version of the provision, which criminalised "carnal knowledge of any person against the order of nature."
South Africa	***Decriminalised*** Following a case decided by the Constitutional Court of South Africa, the state abrogated laws carried through from the Penal Code of 1955 in which Article 600(1) and 601 criminalised consensual same-sex sexual conduct between adults, including the common-law crime of sodomy. Lawmakers retroactively applied the ruling to all cases of "sodomy" dating back to 1994.[31]
Tanzania	***Criminalised*** Section 154 of Tanzania's Penal Code (1998) prohibits "carnal knowledge of any person against the order of nature," with a prescribed penalty of 30 years to life imprisonment. Sections 138a and 157 also prescribe a five-year imprisonment for "gross indecency."
Zambia	***Criminalised*** Per Amendment Number 26 of 1933, Article 155 of the Penal Code states that any person who "has carnal knowledge of any person against the order of nature" has committed a felony and is liable to receive a sentence of up to 14 years in prison. Additionally, Article 178(g) of the Penal Code (1930) criminalises any act of "soliciting for immoral purposes in a public place."
Zimbabwe	***Criminalised*** Article 73 (1) of the Criminal Law (Codification and Reform) Act (Act No. 23) (2004) criminalises anal intercourse between males as well as "any act involving physical contact other than anal sexual intercourse that would be regarded by a reasonable person to be an indecent act." For these two types of conduct, the Code imposes a penalty of imprisonment for up to a year and/or a fine.

Source: ?

An analysis of Table 8.5 shows:

- Six countries - Angola, DRC, Lesotho, Mozambique, Seychelles and South Africa -have decriminalised consensual same-sex sexual acts or never criminalised them in the first place. In Madagascar, same-sex consensual sexual acts are legal for citizens older than age 21 but against the law for everyone else.
- In Botswana, the government is appealing a High Court ruling decriminalising same-sex consensual sexual acts.
- In Eswatini, lawmakers have enshrined the criminalisation of same-sex consensual sexual acts in the country's constitution.
- Consensual same-sex sexual acts remain a crime in Comoros, Malawi, Mauritius, Namibia, Tanzania, Zambia and Zimbabwe.

There is an urgent need for these countries to embark on penal and criminal code reviews to decriminalise same-sex consensual acts. The situation in Eswatini represents an especially

[29] National Report submitted in accordance with paragraph 5 of the Annex to Human Rights Council Resolution 16/21: Mauritius, A/HRC/WG.6/17/MUS/1, 17 July 2013, para. 17.
[30] "Code pénal : La communauté LGBT obtient l'autorisation pour une plainte constitutionnelle" Le Mauricien, 17 June 2020.
[31] Pat Reber, "South Africa Court Upholds Gay Rights" Associated Press, 9 October 1998 (as reproduced in Sodomy Laws, 11 July 2004).

challenging case because the decriminalisation process will require a constitutional amendment. In the absence of enabling policy and legislative frameworks, state-sponsored homophobia and transphobia will persist.

Regional: Crusading couple demand gay rights and support LGTBQ refugees

Shingirai Musekiwa and Elton Chibhebhe fled Zimbabwe to come to South Africa because they are gay.

Now based in Langa, the couple are activists fighting for the human rights of Zimbabwean homosexuals and the repeal of section 78 of the Zimbabwean Constitution, which criminalises homosexuality. They have dubbed their movement Zimbabwe LGBTQ+ Crusader and say they have had interest from about 200 people.

"We are demanding that the section of the Zimbabwean Constitution that criminalises gay people be abolished. It does not allow us to be who we are and to love one another," says Chibhebhe.

Musekiwa grew up in Harare and came to South Africa in 2012 after his preacher uncle who raised him disowned him, he says. His parents died when he was young.

"Instead of talking to me openly at home, my uncle would say horrible things and attack me during his sermons. Fearing that the [Pentecostal] church may attack or report me to the police, I ran away," says Musekiwa.

Chibhebhe fled Bulawayo in 2017. He says his mother accepted his sexuality but not his father.

"Growing up, I used to think I am the only gay in Zimbabwe. Some of the gay people have confessed that they [only have] wives and children because the environment forced them," says Chibhebhe.

The couple has set up a Facebook page, where Zimbabweans ask for help with coming out, coping with discrimination and dealing with family rejection. The couple plans to also run an online awareness campaign on Instagram and Twitter and to hold a march to the Zimbabwe embassy in Cape Town.



Elton Chibhebhe (23) and Shingirai Musekiwa (32) pictured in Cape Town in 2021. The couple left Zimbabwe because it still criminalises homosexuality.
Photo courtesy of Tariro Washinyira

After many people lost jobs during the COVID-19 lockdown, the couple was at one point housing 18 people at their rented two-bedroomed house in Langa. Currently, they have five people in their home. Musekiwa and Chibhebhe both work as bartenders in a five-star hotel.

Victor Chikalogwe of People Against Suffering and Oppression (PASSOP) said they have helped the couple with food parcels and paying rent. He says many gay Africans seeking asylum are still undocumented in Cape Town because of the closure of the Cape Town refugee reception office. They cannot raise enough money to go to Gqeberha (Port Elizabeth) or Pretoria.

"We have a case of someone who went in 2019 and was given an appointment for 2021. When they go there, sometimes they are teased, asked silly questions about their sexuality, and told to prove they are gay," said Chikalogwe.

"So some, even if they have resources to go there, they choose not to go. Some of them end up getting fake papers. Without a paper you cannot find a job, you cannot get any service... If you go to the bank they demand a document. If your family or friends send you money from out of South Africa, you cannot collect it and you cannot apply for a residence permit."

Source: By Tariro Washinyira for GroundUp, July 2021.[32]

Employment

Only five SADC countries protect LGBTQ peoples' rights to equal access to employment: Angola, Botswana, Mauritius, Mozambique, and South Africa. Such protection in employment represents a critical first step to ensuring inclusive workplaces for members of the LGBTQ community. It is crucial for employers to remain vigilant in preventing discrimination against people due to sexual orientation and gender identity and expression.

Only five SADC countries protect LGBTQ peoples' rights to equal access to employment



South Africa: Building LGBTQ-inclusive workplaces

Discrimination and violence against people of diverse sexual orientations and gender identities and expressions represents a serious problem around the world, and South Africa is not immune despite its progressive laws. LGBTQ workers face discrimination in the labour market throughout their employment cycle.

Some common challenges for LGBTQ workers include:

- Limited access to employment, refusal of employment, dismissals, or denial of training opportunities and promotions, and access to social security;
- Evidence of a pay gap between LGBTQ and non-LGBTQ workers - same-sex partners rarely enjoy the same benefits as married couples;
- Limited avenues for workplace dispute resolution around harassment and bullying; and
- Animosity from co-workers and supervisors, e.g. name-calling and physical and sexual violence.

The International Labour Organisation (ILO) undertook country-specific studies to identify the extent and forms of discrimination faced by LGBTQ workers. The Labour Research Service (LRS) and Gay and Lesbian Memory in Action (GALA) conducted the research in South Africa.

Findings from the study, titled *Pride at Work: A study on discrimination at work on the basis of sexual orientation and gender identity in South*

[32] Washinyira, B.T. (2021) Zimbabwean couple demand gay rights, GroundUp News, https://www.groundup.org.za/article/zimbabwean-couple-demand-gay-rights/, accessed 26 July 2021.

Africa, indicate that employers in South Africa need to do much more to make workplaces more welcoming and inclusive for LGBTQ employees.

Key concerns included:
Stereotyping: This is multifaceted, complex and difficult to define in any neat way. For example, while some lesbian women are depicted as sexual predators, other employers see them as a better employment choice compared to heterosexual women, assuming that they will not need time off for pregnancies. Correspondingly, study participants reported that some employers frowned upon lesbian women requesting maternity rights.

Gender policing: Dress code, along with freedom in relation to workplace attire that affirms an LGBTQ worker's identity represents a key factor in participants' sense of belonging, safety and inclusion in the workplace. LGBTQ participants shared numerous examples of how colleagues or employers used clothes and appearance, particularly those affirming an alternative gender, to alienate and marginalise workers in the workplace to the point of dismissal.

Safety: The issue of safety in the workplace is important for LGBTQ workers. Participants spoke about witnessing or personally experiencing sexual harassment, derogatory statements, homophobia, and general religious and cultural prejudices related to LGBTQ identities.

Coming out: Given that workers spend a large part of their day in the workplace, the question of whether or not to come out is an important one for many LGBTQ workers. Study participants spoke about discrimination, prejudice and bias in the workplace as something that constantly wore them down.

Lack of information: One of the main challenges cited by both transgender and non-transgender participants was the lack of information on transgender rights in the workplace as well as how to support transgender colleagues. A person may enter a workspace as a female but then decide to transition during the course of their employment and change the gender marker on their identity documents.

Recommendations included:
Change laws, policies and practices: Given the gaps and weaknesses in existing policy and practice, the study noted an urgent need to address gaps in existing legislative and policy frameworks relating to LGBTQ rights. First, it suggested focusing on broad strategies such as education and raising awareness, which would in turn influence policy; and, second, a focus on the specific issues in each workplace.

More education and training: Given the clear lack of information among all stakeholders in relation to LGBTQ issues, researchers cited an urgent need for training and further information for a wide range of stakeholders on LGBTQ workplace rights. This would include different educational interventions, ranging from broad dialogues and diversity workshops, to work on mainstreaming LGBQ issues in existing programmes.

Leadership development: Findings from the study indicate a clear openness towards LGBTQ workplace rights. However, the study also found a lack of leadership in furthering these rights in South Africa. There is a need for programmes to develop an awareness of LGBTQ issues and foster leadership in this area across all sectors.

Submission of an LGBTQ policy to NEDLAC by the ILO: Given the key role of the National Economic Development and Labour Council (NEDLAC) in terms of furthering LGBTQ workplace rights, the ILO ought to submit an LGBTQ policy for discussion by NEDLAC.

Source: Pride at Work - A study on discrimination at work based on sexual orientation and gender identity in South Africa, 2019.[33]

[33] Labour Research Service, 2019. 'What will it take to build LGBT inclusive workplaces in South Africa?, https://www.lrs.org.za/2019/05/09/what-will-it-take-to-build-lgbt-inclusive-workplaces-in-south-africa/, accessed 3 October 2021.

Violence and discrimination

LGBTQ people face elevated levels of discrimination and violence across the region, which sometimes include hate crimes and even murder. LGBTQ persons experience these crimes at the hands of both the public and the state. By criminalising LGBTQ people and spaces, states create environments that perpetuate violence and discrimination against LGBTQ communities. This includes violence and discrimination from police, the justice system and other authorities.

According to Daniela Paletta, communications coordinator at ILGA World, hate speech on social media forces many LGBTQ people back into silence and isolation. The UN describes hate speech as "any kind of communication that attacks or uses pejorative or discriminatory language with reference to a person or a group on the basis of who they are." It represents language that has the potential to generate intolerance and hatred, which bigots frequently use to confront and denigrate LGBTQ communities.

As with other groups that face marginalisation in everyday life, the online space also represents a revolutionary one for LGBTQ people: it has helped build and strengthen communities. However, with more visibility, came a backlash: 84% of respondents to a survey conducted by ILGA World in 2020 said that online spaces exposed them to hate speech and threats. For many within the LGBTQ community, hate speech represents an inescapable daily reality.

With more people forced to engage exclusively online, attacks against the LGBTQ community intensified during the COVID-19 pandemic, further disrupting the community's safe spaces. The UN Forum on Minority Issues called on states and tech companies to "ensure an inclusive access to the digital world."

Transgender people currently face particularly aggressive attacks, including during legitimate debates on legal reforms, which some transphobic people use as a pretext to deny trans people their right to existence.

Clearly, neither withdrawing from online spaces nor going back to the closet represent viable options. Yet enduring constant abuse can be extremely difficult, especially when perpetrators do not face consequences for their behaviour. It is high time for lawmakers and social media companies to take action.



For many in the LGBTQ community, hate speech online represents a daily reality, which makes effective hate crime legislation increasingly urgent.
Photo courtesy of Anastasya Eliseeva

Online platforms must improve their content moderation policies: harmful content often remains accessible for far too long, further endangering those it targets. Seeing as the business model of social media platforms depends on data analysis, these companies should investigate the insidious ways that hate speech targets different online communities. If they made access to this data open, legislators would have further evidence of the need to improve laws and policies on the matter.

Let us be clear: all citizens are entitled to their opinions, but they cannot aggressively destroy or target others in the expression of their views. Freedom of speech is precious, but this cornerstone of the international human rights framework must never become an excuse to legitimise hatred and intolerance.

Hate speech thrives whenever inequalities rise. Change starts by fostering inclusive and just societies. It continues with empowering people to use social media as a space for more speech

and dialogue, not less. Recognising hate is not the responsibility of governments and tech companies alone: all citizens share virtual spaces and we must work together to call out and prevent hate speech and online discrimination.

Addressing hate speech means keeping it from escalating into incitement to discrimination, hostility and violence. It is a human rights issue, and a matter of basic human decency.[34]



Namibia: Transgender advocate sues government over abuse

Namibian media personality and human rights advocate Mercedez von Cloete is suing the country's Ministry of Safety and Security for transphobic violence she says she suffered at the hands of police in 2017.

The trial hearing concluded on 16 May 2021 and von Cloete is awaiting the verdict. She spoke to African Arguments about her experience:

"A few years ago, I had a very traumatic experience with the Namibian Police, where I was unlawfully detained and brutally assaulted, repeatedly. This was not the first time that something like this had happened to me, but I promised myself that I could not allow it to persist. And so, for the last four and a half years I've been trying to get justice and hold the police accountable.

I always imagined activists to be angry people with posters, shouting and protesting on the streets. As someone who is in no way confrontational, it didn't look anything like me. I've since learned that leaving injustices unchecked is an injustice in and of itself. That's what made me realise that activists are really just people who no longer accept the things they cannot change but instead seek to change the things they cannot accept.

Just like how we need the intelligence and courage to look past complexion and see the community to eliminate racism, I feel we need to look past gender and genitalia or who and how we love to live in a just, accepting and equal society.

I now consider myself an advocate for change, for all the trans and gender diverse people who don't have the agency or support to ensure their rights are upheld. Or who are denied certain fundamental services, rights, protections and freedoms because of who they are. For those who experience continual harassment and police brutality, something which has remained unaddressed for far too long.

Personally, the emotional, psychological and physiological distress cannot be quantified. I'm still healing and just hoping that in November when the final judgement is made, that justice will prevail."



Mercedez von Cloete is suing Namibia's Ministry of Safety and Security.
Photo courtesy of African Arguments

Source: Chris De Beer Proctor for African Arguments, August 2021.[35]

[34] ILGA, 2020. Hate speech on social media is forcing LGBTI people back into silence. It's time to take action, https://ilga.org/hate-speech-social-media-forcing-lgbti-back-silence-take-action, accessed 17 July 2021.
[35] African Arguments, 2021.'Where we belong: Inside the reckoning for queer rights in Namibia | African Arguments', //africanarguments.org/2021/08/where-we-belong-inside-the-reckoning-for-queer-rights-in-namibia/, accessed 12 October 2021.

Conversion therapy

"Conversion therapy" has become a common umbrella term to refer to any sustained effort to modify a person's sexual orientation, gender identity or gender expression. Originally conceived in the mid-20th century as a response to what scientists then considered a "pathology," the medical field framed and administered these approaches as "therapies." Under such a paradigm, doctors at the time understood heterosexuality and the alignment of the sex assigned at birth with the gender identity as "the biologic norm" and characterised sexual diversity as a deviation, a perversion or a mental illness that they could cure, shift or "convert" with specific "treatment."[36]

Now, LGBTQ activists and most members of the medical field view the use of these approaches as problematic for various reasons:[37]

- Common definitions of the word "therapy" refer to any treatment "of a physical problem or an illness," or "someone with a particular illness," or a "treatment that helps someone feel better, grow stronger, etc., especially after an illness." Therefore, using this term to refer to efforts that aim to change a person's sexual orientation, gender identity or expression implies that these characteristics constitute illnesses or that there is something to "heal" or "cure" in those who are not cisgender, gender conforming or heterosexual.
- The use of the term "therapy" conveys that adherents of these approaches ground their practices on sound medical or scientific research but an extensive list of reputable medical and mental health professional associations have repudiated these practices precisely because they lack scientific support.
- The wide array of practices that were (and still are) employed with the aim of modifying a person's SOGIE is so vast and diverse that the term "therapy" does not accurately reflect the nature of many of the practices involved. This



is especially the case when practitioners employ brutal or heinous methods. In this sense, the use of the word "therapy" is clearly inadequate in cases during which a "patient"/victim faces humiliation, debasement, intimidation, abuse or even rape.
- The term "conversion" implies that people can actually be changed or "converted," whereas most serious medical practitioners question the efficacy of any of these attempts.

Mauritius and South Africa both ban conversion therapy. The Sexual Orientation, Gender Identity and Expression and Sex Characteristics (SOGIESC) Unit of the Centre for Human Rights of the Faculty of Law at the University of Pretoria in South Africa urges the adoption of the following recommendations by all countries:[38]

- Enact laws to ban coercive conversion therapies and implement policies that discourage non-coercive conversion therapies, with a particular focus on the use of conversion therapy practices on minors perceived to be sexual or gender minorities;
- Institute guidelines and policies to reinforce technology ethics in the area of conversion therapy and prohibit the coercive use of technology to alter sexual orientation;
- Investigate and prosecute incidents of coercive conversion therapies, particularly those involv-

[36] See, generally: Eli Coleman, "Changing Approaches to the Treatment of Homosexuality: A Review", American Behavioral Scientist 25, No 4 (1982); Jack Drescher, "I'm Your Handyman: A History of Reparative Therapies" in Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives (New York: Haworth Medical Press, 2001); Tom Waidzunas, The Straight Line: How the Fringe Science of Ex-Gay Therapy Reoriented Sexuality (Minneapolis: University of Minnesota Press, 2015), 35-66.
[37] ILGA, 2020, Curbing_Deception,https://ilga.org/downloads/ILGA_World_Curbing_Deception_world_survey_legal_restrictions_conversion_therapy.pdf, accessed 9 October 2021.
[38] Centre for Human Rights, University of Pretoria, Current practices in conversion therapy and emerging technology, https://www.chr.up.ac.za/images/centrenews/2021/Current_practices_in_conversion_therapy_and_emerging_technology_14_May_2021.pdf, accessed 7 October 2021.

ing torture and cruel, inhumane, or degrading treatment;
- Include sexual diversity in the training curriculum of service providers across healthcare, welfare, and policing services;
- Establish a reporting process for informing the institution on human rights abuses resulting from conversion therapies;
- Establish processes to provide remedies for human rights abuses resulting from conversion therapies;
- Design and implement campaigns to promote an end to all forms of conversion therapies; and
- Liaise with community-based organisations to promote awareness on the harmful effects of conversion therapies.

Recognition of LGBTQ rights



Recognising LGBTQ human rights and enshrining them in law and policy represents an integral part of a multi-pronged process to ensure that members of the LGBTQ community enjoy the same rights and freedoms as all other citizens. These include, amongst others, the right to marriage, adopt children, and free expression.

Same sex marriages and civil unions

Only South Africa provides for same sex marriage and civil unions in its legal frameworks. All other SADC countries define marriage as a union between a woman and a man.

Only three SADC countries allow for changing gender markers: Namibia, South Africa, and Zambia

Joint adoption of children and second parent adoption of children

South Africa is also the only SADC country that allows same-sex couples to adopt children. In South Africa, a partner in a same-sex relationship can also adopt the other partner's biological or adopted child regardless of the legal status of their relationship. Preventing LGBTQ people from adopting children violates their rights.

Changing sex designation, name, or gender marker

The ability to change a gender marker or name represents a critical right for transgender and gender-diverse people. Experts refer to this as "legal gender recognition." In countries where people cannot change gender markers, the ability to change names represents a stopgap measure. Research conducted by ILGA suggests that, even where it is possible to change names and gender markers, the process remains inordinately difficult.

Table 8.6: Conditions under which citizens can change gender markers

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. Section 16. Material change.	Unclear, no specific reference to trans and diverse gender identities.
Botswana	National Registration Act 26 of 1986, s.16	(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.	Unclear, no specific reference to trans and diverse gender identities.
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 public health system.
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	Comprehensive legislation, barrier in the Home Affairs.
Not possible currently, law or policy needed in DRC, Eswatini, Lesotho, Madagascar, Mauritius, Seychelles, Tanzania, Zimbabwe			

Source: ILGA, 2017.[39]

[39] ILGA, 2017. Trans Legal Mapping Report, https://ilga.org/downloads/ILGA_Trans_Legal_Mapping_Report_2017_ENG.pdf, accessed 10 October 2021.

Table 8.6 lists the relevant laws and conditions applicable to changing gender markers in those SADC countries that allow it in some way. It illustrates that a variety of acts and laws provide for the change, but issues arise when transgender or gender-diverse people attempt to attain their rights under these laws.

At a practical level, the inability to change gender markers affects trans people in several ways:[40]

- Certain institutions, both private and public, may require a legal gender identity on official documents, this includes health care services;
- If a person presents themselves 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 still use a binary gender system of male and female. This also applies to visa applications, which people often need to complete in person; and
- Correctional services, also known as imprisonment/prison/incarceration or gaol. Gender markers will determine where prison officials house an individual during imprisonment.



In **Botswana**, ND and Ricki Kgositau, two transgender individuals, both filed separate cases as part of a collective litigation strategy challenging the Registrar of National Registration's refusal to change the gender markers on their identity documents.[41] In the landmark judgment, handed down in 2017, the High Court affirmed transgender people's right to have the gender with which they identify reflected in their legal documentation. Importantly, in reaching their decision, the court held that the refusal to issue a transgender person with the congruent legal documentation contravenes the right to protection from discrimination, to privacy, freedom of expression and to equal treatment before the law.



In **South Africa** in 2019, Jade September, a trans woman incarcerated in a prison space designated for males, successfully challenged the Department of Correctional Services for preventing her from expressing her gender.[42] September, who wants to undergo a surgical transition, has not yet been able to access the necessary medical care to do so. The court found the prison's operating procedures - which prevent transgender inmates from expressing their gender - unconstitutional. Significantly, the judgment provided the option for September to transfer to a prison space designated for females. The judgment de-pathologises transgender and gender diverse identities by recognising that biomedical requisites to legal gender change constitute an arbitrary barrier to accessing the full protection of the law.

This judgment is in line with activism across the continent calling for change that addresses the material conditions of transgender and gender diverse people's lives. These rulings represent noteworthy examples of African judiciaries upholding Resolution 275 of the African Commission by effectively applying appropriate laws in ways that respond to the needs of transgender and gender diverse people.[43] Thus, it is critical for all SADC countries to enact and implement laws and policies to facilitate the process of changing gender markers.

Intersex

Intersex is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not fit the typical definitions of female or male. For example, a person might be born appearing to be female outwardly but having mostly male-typical anatomy.

[40] 'Be True 2 Me Guideline: Legal Gender Marker and Forename Change - Be True 2 Me Org', https://www.betrue2me.org/resources/be-true-2-me-guideline-legal-gender-marker-and-forename-change/, accessed 5 October 2021.
[41] ND v Attorney General of Botswana and others; Tshepo Kgositau v Attorney General of Botswana and others [2017].
[42] September v Subramoney NO and Others [2019] 4 All SA 927 (WCC) (23 September 2019).
[43] ILGA, 2017,Trans Legal Mapping Report 2017, https://ilga.org/downloads/ILGA_World_Trans_Legal_Mapping_Report_2019_EN.pdf, accessed 10 October 2021.

Alternatively, a person may be born with genitals that combine the typical male and female reproductive organs and sexual anatomy. For example, a girl may be born with a noticeably large clitoris, or lacking a vaginal opening; a boy may be born with a notably small penis, or with a divided scrotum that has formed more like labia. A person may also be born with mosaic genetics, so that some cells have XX chromosomes and some of them have XY. Though we speak of intersex as an inborn condition, intersex anatomy does not always show up at birth. Sometimes a person does not discover their intersex anatomy until they reach puberty or find out they are infertile. Some people live and die with intersex anatomy without ever knowing.[44]

In 2013, the third International Intersex Forum issued the Malta Declaration,[45] 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 numerous calls for change related to healthcare, legal issues, surgery, and participation.

Regional: Sex testing violates rights and ruins lives, says Human Rights Watch



Human Rights Watch has found that women athletes from the Global South, such as like Caster Semenya (pictured), experience physical and psychological damage from "sex testing" procedures. Photo courtesy of Stylist

Women track and field athletes, largely from the Global South, increasingly face abuse and harm due to "sex testing" regulations, Human Rights Watch said in a recent report. The regulations target women in running events between 400-metres and one mile, and compel women they target to undergo medical interventions if they want to remain in competition.

The 120-page report, *"They're Chasing Us Away from Sport": Human Rights Violations in Sex Testing of Elite Women Athletes*, documents the experiences of more than a dozen women athletes from the Global South who have undergone sex-testing regulations. Human Rights watch found that global regulations that encourage discrimination, surveillance, and coerced medical intervention on women athletes result in physical and psychological injury and economic hardship. The International Olympic Committee - the supreme body in global sports - is developing guidelines to address human rights violations caused by sex testing policies.

"World Athletics has targeted women from the Global South for decades, treating those with high testosterone as less than human," said Payoshni Mitra, scholar and athlete rights advocate. "These regulations demean women, make them feel inadequate, and coerce them into medical interventions for participation in sports. Modern sport should adapt itself to support inclusion and non-discrimination rather than perpetuate exclusion and discrimination."

Human Rights Watch partnered with Mitra and Katrina Karkazis to conduct research in 2019,

[44] What is intersex? | Intersex Society of North America, https://isna.org/faq/what_is_intersex/, accessed 10 October 2021.
[45] 'Malta Declaration' OII Europe, https://oiieurope.org/malta-declaration/, accessed 10 October 2021.

interviewing affected athletes, coaches, and other officials and experts relevant to this issue, as well as reviewing court and medical documents.

For decades, sport governing bodies have regulated women's participation in sport through "sex testing" regulations that target women athletes with some variations in their sex characteristics that cause their natural testosterone levels to be higher than average. The regulations deny these women the right to participate as women for running events between 400-metres and one mile, unless they submit to invasive testing and medically unnecessary procedures. These practices violate fundamental rights to privacy, health, and non-discrimination. Women from the Global South - including runners such as Dutee Chand from India and Caster Semenya from South Africa - have been disproportionately harmed.

To identify those covered by the regulations, officials subject all women athletes' bodies to public scrutiny and require those who seem "suspect" to undergo degrading and often invasive medical examinations. They amount to policing women's bodies based on arbitrary definitions of femininity and racial stereotypes. There is no scientific consensus that women with naturally higher testosterone have a performance advantage in athletics. Despite a wide range of testosterone levels among men, there have never been analogous regulations.

In addition to the human rights violations inherent in the regulations, the impact of their enforcement extends beyond sport. Success in athletics can deliver economic stability for women. From scholarships to housing and food, the benefits can come early and may lead to stable employment outside of sport. Many athletes interviewed grew up in abject poverty. Their success in athletics often became a source of livelihood for their extended families. In some cases, their abrupt departure from sport after disqualification devastated their and their families' economic well-being.

Health experts, human rights advocates, and elite athletes have increasingly spoken out against the regulations. In a 2020 report, the Office of the United Nations High Commissioner for Human Rights recommended immediately revoking sex testing regulations for women athletes. The World Medical Association has recommended that physicians around the world should not observe the regulations as they violate medical ethics.

Governments across the world have committed to gender equality and non-discrimination against women. Governments are obligated to protect the rights of athletes representing their countries and competing on their soil. Human rights standards apply to all. Policies that are inherently discriminatory - such as sex testing regulations - fly in the face of the Olympic movement's commitments to dignity and equality for all, Human Rights Watch said. Regulating fair play is a valid undertaking for sport authorities; committing human rights violations in the process is not.

Source: Human Rights Watch, December 2020.[46]

Transgender

Transgender is a term that includes the many ways that people's gender identities can be different from the sex they are assigned at birth. Transgender (or trans) people use different terms and pronouns to describe themselves. It is always best to clarify these descriptors and use the language and pronoun that a person prefers.

[46] Human Rights Watch, "They're Chasing Us Away from Sport": Human Rights Violations in Sex Testing of Elite Women Athletes (2020). Human Rights Watch. Available at: https://www.hrw.org/report/2020/12/04/theyre-chasing-us-away-sport/human-rights-violations-sex-testing-elite-women , accessed 12 October 2021.

Transgender people express their gender identities in many different ways. Some people use their dress, behaviour and mannerisms to live their lives in the way that feels right for them.

Others take hormones and may have surgery to change their body so it matches their gender identity.[47]



Lesotho: A grandmother's transformative love for her transgender grandchild

Mampolokeng Mosolo is the picture of a dignified, proud African *gogo* (granny). Dressed in her Sunday best - pressed white shirt, knee-length black pencil skirt, impeccable hair and sensible heels - Mosolo commands a soft power during the Khoelenya Community Council meeting in Mohale's Hoek, a remote area in the west of Lesotho.

As the council members discuss sexual and reproductive health and rights, Mosolo addresses her peers with the quiet assurance of someone who has been on a life-changing journey she could not have imagined for herself as a younger woman.

When Mosolo first found out that her grandchild - who was assigned female at birth and raised as a girl - identified as a boy, she thought Mpho had been sucked into a satanic cult.

"I didn't take it very well to hear that my grandchild thought of herself as a transgender boy," Mosolo says, a term she heard for the first time when Mpho broke the news of his gender identity to her.

When Mpho was 16, he would wear trousers to school as the institution's policy gave girls the option to wear dresses or slacks. "When girl students were then told to wear dresses, he refused and stopped going to school," Mosolo says.



Mampolokeng Mosolo, a member of the Khoelenya community council and the grandmother of a transgender man. Photo courtesy of UNAIDS/M. Hyöky

Mpho eventually went back to school later that year to take exams but failed his assessments. He dropped out and then went to a local vocation school to learn sewing. That did not last long either, Mosolo says, as her grandchild faced stigma and discrimination from students and teachers for being a member of the LGBTQ community.

Tampose Mothopeng, a Mosotho activist and human rights defender, says LGBTQ people in the small mountainous country often face a backlash from their families, peers and members of the broader community. "LGBTQ people face a lot of challenges daily," he says. "Rejection, limited access to healthcare services, stigma and discrimination and psychological issues. For instance, the health-

[47] What Does Transgender Mean? | Gender Identification Facts, https://www.plannedparenthood.org/learn/gender-identity/transgender, accessed 7 October 2021.



Members of the Khoelenya Community Council in Lesotho work with Phelisanang Bophelong, a community organisation that provides HIV prevention and treatment support to people living with HIV.
Photo courtesy of UNAIDS/M. Hyöky

care system is designed by the very system that rejected you. We must challenge the system until it sees us as human beings," he emphasises.

Mothopeng runs the People's Matrix Association, a community-based organisation that advocates for LGBTQ and gender-nonconforming people in Lesotho. He says it is essential to have a community driving its own mandate, otherwise organizations cannot fully understand, "the true challenges that communities are going through.

Mosolo and Mpho's relationship took a positive turn after participants at an HIV and gender-based violence workshop referred Mosolo to the People's Matrix Association. The workshop raised issues of sexual orientation and gender identity, and she wanted to know more.

"I received training from the People's Matrix Association. I then sat Mpho down and said, 'My child, I have accepted this because this is something that exists. They say that you are born with it and that you feel it in your blood,'" she says.

The People's Matrix Association works with a wide range of partners, including faith-based organizations, to conduct sensitisation workshops on LGBTQ issues and foster a culture of acceptance between the church and LGBTQ people.

The Khoelenya Community Council works in partnership with Phelisanang Bophelong (PB), a community-based organisation that provides HIV prevention and treatment support to people living with HIV. PB, with the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS), supports the council to run HIV, sexual and reproductive health and rights and gender-based violence sensitisation dialogues with the local community.

Through this forum, Mosolo met many LGBTQ people and, through this experience, came to understand Mpho better.

Mpho is now 23 and working in Cape Town, South Africa. Mosolo hopes he will return home to Lesotho one day. She says she would like to build him and his future wife a home on her land. "I would rest knowing Mpho has a place to call his own," she says.

Mosolo's journey has brought her a great deal of acceptance, a quality she promotes to her peers on the council and to people in her community. She too has become a human rights defender.

"As people we need to accept and embrace that this is here. I have seen with my own eyes that some men fall in love with men. We need to embrace it for children to progress with their lives," she says.

Source: UNAIDS, May 2021.[48]

[48] A grandmother's transformative love for her transgender grandchild, https://www.unaids.org/en/resources/presscentre/featurestories/2021/may/20210520_lesotho, accessed 20 July 2021.

LGBTQ sexual and reproductive health and rights

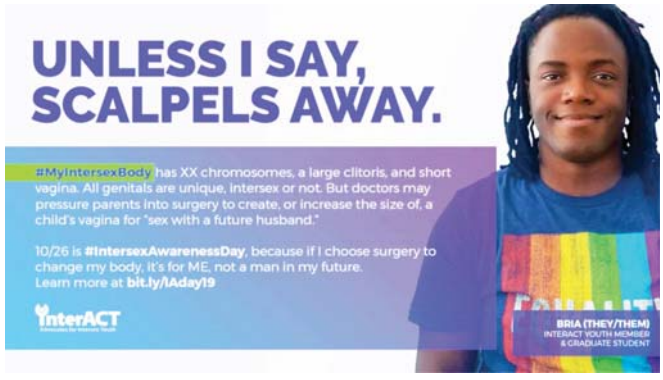
Emergency restrictions due to the COVID-19 pandemic have included limitations to freedom of movement. Access to health services is often one of the exceptional instances in which lawmakers relax these restrictions. However, some countries have required that citizens provide documentation to law enforcement agents that proves their destination before they can access health services, a situation that can lead to invasion of privacy.

Access to equitable health care is a critical concern for LGBTI people during and post-COVID-19

Enforcement agents and lawmakers in contexts with laws criminalising consensual same-sex conduct may not recognise organisations providing health services for LGBTQ people as essential services, forcing many of these providers to close during regional lockdowns. Similarly, law enforcement agents may victimise or harass their clients when they attempt to access health services. The high prevalence of HIV infections in LGBTQ persons in Africa compounds the potential for disproportionate impact to the community. This is especially worrisome because the World Health Organisation has indicated that individuals with underlying conditions and compromised immune systems are more vulnerable to COVID-19.[49]

"Among the many severe impacts of the COVID-19 pandemic is the increased vulnerability of LGBTI people," UN Secretary-General António Guterres acknowledged in a statement in May 2020. "Already facing bias, attacks, and murder simply for who they are or whom they love, many LGBTI people are experiencing heightened stigma as a result of the virus, as well as new obstacles when seeking healthcare."[50]

Access to equitable health care is a critical concern during and post-COVID-19. All SADC states need to put the requisite health care systems and services in place for LGBTQ communities.



[49] Centre for Human Rights , Understanding the disproportionate Impact of Covid-19 on LGBTIQ+persons in Africa, https://www.chr.up.ac.za/images/researchunits/sogie/documents/sogiesc_covid19_pamphlet_.pdf , accessed 8 October 2021.
[50] Guterres, A (2020). May 17 Is International Day Against Homophobia, Transphobia, Biphobia, https://www.voanews.com/a/usa_may-17-international-day-against-homophobia-transphobia-biphobia/6189421.html, accessed 3 October 2020.

Regional: Survey finds that COVID-19 has increased vulnerability of LGBTQ people



The COVID-19 pandemic has made life more difficult for LGBTQ people, according to a new study.
Photo courtesy of The New Humanitarian

The opening session of the 2020 International AIDS Conference shared the findings of a rapid online survey demonstrating the increased socioeconomic vulnerability of LGBTQ people due to COVID-19.

UNAIDS, the LGBTQ Foundation and researchers from the Johns Hopkins Bloomberg School of Public Health and other universities around the globe convened a COVID-19 disparities working group. It surveyed more than 20 000 LGBTQ people in 138 countries in April and May 2020 and found that three quarters (74%) were fully or partially locked down, leading to economic consequences for many.

About 13% of survey participants had already lost their jobs in the wake of the pandemic and a fifth (21%) expected to lose it in the near future. Nearly half the survey participants (47%) faced economic difficulty, with a quarter unable to meet their basic needs, skipping meals or reducing meal sizes.

Of concern, 21% of participants living with HIV reported that they had experienced "interrupted or restricted access" to refills of antiretroviral therapy and 42% of those said they had less than a month's supply on hand.

The survey also found worrisome disruptions for pre-exposure prophylaxis and access to HIV testing. The study also highlighted that racial and ethnic minorities consistently have lower access to HIV services.

Erik Lamontagne, senior economist at UNAIDS and one of the members of the working group, reported at the conference that the crisis had pushed 1% of respondents to start engaging in sex work and that 2% had to continue to sell sex during the COVID-19 pandemic, risking exposure to the coronavirus. The pandemic reduced the ability to negotiate safer sex for 13% of respondents, potentially increasing their risk of acquiring HIV. Respondents also reported reduced access to safe injecting equipment and opioid substitution therapy.

"What worries us is that socioeconomic factors, such as limited access to health care, lower income, unemployment and food insecurity, combined with higher anxiety and depression rates, may place some at higher risk of contracting HIV and affect treatment adherence among people living with HIV," said Lamontagne.

The study shows that COVID-19 increases the vulnerability of groups that already face disproportionately high rates of HIV. Solutions and targeted programmes are required from the global community and governments to sustain prevention, testing and treatment services and to help the LGBTQ community to survive and emerge safely from the crisis.

Source: UNAIDS, July 2020.[51]

Universal Health Care (UHC) is goal 3.8 in the SDGs. The vulnerability of key populations such as the LGBTQ community during the COVID-19 crisis illustrates the need for strengthened public health systems and accelerated UHC. The measures governments take to address COVID-19 must remain relevant beyond the immediate response to the pandemic. Strategies should include the long-term objective of UHC for all by 2030.

[51] Survey shows that the COVID-19 pandemic increases vulnerability of LGBTI people, https://www.unaids.org/en/resources/presscentre/featurestories/2020/july/20200710_survey-covid19-lgbti-people, accessed 12 October 2021.



Malawi: LGBTQ community engaged in battle over healthcare

Eighteen-year-old Precious (not his real name but a pseudonym chosen to protect his identity) has never faced a reporter before, but he is anxious to tell his story nonetheless.

Dressed in a red checked shirt and a pair of camouflage shorts, sporting his signature Mohawk hairdo, he sits in the office of the minority rights group Centre for Development for People (CEDEP) in Lilongwe.

"I realised I was gay at the age of 14 while in secondary school," he said. "My family knows I am different, but no one has ever approached me to find out about my sexual orientation, though I suspect some members of my community know I am gay as I have received some death threats because people think I am evil.

"I had a sexual health issue that required medical attention. I was disappointed with the way the nurse at the health facility handled the situation. After the routine diagnosis, she asked me if I was homosexual. I said 'yes' because I wanted help. She told me that I was evil and my future was doomed because God does not allow that," he said.

The nurse's harassment did not end there.

"She then called her colleagues to come and see me. They took turns pouring insults on me. One of them openly said I did not deserve medical attention. Instead, I should be arrested for indulging in homosexuality, which is an offence. I was totally upset and I left the clinic for a drug store so I could treat myself," he added.

Precious's case is not an isolated one. Many LGBTQ Malawians have had similar experiences when seeking healthcare at public and private facilities in the country.



Malawian LGBTQ activists take part in a protest advocating for their health rights in 2017 in Lilongwe. Photo courtesy of Rodger Bosch/AFP/ Getty Images

CEDEP is campaigning for an end to this discrimination and hostility. Maria Ngulube runs Linkages, a project through which CEDEP and other organisations endeavour to ensure that everyone, including the LGBTQ community, has equal access to healthcare.

"We have had cases of the community complaining of maltreatment at the health centres and clinics, so the project decided to engage the health workers themselves," said Ngulube.

CEDEP and its partners have trained more than 50 health workers in Malawi since the programme started in April 2016. The programme, which Ngulube plans to expand, offers guidance in how to address the specific health needs of sexual minorities.

Ngulube says the religious beliefs and affiliations of health workers and the institutions often contribute to LGBTQ discrimination. Apart from turning to the few public hospitals in the country, much of Malawi's LGBTQ population accesses health care at church-owned facilities operated by the Christian Health Association of Malawi.

Fatsani Kalino is a health worker at Bwaila Referral Hospital, a public facility in Lilongwe, where she works in HIV testing and counselling

[47] What Does Transgender Mean? | Gender Identification Facts, https://www.plannedparenthood.org/learn/gender-identity/transgender, accessed 7 October 2021.

within the sexual transmitted infections (STI) department. She described the pervasive stigma that surrounded the treatment of sexual and gender minorities before CEDEP began its training programme.

"Sometimes we were regarded as LGBTQ health workers. If colleagues learned that we treated an LGBTQ member, they said it means we are promoting sin," Kalino said.

Health workers shunned members of the LGBT community for that very reason. On average, she said she treats between 40 and 80 LGBTQ people each month. "The CEDEP training has helped us to treat clients without stigma and accept them as anyone else, but I wish the society accepted them so that they may be using the social services freely," she added.

Source: Mirriam Kaliza for DW, 2017.[52]

LGBTQ organisations

The ability to organise and operate freely represents a vital right for LGBTQ organisations advocating for change. As well as organising events and promoting LGBTQ rights, these groups often provide safe spaces and shelter for LGBTQ youth to talk about their sexuality or gender identity. In countries where registration of an LGBTQ organisation remains impossible, LGBTQ activists often register using generic umbrella names, such as those used by women's groups or human rights groups. Inability to formally register and operate freely also impedes fundraising. LGBTQ groups can only legally register in nine SADC countries, with seven others (Comoros, DRC, Eswatini, Madagascar, Malawi, Tanzania and Zambia) outlawing it.[53]



In the **DRC**, Article 3 of Decree-Law No. 4 (2001) requires civil society organisations seeking registration to undergo a two-tiered process, with legal personality granted by the minister of justice after the ministry responsible submits a favourable opinion for the sector in which the organisation hopes to engage. According to a joint submission by six LGBTQ NGOs to the 2017 Universal Periodic Review (UPR), DRC legislators have denied most organisations registration when they make reference to LGBTQ people in their constitutions.[54]



In **Tanzania**, a vast body of laws and regulations set the regime for NGOs, many of which pose legal barriers to the registration and operation of organisations working on sexual and gender diversity issues. For instance, various provisions within Chapter 337 of the Societies Act (2002) allow the Tanzanian Registrar to reject, deregister, or outlaw any organisation with "any purpose prejudicial to, or incompatible with, the maintenance of peace, order and good government." Additionally, Section 14(1) of the Non-Governmental Organisations Act (2002) states that the NGO Coordination Board may refuse the registration of NGOs whose activities are "not for public interest or are contrary to any written law."[55] In 2019, lawmakers replaced the expression "order and good government" included in the Societies Act with "order, morality and good governance," as per Article 34(b) of the Written Laws (Miscellaneous Amendments) (No.3) Act (2019). This explicit reference to "morality" increases even more the already sizeable legal barriers to the registration of

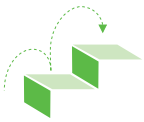
[52] Malawi's LGBT battle for health care, DW, https://www.dw.com/en/malawis-lgbt-battle-for-health-care/a-37280415, accessed 11 October 2021.
[53] Canaries in the Coal mine, 2017, http://theotherfoundation.org/canaries-in-the-coal-mines/, accessed 1 July 2020.
[54] MOPREDS et al., Human Rights Violations Against LGBT People in the Democratic Republic of the Congo (DRC) (2017), 16.
[55] In addition to the laws mentioned in this entry, also see: The National Policy on Non-Governmental Organizations (2001), the NGO Regulations (2004), and the NGO Regulations Amendment Act (2019).
[56] For a comprehensive overview of the numerous thus-related laws currently in force, see Tanzania's entry within the Criminalisation section of the State-Sponsored Homophobia report's thirteenth edition, pp. 373-377.

organisations working on sexual and gender diversity issues, especially because Tanzania lawmakers actively enforce provisions that criminalise consensual same-sex sexual acts.[56]



Zambia's Section 8 of the Societies Act (1958) empowers the Registrar of Societies to refuse to register any society that is prejudicial to, or incompatible with, the peace, welfare or good order in Zambia. In 1998, the Registrar of Societies refused to work with activists who tried to register their group, Lesbians Gays and Transgender Association (LEGATRA), and said that the group could not register the group "any more than I could a satanic organisation."[57] While Zambia has several LGBTQ human rights organisations, they operate underground and strategically negotiate the dangerous legal landscape. In 2016, several UN Special Procedures[58] expressed concern regarding undue delays, the subsequent refusal to register and arrests of civil society and defenders in the registration of the Engender Rights Centre for Justice on grounds of "soliciting for immoral purposes."[59] In October 2019, a Zambian MP raised a motion seeking to ban political parties and organisations that support LGBTQ rights in Zambia. The motion eventually expired.[60]

LGBTQ groups can only legally register in nine SADC countries



Next steps

The lack of recognition of LGBTQ rights represents a fundamental violation of human rights and requires urgent action in all SADC countries. Key recommendations are:

- Ensure that all SADC countries have specific constitutional protections that protect the rights of LGBTQ communities; decriminalise same-sex consensual sexual acts; and recognise the rights of individuals of all sexual orientations, gender identities and expressions.
- Review Penal Codes to remove any clauses that criminalise same-sex consensual sexual acts.
- Advocate for public policy and legislation that criminalises hate crimes; discrimination in the work place based on sexual orientation, gender identity and expression; conversion therapy; and discrimination in all forms.
- Lobby for the legalisation of same sex marriages and the right of same sex couples to adopt children.
- Enshrine in law the ability for sex, gender identity and name changes for people who have transitioned from one sex to another or want to change their gender marker.
- Remove legal barriers to the registration or operation of civil society organisations working on LGBTQ issues.
- Ensure that all measures adopted to mitigate the effects of COVID-19, including socio-economic support, address and respond to the specific vulnerabilities in the LGBTQ community.

[57] Scott Long et al, More Than a Name: State-Sponsored Homophobia in Southern Africa (Human Rights Watch, 2003), 46.
[58] Lily Phiri, Canaries in the Coal Mines: An Analysis of Spaces for LGBTI Activism in Zambia (The Other Foundation, 2017), 18.
[59] The Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression; the Special Rapporteur on the rights to freedom of peaceful assembly and of association; and the Special Rapporteur on the situation of human rights defenders.
[60] For more information, see ZMB 4/2015.

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Media, Information and Communication 9



Journalists cover the Gender and News Summit in Tanzania in 2018. Photo courtesy of Aikha Kimaro

KEY POINTS

- The *Gender and Media Progress Study* (GMPS) remains the largest and longest longitudinal research study on gender equality in the news media in Southern Africa, spanning from 2003-2020. The 2020 GMPS monitored 18630 news items over an entire month.
- The proportion of women sources represents the most important measure of giving a voice to women.
- The GMPS shows a paltry increase in women sources in the media, from 17% in the 2003 *Gender and Media Baseline Study* (GMBS) to 19% in 2010 GMPS, to 20% in the 2015 GMPS, and just 21% in the 2020 GMPS.
- Variations exist across countries in the proportion of women as news sources in Southern African media, ranging from 16% in Democratic Republic of the Congo (DRC), Tanzania and Zambia, to 31% in Seychelles: all still well short of the 50% target.
- At just 2%, topics on Sexual and Reproductive Health and Rights (SRHR) rank among the least covered. Gender Based Violence (GBV) accounts for half of SRHR coverage. At 2% each, sexual diversity, harmful practices, and menstrual health are the least covered SRHR topics.
- Regional media prioritises other topics, including economy (19%), social topics (15%) sports (12%), politics and government news (11%).
- Across all topics, women's voices dominate only in news about gender equality (52%).
- Spokespeople and experts continue to comprise the majority of sources in regional news.
- An analysis of COVID-19 news coverage shows that women's voices accounted for 26% of those interviewed as sources.
- Online GBV increasingly hinders freedom of expression in online spaces, with women journalists disproportionately affected.

Introduction

If George Orwell's famous line about the media is true and "the people will believe what the media tells them they believe," then those seeking gender equality need to continue to push the Southern African media sector to do better. While there has been some progress in both what journalists report on, and how they do their newsgathering, journalism in the Southern African Development Community (SADC) continues to lag behind other regions in its contribution to reporting on gender equality and equity.

Regional media remains rife with problematic and harmful gender disparities in news media content as well as within media institutional structures and practices. This includes sexual harassment within newsrooms. Online violence against women journalists is also on the rise. Meanwhile, media content continues to curtail or ignore women's right to freedom of expression and opinion because women's voices seldom make it to the news. "Tabloidisation" of the media, weak ethical practices, entrenched male dominance, violations of women's rights, and failure to implement gender mainstreaming continue to hinder efforts to achieve gender equality in and through the media.[1]



Egyptian journalist Shahira Amin and Libyan journalist Fatma Ghandour conduct media monitoring during a Women Peace and Security workshop in Addis Ababa, Ethiopia, in 2016. Photo: Tarisai Nyamweda

Severe gender disparities still abound in SADC news media

Findings from the 2020 *Gender and Media Progress Study* (GMPS) show stagnation or regression in progress towards attaining gender equality in the media. The struggle towards reaching equality within media institutions is increasingly less about the numbers (as numbers edge towards equality in most countries) of women entering the profession and more about the pervasiveness of sexism and misogyny - including cyber misogyny.[2] Additionally, women continue to struggle to attain and retain leadership roles within media institutional structures.

Women's relative underrepresentation in mainstream news media has carried over into online news as digital media platforms grow in importance. The GMPS included this area of work for the first time in 2020. Sadly, challenges of news media sexism, gender stereotyping, and gender bias seem intractable across time, space and content delivery platforms.

Media in Southern Africa suffers from similar sustainability challenges emerging in the industry across the world. Cost cutting in a bid to keep newsrooms afloat affects priorities in news coverage and institutional practices. This issue became more critical in the time of COVID-19, with many media houses requesting financial and government support to survive. The pan-

[1] Media Institute of Southern Africa. 2021. Southern Africa press freedom report 2019-2020. Media Institute of Southern Africa. Harare. Available at https://data.misa.org/api/files/1619950689792O1gkm18usemy.pdf, accessed on 18 June 2021.
[2] Daniels, G. and Nyamweda T. 2018. Glass Ceiling: Women in South Africa media houses. Gender Links. Johannesburg

demic created many fault lines in the sector, especially regarding the rights of media workers, the right to freedom of expression, and industry sustainability.

"COVID-19 temporary measures and laws on lockdowns dented freedom of expression gains that had been made over the years," noted a 2020 report from Internews on freedom of expression in Southern Africa. *Titled Things* will never be the same again, it found that, "if there is no financial intervention or adoption of sustainable revenue solutions in SADC, print media that were already in financial dire straits before the pandemic, will close their doors permanently. The pandemic saw countries invoking shutdowns that restricted movement and, in some cases, resulted in companies closing causing loss of jobs and income and impacting on media revenues from newspapers sales and advertising."[3]

During the COVID-19 pandemic, journalists also faced the challenging task of gathering and distributing accurate information, risking their lives to work on the frontlines to collect and disseminate vital public health news. Despite this central role during a pandemic, media practitioners also grappled with the impact of COVID-19 on their lives and work. Throughout the crisis, SADC citizens increasingly saw information and communication technologies as an opportunity and lifeline to access and disseminate news.

Thus, in many ways 2020 provided a timely and urgent opportunity to reflect and take stock of progress made by the news media in representation and portrayal of women in Southern Africa and beyond through gender and media monitoring. This important initiative provides gender and media activists with reliable data to strengthen their work towards a more gender equal and responsive media.

This chapter reflects on these points, highlighting both progress and setbacks made in fulfilling the targets set under the SADC Gender Protocol. It will focus on the findings of the GMPS, especially those related to SRHR and COVID-19, which fit into the #VoiceandChoice theme of this year's Barometer.

The GMPS has tracked progress on women's representation and portrayal in the Southern Africa media at five-year intervals since the first *Gender and Media Baseline Study* in 2003. It builds on and complements the Global Media Monitoring Project (GMMP), a larger research initiative that takes the pulse of selected indicators of gender in the news media globally, including women's presence in relation to men, gender bias, and stereotypes in news stories and other content.

Table 9.1: GMPS comparison to GMMP

Gender and Media Progress Study	Global Media Monitoring Project
Southern African focus	Global focus
Monitoring over one month	Monitoring over one day
Online monitoring	Paper based (final monitoring uploaded onto online database)

Source: Gender Links.

Table 9.1 illustrates the key differences between the GMPS and GMMP studies. Notably, the GMPS monitors media across the SADC region over the span of an entire month, while the GMMP monitors media around the world over one day. Undertaking both studies around the same time provided an opportunity for gender and media activists in the region and beyond to reflect on progress made in the representation and portrayal of women, which represents one of the 12 critical areas of the Beijing Platform for Action.

[3] Internews. 2020. "Things will never be the same again": COVID-19 effects on freedom of expression in Southern Africa, 2020. Johannesburg. Internews. Available at https://www.usaid.gov/sites/default/files/documents/internews_effects_of_covid19_on_freedom_of_expression_in_select_sadc_countries_2.pdf, accessed 3 July 2021

A central question in both studies is whether women's voices have increased or decreased over time and whether the portrayal of women has changed. Importantly, stories on sexual and reproductive health and rights (SRHR) ascertained representation of this critical issue in the media. They focused on nine thematic areas, including menstrual health, maternal health, safe abortion, teenage pregnancies, comprehensive sexuality education, sexual diversity, GBV, HIV and AIDS, and harmful practices.

Table 9.2: GMPS summary

AREA	2003	2010	2015 overall	2020 overall	Highest country	Lowest country	2020 Global[4]
Who speaks in news?	**% W**	**% W**	**% W**	**% W**	**% W**	**% W**	**% W**
Overall	17	19	20	21	28	6	24
Private media	N/A	19	18	22	43	15	
Public media	N/A	20	24	21	35	16	
Community	N/A	22	21	20	67	0	
Who reports?	**% W**	**% W**	**% W**	**% W**	**% W**	**% W**	**% W**
All reporters	N/A	27	29	37	74	23	37
All presenters				55	88	37	
Topic of reporting	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Economics		12	17	19	28	12	17
Politics		19	21	11	24	4	16
Sports		18	17	12	26	4	
Social				16	31	10	
Who speaks on what?	**% W**	**% W**	**% W**	**% W**	**% W**	**% W**	**% W**
Economics	10	12	18	19	31	0	21
Political stories	9	13	14	14	25	6	18
Gender equality				51	`100	0	
SRHR	N/A	N/A	N/A	43	83	0	
Social				12	41	16	
Sports	8	12	13	12	31	0	
COVID-19				**% W**	**% W**	**% W**	**% W**
Sources							
Women sources on stories that mention COVID-19	N/A	N/A	N/A	26	44	16	
Topics related to COVID-19				**%**	**%**	**%**	**%**
Health	N/A	N/A	N/A	34	54	21	
Economy	N/A	N/A	N/A	25%	37	7	
Social	N/A	N/A	N/A	18	32	8	
Politics	N/A	N/A	N/A	4	10	0	
Sports	N/A	N/A	N/A	7	16	0	
SRHR	N/A	N/A	N/A	1	6	0	
Origin of stories	**%**	**%**	**%**	**%**	**%**	**%**	**%**
International	N/A	22	16	12	19	2	
Africa/SADC	N/A	8	8	6	18	1	
National	N/A	42	44	56	77	39	
Local/community	N/A	18	28	25	30	4	

Source: GMPS 2015, GMMP 2020.

Table 9.2 illustrates the key findings from the GMPS studies over the years, including the most recent in 2020. This chapter will highlight and review several of these in further detail.

[4] World Association of Christian Communicators. 2020. 6th Global Media Monitoring Project highlight of findings. Available at https://whomakesthenews.org/wp-content/uploads/2021/07/GMMP-2020.Highlights_FINAL.pdf, accessed on 15 July 2021.

Background: Global efforts for gender equality in and through media *Beijing Declaration and Platform for Action*

Last year marked the 25th anniversary of The Beijing Declaration and Platform for Action (BDPA), an outcome of the 1995 Fourth World Conference on Women adopted by 189 countries as a visionary roadmap for achieving gender equality. The BDPA declared the media one of 12 critical areas of concern for the advancement and empowerment of women. The Platform for Action calls for commitment to end sexism and sexist stereotyping in and through the media. Thus, the need to advance gender equality in and through the media and information and communications technology (ICT) has been at the core of gender and media advocacy work since the 1995 conference through its two strategic objectives:

- Strategic objective 1: Increase the participation and access of women to expression and decision-making in and through the media and new technologies of communication.
- Strategic objective 2: Promote a balanced and non-stereotypical portrayal of women in the media.

Since 1995, other international efforts have reaffirmed the importance of attaining gender equality in and through the media and ICTs. Several legal and normative instruments have stimulated this goal, including:

The Global Media Monitoring Project



The GMMP is a one-day voluntary global monitoring project that has taken place every five years since the Fourth World Conference on Women in Beijing in 1995. It represents the world's longest-running and most extensive research on gender in the news media.

Researchers designed the GMMP to capture a snapshot of gender on one "ordinary" news day for the world's news media. They defined this as a day during which the news agenda contains a run-of-the-mill mix of stories, everyday articles on politics, economy, social issues, crime and other issues. Events during the 2020 GMMP year were somewhat extraordinary; beginning in late 2019 and intensifying during the year as the COVID-19 pandemic ravaged the planet. This sixth installation of the GMMP research thus offered a unique opportunity to scrutinise gender in media coverage during a global catastrophe: a time marked by a worldwide health crisis and the intensified inequalities accompanying it.

The Beijing Declaration provides a roadmap to achieving gender equality in and through the media

GMMP teams in 116 countries monitored 30 172 stories published in newspapers, broadcast on radio and television, and disseminated on news websites and via news media tweets in 2251 news outlets.

The global coordinator, World Association for Christian Communication (WACC), released some preliminary results in March 2021 and launched its full report in July 2021.

Table 9.3: 2020 GMMP research in Africa[5]

	2015	2020
Number of African countries participating	32	43
Women in the news	22%	22%
Women sources in politics and government	16%	18%
Women sources economy	19%	19%
Women sources sciences and health	37%	30%
Women sources social and legal	26%	23%
Women sources crime and violence	28%	24%
Women sources celebrity, arts, media and sports	15%	17%
Women sources other	22%	25%
Women are reporters	35%	27%

Source: GMPS 2015, GMMP 2020.

Table 9.3 shares some information from the 2020 GMMP for African countries, which shows negligible progress on most indicators since the previous study in 2015. In Africa, women once again made up only 22% of sources in the news monitored, even though this time around the study included an additional 11 countries on the continent. Other indicators saw gender equality decreases, including women as sources in science and health; social and legal; on crime and violence; and women as reporters. In SADC, the GMPS found an increase of one percentage point on women sources in the media from 20% to 21% since 2015."[6]

Global Alliance on Media and Gender

The Global Alliance on Media and Gender (GAMAG) is a "global movement to promote gender equality in and through media and ICTs in all formats and locations and across different forms of ownership."

In 2020, GAMAG and its members assessed progress, gaps and opportunities on gender and the media 25 years after Beijing and five years into the implementation of Agenda 2030.[7] GAMAG also submitted findings to the United Nations Special Rapporteur on Violence Against Women for a report presented to the UN Human Rights Council in June 2020. The report provided a picture of the situation of violence against women journalists, which has increased dramatically - both offline and online. The reports discussed the structural conditions that enable GBV against women journalists, and explored how such violence affects the collective right to freedom of expression. The report, however, focused mainly on Asia, Europe and Latin America.

[5] World Association of Christian Communicators, (2020). Global Media Monitoring Project Africa results. World Association of Christian Communicators. Toronto Available at https://worldassociation-my.sharepoint.com/:x:/r/personal/sm_waccglobal_org/_layouts/15/Doc.aspx?sourcedoc=%7BBF70182A-6F1C-49FD-9A9E-86658601DB4F%7D&file=GMMP%20Report_%20Africa%20-%202021-05-15.xlsx&action=default&mobileredirect=true, accessed on 16 July 2021.

[6] Gender Links, (2020). Gender and Media Progress Study. Preliminary findings. Gender Links. Johannesburg. Available at https://datastudio.google.com/u/0/reporting/ee53fd80-a91a-46e0-9cc3-f8c7f352d484/page/eKwT?s=tim9YL3OEew, accessed on 16 July 2021.

[7] Global Alliance on Media and Gender, (2020). GAMAG assessments of progress, gaps and opportunities on gender, media and ICTs 25 years after the Beijing Platform for Action for the Advancement of Women and five years into the implementation of Agenda 2030. Available at https://gamag.net/2020/01/22/beijing-25-gender-media-and-icts/ , accessed 26 June 2020

Step it Up Media Compact

In March 2016, UN Women fostered a partnership with leading media houses for the Step it Up for Gender Equality Media Compact ("Step it Up"). It set out to develop concrete actions for the implementation of the Sustainable Development Agenda with a focus on gender equality and women's rights issues on two fronts: 1) in their reporting, disrupting stereotypes and biases and 2) in increasing the number of women in the media, including in leadership and decision-making functions.[8]

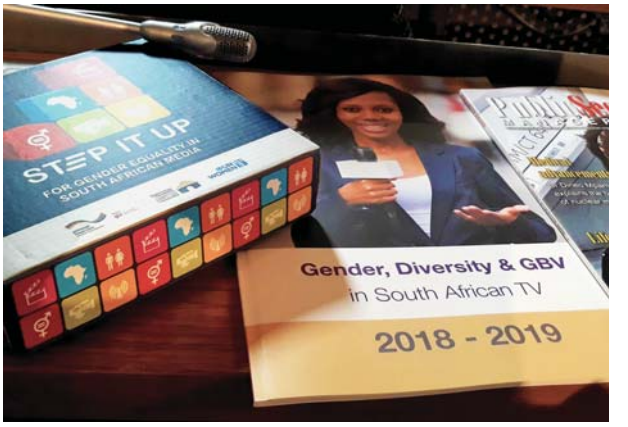
Step it Up encourages media houses, at minimum, to:

- Champion women's rights and gender equality issues through articles, features and news coverage;
- Ensure production of high-quality stories with a focus on gender equality and women's rights, with a minimum of two per month;
- Ensure inclusion of women as sources in stories produced, aiming for gender parity, including across diverse subjects such as business, technology, science and engineering;
- Adopt a gender-sensitive code of conduct on reporting;
- Ensure guidelines for gender-sensitive reporting in orientation and training of staff members;
- Enable equality in newsrooms through gender-sensitive reporting and by ensuring women journalists receive the same opportunities as their male colleagues and can cover diverse subjects from politics to business, science, sports and technology, while encouraging male journalists to also cover diverse issues, including women's rights and gender equality stories; and
- Ensure women journalists have mentors and guidance for career advancement.

In South Africa, UN Women and GIZ, a German development agency, through its Partnerships for Prevention of Violence against Women and Girls programme (PfP), support the Step It Up project. It mainly aims to facilitate behavioural change of key media organisations and practitioners. In 2020, the campaign launched a voluntary Statement of Commitment for Gender Equality in South African Media. In partnership with the media and entertainment industry, civil society, government and regulatory bodies, the campaign aims to actively fight GBV and promote gender equality in South Africa by calling on the media and entertainment industry to uphold the following three key commitments:

1) Gender-sensitive reporting;
2) Un-stereotyping entertainment and story-telling; and
3) Creating an equal and safe space behind the scenes.

Voluntarily signing the Statement of Commitment hopefully motivates South African news and entertainment media organisations and practitioners to reflect and take on the roles and responsibilities that come with the influence they hold. The campaign hopes to guide the way for signatories to become a positive force in the country's struggle with gender inequality and GBV.



Step It Up for Gender Equality in South African Media information pack.
Photo: Tarisai Nyamweda

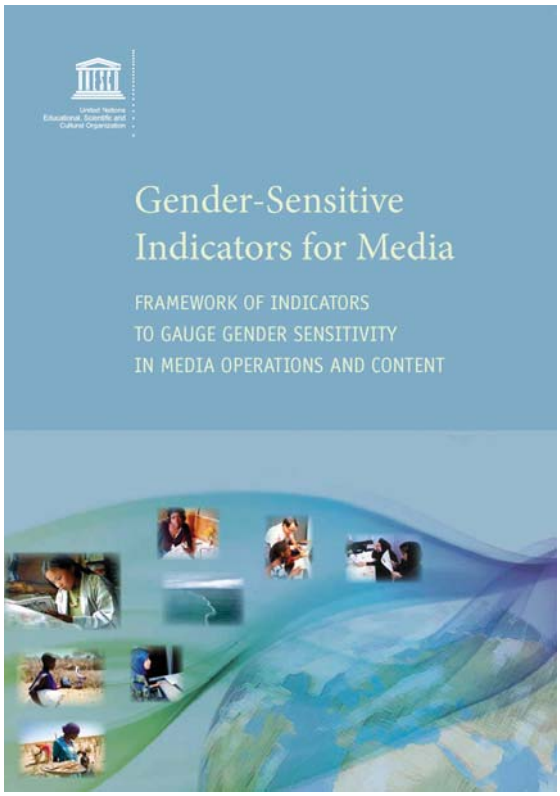
[8] UN WOMEN, (2018). UN Women Media Compact. A partnership to advance women's empowerment with and through the news media. Available at http://www.unwomen.org/en/get-involved/step-it-up/media-compact#sthash.INLxFHhx.dpuf, accessed 1 July 2020

#PayMeEqual campaign[9]

The International Federation of Journalists (IFJ) launched a global campaign called #PayMeEqual that urges media across the world to conduct pay audits in their newsrooms and to act to tackle the gender pay gap. The campaign will survey and document the gender pay gap in journalism at a national level and support its affiliates in their call for equal pay.

Individual journalists can also use this survey to compare their own wage to those holding similar positions. According to IFJ, this survey "is going to fight for equal pay and opportunities." To support its campaign, IFJ calls on members to share stories of equal pay wins on social media using the campaign hashtag.

Gender Sensitive Indicators for Media



The Gender Sensitive Indicators for Media (GSIM) project, hosted by the United Nations Educational, Scientific and Cultural Organisation (UNESCO) aims to contribute to gender equality and women's empowerment in and through media of all forms, irrespective of the technology.

As noted by UNESCO, "the GSIM is a non-prescriptive set of indicators, designed particularly for media organisations. The purpose is to encourage media organisations to make gender equality issues transparent and comprehensible to the public, as well as to analyse their own internal policies and practices with a view to take necessary actions for change."[10]

In 2016, UNESCO trained representatives from 25 French-speaking African national broadcasters on how to apply the GSIM. Through this initiative, UNESCO seeks to strengthen media pluralism and the adoption of gender-sensitive policies in African broadcasting organisations.[11]

Gender and media research in Southern Africa

Gender and media activists in Southern Africa have undertaken some of the most extensive and consistent research on gender equality in and through the media. This research has taken a 360-degree approach to assessing regional media, including looking at media education, content, composition, audiences, regulators and media development organisations. Gender Links (GL) has coordinated this research, together with like-minded organisations, journalism and media studies departments across the region.

[9] International Federation of Journalists, (2021). Time to end the gender pay gap in journalism https://www.ifj.org/media-centre/news/detail/category/women-workers/article/time-to-end-the-gender-pay-gap-in-journalism-says-ifj.html, accessed 24 June 2021
[10] Grizzle, A. (eds). 2012. Gender-Sensitive Indicators for Media. UNESCO. Paris. Available at https://unesdoc.unesco.org/ark:/48223/pf0000217831, accessed 16 July 2021.
[11] UNESCO, (2016). Training Gender-Sensitive Indicators for Media. Available at https://en.unesco.org/training-gender-sensitive-indicators-media , accessed 16 July 2021.

Table 9.4: Gender and media research in the region

YEAR	STUDY	WHAT IT COVERED
2003	Gender and Media Baseline	First regional study to monitor news items on gender in the editorial content of Southern African media. It monitored more than 25 000 news items.
2009	Glass Ceilings in Southern African Media Houses	Survey of women and men in a representative sample of media houses - newsrooms, marketing, management, and administration.
2010	Gender and Media Progress Study (GMPS)	Monitoring of news items from a representative sample of media outlets over a period of one month. This study followed on from the original 2003 *Gender and Media Baseline* study.
2010	Gender in Media Education (GIME) study	Staff and student composition, content and practise of media education and training.
2015	Gender and Media Progress Study (GMPS)	A follow-up to the 2010 GMPS research, covering 14 SADC countries.
2018	Glass Ceilings: Women in South African Media Houses	A follow-up to the 2009 regional research specifically focused on South African media houses.
2020	Gender and Media Progress Study (GMPS)	A follow-up to the 2015 GMPS research, covering 14 SADC countries.

Source: Gender Links.

Table 9.4 shows key gender and media research conducted in Southern Africa over the past two decades, culminating in the 2020 Gender and Media Progress Study (GMPS). Covering 18 630 news items, researchers for the 2020 GMPS study monitored news content in 14 SADC countries over one month.

The 2020 GMPS represents the latest study in two decades of regional research on gender and media in SADC

Gender and freedom of expression

3 May 2021 marked the 30th anniversary of the Windhoek Declaration, a statement of press freedom principles by African newspaper journalists produced by UNESCO in 1991. The sector celebrated 30 years under the theme "Information as a Public Good," underlining the indisputable importance of verified and reliable information. The theme also called attention to the essential role of free and professional journalists in producing and disseminating information, as well as tackling misinformation and other harmful content.

In the 30 years since the creation of the Windhoek Declaration, some parts of the region made great strides in expanding freedom of expression; yet little has changed in the specific promotion of women's freedom of expression and opinion.

Article 19 of the Universal Declaration of Human Rights of 1948 enshrines the right to communicate and states that "everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information, communicate and express themselves in the media." This framing sidesteps several of the challenges specifically faced by women, such as in attaining certain roles in the media, reporting as journalists on certain topics, or expressing themselves, which is one of the reasons subsequent international documents and regional instruments have specifically addressed these topics in relation to freedom of expression and opinion.

This includes instruments such as the Declaration of Principles on Freedom of Expression and Access to Information in Africa, initially adopted in 2002 and upgraded in 2019. It states, "Freedom of expression and access to information are fundamental rights." It recognises the receiving and accessing of information as well as the dissemination of information as a core right for media and citizens. Following its passage, freedom of expression and access to information laws in African countries now must align with the updated Declaration adopted in Banjul, Gambia, in November 2019.



Journalists took to the streets of Anosy, Madagascar, in 2014 following a government crackdown on media freedoms. Photo: Zotonantenaina Razanadratefa

Press freedom and gender equality intertwine: one cannot exist without the other. The idea of gender equality and equality of all voices exists implicitly in the notion of a pluralistic press, which should reflect the widest possible range of opinions. As a 2018 Canadian report on technology and women's empowerment noted, "Any discussion of freedom of expression must ask, whose freedom, defined by whom? It should not be defined, as it typically has, as men's right to squander the profits of communication companies to secure their own economic and political power or continue to omit and stereotype women in the content of their news and programming."[12]

All SADC countries guarantee the right to freedom of expression. They all also have media laws and policies that govern the operations and behaviours of the media. Some countries, however, have embraced stringent media laws that purport to uphold the status quo and which, in many instances, pose a threat to media freedom and democracy. In many ways, media freedom has continued to decline in the region.

The 2021 *World Press Freedom Index* conducted by Researchers without Borders (RFC) reveals that no SADC country ranks among the global top 20. Namibia continues to be the country with the strongest press freedom environment in the region, ranking 24th in the 2021 index, down from 23rd position in 2020. South Africa now sits in 32nd position (also down one spot from last year) and Botswana moved up one spot in 2021 to 38th position out of 180 countries. Zimbabwe (130), Eswatini (141), and DRC (149) sit among the worst global performers.[13]

> Gender equality and freedom of expression intertwine: you cannot have one without the other

[12] Byerly, C. 2018. Technology and women's empowerment in Media and Gender a holistic Agenda, WACC. Canada. Available at https://gamag.net/wp-content/uploads/2018/03/MD-2018-1.pdf, accessed 16 July 2021.
[13] Reporters Without Borders, (2020). Available at https://rsf.org/en/ranking, accessed 14 June 2021

SADC: No freedom of expression without gender equality[14]

On 3 May 2021, as the region continued to struggle with a relentless pandemic, it also commemorated World Press Freedom Day (WPFD) under the theme "Information as a Public Good." The theme called attention to the essential role of free and professional journalists in producing and disseminating information, by tackling misinformation and other harmful content.

In 2021, the commemorations took place amidst increasing evidence of online violence against women and in particular against women journalists. Women's participation in the media is clearly under threat, often leading to self-censorship.

Thirty years since the passing of the Windhoek Declaration (1991), with its aim to promote an independent and pluralistic press, the media still struggles to achieve this goal.

Although many largely describe free media as a mirror in which the public can see itself, in reality this has never been fully reflected. Women remain underrepresented, misrepresented and often treated unfairly in the media. Despite years of activism, education and advocacy aimed at guaranteeing the safety of female journalists, ensuring citizens hear all voices, creating equal opportunities and practicing equal treatment, SADC media still falls short.



Namibia Media Trust Director Zoe Titus speaks at a World Press Freedom Day event in Windhoek in 2021. Photo coutesy of The Namibian

Women news sources have increased by a mere percentage point in Southern Africa since 2015, according to the 2020 Gender and Media Progress Study. Women sources rose from 17% in 2003 to 19% in 2010 to 20% in 2015 and now sit at just 21%.

However, research found that almost half of SADC countries score higher than the regional average. Seychelles maintained its position as one of the better performing countries at 30% on this indicator: the only country that has reached 30% women sources. DRC, Tanzania and Zambia have the lowest number of women's voices in their news content. Yet while DRC remains amongst the worst performers in terms of reflecting women's voices and views, it has logged an increase of 11 percentage points since the 2015 study.

The fact that women's voices make up only one fifth of the views and voices that citizens read, hear and see in the news media is clear evidence that SADC media reflects only a fraction of the region's reality. Gender censorship remains a glaring reality in this absence of diverse voices. Underrepresentation of women's voices systematically silences and sidelines women from conversations about issues that concern them.

The GMPS has once again shone a spotlight on media practice, professionalism and ethics. The media's failure to amplify women's voices acts against the principle of just and inclusive societies.

Gender equality inextricably links with freedom of expression, participation and human rights and it is thus essential that the media give voice to all in society. The Declaration of Principles on Freedom of Expression in Africa (2002) pronounces access to information and freedom of expression as a fundamental and alienable human right. That makes women's access to expression a fundamental right.

Source: Tarisai Nyamweda Gender Links News Service

[14] Nyamweda, T. 2021. Celebrating World Press Freedom Day. Available at https://genderlinks.org.za/news/international-celebrating-word-press-freedom-day/, accessed 14 June 2021

Gaps also persist in the low representation of women working in the media sector, especially at decision-making levels, even though women in most SADC countries consist of 52% of the population. The 2018 study, Glass Ceilings: Women in South African Media Houses, for example, shows that while the country has seen an increase in the proportion of women in management positions it has not neared parity. Women journalists continue to experience unfair practices in their newsrooms, including assignment to certain types of stories or news beats based on their sex. This paralyses their ability to break through the media sector's glass ceiling.

Table 9.5: State of media freedom in SADC

Country	Media provisions
Angola	The constitution protects freedom of speech and of the press; however Angola continues to have a restrictive media environment. Press status for the country is "not free." The only outlets with a truly national reach and most widely accessed - Jornal de Angola, television channel Televisão Publica de Angola (TPA) and Radio National de Angola (RNA) - remain under government's firm grip. Private media is operational; however, it is very limited. In 2020, the state took effective control of several leading media outlets that already had public funding.[15]
Botswana	The Botswana Constitution enshrines freedom of expression in Chapter 12. On the surface, the country has a free and diverse media environment. However, a raft of clauses negate the constitutional guarantee of freedom of expression in many laws, including the Cinematography Act, the Public Service Act, the Media Practitioners Act, the National Security Act, the Cybercrime and Computer Related Crimes Act of 2007, and the Corruption and Economic Crime Act of 1994. Additionally, sections 50 and 51 of the Penal Code on seditious offences, sections 90 to 92 of the Penal Code contain provisions on insult laws, and sections 192 to 199 of the Penal Code provide for criminal defamation.[16]
Comoros	The Comoros Constitution provides for freedom of speech and of the press. However, Reporters Without Borders notes that many journalists self-censor. The government arbitrarily detained several journalists in 2020, prompting the National Union of Comorian Journalists to protest that "being held overnight" had become routine for media personnel.[17]
DRC	DRC laws and the constitution provide for freedom of speech, information, and the press, but, in practice, these rights remain limited. The government and non-state actors (such as armed groups) often use other regulations and methods to restrict freedom of speech and suppress criticism. The political allegiance found in the stories out of most media outlets in DRC normally reflects that of the owner.
Eswatini	The country has approximately 32 restrictive laws, including the Swaziland Television Authority Act 1983; Proscribed Publications Act 1968; Obscene Publications Act 1927; and Books and Newspaper Act 1963, which regulates the registration of newspapers. The Official Secrets Act 1968, Cinematograph Act 1920, and the Sedition and Subversive Activities Act 1938 provide for the suppression of sedition and seditious publications and criminalise criticising the king or any member of the royal family. The Computer Crime and Cybercrime Bill of 2020, if passed into law, will further criminalise publication of "fake news" that damages the country's image, with liability of a fine of up to ten million SZL (about US$620 000) or ten years in prison.[18]
Lesotho	While the Lesotho Constitution does not directly mention press freedom, it guarantees freedom of expression and information exchange. However, multiple laws, including the Sedition Proclamation No. 44 of 1938 and the Internal Security (General) Act of 1984 prohibit criticism of the government, give penalties for seditious libel, and endanger reporters' ability to protect the confidentiality of their sources.[19] Section 14 of the Constitution of Lesotho (1993) states that the right to freedom of expression and opinion is guaranteed including freedom to hold opinions without interference and freedom to communicate ideas and information without intrusion. In 2021, Lesotho promulgated new communications regulations that may affect privacy rights and freedom of expression online.
Madagascar	Madagascar enjoys a diverse and pluralised media landscape, which radio has, in recent times, dominated. Madagascar has a liberal policy towards the media and it has fostered the development of media pluralism and diversity.

[15] Reporters Without Borders, (2021). Press freedom still fragile despite the old dictator's departure. Available at https://rsf.org/en/angola, accessed 16 July 2021.
[16] Friedrich-Ebert-Stiftung, (2018). African Media Barometer Botswana. Friedrich-Ebert-Stiftung. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/15529.pdf, accessed 16 July 2021
[17] Reporters Without Borders, (2021). Alarming setbacks for press freedom. Available at https://rsf.org/en/comoros, accessed 16 July 2021
[18] Media Institute of Southern Africa, (2021). Southern Africa Press Freedom report. Media Institute of Southern Africa. Harare. https://data.misa.org/api/files/1619950689792O1gkm18usemy.pdf
[19] Media Monitoring Africa, (2015). Lesotho Elections 2015 Media Monitoring Interim Results. Media Monitoring Africa. Johannesburg. Available at http://www.mediamonitoringafrica.org/images/uploads/Lesotho_Interim_Report_PrintVersion_2.pdf, accessed 16 July 2021

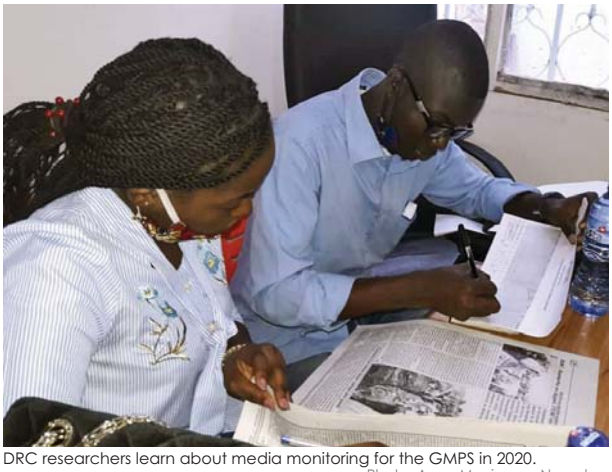
Country	Media provisions
Malawi	Section 36 of the Malawi Constitution states that the press shall have the right to report and publish freely, within Malawi and abroad, and to be accorded the fullest possible facilities for access to public information. Additionally, Section 35 states that everyone shall have the right to freedom of expression. Radio continues to be the most popular medium of accessing information as it has the widest reach and is available in many languages.[20]
Mauritius	Section 12 of the Constitution of Mauritius has always guaranteed freedom of expression. Within the same section, limitations are possible in the "interests of defence, public safety, public order, public morality or public health." Although Mauritius has not signed the SADC Gender Protocol, its constitution guarantees gender equality across all sectors.
Mozambique	Article 48 of the Mozambique constitution explicitly guarantees both freedom of expression and freedom of the press. More specifically, the Press Law guarantees, protects and promotes freedom of the press. However, several aspects of it contribute to limiting the full exercise of these freedoms, such as anti-democratic laws on state secrecy, laws that elevate crimes of defamation, slander and insult to certain figures (including general secretaries of political parties sitting in the Assembly of the Republic) to the category of an attack on state secrecy and the absence of incentives for the circulation of newspapers (including paid carriage).[21] Reporters Without Borders notes a "worrying decline in press freedom" following Filipe Nyusi's re-election as president in 2019.[22]
Namibia	The constitutional guarantee contained in Article 21.1 (a) of the Namibian Constitution gives all Namibians the right to freedom of expression, including freedom of the press and other media.
Seychelles	Seychelles has very few media outlets. The main outlet is the Seychelles Broadcasting Corporation. The creation of the Seychelles Media Commission sought to provide a platform for adjudication on media issues while ensuring more freedom, and the reduction of television and radio licence fees.
South Africa	Article 16 of the constitution protects the right to freedom of expression and the media, with reasonable and justifiable limitations in an open and democratic society. Section 32(1) guarantees freedom to access information, stating that everyone has a right of access to any information held by the state and information held by private persons that is required for the exercise or protection of any right.[23]
Tanzania	Tanzania has a vibrant media industry with strong regulatory systems. The new draft constitution makes provisions for media freedom and free media access to all its citizens. Tanzania has many private media houses as well as a strong community media sector. However, human rights groups, media platforms and independent publishers took the government to court in 2018 over the new Electronic and Postal Communications (Online Content) Regulations, which set out a series of prohibited content affecting bloggers, online radio stations, online streaming platforms, online forums, social media users and internet cafes.[24]
Zambia	Article 20 of the Zambian Constitution protects freedom of expression. Regarding media protection in the constitution, Article 20 (2) states, "subject to the provisions of this constitution no law shall make any provision that derogates from freedom of the press." Political issues continue to dominate the mainstream media, and diversity of content in the print media remains limited. Zambia has made great strides around self-regulation, which has narrowed the divide between state and privately owned media as they united in the establishment of the self-regulatory body, the Zambia Media Council (ZAMEC). However, citizens often cannot express themselves freely due to the perceived elevated levels of political intolerance.[25]
Zimbabwe	In the constitution, Chapter 4 (article 61.1) notes that every person has the right to freedom of artistic expression; and article 61.2 notes that "every person is entitled to freedom of the media." However, "a crisis of the constitution versus constitutionalism" exists in Zimbabwe. Even though legislation on freedom of expression and of the media exists, there is a lack of substance and implementation of the constitutional provisions. An example is the Access to Information and Protection of Privacy Act (AIPPA), which is currently undergoing a process of "unbundling," whereby lawmakers envision access to information, media regulation and privacy issues as separate pieces of legislation rather than a single act. However, the Act still stands in law and has not been changed.[26]

Source: Africa Media Barometer Country reports, Reporters Without Borders, MISA.

[20] Friedrich-Ebert-Stiftung, (2012) .African Media Barometer Malawi. Friedrich-Ebert-Stiftung. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/09541.pdf
[21] Friedrich-Ebert-Stiftung, (2018). African Media Barometer Mozambique. Friedrich-Ebert-Stiftung. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/16084.pd, accessed 16 July 2021.
[22] Reporters Without Borders, News Blackout in the North (2019). Available at https://rsf.org/en/mozambique, accessed on 16 July 2021.
[23] Friedrich-Ebert-Stiftung, (2018). African Media Barometer South Africa. Friedrich-Ebert-Stiftung. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/15527.pdf, accessed 16 July 2021.
[24] Giles, C. "Tanzania's bloggers fight back against $930 fee as court grants injunction." CNN, 7 May 2018. Available at https://edition.cnn.com/2018/04/12/africa/tanzania-blogging-internet-freedoms-africa/index.html, accessed 16 July 2021.
[25] Friedrich-Ebert-Stiftung, (2013). African Media Barometer Zambia. Friedrich-Ebert-Stiftung. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/10575.pdf, accessed on 16 July 2021.
[26] Friedrich-Ebert-Stiftung, (2020). African Media Barometer Zimbabwe. Friedrich-Ebert-Stiftung. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/17189.pdf, accessed on 16 July 2021.

Women and men in media practise

SADC Protocol Article 29.4: State parties shall take measures to promote the equal representation of women and men in the ownership and decision-making structures of the media.



DRC researchers learn about media monitoring for the GMPS in 2020.
Photo: Anna Mayimona Ngemba

Achieving gender equality in the media industry has been a long and contentious battle that feminist media activists continue to fight globally.

Diversity in media workforce composition remains a critical issue in the sector. Having a diverse media workforce will pave the way for an industry that reflects the communities it represents. A diverse work force also helps shift what the media prioritises as it incorporates different perspectives into news coverage on diverse issues.[28] Women in media continue to face a myriad of challenges in media practise, including sexism, sexual harassment, gender pay gaps, gendered division of labour and more recently new threats and impediments linked to online harassment and "cyber misogyny" have emerged via social media.[27]

Recent research on media composition reveals that more women have been securing jobs in the media sector. However, understanding the scope of the issue involves more than analysing mere numbers. Vertical segregation in the news media remains - a problem that leaves women largely absent from key editorial decision-making roles. Horizontal segregation, which results in gendered divisions of tasks associated with reporting, also remains an ongoing challenge.[29]

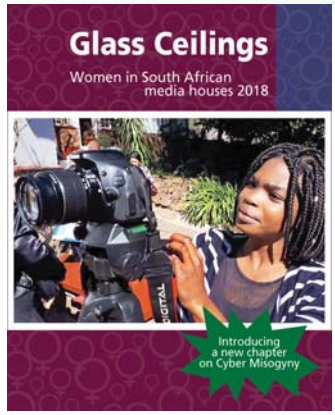
Media decision makers, both men and women, need to adequately and meaningfully assess what women do in the media, what roles they play, what kinds of stories they tell, and how much they earn - all with an eye to improving representation and diversifying reporting and revenues. Reports show that almost equal numbers of women and men work in newsrooms yet women continue to hit a glass ceiling in most media houses. In South Africa, for example, a recent Glass Ceiling study found that systemic sexism and misogyny continues in the media, ensuring newsrooms remain hostile environments for women.[30]

[27] Lowe Morna et al. 2018. (eds) Southern African Gender Protocol Barometer. Gender Links. Johannesburg
[28] Daniels, G and Nyamweda, T. 2018. Glass Ceilings: Women in South Africa media Houses. Gender Links. Johannesburg
[29] Ibid.
[30] Ibid.



South African media still hobbled by misogyny

In 2018, Gender Links and the South Africa National Editors Forum (SANEF), with support from the Media Development and Diversity Agency (MDDA) conducted a new study, *Glass Ceilings: Women in South African Media Houses*, a follow-up to the 2009 Glass Ceilings studies with a focus on South African media.



Some of its most glaring findings do not relate to numbers of women in newsrooms, as women and men seem to have reached parity, although men still dominate in most senior positions. The research found that struggles for women have become more about the sexism that persists even as their numbers increase.

Meanwhile, while race and gender dynamics in South African media have changed dramatically, black women remain grossly underrepresented in key decision-making positions and the pay gap is widening, especially in the age of digitisation. The old boys' network is alive and well. In the #MeToo and #TotalShutDown era, the conversation has shifted beyond numbers to the underlying patriarchal norms that continue to fuel sexist attitudes, harassment and its newest ugly form - cyber misogyny.

The research also notes that women still hit a glass ceiling at senior, top management and board levels, when female representation wanes. Women represented only 36% of top managers, 46% of senior managers and 19% of those on boards of directors in media houses in South Africa.

Although the research shows gender parity as a reality in the overall composition of South African media houses, all these underlying factors highlight persistent gender inequalities. However, a new cohort of young media women has been asserting their rights and the Glass Ceilings 2018 study reflects both a feminist backlash and an increased anger and assertiveness by women in the media against sexism. This may be the result of the general zeitgeist of the times, both globally and nationally.

Source: Glass Ceilings Women in South African media houses 2018, South African National Editors Forum (SANEF) and Gender Links



The African Media Barometer, a media perception index by Friedrich-Ebert-Stiftung (FES) and the Media Institute of Southern Africa (MISA) notes that more women in **Madagascar** have been choosing to pursue careers in journalism. It found that an increasing number of women work in editorial offices, as both editorial managers and journalists. However, the country's media still does not adequately represent women as media sources, except in stories stereotypically viewed as "women's stories" (such as society, fashion, cooking and gender).[31]



In the case of **Zimbabwe**, the fact that fewer women work in newsrooms in general, and in senior positions specifically, attests to the underlying challenges in a society that still marginalises and restricts women to certain workspaces and positions. The gender-insensitive media environment forces out or deters women

[31] Friedrich-Ebert-Stiftung, (2019). African Media Barometer Madagascar. FES Media. Windhoek. Available at http://library.fes.de/pdf-files/bueros/africa-media/16282.pdf, accessed 16 July 2021.

from entering newsrooms. Lack of gender policies in media houses also often results in employers automatically hiring men over women. Cultural impediments that restrict women from travelling away from home and working in the evenings also serve as barriers for female journalists.[32]



Despite its more conducive environment for press freedom in **Namibia**, women remain under-represented in senior management at media houses. Research has also found that women make less money than their male colleagues do. Anecdotal evidence of entrenched misogyny leading to toxic cultures in some newsrooms compounds this. Women journalists are also prone to attacks, as illustrated by the example of two female journalists, Charmaine Ngatjiheue and Jemima Beukes, who said the president's security detail "manhandled" them while they tried to report on the opening of a new facility at a Windhoek hospital.[33] The 2020 Global Gender Gap Report reinforces these realities, stating, "There is still a 31.4% average gender gap that remains to be closed globally."[34]



In **South Africa**, the *Glass Ceilings* study noted that sexual harassment is a daily reality for women in the media, yet leaders in the industry do not prioritise it. In 2018, 87% of media houses surveyed said they had sexual harassment policies, compared to 82% found in a 2009 study of the same title. Yet countless first-hand accounts in the report attested to sexist attitudes, practices and harassment at work and in the field.

Limited research exists globally on institutional practices, careers and promotion within media industries. The 2009 International Women's Federation report remains the only global study carried out to ascertain these issues. Furthermore, the 2017 Barometer noted, "there is presently limited data on ownership of media by women and men in the region - the welcome new parameter introduced in the Post-2015 SADC Gender Protocol. However, the governance structures of media houses in Southern Africa remain firmly in the hands of men (70%), with women constituting only 30% of those on boards of directors."[35] Various factors influence this lack of equal representation. Media houses often struggle with a gendered division of labour, which dictates news practices. Women often cover soft news beats compared to the hard news beats covered by men.

Sexual harassment is a daily reality for women in the media



In **Botswana**, MISA notes that gender representation in newsrooms has barely improved in the past decade. The work environment is generally not conducive for women and made worse by low salaries and misconceptions that label women as "lazy" and unable to take on certain tasks. This has relegated female journalists to entertainment reporting, while their male colleagues cover politics and investigative segments.[36] This affects what journalists report and whose opinions they consult. It also affects the portrayal of women in the media.

[32] Mpofu, S. "Zimbabwe media work space still a male domain," Zimfact 16 September 2019. Available at https://zimfact.org/analysis-zimbabwe-media-work-space-still-a-male-domain/, accessed on 16 July 2021.
[33] Guchu, W. "Assaulted journalists dismiss state house apology", Eagle FM, 3 June 2020, Available at https://www.eaglefm.com.na/news/assaulted-journalists-dismiss-state-house-apology/, accessed on 16 July 2021.
[34] Media Institute of Southern Africa, (2021). Southern Africa press freedom report 2019-2020. Media Institute of Southern Africa. Harare. Available at https://data.misa.org/api/files/1619950689792O1gkm18usemy.pdf, accessed 18 June 2021
[35] Lowe Morna, C et al (Eds).2019 Southern Africa Gender Protocol 2017 Barometer, Gender Links, Johannesburg.
[36] Media Institute of Southern Africa, (2021). Southern Africa press freedom report 2019-2020. Media Institute of Southern Africa. Harare Available at https://data.misa.org/api/files/1619950689792O1gkm18usemy.pdf, accessed 18 June 2021.

Figure 9.1: Women reporters over time - regional

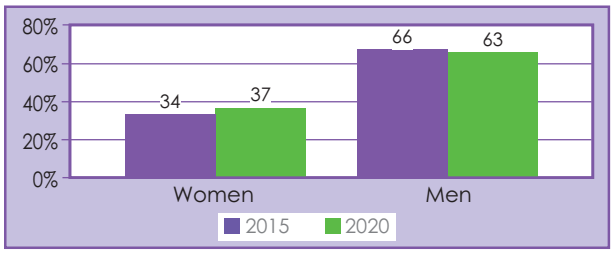
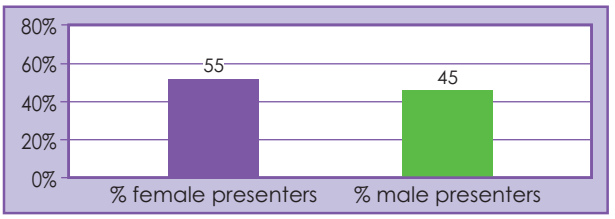


Figure 9.2: Who presents in the media in SADC

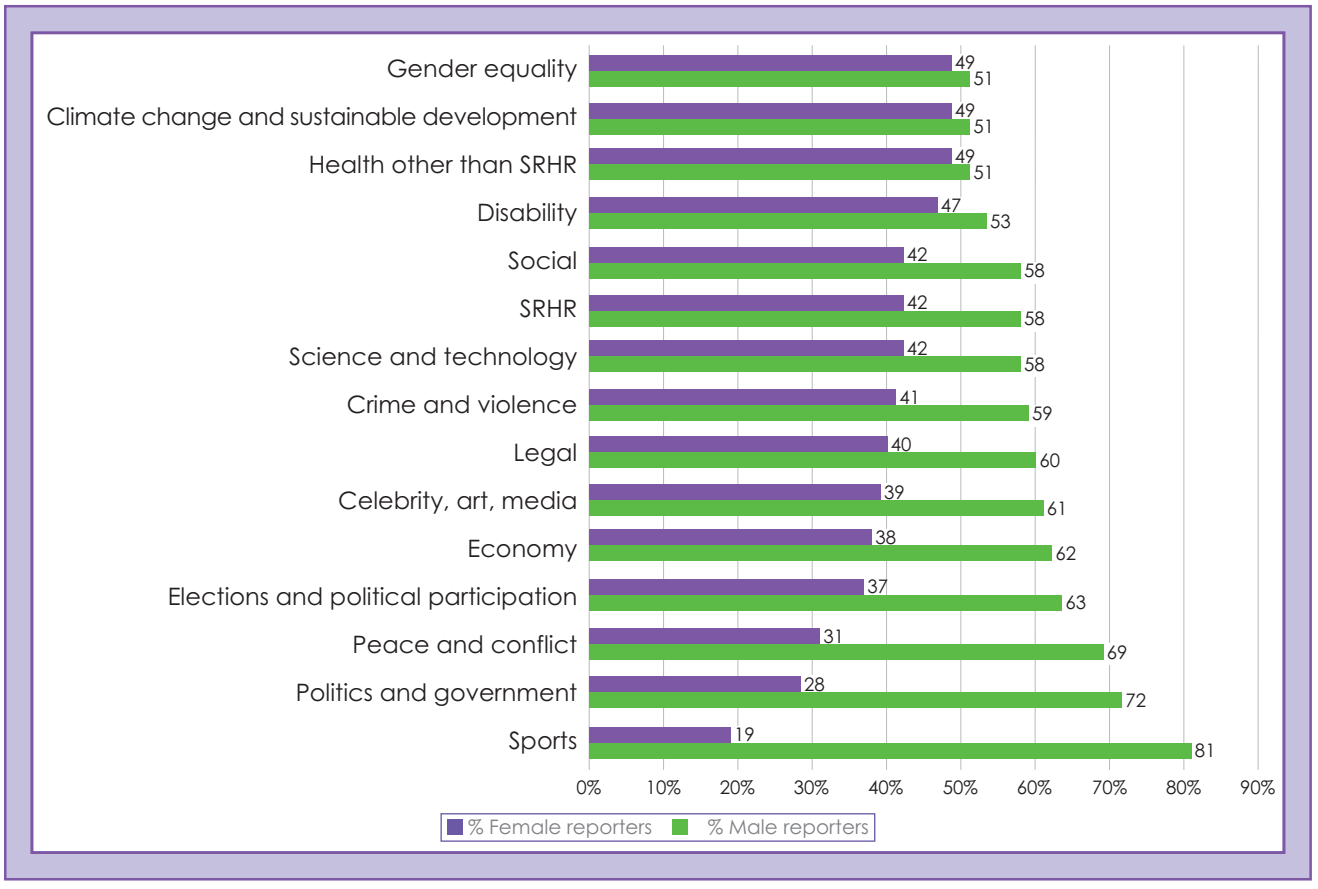


Source: Gender and Media Progress Study 2020.

Figure 9.1 illustrates that the GMPS found that newsrooms continue to employ more men as reporters. The number of women reporters in the region increased by just three percentage points between 2015 and 2020. At this rate of progress, SADC newsrooms will take more than two decades to reach parity.

Figure 9.2 illustrates that more women present the news media in the region, on screens and radio airwaves, making up 55% of news hosts compared to men at 45%. This is one area where women have dominated over the years. Although beat journalism has declined in recent years as newsrooms cut budgets and ask generalist reporters to do more with less time and focus, a tendency for journalists to gravitate to certain topics remains.

Figure 9.3: Who reports on what



Source: Gender and Media Progress Study 2020.

The 2020 GMPS also ascertained which topics women and men reporters[37] cover across the region. Figure 9.3 shows that women and men cover different topics. Across all thematic areas, women journalists remain underrepresented, with the biggest difference on issues such as sports, political, and economic reporting. However, women get closest to parity on topics that media decision-makers have often viewed as "women's issues," such as in gender equality, health and social issues - once again underlining the sexist attitudes that pervade SADC media houses.



In **Malawi**, sexual abuse and harassment in the newsroom is a growing concern, with some female reporters saying male colleagues forced them into relationships or threatened their jobs. MISA Malawi, together with the Association of Women in Media and Women Lawyers Association, teamed up to support and empower female journalists to tackle the issue. Their initiative involves commencing both criminal and civil proceedings against perpetrators as one way of improving the working environment for women.[38]



A female journalist interviewed by MISA for its Southern Africa press freedom report 2019-2020 stated that in **Lesotho**, "Women find themselves easily sexually harassed, including by sources, because their employers inadequately remunerate them." Women noted that sources often promise information on stories at "private meetings."[39] Because of pressure to deliver in the male-dominated industry, they end up in places where men can easily harass them. Majirata Latela, a female journalist working with The Reporter, stated that a source once asked her what she would "give in exchange for the information." Others argue that some female journalists succumb to sexual advances to "retain information channels," while some simply want to put food on their table, given the poor pay of media workers.[40]



Lucia Mabetha, the Gender Links Lesotho country manager speaks to members of the media in 2018 in Maseru. Photo: Ntolo Lekau

COVID-19 and journalism

Despite the many challenges presented by the COVID-19 pandemic, journalists continue to report from its frontlines. This means media workers in SADC face new and dangerous occupational risks while reporting on the crisis. At the same time, the economic impact of COVID-19 poses an existential threat to journalism, freedom of expression, and to the individual rights of journalists. It has already had a significant impact on media institutions and news reporting practices.



In Botswana, journalists worry that the pandemic has provided an opportunity for the government of Mokgweetsi Masisi to roll back press freedoms. Journalists now risk prison sentences of up to five years if they publish any information about COVID-19 that has not come from the director of public health services or the World Health Organisation (WHO), according to Reporters Without Borders.[41] In May 2021, the Committee to Protect Journalists reported that police had

[37] This included reporters from all media types monitored: print, online radio and TV reporters in the field.
[38] Media Institute of Southern Africa, (2021). Southern Africa press freedom report 2019-2020. Media Institute of Southern Africa. Harare. Available at https://data.misa.org/api/files/1619950689792O1gkm18usemy.pdf, accessed 18 June 2021
[39] Ibid
[40] Ibid
[41] Reporters Without Borders, (2020). The 2020 pandemic has challenged press freedom in Africa. Available at https://rsf.org/en/botswana, accessed 7 July 2021.

arrested Oratile Dikologang, co-founder of *Botswana People's Daily News*, and charged him over social media posts about COVID-19, according to local media reports.[42] Losses in advertising revenue resulting from the pandemic have also fuelled self-censorship by media as they struggle to retain advertisers.

Research in Southern Africa illustrates the different impact of COVID-19 on women and men within the journalism fraternity. Indeed, COVID-19 has exacerbated existing disparities. Decision-making about how to operate or allocate resources during the pandemic often excluded input from women, since men continue to occupy most leadership roles in institutional structures.[43] Furthermore, many women lost their jobs during the pandemic because of the less prominent roles they occupy. Women journalists also reported vulnerability to retrenchments and salary cuts as well as other measures to cut costs.[44]



Zimbabwe: "Failing is not an option" - COVID-19's impact on women journalists[45]

Due to COVID-19, challenges have arisen with safety concerns, coping mechanisms of journalists in general, and female journalists in particular topping the list. Unlike their male counterparts, female journalists carry a double burden. As COVID-19 snakes its way around the world, it has started exacerbating gender inequalities, hence the need to listen to experiences of female journalists.

"My first thoughts were that we are going to drop like flies considering our collapsed health system. I thought that if the US and Britain were struggling to contain the disease, what about poor Zimbabwe," said Faith Zaba, the editor of the weekly Zimbabwe Independent. "I was even more worried after broadcaster Zororo Makamba died; it was the conditions under which he died that put me in panic mode. All of a sudden you start thinking about what would happen to your kids if you die from COVID-19."

In Zimbabwe COVID-19 announced its arrival with the death of Makamba, a celebrated broadcaster, perhaps a strong message that journalists, too, are at high risk. Covering pandemics and other health crises are one of many ways that journalists put their own safety on the line. Just like soldiers in war, journalists also risk their lives to gather information to empower people and ensure communities are safe.



"You start thinking about what would happen to your kids if you die from COVID-19," said Faith Zaba, editor of the *Zimbabwe Independent*, in June 2020 while speaking about the worries journalists have faced while reporting on the COVID-19 pandemic.

Photo courtesy of Zimbabwe Situation

The COVID-19 situation is even worse for female journalists, who already faced numerous gender barriers in their line of duty before the pandemic. "I no longer have time to rest due to the pressure at work. The worst part is I do health reporting so all pressure is mounted on me and sometimes I have been forced to do stories that directly expose me to COVID-19," said Amanda Moyo-Ndlovu.

COVID-19 response strategies, including lockdown and physical distancing, while proving effective in the fight against the pandemic, have complicated the work of

[42] Committee to Protect Journalists, (2021). News editor in Botswana faces jail time over Facebook posts, alleges suffocation by police. Available at https://cpj.org/2021/05/news-editor-botswana-jail-facebook/, accessed 4 July 2021
[43] Media Institute of Southern Africa, (2021). Southern Africa press freedom report 2019-2020. Media Institute of Southern Africa. Harare. Available at https://data.misa.org/api/files/1619950689792O1gkm18usemy.pdf, accessed 18 June 2021
[44] Ibid
[45] Mpofu, T. COVID-19 experiences of female journalists, Gender Links News Service, 22 June 2020. Available at https://genderlinks.org.za/news/journalism-covid-19-experiences-of-female-journalists/, accessed 2 July 2021.

journalists in general and female journalists in particular.

"I have found myself working longer hours and more than I do when I am working from the office. When you work from the office at the end of the day, you leave your work at the office and go home. There is a balance between work and home life. But now there is no such separation," said Zaba.

Zaba, one of the few female editors in the country, said that convincing news sources, most of whom prefer anonymity, to agree to an interview over the phone, something that they are not comfortable with, is not a mean task.

"Just imagine trying to do an investigative piece over the phone and at a distance. It is not easy but we cannot afford to compromise our brand, we have to maintain the high quality," she added. "This means more work and pressure from editors who want their stories done and multi-sourced either way and that is so stressful. I have to work extra hard, longer hours and of course find time to breastfeed my baby although I sometimes knock off very late and start work early."

According to Zaba, who has been working from home, covering COVID-19 is even worse for female editors. "It is more difficult for the female journalists and worse still for a female editor. My day starts with sweeping the house. I then sit on the computer and start editing. In between, I have WhatsApp and Zoom meetings. I also have to deal with resource issues for the reporters and the rest of the team.

"I sometimes forget to eat breakfast. I have been having more of brunch (breakfast and lunch combined). In between, I have to cook for the kids and wash dishes. I have been struggling to separate work and home life. The kids have been suffering as I am unable to spend enough time with them," she said adding that there are days when her children have come to her bedroom at midnight and ordered her to switch off the computer and go to bed.

"There are days I have had to work until 2am. Sometimes I envy my male colleagues because unlike us, they can be totally focused on their work without other distractions. Sometimes I feel like I am working on batteries. "I push myself because I can't afford to fail. If I fail, I would have let down my female colleagues and closed the door on them. Failing is not an option for me."

In the middle of editing stories and managing the newsroom from a distance, Zaba like most female journalists, has to think about feeding the family.

"With everyone at home, it's more expensive to feed the family. On the technological side, data is now very expensive and so are voice calls," she said, adding that her social life is almost zero. With schools closed, Zaba, like many other mothers, has to ensure that children have access to the internet to participate in e-learning.



"Female journalists rose up to the occasion," said Ruth Butaumocho, managing editor of *The Herald*, speaking about the important role women played in reporting the pandemic throughout 2020.
Photo courtesy of The Herald

Despite all these challenges, *The Herald*'s managing editor, Ruth Butaumocho, said female journalists have measured up to the task right from the start of COVID-19 coverage. "They were there in time; they would even stay longer hours and even go home as early as 1am. Remember this was the time when press conferences would just mushroom from everywhere. I am happy to say that, of course there could have been other peripheral challenges, but female journalists rose up to the occasion."

"One major lesson is that I don't have to burn fuel every day to drive to the office; I can just be as effective working from home. You don't need physical meetings because virtual ones

are just as effective. We all have been stampeded into embracing the fourth revolution, which is a good thing," said Zaba as if to describe the new normal for journalists.

According to Butaumocho, COVID-19 has taught journalists to appreciate the importance of research, multi-sourcing and robust use of technology. "We now appreciate the importance of learning to use the ordinary technology. I remember in our newsroom at some point we had to urgently convene on Zoom and guess what, a lot of people didn't even know what Zoom is all about. But since that time people have learnt to experiment with a lot of technological initiatives."

Before COVID-19, several media monitoring studies, including the *Gender and Media Progress Study*, revealed that many media leaders treat health reporting as a less important news beat, often assigning it to female journalists. But coronavirus has turned health into the story of the century.

"COVID-19 has taught me that health is not a health matter, it is economic, political, social, scientific and biological. It has a bearing on countries, governments, people and social life notwithstanding the economic cost it comes with it," said Lulu Brenda Harris, a reporter with the Centre for Innovation and Technology (CITE) an online news platform.

Source: Thabani Mpofu, GL News Service

Vaccine justice for journalists

Some of the best journalism occurs at close proximity to the news as it unfolds. However, this type of work proved more difficult in the context of COVID-19, a highly infectious and deadly virus. Despite this, journalists across SADC put their lives, and the lives of their family members, at risk over the past year to report on the crisis and provide essential public health news to citizens across the region. Since the start of the pandemic, dozens of journalists across the SADC region - and around the world - have died after contracting COVID-19 in the line of duty.[46]

Thus, as vaccines begin rolling out across the region, media advocacy and support agencies have pushed SADC governments to consider journalists among the vaccine priority groups so they can remain safe while carrying out their important work. In June 2021, South Africa, the country hardest hit by COVID-19 in the Southern Africa region, announced that it would prioritise journalists in its vaccine roll out. This is in line with the country's aim to protect those working on the frontlines of the COVID-19 pandemic.



Prominent South African journalist Karima Brown is one of many Southern African journalists who lost their lives to COVID-19 in March 2021. Photo: Twitter

[46] Allsop, J. COVID is still killing journalists around the world. Columbia Journalism Review, 23 June 2021, Available at https://www.cjr.org/the_media_today/covid_journalists_south_africa.php, accessed 4 July 2021.

SANEF welcomes decision to prioritise journalists in vaccine roll out[47]

29 June 2021 - The South African National Editors' Forum (SANEF) welcomed the government's decision to follow through on its promise to prioritise journalists in the country's vaccine rollout programme. Journalists, as designated frontline workers, have risked their lives every day for the past 16 months, working throughout the pandemic as part of their responsibility to the public.

Even during the different peaks of the pandemic, they have not had the option to suspend work or work from home because of the nature of their work and the critical service they provide. They have traversed the country, going to hospitals, clinics, vaccination sites, mass rallies, press conferences etc. to reflect on the pandemic, in service to the country to ensure that the public is adequately informed.

In June 2021, the government of South Africa informed SANEF that journalists would be next in line as soon as all media houses submit their information regarding their employees' age groups and regions where they are stationed. All community media establishments around the country including freelance journalists will also receive forms that they must complete and submit to Government Communications and Information System (GCIS).

SANEF particularly appreciates the government's decision to not only inoculate frontline journalists but to accommodate all categories of media workers as the government wants to target and deal with the media as a sector than a selected group.

Details about the programme and what needs to be done to get the whole sector vaccinated will be forthcoming. We call on all journalists and the media fraternity to vaccinate so that the government can quickly move onto the next priority sectors.

SANEF made an impassioned plea to the National Coronavirus Command Council (NCCC) for journalists to be on the list of essential workers and be prioritised in the second phase of the rollout. We also lobbied President Cyril Ramaphosa, pleading the case for journalists to be considered for vaccination. SANEF was extremely concerned that without a plan to vaccinate journalists, they will continue to be infected by the disease. SANEF argued that, like other front-line workers, journalists posed a serious threat to their families and that this had an equally daunting impact on the state of their mental health.

SANEF observed that small newsrooms battle with the job's demands as their colleagues get infected in the line of duty and are forced to isolate. Despite the risk, they remained committed to the cause, going beyond the call of duty as the nation struggles through these unprecedented times.

Source: SANEF statement, 29 June 2021

[47] SANEF. SANEF welcomes the government's decision to prioritise journalists in the vaccine rollout plan, 29 June 2021. Available at https://sanef.org.za/sanef-welcomes-the-governments-decision-to-prioritise-journalists-in-the-vaccine-rollout-plan/, accessed 3 July 2021.

Women in media content

SADC Protocol Article 30.2: State parties shall encourage the media to give equal voice to women and men in all areas of coverage, including increasing the number of programmes for, by and about women on gender-specific topics that challenge gender stereotypes.

UN Women Executive Director Phumzile Mlambo-Ngcuka has said the ways media depicts women has "a profound effect on societal attitudes and reinforce traditional gender roles. Women and girls are half of humanity. Giving equal time and weight to their stories, featuring them as positive models not victims, plays an under-appreciated part in creating a better, freer world for all of us."[48]

Unfortunately, news stories continue to portray women in a limited number of roles. Sexualised images of women remain rife, and media tends to define women in terms of their physical appearance, not abilities. When it is not portraying women as sex objects, the media most often shows women as victims of violence or homemakers.[49] Although stereotypes of women as caregivers (such as the selfless mother so popular in advertisements) have positive connotations, they nevertheless represent stereotypes, which usually do not reflect women's complex experiences and aspirations.


Maria Moureno, a councillor from Mozambique, being interviewed by a Televisão de Moçambique journalist in Maputo. Photo: Raul Manhisse

In addition to appearing in a limited number of roles, women are often simply missing from the media. Media remains much less likely to feature women in news stories and less likely to interview women for their opinions.[50] Certain news categories further silence women, especially rural women, elderly women, young women and women from certain religious and ethnic groups. This strips these women of their voice, agency and ability to participate in the development of their communities.

When the media does cover issues of concern to women, such as violence, SRHR, and women in decision-making, it often confines this coverage to special pages and segments, tagged as "women's issues," rather than leading news.

As the GMMP noted, "Mainstream media coverage continues to rely on men as experts in the fields of business, politics and economics. Women in the news are more likely to be featured in stories about accidents, natural disasters, or domestic violence than in stories about their professional abilities or expertise."[51] Although women desire to contribute to the national discourse and to their local public sphere, media often does not recognise or amplify their voices.

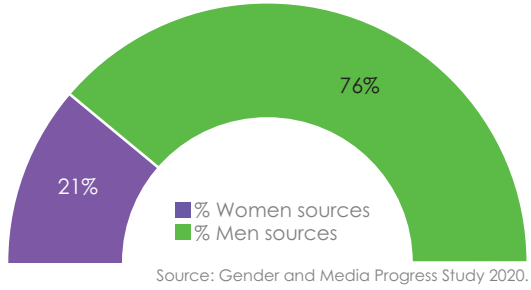
The Sustainable Development Goals (SDGs) advocate the imperative of "leaving no one

[48] World Association of Christian Communication, (2015).Who makes the news? The Global Media Monitoring Project report. World Association of Christian Communication. Toronto.
[49] Spears, G. Seydegart, K. and Gallagher, M. 2000. Who Makes the News? Global Media Monitoring Project 2000. World Association of Christian Communication. London. Available at http://www.erinresearch.com/documents/gmmp2000.pdf, accessed 16 July 2021.
[50] Ibid
[51] Ibid

behind," yet that is exactly what is happening when media silences women's voices, experiences and concerns. The under-representation and misrepresentation of women can also significantly skew the way women and girls view themselves.

The *Gender and Media Progress Study* gauges the extent of progress in achieving gender equality in and through media content. Since 2003, it has represented the largest and longest running longitudinal study and most extensive research on gender equality in the news media in Southern Africa. The GMPS 2020, conducted in 14 SADC countries,[52] is a follow up to the GMPS 2015 study. This data and information provides the region with insights into how the news media performs, including on progress made and the gaps that still need filling. The GMPS covers gender representation within news media content. Coinciding with the sixth GMMP study in 2020, the GMPS also enables Southern African countries to benchmark themselves against global findings as the two studies measure similar parameters. The GMPS borrows greatly from the GMMP but extends its period of monitoring to one month to ensure collection of a wider mix of stories. The section that follows presents some of the key issues for this research, particularly on SRHR.

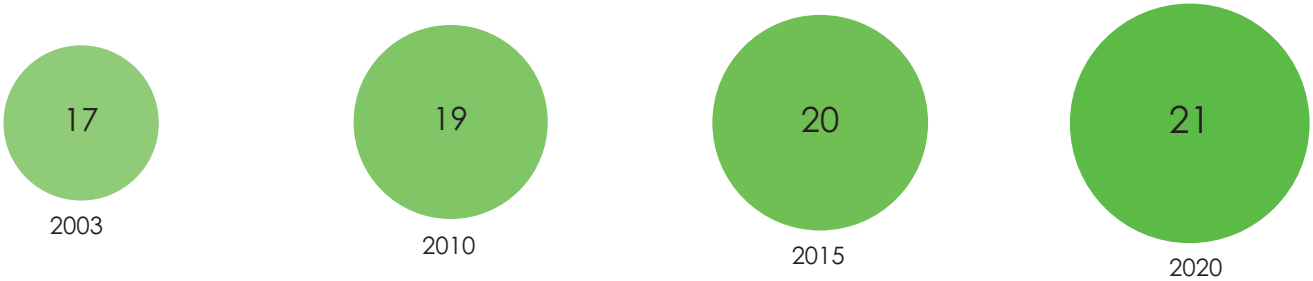
Figure 9.4: Women and men news sources in SADC media



Source: Gender and Media Progress Study 2020.

Figure 9.4 shows the continued and substantial bias towards men's perspectives in news coverage in the Southern African region. The GMPS 2020 reveals that across the region women make up 21% of the voices heard, read about, or seen in online, print, television and radio news[53] across the 14[54] SADC countries where researchers monitored news media.

Figure 9.5: Proportion of women sources over time

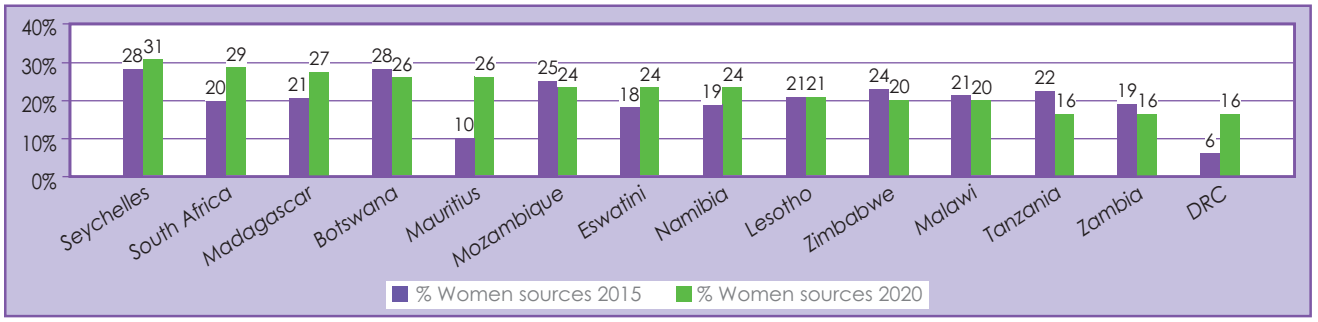


Source: Gender and Media Progress Study 2020.

Figure 9.5 illustrates the minimal increase in the proportion of women sources over the years of study, from 17% in the 2003 GMBS to 21% in the GMPS 2020. This shows that, over a period of close to 20 years, news coverage has improved by merely four percentage points when it comes to accessing women as sources. Men still overwhelmingly relay information to media consumers in the region.

[52] Angola did not collect a big enough sample for analysis and inclusion in the study.
[53] Some sources in the monitoring were neither identified as women nor men.
[54] Although Angola monitored in the GMPS 2020 the number was not an adequate number for analysis. The figures are not included here.

Figure 9.6: Women and men news sources by country

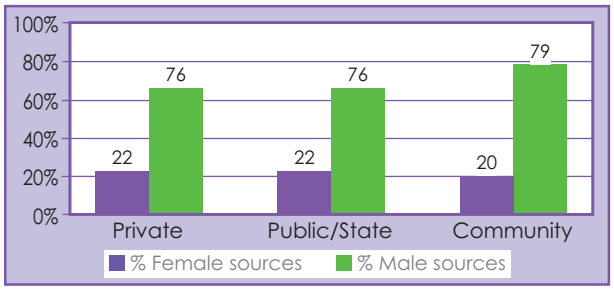


Source: Gender and Media Progress Study 2020.

Figure 9.6 shows individual performance across the 14 countries in which researchers monitored news media, comparing 2015 and 2020. Women's voices remain significantly less frequent in news media across all countries, ranging from a high of 31% in Seychelles to a low of just 16% in DRC, Tanzania and Zambia. Only Seychelles surpassed the 30% mark for women sources: a target that gender and media activists hoped to achieve by now when they launched the SADC Protocol on Gender and Development in 2008. Seychelles has consistently had the highest proportion of women news sources in the media over the longitudinal monitoring of the GMPS.

The data also shows a worrying decline in six SADC countries: Botswana, Malawi, Mozambique, Tanzania, Zambia, and Zimbabwe. Meanwhile, Lesotho has remained constant while other states have seen increases, with the biggest gain in Mauritius, from 10% in 2015 to 26% in 2020.

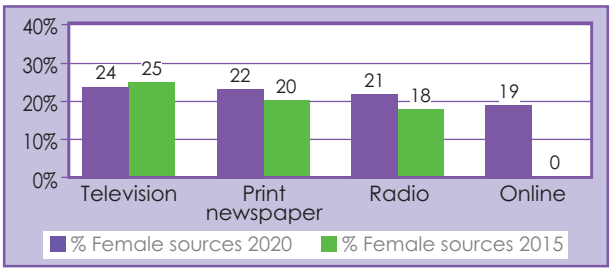
Figure 9.7: Women and men sources by ownership across SADC



Source: Gender and Media Progress Study 2020.

Public and private media lead the way by a small margin on women's representation, as illustrated in Figure 9.7, which disaggregates women sources according to types of media ownership. It shows that the GMPS 2020 study found that journalists working for public and private media access more women voices (22%), compared to 20% in community media. As the form of media closest to the people, community media should excel on this indicator, providing access to all segments, including the voices of community women. So far, it has yet to do so. These figures remain significantly lower than the target of 30% women sources. Public media has thus failed at its mandate to represent all constituent voices.

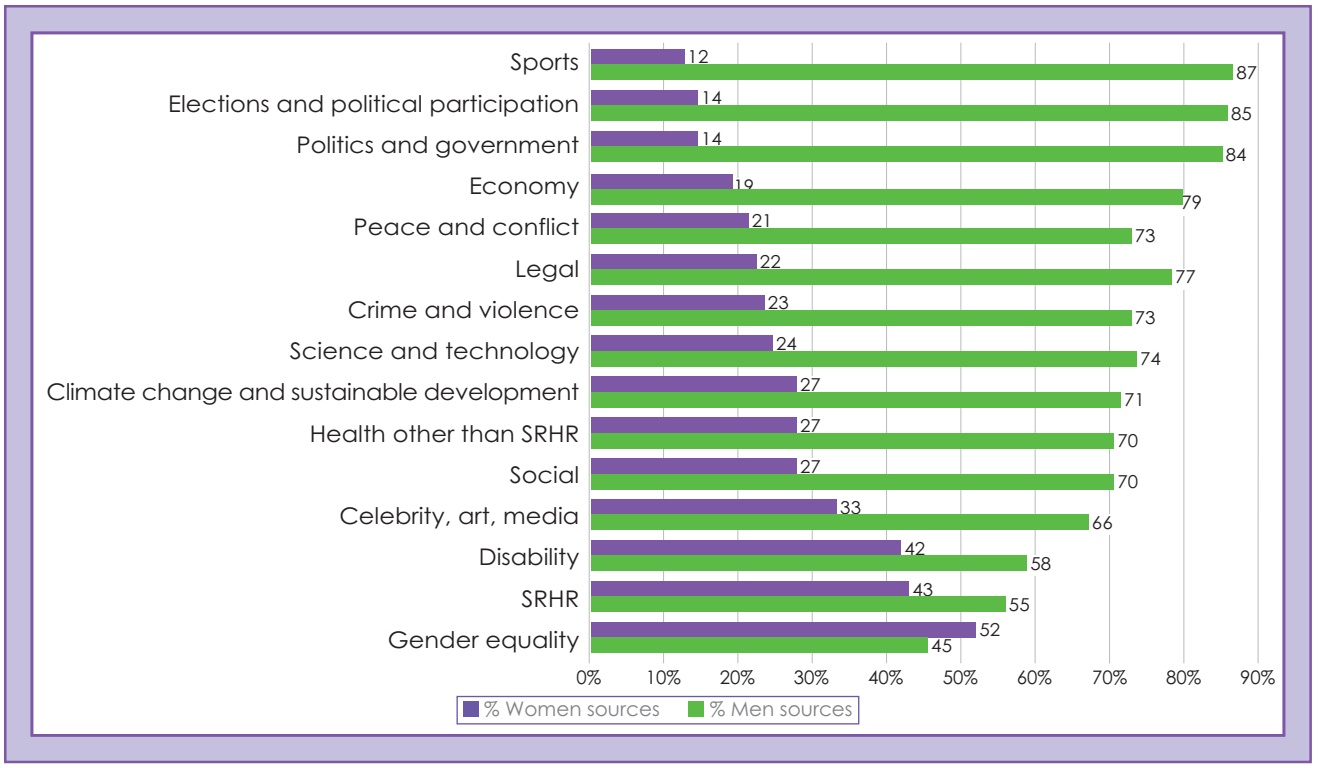
Figure 9.8: Women and men sources by medium over time in SADC



Source: Gender and Media Progress Study 2020.

The most recent GMPS found no material difference in the way that different news mediums access women sources compared to 2015. Figure 9.8 shows that television continues to be the medium where women's voices appear the most, however it receded by one percentage point from 25% to 24%. Print and radio experienced slight gains, with print media now at 22% and radio at 21%. For the first time, the GMPS monitored online news platforms that do not have an offline presence. The underrepresentation of women's voices in other mediums continues across online news platforms: women sources in online media comprise only 19% of those accessed - the lowest amongst the four groups.

Figure 9.9: Who speaks on different topics

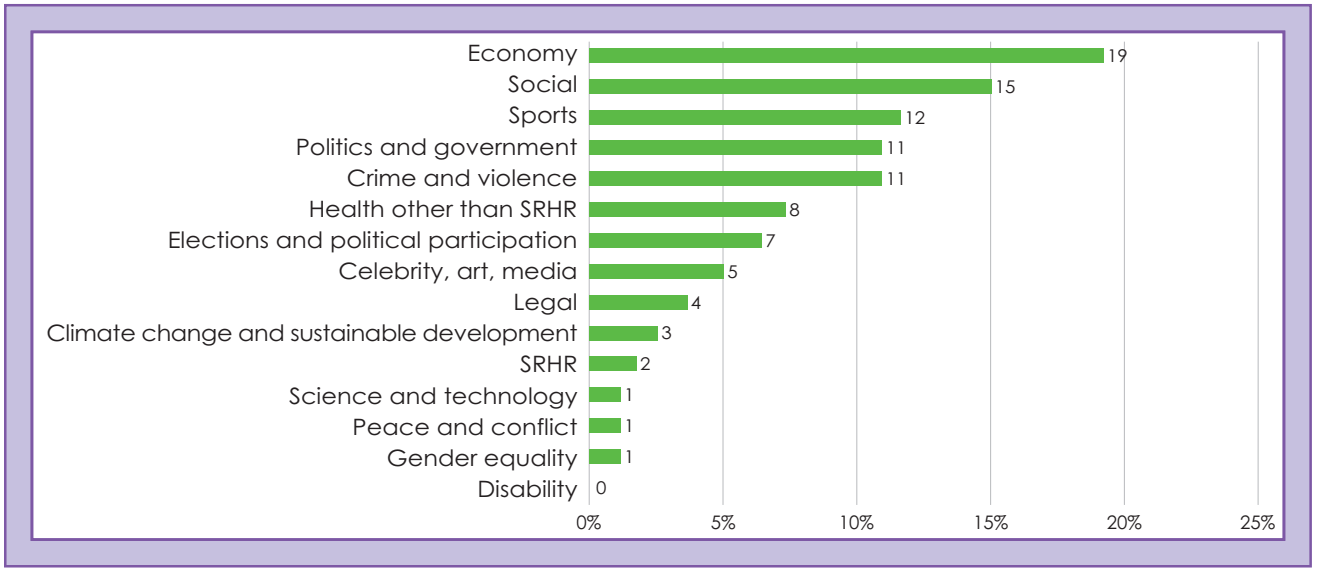


Source: Gender and Media Progress Study 2020.

Figure 9.9 shows that women speak most on stories about gender issues and least in stories about sports. Gender equality (53%) represents the only topic category in which women's voices dominate. Journalists access women's views and their voices seldom in news about politics and government (14%) and the economy (19%).

Journalists spoke to women more in stories about SRHR at 43% and disability at 42%. Given the significance of these issues for women, however, it is worrisome that SADC's media has yet to reach gender parity in its sourcing of voices for stories on these topics.

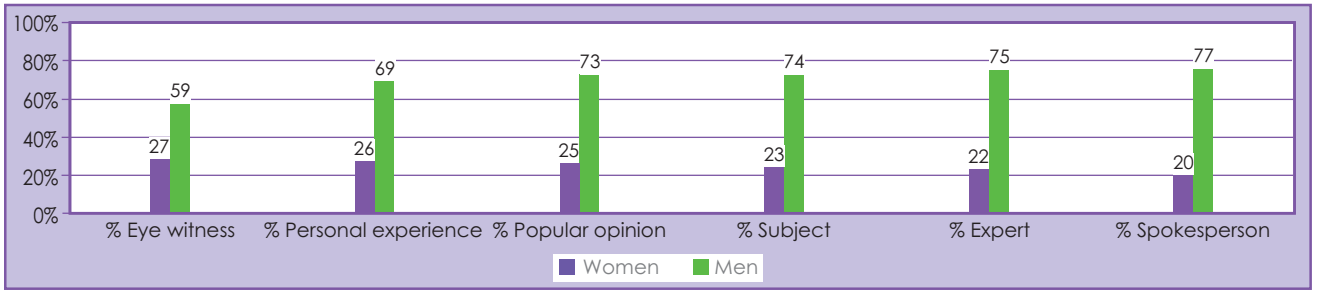
Figure 9.10: Topics covered by the media in SADC



Source: Gender and Media Progress Study 2020.

Figure 9.10 shows GMPS research on the most common story topics, with economy (19%), social (15%), sports (12%), and politics and government news (11%) continuing to dominate coverage in Southern Africa, as they did in 2015. SRHR, a new topic area of study introduced in the GMPS 2020 ranks amongst the least covered at 2%. This broad category included news about menstrual health, maternal health, safe abortion, GBV, HIV and AIDS, sexual diversity, harmful practices, and sex education. Within the SRHR topic category, stories about GBV accounted for half of all coverage, while news outlets cover stories about sexual diversity, harmful practices and menstrual health least at 2% each.

Figure 9.11: Function of news sources in SADC



Source: Gender and Media Progress Study 2020.

Figure 9.11 divides all sources into categories, with telling results that underscore the other GMPS findings about the roles for women that society most values. Men dominate in all areas, especially those associated with expertise and authority: spokespersons (77%) and experts (75%).

The numbers of women sources go up when women speak to journalists not as experts or subjects of stories, but instead to provide personal testimony or eyewitness accounts. This constitutes subtle stereotypes that relegate women to contributing most often on "soft issues."

Coverage of SRHR

Gender activists view the media as a critical tool for raising public awareness about SRHR issues and women's access to, and control of, SRHR services. Because of this, the role of journalists should go beyond informing and educating to analysing and providing critical reportage and investigations on SRHR issues. The COVID-19 pandemic illustrated the important need for media practitioners to embrace their roles linked to advocacy and watchdog journalism when reporting on critical health issues.

> Mass media can contribute to efforts to address SRHR challenges by focusing public attention on these issues

[55] Oronje et al. 2011. Engaging media in communicating research on sexual and reproductive health and rights in sub-Saharan Africa: experiences and lessons learned in Health Research Policy and Systems Volume 9, (Supplement1): S7. Available at https://www.researchgate.net/publication/51224982_Engaging_media_in_communicating_research_on_sexual_and_reproductive_health_and_rights_in_sub-Saharan_Africa_Experiences_and_lessons_learned, accessed 20 June 2021

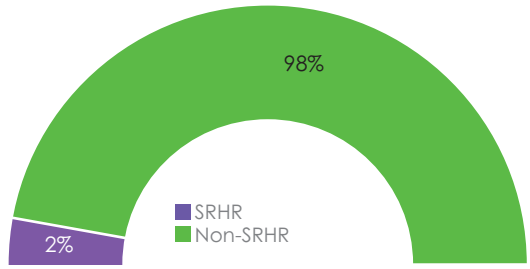
The mass media can contribute meaningfully to efforts to address SRHR challenges by focusing public attention on these issues, making them more visible in development discourse, and providing accurate and comprehensive information.[55]

According to the Panos Institute Southern Africa, a regional communication for development organisation, "Journalists must contextualise issues and strive for objectivity and balance. Because human rights are more than just legal issues, there must be a reflection on the impact of the promotion or the abuse of human rights on real people's lives."

It behoves good journalists and reporters, especially those reporting on politics, health and SHRH, to have a broad understanding of women's rights to health and of the multiple factors at play that may impede enjoyment of those rights. They can do this by employing a rights-based approach in reporting - a method that some media experts see as essential to all types and beats of journalism.

An article by Rosanne Anholt[56] notes that, if citizens read or hear about family planning methods that emphasise the dangers of the procedure or the possible negative consequences, they may hesitate to use them. On the other hand, if articles about family planning methods focus on women's rights to decide and have a voice and choice on whether and when to have children - more women may very well consider using a family planning method. Despite their power to promote good SRH outcomes, media often fail to prioritise these issues or accurately report them. Media coverage of reproductive health issues remains inadequate in sub-Saharan African media partly due to the weak capacity and motivation for reporting these issues by media practitioners.[57]

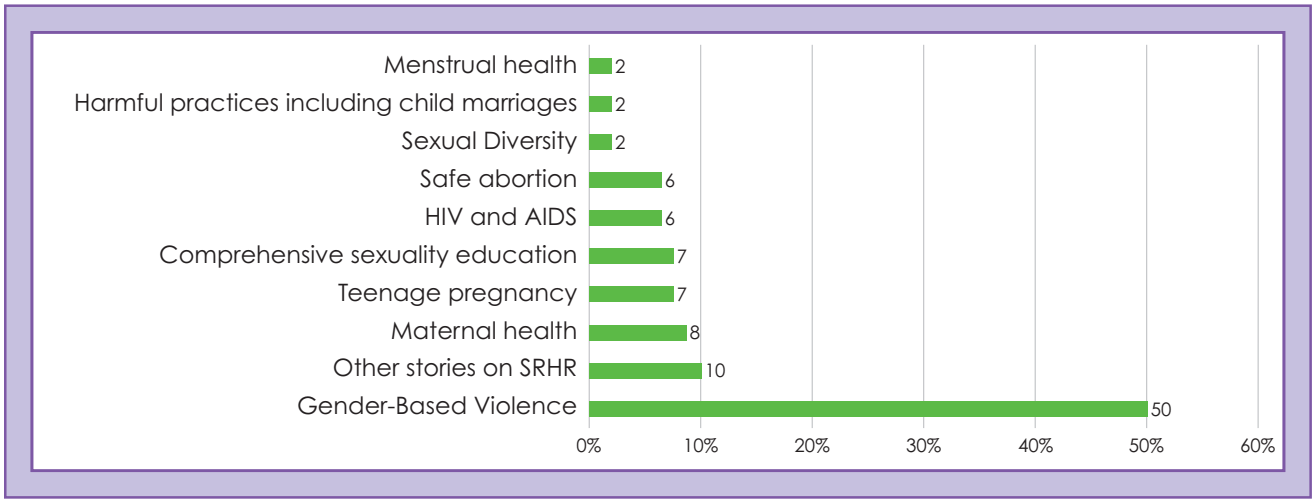
Figure 9.12: Coverage of SRHR in SADC



Source: Gender and Media Progress Study 2020.

As noted earlier, Figure 9.12 shows that SRHR remains far from a common theme in the media, constituting just 2% of all stories covered during the monitoring period: 325 news stories overall across various news media.

Figure 9.13: SRHR topic breakdown



Source: Gender and Media Progress Study 2020.

[56] Anholt, R. 2016 Writing women's reproductive health: A Uganda case study in the Health Journalists Network Union. The Health Digest. Sexual and Reproductive Health Rights for Youth and Adolescents. Issue 08 P32-35 Available at http://www.ideas42.org/wp-content/uploads/2015/09/SRHR-draftlay.pdf, accessed 20 June 2021.

[57] Oronje et al. 2011. Engaging media in communicating research on sexual and reproductive health and rights in sub-Saharan Africa: experiences and lessons learned in Health Research Policy and Systems Volume 9, (Supplement1): S7. Available at https://www.researchgate.net/publication/51224982_Engaging_media_in_communicating_research_on_sexual_and_reproductive_health_and_rights_in_sub-Saharan_Africa_Experiences_and_lessons_learned, accessed 20 June 2021.


GBV: police can't cope

INVESTIGATIONS: OUT OF 10 000 CASES, JUST 2 000 HAVE BEEN DEALT WITH

'Need for more teachers will be clear later'

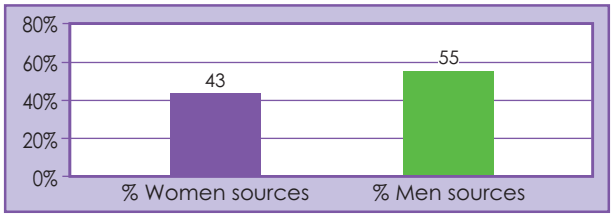
PAINT BY NUMBERS

A story from The Citizen in South Africa during the GMPS monitoring period in September 2020 with the headline, "GBV: Police can't cope." .

Figure 9.13 illustrates that some topics under the SRHR umbrella received much more media attention, especially GBV. Stories about GBV represent the most covered SRHR news topic by far, making up 50% of all the SRHR news stories covered in the media.

Least covered topics include menstrual health, harmful practices and sexual diversity. News owners and editors often share some of the blame for the lack of coverage of SRHR stories, according to some media experts. They believe the lack of stories on SRHR link to the fact that journalists lack the support, capacity and knowledge required to report informatively on these topics. Thus, leaders in the media industry should look into training opportunities for their teams.

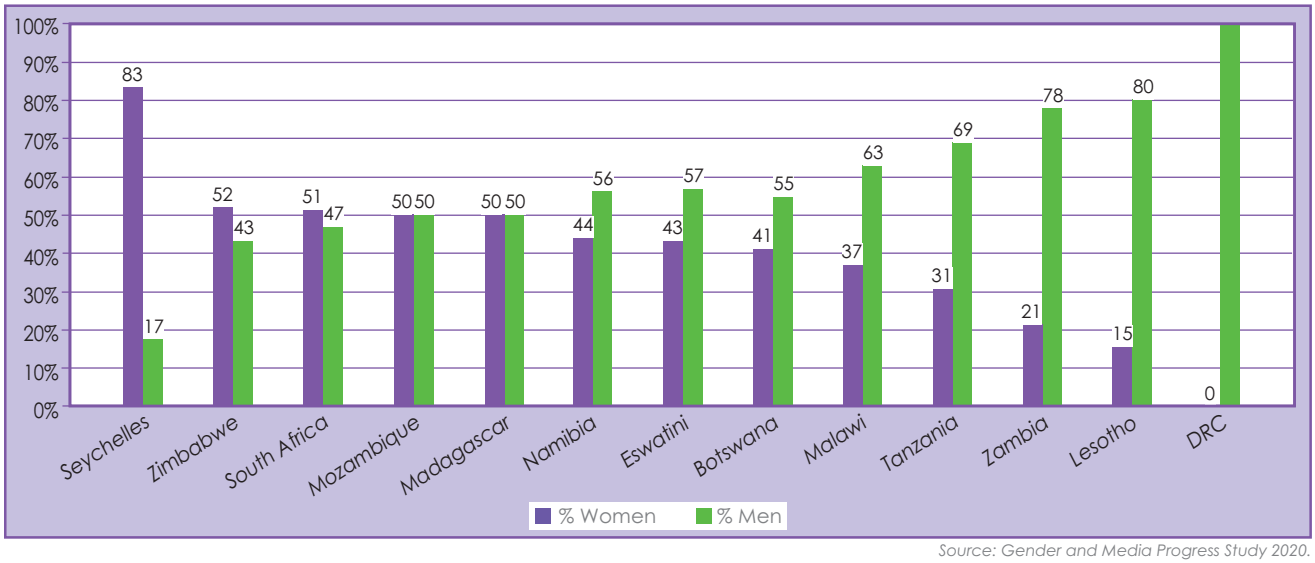
Figure 9.14: Who speaks on SRHR in SADC



Source: Gender and Media Progress Study 2020.

Even in coverage of SRHR issues, men's voices still eclipse women's voices. Figure 9.14 illustrates this, showing that journalists accessed women sources on SRHR in only 43% of stories. In this category, researchers classified some sources as "other," which means a source's sex was unclear. However, men's voices still outnumbered women's in SRHR stories at 55%. This imbalance may be due to frequent presentation of SRHR issues as they link to political controversies rather than within stories about healthcare, sexuality, or maternal and child health.

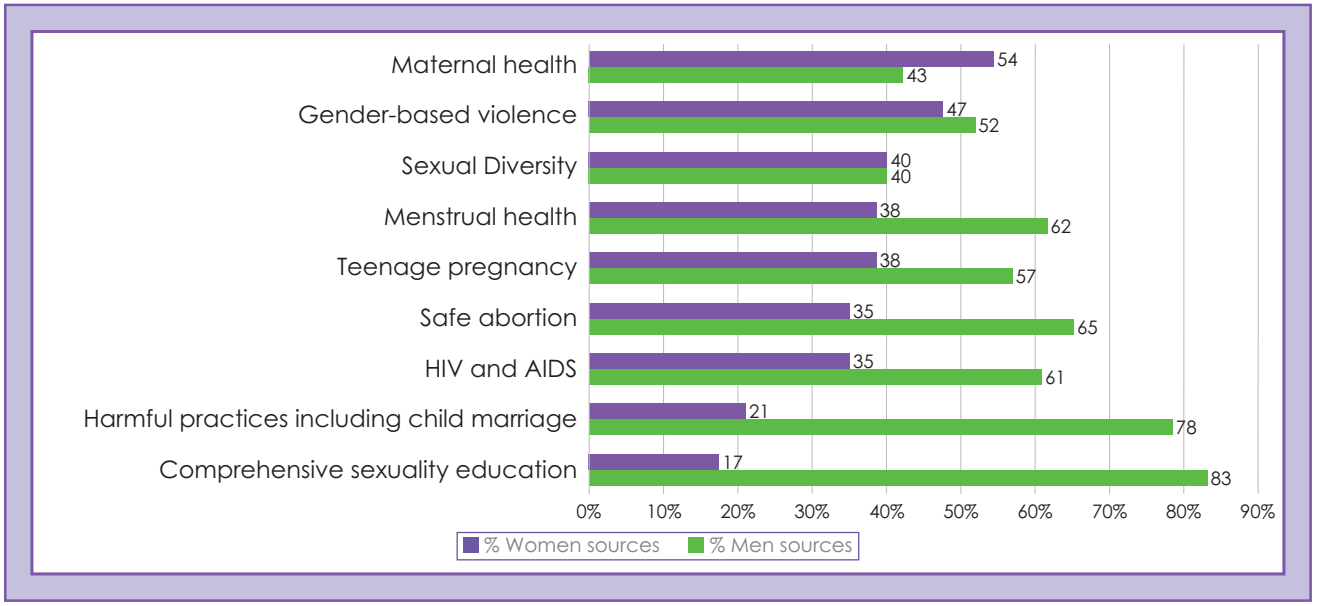
Figure 9.15: Who speaks on SRHR in SADC by country



Source: Gender and Media Progress Study 2020.

Figure 9.15 shows that, although the overall regional average of women sources in SRHR stories ranked 43%, researchers found vast differences between member states, ranging from no women sources in SRHR stories in DRC to 83% in Seychelles. The research found that women's views and voices on SRHR constituted 50% or more in six countries: Angola, Madagascar, Mozambique, Seychelles South Africa and Zimbabwe.

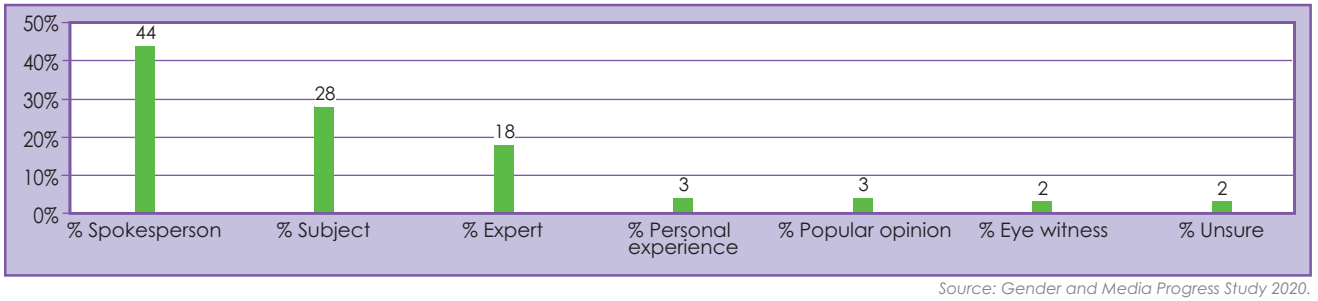
Figure 9.16: Who speaks on SRHR sub-topics



Source: Gender and Media Progress Study 2020.

Figure 9.16 illustrates that, when it comes to stories about SRHR topics, women's voices appear as systematically stifled as news sources. Out of the nine SRHR topic areas analysed, GMPS researchers found that women marginally speak more often as sources in only one topic category, maternal health.

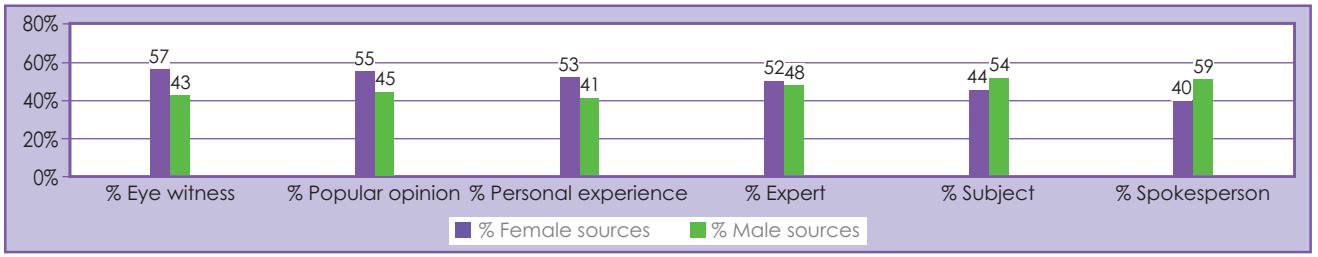
Figure 9.17: Function of SRHR sources in SADC



Source: Gender and Media Progress Study 2020.

Figure 9.17 illustrates that official views from spokespeople and experts, as opposed to personal experiences, dominate SRHR coverage in the region. Spokespeople constituted 44% of sources, while personal experiences ranked among the lowest of all source categories, at 3%. This shows that the media frequently misses opportunities to tell the real stories of girls, women and families affected by SRHR issues - those who researchers and gender activists know face considerable challenges in realising their sexual and reproductive health rights.

Figure 9.18: Function of SRHR sources by sex

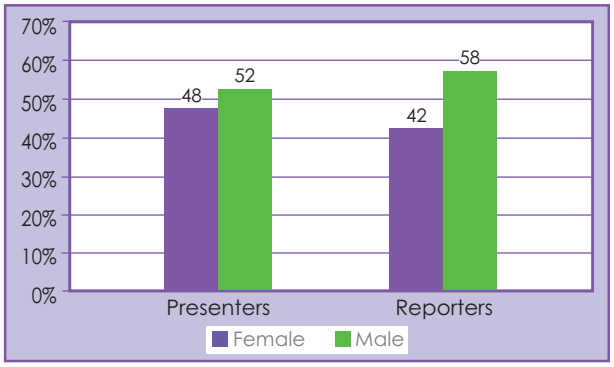


Source: Gender and Media Progress Study 2020.

A role analysis by sex of sources provides insight into whether media accesses women more as experts (a role that relies more on authoritative knowledge) or as sources to talk about their personal views and experiences. Figure 9.18 illustrates that women feature more often in SADC media both as eyewitnesses and to share popular opinions about SRHR issues. Women also feature more in SRHR news stories as experts, which may be due to the predominance of women's rights organisations and women's rights activists quoted in these stories.

Figure 9.19 highlights that men reporters and presenters[58] surpass women reporters and presenters in coverage of SRHR. Only 42% of women reporters identified in the monitoring period covered SRHR issues, while 48% of women presented on SRHR stories. The fact that men outnumber women in covering SRHR issues may be one reason why SADC media speak with more male sources on SRHR topics.

Figure 9.19: Women and men reporters and presenters on SRHR topics



Source: Gender and Media Progress Study 2020.



Media advocates put safe abortion on the political agenda in Malawi

During the GMPS monitoring period, coverage of Malawi's abortion bill represented one of the key areas of interest. Discussions related to the bill occurred against the backdrop of Malawi's contested election. During this time, Malawi's abortion bill became a contentious issue and one prominent media agency, Centre for Solutions Journalism (CSJ), declared the year 2020, "the year for the new abortion law."

Safe abortion has long been a topical issue in Malawi as policymakers, government, the church, and citizens have different views on the issue and the bill in question. CSJ believes that Malawi lawmakers should address the country's poor maternal and child health statistics and abide by international treaties to which the country is a signatory, and take action.

[58] This is as defined by bylines and on-screen appearances.


Weekend NATION

DEAD ON ARRIVAL

ABORTION BILL

- 80% of MPs to reject Bill
- 18% undecided
- 1.4% support it

Termination of PREGNANCY BILL

Fuel transporters confront govt

Thanks to coordinated media advocacy efforts, stories like this one in *Weekend Nation* on 26 September 2020 have ensured that Malawi's safe abortion bill receives adequate and informed debate, even during the COVID-19 crisis.

The approaches and methods adopted by CSJ in its advocacy include meetings, research, and dissemination of information on the subject of abortion. The College of Medicine under the University of Malawi has also provided research on maternal, sexual and reproductive health, most of which forms the basis for law reform on termination of pregnancy. With this statistical evidence, the public have been getting a truer picture of the gravity of the problem of unsafe abortion.

CSJ also runs a multimedia programme to mobilise support for the proposed bill among faith-based groups, policymakers and the public. The programmes include trainings, publishing newspaper columns along with opinion and analysis, and *Chichewa* language radio programmes on local radio stations called *Uchembere ndi Ufulu*, loosely translated as "motherhood and rights." CSJ also uses these platforms to engage experts and the public on the issue of safe abortion. So far, with the goal of providing information on the bill and neutralising anti-choice activities, CSJ has conducted trainings for MPs, religious leaders, NGOs and youth groups

It also aims to share stories and give voice to survivors and those affected by the consequences of unsafe abortion. CSJ documents these stories so that audiences have a picture of the magnitude of the problem in Malawi.

In 2020, CSJ premiered an SRHR documentary on three national television channels: Times, Zodiak Broadcasting Station (ZBS) and Mzati as well as social media platforms. Titled *Mdula Moyo wa Chinunu* (Silent Killer on the Prowl), the documentary details real stories from women in Lilongwe and Blantyre who died due to pregnancy-related causes. It captures untold stories of women who suffered violent crimes, including rape. These women told reporters of their fear to report these issues. The documentary also captures stories of women who died from other preventable maternal health conditions.

The documentary features prominent Malawians, including traditional chiefs. Through it, CSJ hopes to reach one million people, especially those in the rural areas. The programmes have allowed robust debate on the abortion law, even amidst political turbulence and the recent COVID-19 global pandemic.


Chisale Mhango is a gynaecologist with Malawi's College of Medicine who has come out in favour of safe abortions. Photo courtesy of Nyasa Times

CSJ has also been working with experts to provide evidence-based background and context for the termination of preg-nancy bill. This includes Chisale Mhango, a gynae-cologist with the College of Medicine who has a column in the *Daily Times* on safe abortion and the proposed law.

Part of the campaign has been to challenge the many myths about the bill and the potential political consequences. Drawing examples from other countries, Mhango observes that passing safe abortion bills has not necessarily led to MPs or other democratically elected legislators losing their seats.

Mhango has also written about the miscon-ceptions linked to religion, arguing that abortion is a health issue, not a religious one. He notes that experiences from other countries show that abortion rates actually decline once

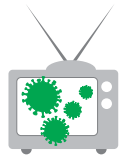
politicians reform abortion laws to better protect women and give them more choice. Another misconception he addresses connects to the concern among some that Malawi does not have the capacity to cope with delivery of safe abortion. On this issue, he observes that the law reform likely means that the number of abortions will remain the same; it will only shift them from unsafe abortions to safe abortions.

CSJ also supports articles published by opinion leaders, including people like Pastor Esitedi Chikopa, for example, who said the deaths of two members in his congregation due to unsafe abortion sparked his interest in the debate. He says the condemnation of women who procure abortion distresses him, observing that: "As master condemners, we have no compassion for many women who induce abortion in Malawi annually. We have no concern for women who die due to unsafe abortions because we are disciples of Biblical literalism instead of being experts in practical hermeneutics (the branch of knowledge that deals with interpretation, especially of the Bible or literary texts)."

The prominence given to the subject has allowed the mainstream media to adopt and champion the subject for further exploration. The signing of a communique to lawmakers by chiefs, religious and political leaders encouraging them to pass the safe abortion bill reflects an increased understanding of the bill and acceptance of its benefits.

Source: Maclan Kanyangwa submitted to Gender Links as part of the Political Discourse Analysis

COVID-19 in the news

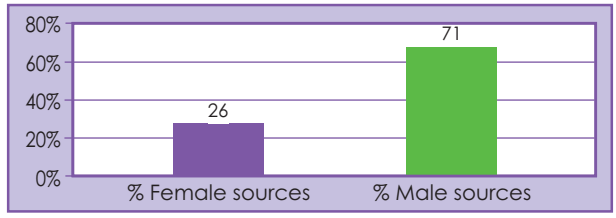


COVID-19 was clearly the biggest story of 2020 - both in SADC and around the world. Across the region, most journalists turned their attention to focus on coverage of the pandemic. This included government responses, information about lockdowns, infection numbers, deaths, and the effects on the virus on the region's economies, politics, sports, and so on.

COVID-19 was clearly the biggest story of 2020 - both in SADC and around the world

To add to this body of knowledge on gender and media during COVID-19, the GMPS also monitored how the media covered the pandemic and whose views and perspectives featured in the news. This section analyses news coverage of COVID-19 stories by assessing three indicators: sources, reporters, and topics.

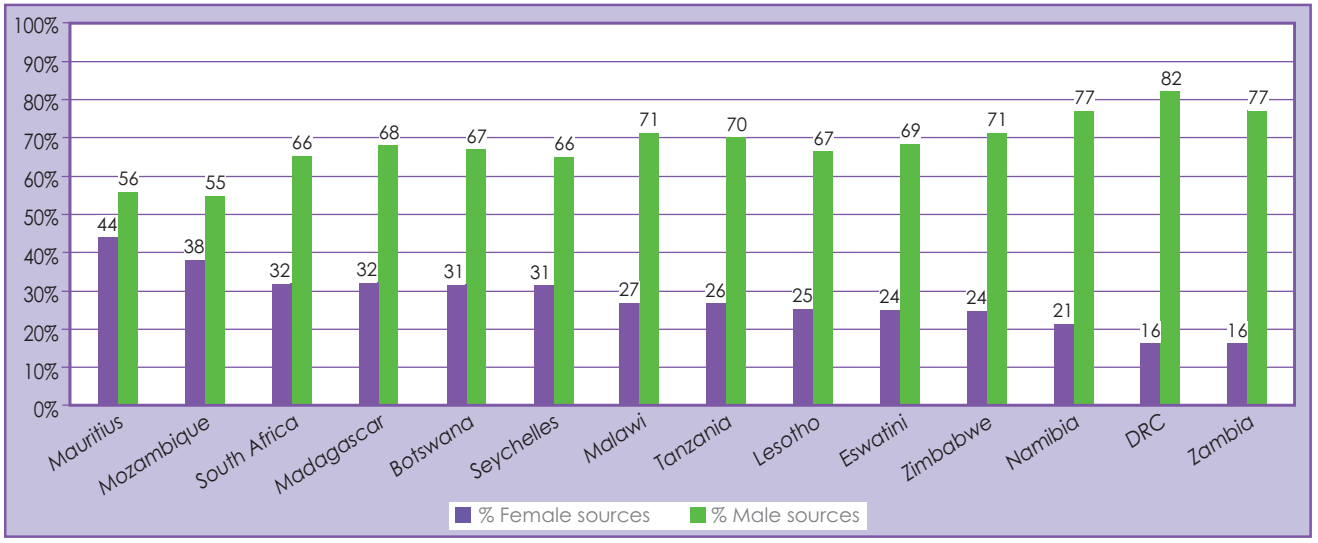
Figure 9.20: Women sources in stories about COVID-19



Source: Gender and Media Progress Study 2020.

Figure 9.20 shows that stories about COVID-19 mirrored other SRHR and health stories in the region by turning mostly to men as sources, with women comprising only one of every four people quoted. Unfortunately, in times of crisis, journalists may tend to revert to official or established sources, who will most often be men.

Figure 9.21: Women and men sources on COVID-19 in SADC



Source: Gender and Media Progress Study 2020.

Figure 9.21 shows the proportion of men and women sources in COVID-19 stories across all Southern African countries. The proportion of women sources across the region varies, ranging from a low of 16% in Zambia and DRC to 44% in Mauritius. As researches found elsewhere throughout the GMPS research, the proportion of women voices on COVID-19-related news came in lower than that of men across all countries.

Restrictions on the use of non-government sources in Botswana and Zambia meant few experts spoke about COVID-19 in the media

Function of sources

The absence of women's perspectives in COVID-19-related news coverage means that women have limited influence over the framing of the crisis and, consequently, limited influence over policy decisions related to it. As a result, women face a greater risk of marginalisation amid the most significant global health crisis of our lifetimes. Restrictions on the use of sources outside government, implemented in Botswana and Zambia, resulted in very few experts speaking about the virus. Governments have so far represented the main sources of information on COVID-19 even as they juggle multiple priorities, including the ongoing struggle to procure vaccines.

[59] Internews. 2020. "Things will never be the same again": COVID-19 effects on freedom of expression in Southern Africa, 2020. Johannesburg. Internews. Available at https://www.usaid.gov/sites/default/files/documents/internews_effects_of_covid19_on_freedom_of_expression_in_select_sadc_countries_2.pdf, accessed 3 July 2021.

Zambia: Telling the lived realities of COVID-19



Couple lives to tell COVID story

Lawrence, Nakasafya were showing symptoms of COVID-19

Lawrence and Nakasafya Thompson's story appeared in the *Zambia Daily Mail* on 7 September 2020. Photo: *Zambia Daily Mail*

This story by Zio Mwale for the *Zambia Daily Mail* of 7 September 2020 focused on the COVID-19 experiences of one family affected by the pandemic.

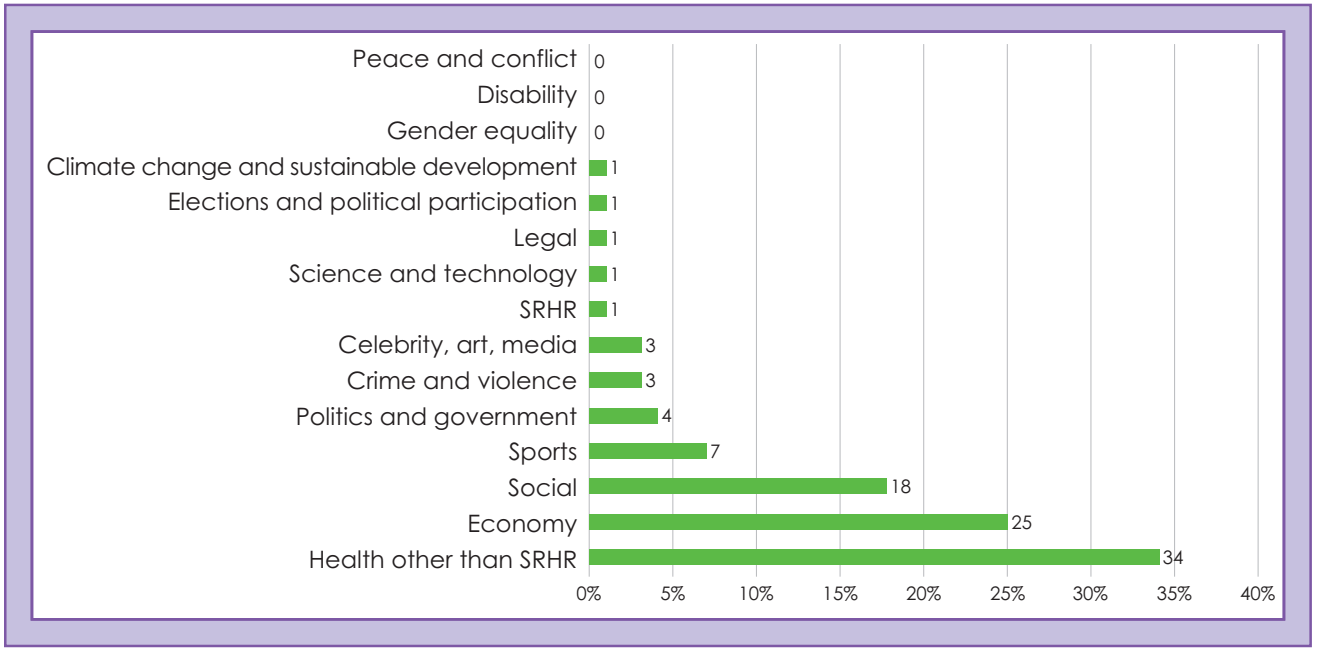
"Couple lives to tell COVID story," noted the headline for the article, which tells the story of a couple in Zambia who both contracted COVID-19. Mwale, a male journalist, speaks to both Lawrence and Nakasafya Thompson and shares their story, although he details more of Lawrence's story.

The journalist highlights the sources in similar ways and provides both with an opportunity to tell their stories in the hopes that it might help other Zambians during the pandemic.

Mwale mentions other family members but does not access their voices. Although the front-page story focuses on the subjects in the story - arguably those most affected by it - other diverse perspectives would have improved it. This could include neighbours, healthcare professionals or other family members affected by the COVID-19 pandemic.

Source: Perpetual Sichikwenkwe GMPS Qualitative case study

Figure 9.22: Topics related to COVID-19



Source: Gender and Media Progress Study 2020.

Figure 9.22 shows that journalists covered COVID-19 primarily within its context as a health news story. Many also closely linked the crisis to its impact on the region's economies (25%), social life (18%), sports (7%) and politics and governance (4%).However, journalists did not pay nearly enough attention to how the COVID-19 pandemic affected issues like SRHR (1%). For example, few stories addressed the challenges in access to SRHR services such as birth control and safe abortion during lockdown. Under the Southern Africa Gender Protocol Alliance #VoiceandChoice campaign, GL sought to influence reporting on COVID-19 by supporting journalists to produce in-depth stories on COVID-19 and SRHR throughout the year.

ICTs and women's empowerment



SADC Protocol Article 31: State parties shall put in place information and communication technology policies and laws in the social economic and political development arena for women's empowerment regardless of race, age, religion or class. These policies and laws shall include specific targets developed through an open and participatory process in order to ensure women's and girl's access to ICTs.

Goal 5 of the SDGs highlights the role of media and ICTs in women's advancement, encouraging member states to enhance the use of enabling technology, in particular ICTs, to promote women's empowerment.[60]

ICTs continue to grow as effective tools for women to amplify their voices and help them mobilise to advance their concerns. However, for more women to achieve this, they need meaningful access to ICTs. Access can be enabled or stunted by several factors, including affordability, relevant content, skills, and security. Research on the topic notes that ICTs: "allow isolated women to gain access to information that was not previously made available, thus helping them to become better informed members of society and consequently empowering them to speak up."[61]

Men control most ICTs used as development tools as they more often have the necessary resources, leaving women at a disadvantage in accessing productive and important information. Social and professional networks provide essential platforms for men and women to share ideas online. However, due to limited access to ICTs, particularly in rural areas where connectivity continues to be a challenge, it is difficult for women to access ICTs to improve livelihoods.



In **Namibia**, policymakers developed a bill on access to information and a draft information policy to ensure access to ICTs; however, neither address the different and unique needs of women and men. The Ministry of Gender Equality and Child Welfare (MGECW) provided inputs to the draft information policy to ensure that it incorporates specific provisions for access to ICTs by women.



The ICT policy of **Seychelles** is gender neutral and does not address gender in detail. However, men and women in the country both

[60] SDG (5.b)
[61] Hafkin and Taggart. 2001. Gender, Information Technology and Developing Countries: An Analytic Study. Washington D.C.: USAID, June 2001 http://pdf.usaid.gov/pdf_docs/Pnacm871.pdf

have good access to ICTs compared to many other countries in the region. Member states like Seychelles have struggled to implement ICT policies that address the gendered elements of access and other challenges unique to women. As more member states develop frameworks like the Seychelles ICT policy, they must critically address the digital gender divide and include strategies or programmes on mainstreaming gender in the ICT sector.[62]



The 2021 Cybercrimes Act in **South Africa** provides an opportunity to protect the dignity of women from practices such as gender trolling, threats and revenge pornography online. Under this new Act, South African lawmakers see three types of messages - which include data messages on social media platforms - as "harmful." Any person who violates the act faces a fine, imprisonment of up to 15 years, or both. Harmful data messages include:

- Data messages inciting violence or damage to property;
- Messages threatening people with violence or damage to their property; and
- Data messages containing intimate images sent without consent.[63]

Although the proliferation of ICTs provides many positive possibilities, it adds another dimension to gender inequality, according to research from the SADC region. "New media can also be a double-edged sword for women's rights. Much as women can claim this space to make their voice count, it is also a space that can be used to fuel violence, conflict and misogyny."[64] The struggles that women face in daily life often extend onto their private digital media platforms.

Online GBV

Apart from the above restrictions inherent in legal and policy frameworks that limit freedom of expression and opinion, the threat of online violence against women continues to grow in the region. Promoting gender equality - especially women's rights to equal and free participation - represents an integral component of freedom of expression and opinion. Thus, gender activists maintain that online GBV also entails a freedom of expression issue - and one that legislators and media leaders must urgently address.

In 2017, in a report on the safety of journalists and the issue of impunity, United Nations Secretary General António Guterres noted that women journalists disproportionally and increasingly face online threats of violence, including sexual violence, trolling, doxing and being "swatted." The latter is a harassment tactic involving deceiving an emergency service into sending a police or other emergency service response team to another person's address.

Guterres said, "Women who cover topics such as politics, law, economics, sport, women's rights, gender and feminism are particularly likely to become targets of online violence."[65]

The perpetuation of online GBV limits public participation that could support the actualisation of human rights such as freedom of expression. Some journalists have dubbed the online violence against women journalists the "new frontline in journalism safety" - a particularly dangerous trend for women journalists.[66] With all this violence at play, activists note that policymakers must remember that attacks

[62] SADC and SARDC. 2018. SADC Gender and Development Monitor 2018. SADC, SARDC. Gaborone, Harare.
[63] Kahla, C and Hlatshaneni, C. "Being an internet troll can land you in jail - what you need to know." The Citizen, 3 June 2021. Available at https://citizen.co.za/news/2512967/cyber-crimes-bill-parliament-act-2/, accessed 16 July 2021.
[64] Ibid.
[65] Guterres, A. 2017. Report by the secretary General: The safety of journalists and the issue of impunity seventy-second session Item 73 (b) of the provisional agenda. A/72/290 - E - A/72/290 -Desktop (undocs.org), accessed 2 July 2021.
[66] UNESCO.2020. Online violence Against Women Journalists: A Global Snapshot of Incidence and Impacts.

against female journalists pose a clear threat not only to their safety and well-being, but also to the diversity of the press and to freedom of expression.[67]

The 2018 *Glass Ceilings* study in South Africa also found that cyber misogyny represents a growing threat. South Africa has limited ways to protect women journalists targeted through cyber misogyny, an increasingly threatening form of silencing of women journalists. Gender activists have called for a multi stakeholder approach to tackle the issue. In the study, while only 6% of official respondents felt cyber misogyny is an issue in South Africa, 30% of women and 9% of men agreed that women journalists experience cyber violence. Cyber misogyny may just be emerging, but like the speed of the social media that spawned it, it risks spiralling out of control if not seriously addressed. The study also notes that cyber misogyny is both a cause and consequence of the sexist stereotypes that pervade media houses. The surest long-term solutions involve ridding not only our newsrooms, but our societies, of the misogyny that finds its way to, and mutates on, social media platforms. Any solution must involve both systemic and holistic solutions.

Women journalists disproportionally and increasingly face online threats of violence

Big tech commits to tackle online abuse of women[68]



In July 2021, four of the world's largest tech companies - Facebook, Google, TikTok and Twitter - announced a bold package of commitments to tackle online abuse and improve women's safety on their platforms at the UN Generation Equality Forum in Paris.

The four companies committed to:

Build better ways for women to curate their safety online by:

- Offering more granular settings (e.g. who can see, share, comment or reply to posts);
- Using more simple and accessible language throughout the user experience;
- Providing easy navigation and access to safety tools; and
- Reducing the burden on women by proactively reducing the amount of abuse they see.

Implement improvements to reporting systems by:

- Offering users the ability to track and manage their reports;
- Enabling greater capacity to address context and/or language;
- Providing more policy and product guidance when reporting abuse; and
- Establish additional ways for women to access help and support during the reporting process.

[67] UNESCO 2019 . UNESCO stands up against the online harassment of women journalists. Available at https://en.unesco.org/news/unesco-stands-against-online-harassment-women-journalists, accessed 16 July 2021.
[68] Web Foundation.2021. Facebook, Google, TikTok and Twitter make unprecedented commitments to tackle the abuse of women on their platformshttps://webfoundation.org/2021/07/generation-equality-commitments/, accessed 1 July 2021.

SADC Protocol Article 29: State parties shall ensure that gender is mainstreamed in all information, communication and media policies, programmes, laws and training in accordance with the Protocol on Culture, Information and Sport.

Media training aims to equip journalists and reporters with a thorough understanding of issues and newsgathering tools. It should assist them in developing and producing media content in a gender responsive manner. However, comprehensive and accurate media reporting on issues such as SRHR presents a challenge for many journalists as pernicious myths and misconceptions abound on SRHR topics.

Yet, media's role in advancing SRHR and particularly the bodily autonomy and integrity of African women and girls is fundamental to respecting and fulfilling women's human rights.[69]

Consistent and accurate media training on the topic thus continues to be of paramount importance.

Gender Links and other likeminded organisations in the SADC region have conducted training across Southern Africa on strengthening SRHR reporting and helping the media to understand the subject. Training also provides journalists with much-needed direction on informative, entertaining and educational storytelling that leverages and highlights existing SRHR laws and policies.

SADC: GL strengthens reporting on key SRHR issues



Selima Henoka, a journalist from the Namibia Broadcasting Corporation (centre), speaks with Gladness Munuo of the Gender and Media in Southern Africa-Tanzania Network (left) and Malawian journalist Penelope Paliani-Kamanga during an SRHR workshop in Johannesburg in April 2019.

Photo: *Tarisai Nyamweda*

In 2019, Gender Links trained 109 journalists[70] from across Southern Africa on SRHR reporting techniques in an effort to strengthen reporting on these topics in the region.

Workshops also aimed to increase media coverage of SRHR from a human rights perspective, including stories that challenge discriminatory social norms and stereotypes. The sessions provided an opportunity to raise awareness on the SRHR SADC Strategy and SRHR provisions in the SADC Protocol on Gender and Development and related instruments.

GL took a hands-on and practical approach, linking content knowledge to core journalism skills and technical tools. The organisation also gave journalists small grants to allow them to go out and undertake field reporting whilst receiving support from a skilled mentor.

At the end of each training session, participants produced news stories for their media houses on various SRHR thematic areas, including menstrual

[69] The African Women's Development and Communication Network (FEMNET). 2019. SRHR media training. FEMNET. Nairobi. Available at Nairobi https://femnet.org/wp-content/uploads/2020/02/FEMNET-SRHR-Media-Training-Manual-2019 .pdf, accessed 16 July 2021.
[70] This figure is from seven workshops.

health, maternal health, Comprehensive Sexual Education (CSE) and services, child marriages, teenage pregnancies, safe and legal abortion, HIV and AIDS, sexual diversity and GBV. Journalists produced more than 100 news stories in the mainstream media in 15 SADC countries, which the GL News Service republished. The linkages that these journalists made between SRHR and key policy issues led to new and innovative SRHR coverage in the region.

GL took a similar approach to support the media in strengthening reporting on Women's Political Participation in Botswana, Eswatini and Zimbabwe, reporting the SDGs in Tanzania and supporting gender sensitivity in news and entertainment media in South African broadcast media.

Conclusion

The SADC Protocol on Gender and Development is one of the most comprehensive tools available to help the media promote equal participation and voice. Yet while the Protocol foregrounds the importance of gender equality in the media, journalistic representations continue to create and recreate discourses that impede processes of gender transformation in and through the sector.

Progress in achieving gender equality in and through the media as envisioned by this SADC Protocol occurs at an extremely slow pace, as evidenced by the 2020 GMPS. Although the region has seen some gains, it regularly logs as many setbacks, even as it grapples with new and emerging threats to women working in the sector. After many years of activism and pressure, representation of women in media is finally edging towards equality. Indeed, the region has also seen improvements in coverage on some topics, including the work of inspiring female journalists covering the COVID-19 pandemic despite the risks.

However, not enough reporters and presenters strive to access women sources. Journalists, both men and women alike, simply do not interview and quote enough women; which means they misrepresent issues and the societies in which we live, where women make up more than 50% of the population. Men still largely tell stories that primarily affect women, and men often frame these stories in terms of how men understand, relate to, and experience them, once again leaving women behind.

Observations from the GMPS show that there is a need for continued media engagement to strengthen news coverage. The media needs support to build and strengthen its capacity and its ability to view news through a gender lens. New and exciting developments, including those linked to our digital era, drive media and storytelling more than ever before. Thus, activists, researchers and governments must follow suit and ensure their research, policymaking and programming is easily available for media to reference and understand. Clear, concise and accessible information, research and data will enhance media's coverage of issues such as SRHR.



Eswatini journalist Lofana Mavusu presents his learnings at the 50-50 #VoiceandChoice summit in March 2021 in Piggs Peak, Swaziland.
Photo: *Gender Links*

Next steps

Strengthen monitoring: The sector needs to both champion the use of, and help gather, more good quality and reliable data on existing and emerging gender and media issues that interest practitioners as well as academia, civil society and government. This is a key stepping-stone to strengthening advocacy and policy change. Media monitoring is an expensive venture so agencies that do it will require financial support to execute it and share it.

Expert databases: Media houses and other industry leaders should compile lists of women experts on a wide range of topics that journalists can consult and use to offset their tendency to revert to official male experts.

Revive advocacy campaigns: Using the data and best practices coming out of the GMPS and GMMP research, women's rights activists need to commit to sustained campaigns. There is need for better collaboration on gender and media activities, as well as regional campaigns that build on the findings of these studies. It is high time the region revived and renewed its gender and media movement, including by employing digital media in new ways, to help finance campaigns and ensure sustainable and ongoing media development work in the region.

Support post-GMPS seminars: GL and partners in the Gender Protocol Alliance will take forward the results of the GMPS through seminars and advocacy on digital equality and gender-sensitive approaches to freedom of expression. The work will highlight the findings of the GMPS research and spread public awareness on the need to increase women's voices and concerns. It will also hold news media accountable for professionalism in journalism through fair, balanced and accurate portrayals of women in the media as a way to contribute to the achievement of gender equality. Country GMPS launches will align with barometer launches to disseminate critical and current information in each country.

Taking stock post-COVID-19: As the pandemic evolves and eventually subsides, it will be important for regional gender and media activists to analyse learnings from the pandemic as they pertain to the industry. This includes research into the successes and failures of public health and SRHR reporting during the pandemic and lockdowns. Journalists should also explore how various political approaches to these issues helped and hindered the spread of COVID-19 and the economic and social fallout from it.



Khalila Abdul and Alicia Evance, then journalism students at the University of Dar es Salaam, review pictures taken at the Gender and Media Summit in Tanzania in 2018.
Photo: *Aikha Kimaro*

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Climate Justice 10



Flooding in Mauritius. Photo courtesy of La Sentinelle.

KEY POINTS

- The temperature in Southern Africa has increased significantly over the last century, at a rate of 0.4°C per decade between 1961 and 2014[1].
- The Southern African region is vulnerable to the impact of climate change due to high levels of poverty, high pre-existing disease burden, fragmented health services; water and food insecurity.
- Women are particularly affected by climate change as principal caregivers and food providers for families and communities. Climate change impacts directly on their sexual and reproductive rights (SRHR). Women constitute the majority of those affected by the climate crisis and of those with the least resources for climate adaption.
- Women's employment in the agricultural labour force ranges from 4% in Mauritius to 82% in Malawi. Ten Southern African Development Community (SADC) countries exceed the global average of 25% women in agriculture. In seven of these countries women outnumber men in the sector, making it one of the most important sectors for women's employment[2].
- Food insecurity is one of the biggest threats facing SADC countries because of climate change. In 2018, more than half of the population in nine SADC countries experienced moderate or severe insecurity[3].
- Malnourishment decreased globally from 10% in 2010 to 9% in 2018 but increased in seven SADC countries in the same period.
- There has been an increase in access to clean cooking fuels and technology in four SADC countries (Mauritius, Seychelles, South Africa and Botswana). But only half the populations of these countries have access to clean cooking fuels and technology.
- No substantial studies assessing the association between climate change and health have been conducted in the SADC region. This points to the need for evidence and data gathering. Any studies on the health impacts of climate change should specifically address SRHR.

1 Davis-Reddy, C.L. and Vincent, K. 2017: Climate Risk and Vulnerability: A Handbook for Southern Africa (2nd Ed), CSIR, Pretoria, South Africa.
2 World Bank data, https://data.worldbank.org/indicator/SL.AGR.EMPL.FE.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ&view=chart accessed 2 September 2021
3 World Bank Data, Food Security Portal https://data.worldbank.org/indicator/SN.ITK.MSFI.ZS?locations=AO-BW-KM-CD-SZ-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZW-ZM-LS, accessed 2 September 2021

Introduction

Climate change is the biggest existential crisis of our time. According to the latest report by Working Group I to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change (IPCC)[4] the evidence is irrefutable: global heating is affecting every region and climate system on Earth. The report provides new estimates on the likelihood of crossing the global warming level of 1.5°C in the next decades. It finds that unless there are immediate, rapid and large-scale reductions in greenhouse gas emissions, limiting warming to close to 1.5°C or even 2°C will be beyond reach. The only way to avoid this threshold is by pursuing the most ambitious path.[5]

The climate crisis is just another manifestation of global inequality. The richest 1% are responsible for 15% of cumulative emissions. The countries that have contributed least to the climate crisis are most severely affected by its impacts. They also have most limited access to resources to adapt. The global average amount of CO2 emissions per person was five metric tons in 2014. This ranges from 15.5 metric tons in North America in 2016 to just 0.8 metric tons in Sub-Saharan Africa and 1.4 metric tons in Pacific Island small states. Major differences also exist in levels of greenhouse gas emissions among individuals. Between 1990 and 2015, the poorest half of the world's population emitted 7% and the richest 10% emitted 52% of all carbon emissions.[6]

Gender equality, SRHR and climate change are inextricably linked. Climate change is increasing social, economic and gender inequalities. As global temperatures rise, extreme weather events like floods, droughts, and heatwaves threaten the health and rights of girls and women. In turn, gender, sexuality, age, wealth, indigeneity, and race are determining factors in the vulnerability to climate change.[7] Climate justice, which took a backseat at the height of the COVID-19 outbreak, is back squarely on the agenda. It requires the same urgent action as that taken to curb COVID-19.



Women walk long distances to collect water in Madagascar, where almost half of the country does not have access to clean water.

Photo: Zotonantenaina Razanadratefa

[4] Intergovernmental Panel on Climate Change (IPCC), The Working Group I report is the first instalment of the IPCC's Sixth Assessment Report (AR6), which will be completed in 2022.
[5] https://www.ipcc.ch/2021/08/09/ar6-wg1-20210809-pr/ accessed 4 September 2021
[6] Ibid
[7] International Planned Parenthood Federation (IPPF), Position paper: The climate crisis and sexual and reproductive health and rights, January 2021, pp 5
Women Deliver, The link between climate change and sexual and reproductive health and rights: An evidence review, January 2021

Table 10.1: Key climate justice indicators

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
National adaption Plans submitted to UNFCCC[8]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
National Adaption Programme of Action	2011	No	No	2006	No	2007	2006	2006	No	2008	No	No	2018 (draft)	2007	2007	2019
Country has signed and ratified the global climate change treaty (Paris Agreement)[9]	2016 (signed but not ratified)	Signed and ratified in 2016	Signed and ratified in 2016	Signed in 2016, ratified in 2017	Signed and ratified in 2016	Signed and ratified in 2016	Signed in 2016, ratified in 2017	Signed in and ratified in 2016	Signed and ratified in 2016	Signed in 2016, ratified in 2018	Signed and ratified in 2016	Signed and ratified in 2016	Signed and ratified in 2016	Signed in 2016, ratified in 2018	Signed and ratified in 2016	Signed in 2016, ratified in 2017
Number of National climate change policies/guidelines[10]	Nine (2008, 2x2010, 2x2012, 2x2013, 2x2014)	Two (both of 2009)	No data	Four (2 of 2011 and 2014)	No data	No data	Three (2003, 2010, 2013)	No data	No data	11 (1995, 4x2009, 3x2011, 2x2013, 2014)	No data	No data	Four (2008, 2009, 2010, 2011)	Five (2003, 2005, 2012, 2013, 2014)	No data	Five (2003, 2006, 2x2011, 2012)
Prevalence of moderate or severe food insecurity in the population (%)[11]	67	67	No data	No data	63	50	No data	82	21	68	56	14	43	55	No data	67
Prevalence of undernourishment (% of population)[12]	19	No data	No data	No data	17	33	42	19	5	33	15	5	6	25	No data	No data
Access to electricity (%)[13]	45.7	data	84	19	77.2	44.6	26.9	11.2	100	29.6	55.2	100	85	37.7	43	41
Access to clean fossil fuels and technology for cooking[14]	48.1	70.2 64.1	9.3	4	49.7	35.6	0.9	2.5	93.3	3.7	42.2	90.4	84.8	2.2	16.4	29.1
Employment in agriculture, female (% of female employment)[15]	75	15	32	72	10	40	60	82	4	80	20	4	4	67	55	69

Source: Various, Gender Links, 2021.

Table 10.1 Summarises the nine climate justice indicators discussed in this chapter. It shows that:

- No country in the SADC region has submitted its National adaption Plan to the UNFCCC.
- All SADC countries, expect Angola, have signed and ratified the global climate change treaty (Paris Agreement). Angola has signed but not yet ratified.
- More than half of the population in nine SADC countries experience moderate or severe insecurity.
- In only two countries do the entire population have access to electricity, and in nine countries less than half the population has access to electricity.
- Less than half the populations in 12 SADC countries have access to clean fuels and technology for cooking.
- The agriculture sector is the main employer of women in Angola, DRC, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe.

[8] UNFCCC data https://www4.unfccc.int/sites/NAPC/Pages/national-adaptation-plans.aspx
[9] UNFCC Agreement signatories, accessed from https://en.wikipedia.org/wiki/List_of_parties_to_the_Paris_Agreement#Signatories on 11 July 2020
[10] UNFCC Country Profiles , https://www4.unfccc.int/sites/NAPC/Pages/NationalPolicies.aspx
[11] World Bank Data, Food Security Portal https://data.worldbank.org/indicator/SN.ITK.MSFI.ZS?locations=AO-BW-KM-CD-SZ-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZW-ZM-LS, accessed 2 September 2021
[12] World Bank data https://data.worldbank.org/indicator/SN.ITK.DEFC.ZS?locations=AO-BW-KM-CD-SZ-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZW-ZM-LS accessed 2 September 2021
[13] World Bank Data, Access to Electricity, https://data.worldbank.org/indicator/EG.ELC.ACCS.ZS?locations=SC-MU-MZ-KM-AO-BW-NA-MW-MG-CD-SZ-LS-ZA-ZM-ZW accessed 1 September 2021
[14] World Bank Data, Access to Clean cooking fuel and technology https://data.worldbank.org/indicator/EG.CFT.ACCS.ZS?locations=AO-BW-CD-KM-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZM-ZW accessed 3 September 2021
[15] World Bank data, https://data.worldbank.org/indicator/SL.AGR.EMPL.FE.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ&view=chart accessed 2 September 2021

COVID-19 and Climate justice

Global inequality is also playing out in the parallel COVID-19 crisis. By 5 October 2021 just five percent of the African population had been fully vaccinated, compared to 34% globally and 63% and 48% of the European Union and North American populations respectively[16]. Countries in the global north have already started administering booster shots to their populations while the most vulnerable in Africa have not yet received their first shot.

COVID-19 has already claimed the lives of 4.6 million lives worldwide since the start of the pandemic[17]. Climate change is expected to cause around 250,000 additional deaths annually between 2030 and 2050. Both crises are the result of human behaviour.[18]

COVID is known to impact particularly the elderly and those with underlying health conditions, causing severe respiratory disease. Climate change affects air quality, drinking water, food supply and shelter - all important for good health. Both crises impact women disproportionately as primary caregivers.

At the start of the pandemic there were encouraging outcomes due to the lockdown restrictions to stem the spread of the disease. Improvements in air quality because of reduced air travel were a short lived reprieve. Now we face a new crisis, in COVID-19 medical waste management.

"Recent studies estimate that we use an astounding 129 billion face masks globally every month -- that is 3 million a minute. Most of them are disposable face masks made from plastic microfibers." [19] This presents an immediate health risk and a potential environmental catastrophe. Massive production of mostly single use PPE for the world has led to waste being produced that once used should be treated as infectious or offensive waste. Disposal should be handled in a way that prevents the transmission of infectious disease to the wider population. However, there are no international or national strategies to address this as yet.



An estimated three million masks are discarded globally every minute.
Photo courtesy of Ashifa Kassam, The Guardian

There are also clear parallels between water scarcity as a result to climate change and the increased need for improved of water and sanitation services to curb the spread of COVID-19. Already scare water resources are going to become even scarcer.

This chapter seeks to draw the links between SRHR, the climate crisis and COVID-19. There is still much work that needs to be done to strengthen the evidence base on the interlinkages between SRHR and the climate crisis.

[16] Oure World Data, https://github.com/owid/covid-19-data/tree/master/public/data accessed 5 October 2021
[17] https://www.news-medical.net/health/Climate-Change-and-COVID-19.aspx
[18] The World Health Organisation, Climate change and health, https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health accessed 13 September 2021
[19] Science Daily, Face masks and the environment: Preventing the next plastic problem, https://www.sciencedaily.com/releases/2021/03/210310122431.htm accessed 9 September 2021

Policy framework

Gender aware climate change policies



Article 31, 1a: State parties shall develop policies, strategies, and programmes to address the gender issues in climate change in accordance with the SADC Protocol on Environment and Sustainable Development.

Article 20.2 of the Protocol on Environmental Management for Sustainable Development: State parties shall undertake gender analysis and gender mainstreaming of all environmental management, climate change and sustainable development policies, programmes, projects and budgets.

International frameworks on climate change

Despite the international mechanisms and frameworks for addressing climate change over more than 25 years, we are still heading towards a crisis referred to by UN Secretary-General Antonio Guterres as a "code red for humanity".

United Nations Framework Convention on Climate Change (1992) UNFCCC provides a framework for climate action but does not contain specific mitigation obligations. Since 1992, the Conference of the Parties (COP) has met annually to implement and further develop the international climate regime.

International Conference on Population and Development in 1994 was a defining moment for sexual and reproductive health and rights. It marked an important shift away from the population-focused objectives of the preceding decades towards recognition of sexual and reproductive health and rights as a human rights issue.[20] The Programme of Action adopted at the Conference defines reproductive rights as "rest[ing] on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" and as also including the "right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[21]

The Paris Agreement adopted in December 2015 at COP 21 a legally binding agreement adopted under the UN Framework Convention on Climate Change that sets a target of keeping the rise in global temperature in the 21st century well below 2°C above pre-industrial levels and to pursue efforts to limit it further to 1.5°C. It also sets "a global goal on adaptation of enhancing adaptive capacity, strengthening resilience and reducing vulnerability to climate change, with a view to contributing to sustainable development" and calls on developed country parties to provide financial resources to assist developing country parties with regard to both mitigation and adaptation efforts. It highlights that parties "should, when taking action to address climate

[20] Pizzarossa, LB (2018) Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law. Laws 2018; 7, 3, p.29.
[21] UNFPA (2014) Programme of Action of the International Conference on Population and Development - 20th Anniversary Edition.

change, respect, promote and consider their respective obligations on human rights, the right to health, the rights of indigenous peoples, local communities, migrants, children, persons with disabilities and people in vulnerable situations and the right to development, as well as gender equality, empowerment of women and intergenerational equity."[22]

The 2030 Agenda for Sustainable Development adopted in 2015, sets 17 goals and targets across social, economic and environmental areas of sustainable development. Sustainable Development Goals (SDG 13) is focused on climate change and calls for urgent action to combat climate change and its impacts, including through a strengthening of resilience and adaptive capacity. Goals on SRHR are covered in goal three on good health and wellbeing.

The Sendai Framework for Disaster Risk Reduction 2015-2030 includes access to sexual and reproductive health services among measures highlighted as important to enhancing resilience and to empowering people disproportionately affected by disasters.[23]

The ***New Urban Agenda, adopted in 2016***, points to threats to cities and human settlements from climate change and commits to promotion of universal access to sexual and reproductive healthcare services with a view to fostering healthy societies.[24]

Regional strategies and policies

SADC has a range of instruments to guide States in addressing climate change at the country level, though it is worrying that these are dated, with nothing more recent than 2015.

- The ***SADC Policy Paper on Climate Change (2011)*** highlights the current and projected impacts of climate change on the region and suggests possible adaptation options.
- The ***SADC Climate Change Adaptation Strategy (2011)*** recognises that water issues will impact a range of sectors, including energy, health and agriculture. Adaptation measures identified are water governance and management and infrastructure development.
- The ***Disaster Risk Reduction Strategic Plan (2006-10)*** sets out the strategic direction to achieve the long-term goal of building resilience of SADC nations and their communities.
- The ***SADC Climate Change Strategy and Action Plan (CCSAP) (2015)*** is structured to be a 25-year strategic document with five-year review planning cycles and considers Science, knowledge and practice; Local ownership; Capacity Building; Balanced approach to adaptation and mitigation; Alignment and integration; Gender mainstreaming; Communication, advocacy and awareness rising; and Parity as its guiding principles."[25] The strategy takes cognisance for the need of enhanced adaptation to the impacts of climate change bearing in mind the diverse and gender differentiated levels of vulnerabilities that are more pressing for the region.[26]
- The ***Framework of Sub-Regional Climate Programs (2010)***, developed under the African Ministerial Conference on the Environment (AMCEN), maps programs and actors working on climate change adaptation in Southern Africa and identifies gaps or focus areas that are not being addressed in terms of adaptation.

There is some reference to health impacts of climate change but these are limited and none of these documents make the link between climate change and the impacts on SRHR.

[22] United Nations (2015) Paris Agreement. Available at: https://unfccc.int/files/essential_background/ convention/application/pdf/english_paris_agreement.pdf.
[23] United Nations (2015) Sendai Framework for Disaster Risk Reduction 2015-2030. Available at: https://www.preventionweb.net/files/43291_sendaiframeworkfordrren.pdf.
[24] See United Nations (2016) New Urban Agenda. Available at: http://habitat3.org/wp-content/uploads/ NUA-English.pdf.
[25] SADC Climate Change strategy and action plan (CCSAP), pp 4
[26] SADC CCSAP, p12

National

Under the UNFCC countries are required to submit regular National Communication on climate change.

COP, in 2001, established the least developed countries (LDC) work programme, that included the **National Adaptation Programmes of Action (NAPAs)**, to support countries to address the challenge of climate change given their particular vulnerability providing a process to identify priority activities that respond to their urgent and immediate needs with regard to adaptation to climate change.

Table 10.2: SADC Countries national communication and NAPA submission

Country	National Communication	National Adaptation Programme of Action (NAPA)
Angola	2012	2011
Botswana	2011, 2019	not available
Comoros		not available
DRC	2009, 2015	2006
Eswatini	2016	Not available
Lesotho	2001, 2013	2007
Madagascar	2004, 2010	2006
Mauritius		not available
Malawi	2002, 2011	2006
Mozambique	2006	2008
Namibia	2002, 2015, 2020	not available
Seychelles		not available
South Africa	2011, 2018	2018 (draft)
Tanzania	2014	2007
Zambia	2002, 2013	2007
Zimbabwe	2013, 2017	2019

Source: USAID, Regional Factsheet, Climate Risk Profile Southern Africa, 2016.

Table 10.2 shows that all countries except Comoros, Mauritius and Seychelles have submitted at least one communication to the UNFCC. These countries are also three of the five countries (Botswana, Comoros, Eswatini, Mauritius, Namibia and Seychelles that have not developed or submitted a NAPA. It is worrying that the three small island states have not developed adaption strategies or programmes of action considering their particular vulnerability to climate change.

An overview of health considerations in the National Adaptation Programmes of Action for climate change in least-developed countries and small island states found that health was not seen as a priority, as most activities focused on biodiversity and agricultural activities. Very few institutions specialising in climate change and health were identified in the SADC region.[27] In addition to regional strategies, several member countries have identified other priorities in national strategies and plans.

[27] Young T, Tucker T, Galloway M, Manyike P, Chapman A, Myers J, Climate change and health in SADC region: Review of the current state of knowledge, 3 September 2010

Climate change in Southern Africa

The Southern African region is vulnerable to the impact of climate change due to high levels of poverty, high pre-existing disease burden, fragmented health services, and water and food insecurity.[28]

Southern Africa has been significantly warming over the last century, and trend analysis of the temperatures across the region indicate that temperatures have increased, with more rapid increases in minimum temperatures (1-1.5°C on average), especially in the interior regions (1.6-2°C on average) or a rate of 0.4 °C per decade between 1961 and 2014.[29] There has been reduced rainfall and more extreme weather events such as floods and cyclones.

Climate extremes are a major impediment to resilience in Southern Africa, where livelihoods and economies are highly sensitive to weather fluctuations. The primary source of income for the region's rural population is agriculture, much of it rainfed and allocated to cereal production.[30] African women play a central role in the continent's agriculture sector. As the backbone of the sector they represent 52% of the total population in the sector and are responsible for approximately 50% of the agricultural labour on farms in Sub-Saharan Africa. They also produce 60% to 80% of the continent's food yet they own just 10% of all agricultural land and just 2% of land rights.[31]

Changing climate patterns including increasing temperatures and increased intensity, frequency and duration of extreme events pose a great threat to agricultural sector. Some of the potential impacts on the sector include crop failure and reduced yield; more conducive environments for pests and pathogens, changes in areas suitable for agriculture and or crops, changes to access in food and increase in price volatility of food imports and increased costs.



Former Councilor Maneo Tsoho weeding her garden in Lesotho.
Photo: Ntolo Lekau

Women are therefore most affected by food insecurity, as those primarily responsible for the nutritional needs of their families and communities, from growing crops to putting food on the table. Food insecurity also negatively impacts women's reproductive health from pregnancy to birthing.

Changing temperature and rainfall patterns are also likely to exacerbate multiple negative health outcomes, reversing the progress made in the region over the last 10 years. The region faces a heavy disease burden largely due to poor waste management practices, inadequate drinking water and sanitation, limited access to health care facilities, scarce financial resources.[32] More frequent extreme rainfall and flooding could lead to increased incidences of malaria and waterborne diseases adversely affecting women's maternal health.

No substantial studies assessing the association between climate change and health in the SADC region have been conducted. Research has focused on infectious diseases - particularly malaria - and little work had been done on attributing disease burden to climate change and evaluating strategies to adapt to climate change.[33]

[28] Ibid
[29] WFP, Climate change in Southern Africa, June 2021
[30] USAID, Regional Factsheet, Climate Risk Profile Southern Africa, 2016
[31] Bongiwe Njob, Susan Kaaria , FAO, 'Women and AgricultureThe Untapped Opportunity in the Wave of Transformation' Background paper presented at the conferec, 'Feeding Africa' 21-23 October 2015.
[32] USAID, Regional Factsheet, Climate Risk Profile Southern Africa, 2016
[33] Young T, Tucker T, Galloway M, Manyike P, Chapman A, Myers J, Climate change and health in SADC region: Review of the current state of knowledge, 3 September 2010



Several lasting impacts of the 27-year civil war have increased **Angola**'s vulnerability to the effects of climate change. While historically data is limited due to the destruction of weather station makes it difficult to predict climate variability, recent cycles of drought and floods in the south have caused an estimated $242.5 million in agricultural losses.

Food insecurity has increased since people left their farms and moved into cities during the war, with devastating effects on the agricultural sector. Small holder farmers comprise 90% of the sector, primarily through subsistence, rainfed cultivation. Despite the fertile soil, just ten percent of the arable land is cultivated. Angola is one of the top three food insecure countries in the SADC region. Migration to coastal areas has concentrated the population on coastlines, which are vulnerable to rising sea levels.

Malaria and diarrhoea are the leading causes of death in the country. More frequent extreme rainfall and flooding could lead to increased incidences of waterborne diseases and temperature shifts may alter the range of disease vectors and duration of malaria transmissions seasons.[34]



Botswana has observed considerable temperature increases and since the 1970s, and average temperatures have increased 1.5°C, with central, arid parts of the country's interior observed to have increased by as much as 2°C. Rainfall is highly variable but an overall reduction has been observed across the southern Africa region. Higher temperatures, land and water scarcity, flooding, drought, and displacement in Botswana will negatively impact agricultural production, causing a breakdown in food systems, which will affect marginalised groups disproportionately. Botswana is one of the top three most food insecure countries in the region. Botswana, the prevalence of stunting in children under age 5 was 31.4% in 2008, the prevalence of underweight children and wasting in children under 5 was 11.2% and 7.2%, respectively.

The significant increase in temperatures and incidences of floods and droughts is expected to have significant adverse health effects. Currently, 30% of the population of Botswana is exposed to some risks of malaria infection every year. During years of heavy rainfall, the risk of malaria shifts westwards and southwards. Diarrheal disease may be exacerbated by climate variability and change as variable rainfall patterns are likely to compromise the supply of fresh and clean water. The effects will be an increase in vector-borne and waterborne diseases, severe malnutrition, and increases in flood incidence and displacement of people.[35]



The **Comoros** is a small archipelago in the southwestern Indian Ocean and is made up of diverse coastal and marine environments from low coasts to cliffs and mountains, and it has an active volcano. The Comoros is densely populated, with approximately 465 inhabitants per km^2, and more than half of the population (53%) of 869,595 (2020) people is under the age of 20. High population density places intense pressure on natural resources and the environment. Poverty is widespread throughout the Comoros, with 40% of the population living below the poverty line.

Due to its location and topography Comoros is among the most climate vulnerable countries in the world, and 54.2% of the population live in at-risk areas. Changes in climate by 2050 are estimated to be a raise in mean annual air temperature to an average of 28°C, a change that represents a 1°C increase compared to the current situation. A sea level increase of 4 mm/year for a total increase of 20 cm by 2050 is also expected.

Agriculture, including fishing, hunting and forestry accounts for 50% of GDP, employs the majority of the labour force and provides most of the exports. Export income is heavily reliant on the three main crops of vanilla, cloves, and ylang ylang (perfume essence); and the Comoros' export earnings are easily disrupted by disasters such as fires and extreme weather.[36]

[34] USAID, Factsheet, Climate Risk Profile Angola,2018
[35] Climate Risk Profile: Botswana (2020): The World Bank Group.
[36] Climate Knowledge Portal, https://climateknowledgeportal.worldbank.org/country/comoros , accessed 15 September



The **DRC** is at risk of many natural hazards, including volcanic eruptions, earthquakes, floods, and droughts. Vulnerability to these hazards is exacerbated by poverty and political insecurity. The most impactful natural disasters in the DRC have been floods and epidemics which accounted for 27% and 58% of all disasters, respectively. Lower-income populations tend to reside in more hazard prone locations, with high potential for significantly increased exposure of already vulnerable populations.

The agricultural sector is critical to the DRC's economy and food security and is considered one of the most vulnerable to projected climate changes. The agricultural sector accounts for 40% of the national GDP, employs 70% of the country's population, of this 72% are women, and this is their primary source of income. Food security will be affected by land and infrastructure degradation due to erosion/landslides, a rise in livestock and crop diseases due to temperature increases, direct crop failure due to floods and heavy rains.

Malaria is a leading cause of morbidity and mortality in the DRC and it is projected to extend in both seasonality and geography. Rising temperatures and increased humidity will impact the lifecycle and habitat of malaria-carrying mosquito and parasite species, resulting in a change and spread of the temporal and geographic range of malarial zones. In existing malaria-prone areas, malaria cases are projected to triple by mid-century.[37]



Eswatini is at high risk of natural hazards, which are expected to primarily affect the agricultural sector, through seasonal flooding and periods of drought exacerbating the country's existing challenges of food insecurity, ability to attain development goals. Both minimum and maximum temperatures are projected to increase by as much as 1.9°C by the 2050s.[38]

The agricultural sector contributes nearly 11% of the country's GDP and occupies 75% of crop land. Over the past decade, Eswatini has experienced more frequent and intense extreme weather events, including an El Niño-induced drought in 2015 and 2016, resulting in a sharp decline in crop-production levels and crop diversity. Declines in crop production are major setbacks to subsistence and commercial farmers as well as to a national economy in which agriculture ranks second only to manufacturing, increasing vulnerability for the more than 70% of the population that is reliant upon the subsistence farming. Eswatini is one of the most food insecure country in the region with 63% of the population experiencing moderate or severe food insecurity.

Increasing temperatures and changing rainfall patterns and catastrophic weather events will pose health risks including increased deaths due to heat waves, and natural hazards, such as floods, vector-borne diseases such as malaria and other existing and emerging infectious diseases. Given the country's high prevalence of HIV/AIDS, these households are also expected to be particularly vulnerable.[39]



More than 90% of disasters in **Lesotho** are related to climate variability and change, specifically, drought, snowfall, hailstorms, strong wind, localized floods, and early frost and pest infestations. Water, agriculture, forestry, human health, and livestock are the country's most vulnerable sectors with respect to climate variability and change. Most recently, the country suffered from a severe drought from 2015 to 2017, due largely to El Niño events that affected Southern Africa. This had dramatic impacts to the country's food security situation and required international food assistance from international donors.

Agriculture is a key economic sector and a major source of employment in Lesotho, with 60%-70% of the country's labour earnings derived from agriculture. Agriculture is predominantly small-

[37] Climate Risk Profile: Congo, Democratic Republic (2021): The World Bank Group.
[38] Climate Risk Profile: eSwatini (2021): The World Bank Group.
[39] Afrobarometer Dispatch No. 226 | Sipho Kunene, Dispatch No. 226 | 6 August 2018

scale, and characterized by rainfed cereal production with extensive animal grazing; the livestock subsector contributes approximately double that of the crop subsector. Home gardening is also an important source of horticultural produce, with an estimated 70% of rural households producing vegetables. The growing vulnerability and deepening food insecurity are generally associated with widespread livelihood failure for many rural households. Just less than half the population (49%) experience moderate or severe food insecurity.

Health systems and outcomes will also be affected, as climate change trends could aggravate heat stress, increase the range of vector-borne diseases including malaria, dengue fever and yellow fever, and exacerbate air pollution, which could impact communicable diseases such as HIV/AIDS, TB, and other respiratory disease. With the upsurge in HIV/AIDS related chronic illnesses, family members have assumed greater roles in care giving, a practice that represents a drain on household resources, depresses productive capacities, and further threatens food security and livelihoods.[40]



Madagascar is the world's fourth largest island and home to a diverse and unique range of species and ecosystems, many of them vulnerable to current and future climate patterns. The driving sectors of Madagascar's economy include agriculture (predominantly rainfed), fisheries and livestock production, all of which rely on climate-sensitive natural resources. Food security is a major concern, with 25% of the country's rural population classified as severely food insecure.

Madagascar is vulnerable to extreme weather events, and has the highest risk from cyclones in Africa. These events are becoming increasingly frequent and intense: in the past 20 years Madagascar has been struck by 35 cyclones, eight floods and five periods of severe droughts (a three-fold increase over the previous 20 years), causing $1 billion in damages and affecting food security, drinking water supply and irrigation, public health systems, environmental management and quality of life. Projected changes include, average temperature increase of between 2.5° - 3°C by 2100 and reduced rainfall during the dry season and increased amounts of rain will fall during the rainy season by 2065.

Climate change will have negative effects on health, for example, incidence of diarrheal disease increase during the cyclone season, which increases flooding and leaves standing water, a breeding ground for waterborne diseases. Malaria is an important cause of overall mortality in the country, and higher temperatures would expand the disease vector's range, particularly to higher elevations where a large percentage of the population lives. Acute respiratory diseases, known to be exacerbated by higher temperatures, are also a concern as they are the number one cause of death in children under five.[41]



Malawi is a low-income country facing a number of challenges that increase its vulnerability to a changing climate, including high population growth, dependence on rainfed agriculture, high rates of malnutrition and HIV/AIDS and inadequate power supply. Poverty rates are high and on the rise in rural areas, where 85% of the population reside.

Agriculture is central to Malawi's economy, contributing nearly 40% of GDP and roughly 90% of the country's export earnings. Improving agricultural production is key to poverty reduction, but the increased frequency and intensity of drought and flood events hinder progress. In 2015 maize production fell by 30% due to floods in the south, followed by a countrywide drought that put 17% of the population at risk of food insecurity and depressed macroeconomic growth. The majority of agriculture production is rainfed and focused on maize. Erratic rainfall poses a challenge to maize productivity, as do higher temperatures and droughts, as well as dry spells during the rainy season. The increased frequency of droughts and floods, along with higher temperatures, negatively impacts on fisheries, wildlife and forests, which provide food, income, fuel and other environmental services to vulnerable populations.

[40] Climate Risk Profile: Lesotho (2021): The World Bank Group.
[41] USAID, Factsheet, Climate Risk Profile Madagascar, 2016

Climate change is likely to exacerbate the generally poor health conditions in Malawi, which include high rates of infant and maternal mortality, malaria, diarrheal diseases, HIV/AIDS and malnutrition. As temperatures increase, the incidence of malaria is expected to increase and spread into higher altitudes. Recurring floods in the south put already vulnerable, displaced communities without access to clean water or sanitation at greater risk of cholera and other diarrheal diseases.[42]



The small island state of **Mauritius** is amongst the most vulnerable countries to the impacts of climate change including intense cyclones, abnormal tidal surges, prolonged droughts, flash floods and increase in sea temperature. Climate records from the 1960s to 2014 show warming of about 1.2°C and a decreasing trend in rainfall. Sea levels are rising at a rate of 5.6 millimetres (mm) per year at mainland Mauritius and 9 mm per year at the island of Rodrigues, higher than the global average of 3.3 mm per year. This impacts on beaches, which sustain the tourism industry, a major pillar of the economy. The frequency of tropical cyclone strength storms and other extreme weather events such as flash floods have affected the economy, ecosystems and livelihoods.[43]

The projected reduction in rainfall and an increase in evapotranspiration may make agricultural production decline by as much as 15 to 25% by 2050. With a decrease in rainfall of 10 to 20% and a temperature increase of two degrees, sugar yield is expected to decline by one half to two thirds. It is estimated that over the next 50 years, half of the beaches will be lost to the point of supporting no visitors. Extreme weather events, including heavy rains, storms and flash floods, are likely to become ever more frequent and intense in Mauritius.[44]



Poverty, weak institutional development and frequent extreme weather events make **Mozambique** especially vulnerable to climate change. Climate-related hazards such as droughts, floods and cyclones are occurring with increasing frequency, which is having a cumulative and devastating impact on a population that is insufficiently prepared.

Central Mozambique is projected to experience recurrent agricultural losses as a result of droughts, floods, and uncontrolled bush fires. The densely populated coastal lowlands will be increasingly affected by severe erosion, saltwater intrusion, loss of vital infrastructure and the spread of diseases such as malaria, cholera, and influenza. Changing rainfall patterns will lead to a decrease of soil water recharge, impacting ground water resources and the water table in wells.

Mozambique's vulnerability is to a large extent due to its dependence on agriculture, which contributes about 28% of its GDP and employs 81% of its labour force. Most of the country's agricultural production is done by small-scale subsistence farmers and 95% of food production is rain-fed. Few farmers can afford to invest in advanced agricultural technologies - and those who do, often on more fertile soils along river-banks and flood plains, risk destruction of harvests by floods.[45]



Namibia is one of the largest and driest countries in sub-Saharan Africa, characterised by high climatic variability through persistent droughts, unpredictable and variable rainfall patterns, variability in temperatures and water scarcity. The climate is generally hot and dry with sparse and erratic rainfall. 92% of the land area is defined as very-arid, arid or semi-arid. Namibia is highly vulnerable to natural disasters such as droughts, flooding, water scarcity, extreme heat, and wildfires. The population is at most at risk from floods, drought, and disease outbreaks. The 2013 drought in Namibia was so severe that it affected approximately 37% of the population and was declared a national disaster. In Namibia, floods have affected over 1 million people at a cost of approximately $100 million per year.

[42] USAID, Factsheet, Climate Risk Profile Malawi, 2017
[43] World Bank, Climate Knowledge portal https://climateknowledgeportal.worldbank.org/country/mauritius/climate-data-historical accessed 6 September 2021
[44] Ramano,K and Dombrowski K, Mauritian minister warns: "It is a matter of life and death", Development and Cooperation, 23 April 2021
https://www.dandc.eu/en/article/small-island-developing-states-are-hardly-responsible-climate-change-most-affected accessed 6 September 2021
[45] Danish Ministry of Foreign Affairs (MFA) Climate change Profile Mozambique, April 2018

The agricultural sector is critical to Namibia's economy and the overall food security and contributes approximately 7%-10% of the country's GDP. Agriculture impacts directly on the livelihoods of 70% of the population which is largely dependent on rain-fed crop production, with nearly 48% of Namibia's rural households dependent on subsistence agriculture.

Namibia's health services are shared between the public and the private sector. Infant and child mortality is comparatively low, but the maternal mortality ratio has increased, despite the fact that over 70% of births are delivered in hospitals. The five leading causes of deaths (all age groups) are HIV/AIDS, diarrhoea, tuberculosis, pneumonia, and malaria. Malaria is one of the major health problems, however, year-on-year incidences of malaria are highly variable, and closely correlated with the prevailing temperature, rainfall, and humidity.[46]



Seychelles is an archipelago of 115 islands with just 98,000 citizens. Seychelles has the highest GDP per capita in Africa at $12.3 billion. The small island state is highly dependent on tourism. Climate change poses long term sustainability risks.[47]

Sea level rise, storm and tidal surges, extreme sea-surface temperatures, and coastal flooding will have serious consequences for livelihoods in the Seychelles. Changes in long-term rainfall patterns and temperature will also have adverse consequences for water, food and health.[48]



South Africa is located within what is considered a 'drought belt' and is the fifth most water scarce country in sub-Saharan Africa. Approximately 50% of the country's water supplies are used by its extensive industrial agriculture sector. Approximately 50% of the country is classified as arid or semi-arid.[49]

South Africa is highly vulnerable to climate variability and change due to the country's high dependence on rain-fed agriculture and natural resources, high levels of poverty, particularly in rural areas, and a low adaptive capacity. The three most significant drivers of climate-related disasters in South Africa are drought, floods, and wildfires. Drought affected an estimated 15 million South Africans between 1980 and 2013. The floods that occurred between 1980-2013 affected over 483,000 people. Wildfire damage to agriculture and forestry is also significant. Coastal storms can impact developments, infrastructure, fishing communities, as well as coastal biodiversity. Annually, these disasters incur approximately Rand 3 billion (US$ 163.3 million) a year in damages.

South Africa is likely to become hotter and drier in the future, with rainfall variability continuing and temperatures rising, the country will continue to experience extreme events like droughts, floods, and other climate-related hazards.

The high evaporation rate of already dry soils and the virtual absence of permanent surface water over large parts of the country make water a scarce resource, with some projections indicating that even without climate change, the country is likely to run through its existing surface water resources in the near-term future.[50]



Rising temperatures, longer dry spells, more intense heavy rainfall and sea level rise make **Tanzania** the 26th most vulnerable country to climate risks. Thirty-two percent of the population lives in urban areas, and 75 percent of that population lives in informal settlements that are increasingly at risk from water scarcity, flooding and heat extremes. The agricultural sector makes up about 25% of GDP and employs 75-80% of the population. In rural areas, there is high dependence on rainfed agriculture. About 80% of agricultural production comes from rainfed, low-input smallholder farms highly vulnerable to weather variability. Livelihoods and food supply also depend on coastal and inland fisheries, which are increasingly threatened by warming ocean and freshwater temperatures, and

[46] Climate Risk Profile: Namibia (2021): The World Bank Group.
[47] https://climateknowledgeportal.worldbank.org/country/seychelles/climate-sector-agriculture
[48] The Seychelles National Climate Change Committee Seychelles National Climate Strategy, November 2009
[49] Climate Risk Profile: South Africa (2021): The World Bank Group.
[50] Climate Risk Profile: South Africa (2021): The World Bank Group.

sedimentation after heavy rains. Sea level rise is putting coastal infrastructure, coastal populations (about 25 percent of the total population), and coastal ecosystems at risk of inundation, salinisation and storm surge.

Diarrheal diseases and malaria, both leading causes of death in Tanzania, are likely to escalate due to increasing temperatures and heavy rainfall. Ninety three percent of the population remain at risk to malaria. New cases are emerging in historically malaria-free regions. Projected increased flooding threatens further outbreaks of waterborne diseases such as cholera and typhoid, as just 61% percent of the population has access to improved drinking water sources and only 19% to improved sanitation.[51]



Changes in climate pose challenges to **Zambia**'s ongoing efforts to combat poverty, reduce food insecurity and sustainably manage natural resources. Almost 60% of the population live under the poverty line. Droughts and floods have increased in frequency and intensity over the last two decades, which have adversely impacted food and water security.

Agricultural constitutes 9% of GDP, consisting largely of rainfed subsistence farming, which is highly sensitive to climate change. Agriculture is the mainstay of rural employment in Zambia. Most livelihoods depend on staple crops like cassava and maize, whose yields rely on a timely rainy season and stable temperatures. Increasing temperatures and erratic rainfall patterns have altered crop water requirements, significantly impacting yields. Higher temperatures have also increased the spread and incidence of pests and diseases. Reduced agricultural productivity will likely exacerbate already high rates of food insecurity and malnutrition.

Zambians already suffer from climate sensitive diseases such as malaria and diarrhoea. Malaria affects over four million Zambians annually and cholera is a recurring problem in peri-urban areas and is linked to weather, in 2010 an outbreak in Lusaka following heavy rains and flooding, reached 4,500 cases. Inadequate health coverage, high levels of poverty and fragmented water supply and sanitation all contribute to the health sector's vulnerability.[52]



Zimbabwe has endured various natural hazards, including droughts, epidemic diseases, floods, and storms over the past century. From 1900 to 2017, events captured in the EM-DAT Emergency Events database for Zimbabwe include seven drought events, 22 epidemic episodes, 12 floods, and five storms. These resulted in 7,000 deaths, with more than 20 million people affected, and total damage estimates of $950 million. Zimbabwe's annual rainfall has been decreasing in the past decades and annual temperature has increased by roughly 0.03 degrees Celsius per year from 1970 to 2016.

In 2016, agriculture covered 42% of the total land area but accounts for 67% of the total employment. Approximately 80% of agricultural production is rain-fed and the remaining 20% is irrigated, making it one of the most irrigation dependent countries in SADC. This sector is therefore highly vulnerable to climate change, especially rainfall variability and climate-induced extreme weather events. Droughts lead to poor harvests and reduced productivity. They will have adverse effects on food security and malnutrition. Zimbabwe is one of the most food insecure countries in SADC: 67% of the population experience moderate or severe food insecurity.

Climate change is also predicted to have a wide range of impacts on human health including temperature related morbidity and mortality caused by extreme temperatures and those caused by extreme weather events such as malnutrition, water-borne, as well as food borne and vector-borne diseases.[53]

[51] USAID, Factsheet, Climate Change Risk Profile Tanzania, 2018
[52] USAID, Factsheet, Climate Change Risk Profile Zambia, 2016
[53] Climate Risk Profile: Zimbabwe (2021): The World Bank Group.

Table 10.3: Gender dimensions of climate change in SADC

Area of concern	Gender implications
Food security	Most women in the region take part in farming, but they have trouble obtaining education, income, land, livestock, and technology. This means that climate change may negatively impact female farmers more than male farmers by further limiting their resources. Women produce between 60% and 80% of all food in the developing world, yet they own just 10% of all agricultural land and just 2% of land rights.
Water	Many countries in the region have been experiencing droughts and water shortages. This has compromised livelihoods, particularly for many women and young girls who must ensure availability of water. They now travel longer distances to collect water, often exposing themselves to dangerous threats such as human trafficking and sexual violence.
Division of labour	Gender-based prejudices and stereotypes exclude women from areas of the green economy such as transport and energy, wasting human resources and preventing the SADC region from achieving its full competitive potential.
School drop-out	In many countries, men force girls and young women to stay out of school to look for opportunities to generate income for their families as agricultural production in the region declines.
Land	Women, especially single women and widows, still struggle to access land for resettlement and production, including farming, to generate income for their families.
Transport	Women depend on access to public transport to a larger degree due to lower levels of car ownership, but also because of their preferences for the use of environmentally friendly solutions such as public transport.
Health	Women are more likely to have a greater awareness of health issues and more highly developed risk perceptions, which often impacts how they perceive health and environmental issues. Men tend to be more strongly oriented towards convenience.
Stress	Stress levels and related diseases may increase for both women and men. Because society expects men to support the family, they experience and express stress in different, often more devastating ways than women.
Migration	In many countries, men migrate from rural areas and small towns to move to big cities due to declines of natural resources and agriculture. They often leave women behind to care for the children and the elderly on their own.
Gender violence	Incidents of sexual violence remain frequent in shelters where natural disaster victims take refuge; and men and women share limited space with no privacy. These shelters usually lack safe and adequate ablution blocks and often women and girls must walk alone outside at night to relieve themselves, risking sexual abuse.
Energy poverty	Due to their lower average income, women are at greater risk of energy poverty than men and have fewer options for investing in low-carbon options such as energy efficiency and renewable energies.
Decision-making	The climate change sector does not equally include men and women at decision-making levels. There is an urgent need to improve gender equality in decision-making in this field, especially the transport and energy sectors. It is also important to increase the number of women with relevant qualifications in scientific and technological areas and who participate in relevant scientific bodies at the highest level.

Source: Gender Links, 2020.

Table 10.3 summarises several gender dimensions of climate change. It shows how every aspect of women's lives are impacted by climate change.

Direct and indirect impact of climate change on individuals' SRHR

Food insecurity

Food insecurity is one of the biggest threats posed by climate change for women as principal caregivers and food providers of families and communities. Altered weather patterns are severely affecting crop production, with detrimental effects on food and nutrition security. Over the last decade, cereal production has fallen, and the region has been recording cereal deficits ranging between 0.1 and 8.9 million metric tonnes. The weather-related effects of the 2015/2016 El Niño alone had a significant negative impact on cereal production. Cereal production decreased by 24% to 33 million metric tonnes, down from 41 million metric tonnes in 2014, inducing an overall cereal deficit of 7.9 million metric tonnes.[54]

The SADC Climate Change Strategy and Action Plan (SADC CCSAP) commits to "ensuring enhanced contribution to agricultural development and food, nutrition and security by women, youth and other vulnerable groups by guaranteeing them effective access to productive resources, services and social/ economic opportunities. In particular, Member States acknowledge that women in agriculture who make up more than 50% of the rural population, play a central role in producing, harvesting, processing, storage and marketing of food"[55] making it a critical employer.

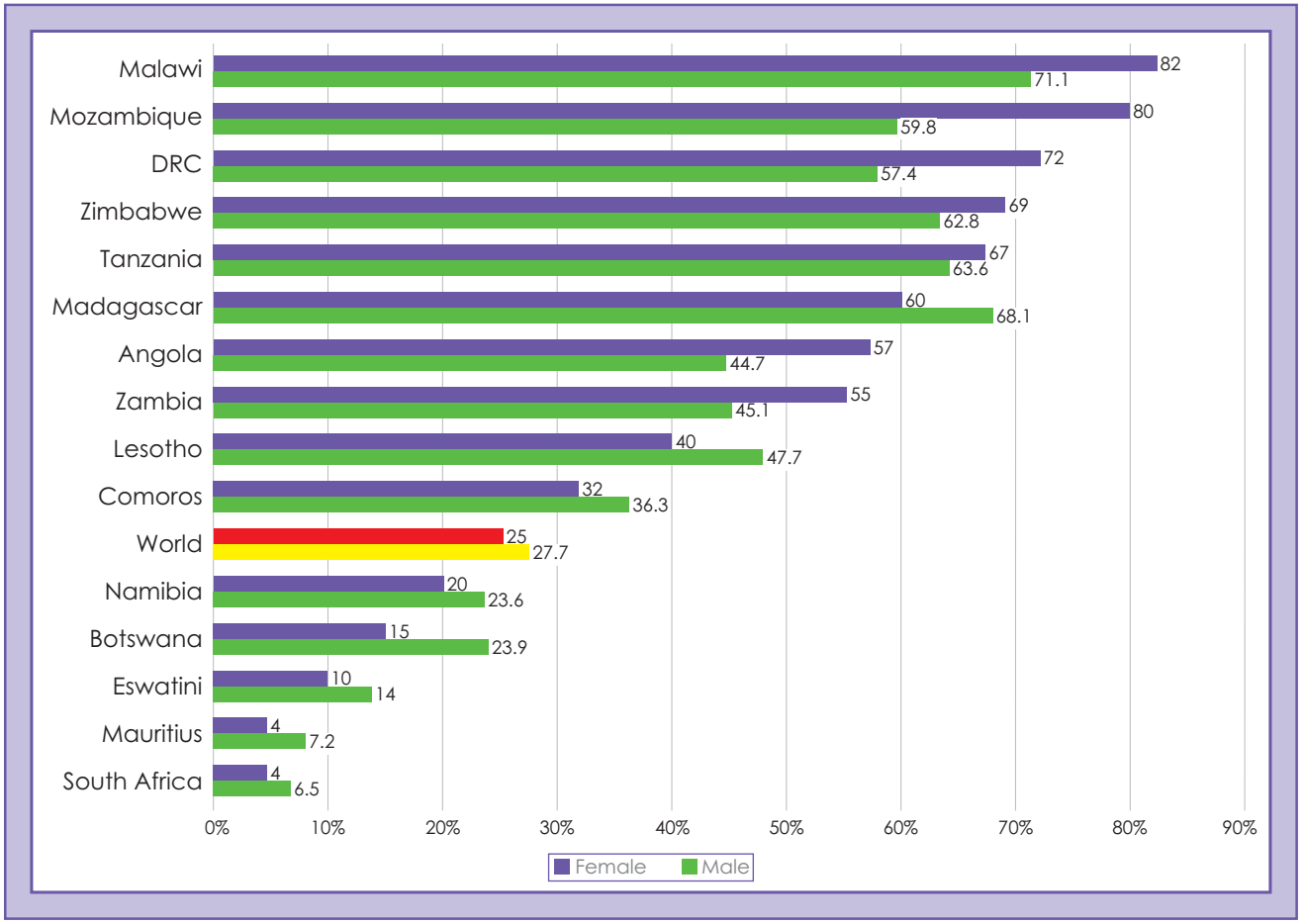
While women make up a large proportion of those in the agricultural sector, they traditionally have less access than men to productive resources, services and opportunities, including land, financial services, education and technology. This means that climate change may negatively impact female farmers more than male farmers by further limiting their resources.



Smallholder farmers from Eswatini's eastern Lubombo district. Photo courtesy of Mujahid Safodien/IRIN

[54] Southern Africa Development Community (SADC), 2020. Synthesis Report on the State of Food and Nutrition Security and Vulnerability in Southern Africa.
[55] SADC Secretariat, SADC Climate Change Strategy and Action Plan (SADC CCSAP), 2015, p28

Figure 10.1: Female and male employment in agriculture (%)



Source: World Bank Data (2010-2019).[56]

Figure 10.1 shows that in eight SADC countries (Malawi, Mozambique, DRC, Zimbabwe, Tanzania, Angola and Zambia) the agriculture sector is the biggest employer of women and in seven of these countries women outnumber men in the sector, highlighting the importance of this sector to women's lives and livelihoods. Namibia, Botswana, Eswatini and Mauritius have less than 20% women employed in agriculture.

Although women predominate in the sector they have less access to resources and socially sustainable agricultural inputs, markets and climate resilient farming technologies and information. Governments should prioritise investing in women in the agricultural sector and ensure that adaption strategies address their specific needs and circumstances.

[56] https://data.worldbank.org/indicator/SL.AGR.EMPL.FE.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ&view=chart accessed 2 September 2021; https://data.worldbank.org/indicator/SL.AGR.EMPL.MA.ZS?locations=AO-BW-CD-KM-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZM-ZW&view=chart accessed 8 September 2021



Women farmers taking the lead in Zambia

With EU support of more than EUR 12 million (USD 14 million), Food and Agriculture Organisation of the United Nations (FAO) worked alongside the Ministry of Agriculture in Zambia to launch the Conservation Agriculture Scaling Up Project in 2013. It set out to increase productivity and production of crops in 31 districts across Zambia. The project benefited more than 229 000 Zambian farmers - 40 percent of them women. In addition, it specifically zoomed in on productivity loss connected to soil degradation, high inputs prices, poor produce markets and poor farming practices. The overarching goal was to reduce hunger and to improve families' food security and nutrition along with their incomes - all the while promoting the sustainable use of natural resources through conservation agriculture (CA).

As is the case in many parts of the world, Zambian women work in agriculture with little reward or income in return for their labour. They traditionally have less access than men to productive resources, services and opportunities, including land, financial services and education. Recognising this, the project ensured the participation of rural women, who received support and education that helped them improve their yields, increasing their food security and that of their families.

This story illustrates the impact of investing in women:

When Margaret Chisangano acquired almost five hectares of land, she began rearing goats. Chisango allocated one hectare to grow maize, a staple food for most Zambians. But declining soil fertility and erratic rains led to a poor harvest. As the years went by, the land increasingly dried up to such an extent that even in the years with good rain there was a reduced yield.

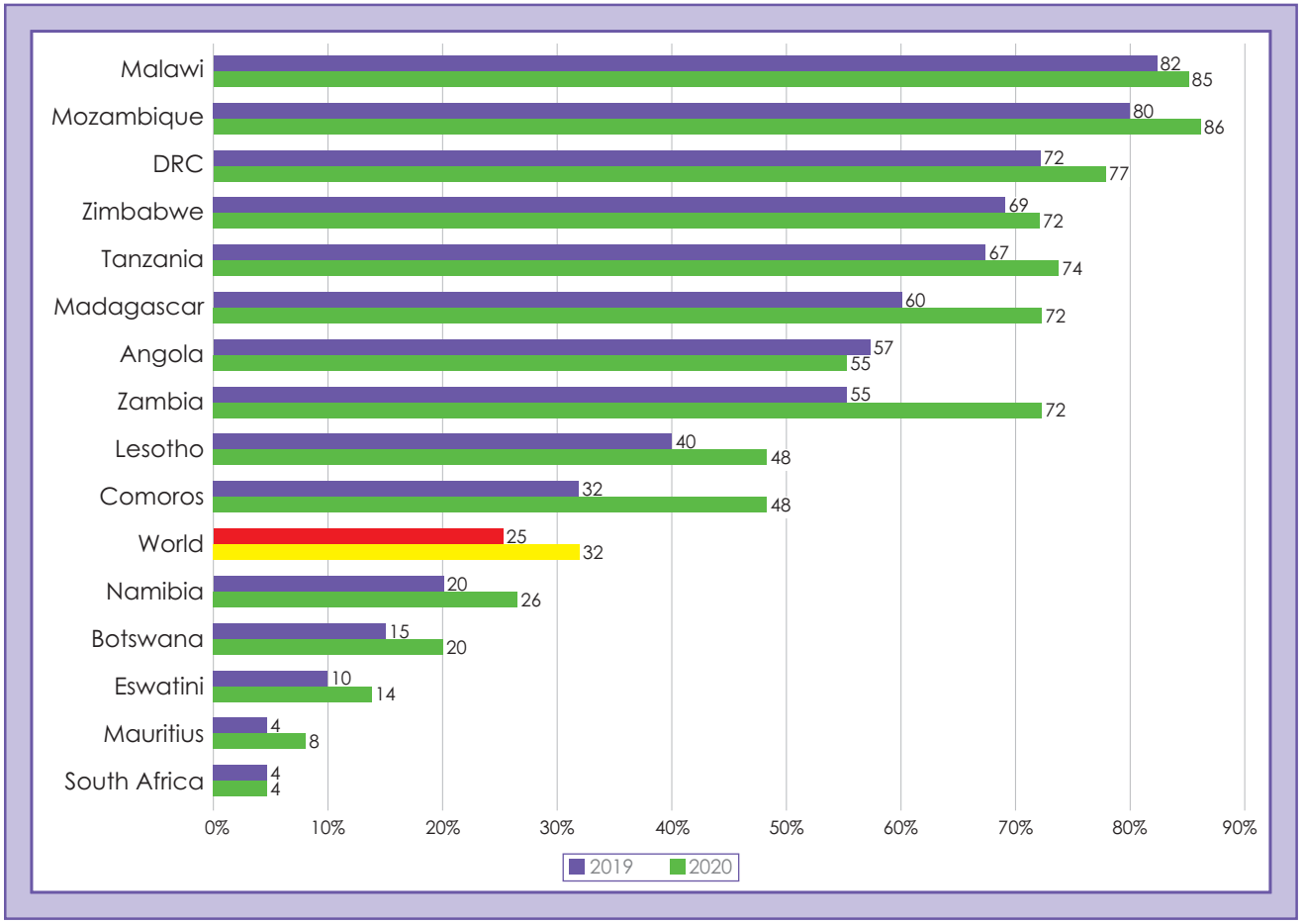
Chisango had difficulty supporting her five dependent children with her seasonal income. Having a year-round income meant the difference between bare survival and providing a decent life for the family. The benefits were almost immediate once she adopted conservation agriculture practices. "Once I started CA, my yields improved," she said. "From one hectare, I started producing 120 bags [of maize] where previously I was producing just ten bags."

Handling prolonged drought as a result of climate change is a major challenge in Zambia, but the farmers involved in the scheme prepare the land and plant early. This means there is minimal soil disturbance with greater water infiltration and retention in the soil. This results in increased production, which allows farmers to make good profits and reinvest in their land. The EU-FAO collaboration has long-term effects on the people in Chongwe district. From a thatched grass-roof hut Chisango moved her family into a five-room house with modern facilities. Her days of vulnerability are gone. "Today I have a house and I bought a vehicle from the profits I made through CA - I believe CA opened opportunities for me that would otherwise be unavailable."

Source: Women farmers taking the lead in Zambia, Food and Agricultural Organisation of the United Nations, 8 March 2019.

The decrease in women's employment in the agricultural sector, and what this means for their food security is a serious concern that needs to be monitored. Over the last decade women's employment in the sector has started to decline.

Figure 10.2: Employment in agriculture, female (% of female employment) 2010 -2019



Source: World Bank Data (2010-2019).[57]

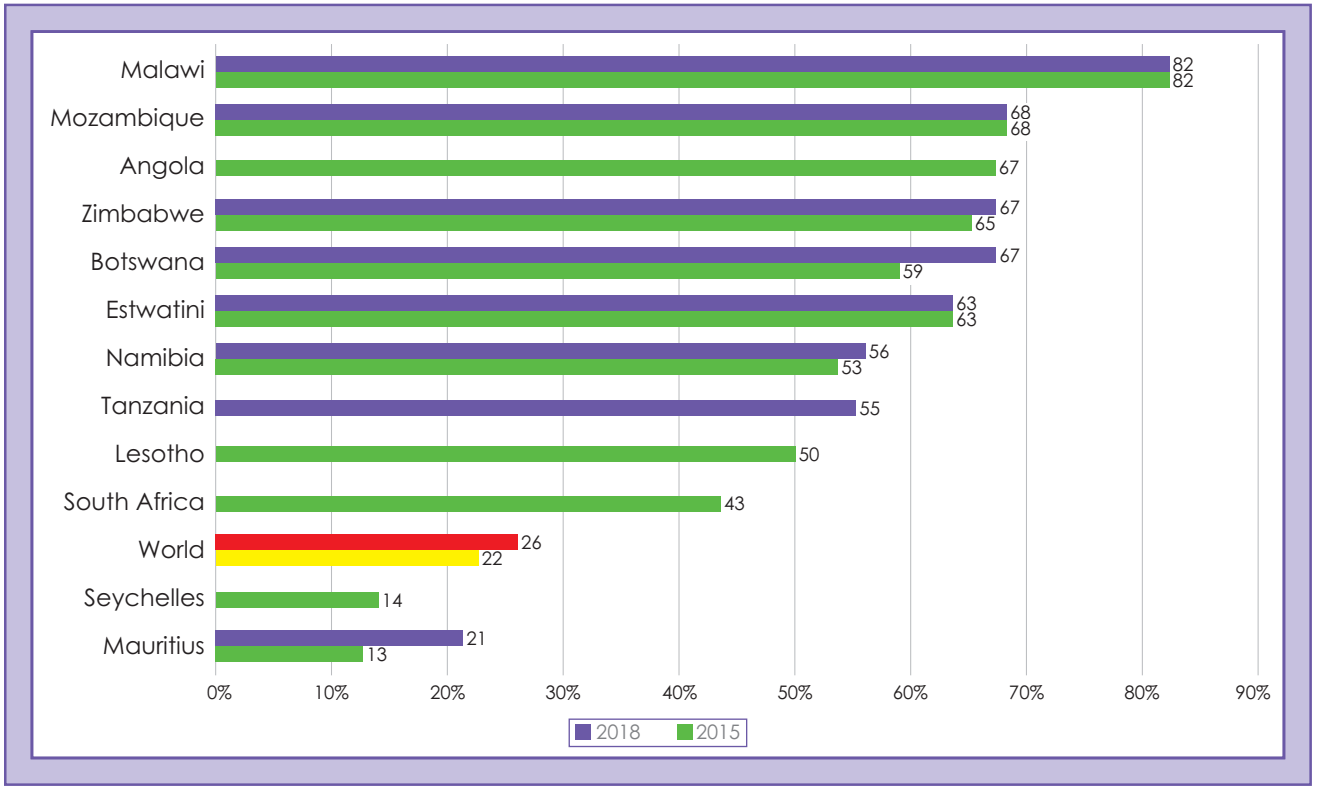
Figure 10.2 shows that women's employment in agriculture has decreased in all SADC countries, except Angola, between 2010 and 2019, in line with the global trend. Zambia witnessed the biggest reduction from 72% in 2010 to 55% in 2019.



Women's employment in agriculture has decreased in all SADC countries. Photo: Gender Links

[57] https://data.worldbank.org/indicator/SL.AGR.EMPL.FE.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ&view=chart accessed 2 September 2021

Figure 10.3: Prevalence of moderate or severe food insecurity in the population (%) 2015-2018



Source: World Bank Data (2015-2018).[58]

Figure 10.3 shows that food insecurity has increased in all SADC countries, except Malawi and Mozambique where it has remained the same over the last three years. In 2018, nine SADC countries - more than half of the population - experienced moderate or severe food insecurity. This proportion increases to a massive 82% in Malawi. This is an extremely worrying trend and one of the greatest risks of climate change.

While regional data is not yet available, anecdotal evidence shows that the impact of COVID-19 has pushed families further to the brink of survival, dramatically increasing food insecurity for the poorest most vulnerable. This threatens to roll back years of progress.

"According to the World Food Programme, up to 96 million additional people were pushed into acute food insecurity in 2020 across 54 IDA countries. Added to the 137 million acutely food insecure people at the end of 2019 across these countries, this brings the total to 233 million people by the end of 2020. People living in fragile and conflict-affected situations are particularly at risk. World Bank projections suggest this could further increase to about 330 million in 2021."[59]

Women in the informal sector have been particularly affected, as they were not able to access markets and sell their products, reducing income and money available for food and essentials.

[58] https://data.worldbank.org/indicator/SN.ITK.MSFI.ZS?locations=AO-BW-KM-CD-SZ-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZW-ZM-LS, accessed 2 September 2021
[59] Townsend, R, Gautam M, Responding to a stark rise in food insecurity across the poorest countries, 21 February 2021 https://blogs.worldbank.org/voices/responding-stark-rise-food-insecurity-across-poorest-countries accessed 8 September 2021



Climate change induced hunger crisis in Madagascar



Ambonavio, Madagascar. Photo: Zotonantenaina Razanadratefa

Southern Madagascar is experiencing its worst drought in four decades with more than 1.14 million people food insecure.

Since last September, the start of the lean season, the situation had turned critical as families had already depleted their food supplies and gone through vital seed stocks, leaving nothing for the November/December 2020 planting season.

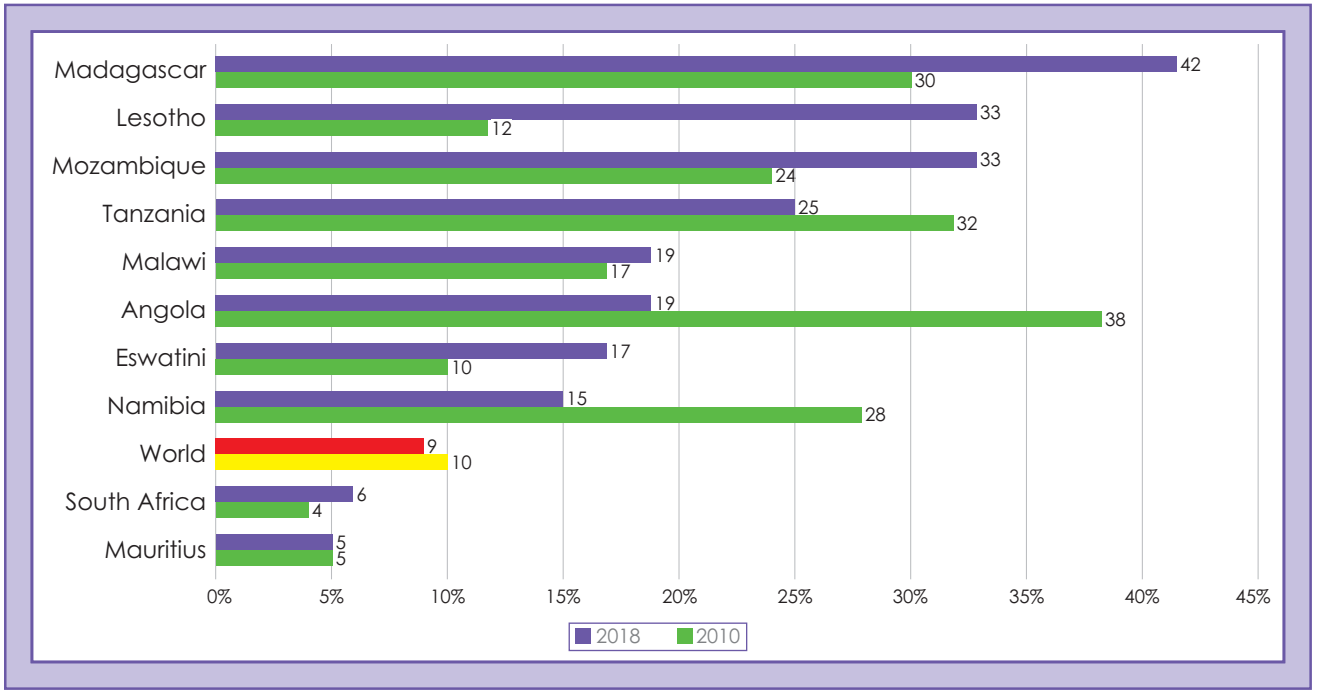
Currently, up to 80% of the population in certain areas in the south are resorting to desperate survival measures, such as eating locusts, raw red cactus fruits or wild leaves.

Moreover, with a lack of rain during the last planting season, prospects for the 2021 harvest are poor, indicating another longer tougher lean season from October to March 2022. WFP said that food production this year is expected to be "less than 40 per cent of the last five-year average", which only adds to the difficulties faced by communities already on the brink of survival to feed themselves.

At the same time, semi-arid conditions in southern Madagascar, combined with high levels of soil erosion, deforestation and unprecedented sandstorms, have transformed arable land into wasteland across the region. Most districts in the South are in the throes of a nutrition emergency with Global Acute Malnutrition (GAM) levels in children under five, nearly doubling over the last four months - touching an alarming 16.5 per cent - the Ministry of Health reported. And in the worst affected district of Ambovombe, GAM has risen above 27 per cent, putting the lives of many children at risk.

Source: Humanitarian Aid, Madagascar edges toward famine, UN food agency appeals for assistance, 29 April 2021, https://news.un.org/en/story/2021/04/1090922 accessed 7 September 2021.

Figure 10.4: Prevalence of undernourishment (% of population) 2010 - 2018



Source: World Bank Data (2010-2018).[60]

Figure 10.4 shows that the prevalence of malnourishment has decreased globally from 10% in 2010 to 9% in 2018, but has increased in seven SADC countries (Mauritius, South Africa, Eswatini, Malawi, Mozambique, Lesotho and Madagascar).

While Mauritius has the lowest prevalence of food insecurity and undernourishment in the region, it has seen the biggest increase in those experiencing food insecurity, which could be attributed to climate change and reduced rainfall.



Below-average rains in early 2021 undermine production prospects

About 40% of Mauritius' land is used for crop cultivation. Ninety percent of this is sugarcane, a major export earner. Tea, tobacco and a small number of food crops, mainly vegetables and fruits make up for the remainder. Below-average rainfall amounts in January and February 2021 reduced soil moisture levels and consequently impaired production prospects. According to Statistics Mauritius, production of food crops was estimated at 95,000 tonnes in 2020, about 7% below the previous five-year average and nearly unchanged compared to the output in 2019.

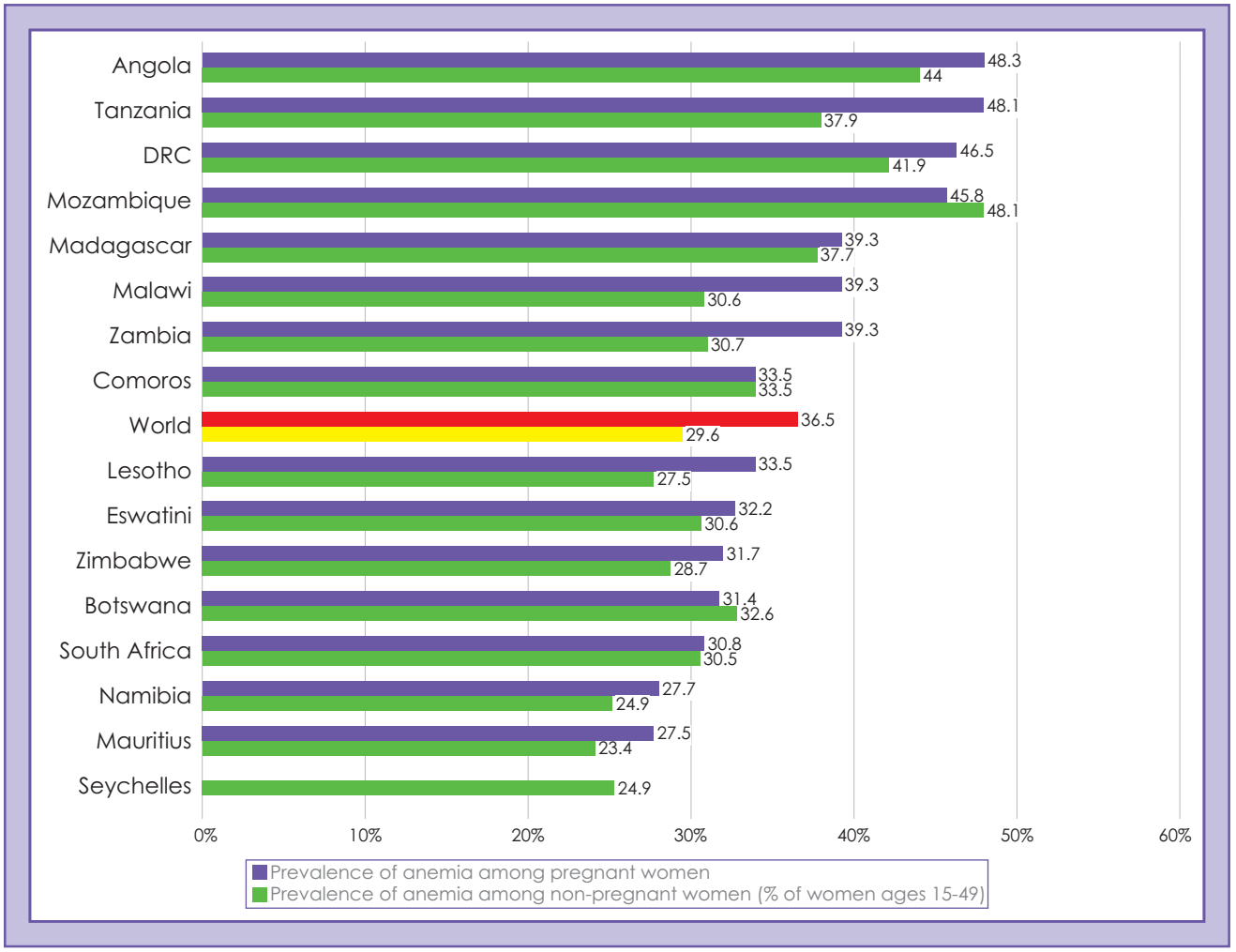
Below-average production reflects unfavourable weather conditions during the first semester of 2020 that adversely affected yields. COVID-19 lockdowns also had a negative impact. Production of sugarcane in 2020 dropped to 2.6 million tonnes, about 23% lower on a yearly basis and nearly 30% below the previous five-year average, mostly reflecting a significant fall in yields, following unfavourable weather conditions. Between 2015 and 2018 food insecurity has increased by 7,5 percentage points.[61]

[60] https://data.worldbank.org/indicator/SN.ITK.DEFC.ZS?locations=AO-BW-KM-CD-SZ-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZW-ZM-LS accessed 2 September 2021
[61] UNFAO, Global information and early warning system on food and agriculture, Mauritius Country Brief, 14 May 2021

Food insecurity is a major threat for pregnant women and young children. Anaemia affects an estimated 25.9% of women of reproductive age; 14.2% of infants have a low weight at birth.

Iron deficiency is the most common form of micronutrient malnutrition globally, according to the World Health Organization. Severe anaemia often results from malnutrition, parasitic infections, or underlying diseases.

Figure 10.5: Prevalence of aneamia in pregnant and non pregnant women aged 15-49 (%)



Source: World Bank Data (2019).[62]

Figure 10.5 shows that eight countries in the SADC region have a higher prevalence of anaemia in both pregnant and non-pregnant women, compared to the global average. The prevalence is higher among pregnant women. The prevalence of anaemia in women of reproductive age in four of the countries in the region (Angola, DRC, Mozambique and Tanzania) classified as severe (>40%). Anaemia in children 6-59 months is classified as severe in all (except Zimbabwe -38%) countries in the region (42% in Eswatini - 68% in Mozambique).[63]

[62] https://data.worldbank.org/indicator/SH.ANM.NPRG.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZM-ZW accessed 2 September 2021
[63] World Food Programme, Climate Change in Southern Africa A position Paper for the World Food Programme in the region, June 2021, p22

Maternal health



Pregnant women and new-borns are increasingly being recognised as vulnerable populations in the context of climate change. The effects can be direct or indirect through heat stress, extreme weather events and air pollution, potentially impacting both the immediate and long-term health of pregnant women and new-borns through a broad range of mechanisms.

A large number of studies suggests an association between heat exposures and the risk of preterm birth, premature rupture of membranes, low birthweight and stillbirth. Low birthweight infants have increased susceptibility to a series of complications, including infections. In addition, dehydration from increased sweating as part of thermoregulation in pregnant women can trigger the onset of early labour and prolong duration of labour. Extreme heat may lead to elevated blood pressure and possible pre-eclampsia in pregnancy, one of the three main causes of maternal deaths globally[64].

Air pollution has also been shown to increase the risk of low birthweight infants and preterm birth. The number of air pollution-associated preterm births was 2.7 million in 2010, 18% of total preterm births globally[65]. Preterm births represents 11% of all births globally and 35% of all neonatal deaths, and is the leading cause of neonatal deaths globally and a significant contributor to long-term ill-health[66]. Lack of access to clean energy is a significant cause of climate change and impacts on maternal and neonatal health.

Other indirect consequences of climate change may be altered disease patterns and an increase in vector-borne diseases such as malaria, dengue and schistosomiasis, which are important complicating infections during pregnancy, malaria in particular. In addition, there are psychological consequences of climate change in conjunction with extreme weather events.

The proportion of maternal and neonatal mortality and morbidity attributable to climate change has not been comprehensively estimated, which justifies additional research efforts, particularly in low-and middle-income countries.[67]

Disruption of health care services

Climate change exacerbates the existing challenges that women and girls face in accessing sexual reproductive health services. Damage to infrastructure, as a result of extreme weather events such as flood and cyclones, results in services being disrupted due to road and transport system damage. Reduced access to SRH services such as contraception results in unwanted pregnancies and unsafe abortions (one of the leading causes of maternal mortality).

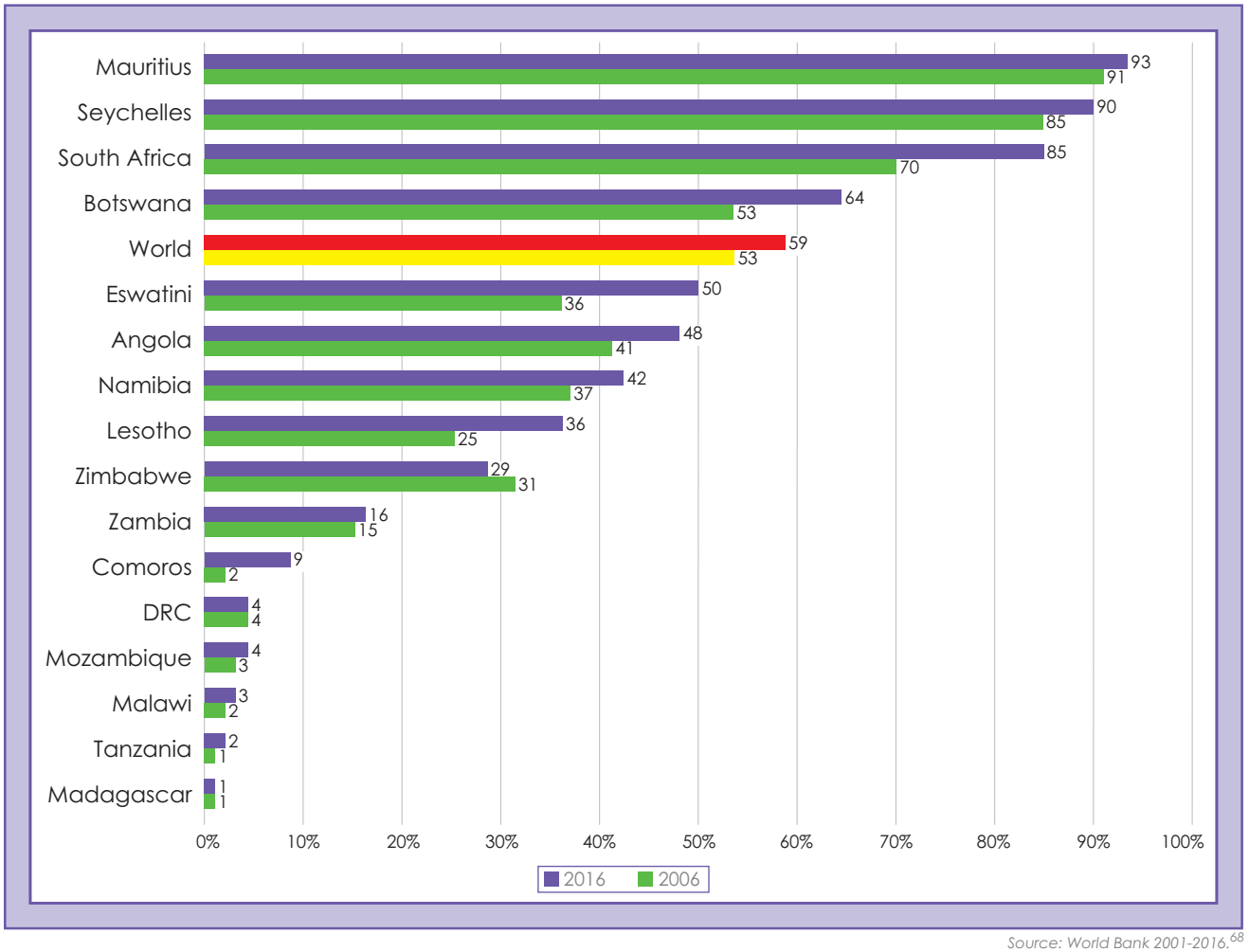
In humanitarian relief services SRH services are often underfunded and under-prioritised in response strategies. The absence of, or limited reference in any of the strategies or action plans abut health impact of Climate change and link to SRHR is a glaring gap that needs to be addressed in mitigation and adaption strategies.

[64] Acta Obstetricia et Gynecologica Scandinavica, Maternal and newborn health risks of climate change: A call for awareness and global action, published by John Wiley & Sons Ltd on behalf of Nordic Federation of Societies of Obstetrics and Gynecology (NFOG)February 2021, pp 567
[65] Ibid
[66] Ibid
[67] Ibid

Increased workload and burden of care of women

In SADC less than half the population (48%) have access to electricity and just 23% have access to clean fuel for cooking. As principal caregivers they are responsible for household task including collecting fuel and doing the cooking. Drought and deforestation means that women and young girls have to travel further to collect fuel for cooking.

Figure 10.6: Access to clean fuels and technologies for cooking (% of population)

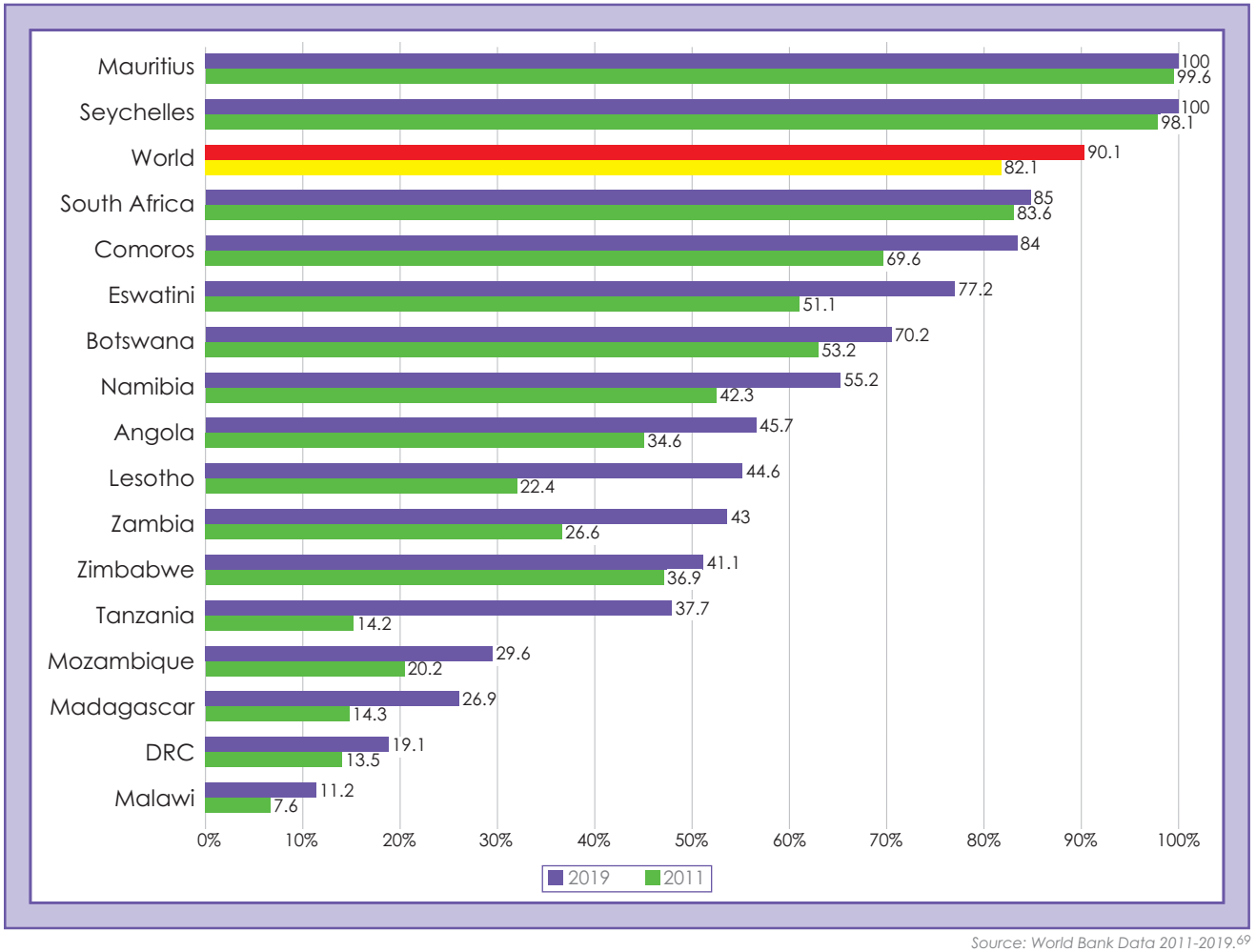


Source: World Bank 2001-2016.[68]

Figure 10.6 shows that there has been an increase in access to clean cooking fuels and technology. But only four SADC countries (Mauritius, Seychelles, South Africa and Botswana) have more than half their population having access to clean cooking fuels and technology. In six countries (Madagascar, Tanzania, Malawi, Mozambique, DRC and Comoros) less than 10% of the population has access to clean cooking fuels and technology.

[68] https://data.worldbank.org/indicator/EG.CFT.ACCS.ZS?locations=AO-BW-CD-KM-SZ-LS-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZM-ZW accessed 2 September 2021

Figure 10.7: Access to electricity (% of population) 2011-2019



Source: World Bank Data 2011-2019.[69]

Figure 10.7 shows that while there has been an increase in access to electricity across the region, 14 SADC countries remain below the global average of 90%.

Increase in sexual and gender-based violence

The climate crisis fuels violence against women in a number of ways and as resources dwindle women become more vulnerable to exploitation and violence. In periods of prolonged drought, women and girls make more frequent and longer journeys to obtain food or water, which makes them vulnerable to sexual assault. Girls spend more time fetching water and have fewer days in school. They may even drop out. Research by the UNDP in Uganda found that women spending more time and energy finding food and water meant that they might not have time to complete their other household and family responsibilities. This extra work meant that they became too tired for sex. Some men respond to this with violence. In families where men left home to seek a living elsewhere, women and children were left to fend for themselves, which made them vulnerable to violence and sexual exploitation.[70]

[69] https://data.worldbank.org/indicator/EG.ELC.ACCS.ZS?locations=SC-MU-MZ-KM-AO-BW-NA-MW-MG-CD-SZ-LS-ZA-ZM-ZW-TZ, accessed 2 September
[70] UNDP Blog, Why climate change fuels violence against women, January 2020, https://www.undp.org/blogs/why-climate-change-fuels-violence-against-women accessed 8 September 2021

Poor harvests, livestock loss, lower earnings and food insecurity may cause women to resort to trading in sex in exchange for food or rent. Young women are particularly vulnerable to transactional sex, as they have no access to resources, they may need for food, education or necessities like menstrual hygiene products, and are preyed on by older wealthier men. Some families may resort to forced and early marriages of their daughters to better cope with food scarcity.

Water scarcity and poor water quality

Safe drinking water and sanitation are two of the essential elements that determine improvement of living standards and good health. As those who bear the primary responsibility of collecting water, easy access to safe water and sanitation is particularly important to women and girls. Droughts as a result of climate change tend to lengthen the distances that have to be walked as water sources become scare due to reduced rainfall. Increased rainfall and floods are also a risk as flood water can contaminate drinking water (surface water, groundwater, and distribution systems) and may increase the incidence of water-borne and water related diseases in both urban and rural settings.

Table 10.4 Access to basic water and sanitation

Country	Basic sanitation % population	Basic drinking water % population
Seychelles	100	
Mauritius	96	100
Botswana	77	99
South Africa	76	93
Eswatini	58	69
Angola	50	56
Lesotho	43	69
Zimbabwe	36	64
Comoros	36	80
Namibia	35	83
Tanzania	30	57
Mozambique	29	56
Malawi	26	69
Zambia	26	60
DRC	21	43
Madagascar	11	54

Source:SDG Dashboard.[71]

Table 10.4 shows that water resources are unevenly distributed across the region ranging from 43% in Mozambique to 100% in Mauritius. Access to basic sanitation ranges from 11% in Madagascar to 100% in Seychelles. It has been projected that almost all countries in the region are likely to experience significant reduction in stream flow. Water-related health problems linked to water scarcity are predicted to worsen due to increased rainfall variability and high temperatures.[72]

Absent, inadequate, or inappropriately managed water and sanitation services expose individuals to preventable health risks. Contaminated water and poor sanitation are linked to transmission of diseases such as cholera, diarrhoea, dysentery, hepatitis A, typhoid, polio, schistosomiasis - an acute and chronic disease caused by parasitic worms contracted through exposure to infested water.

Diarrhoea is the most widely known disease linked to contaminated food and water but there are other hazards. Approximately 829 000 people are estimated to die each year from diarrhoea as a result of unsafe drinking-water, sanitation, and hand hygiene. Yet diarrhoea is largely preventable, and the deaths of 297 000 children aged under 5 years could be avoided each year if these risk factors were addressed.

Substandard sanitation practices compromises women's menstrual hygiene and saline contamination of drinking water has been linked to pre-eclampsia, eclampsia and hypertension among pregnant women.

[71] SDG Sustainable Development Goals Country Profiles, https://dashboards.sdgindex.org/profiles, accessed 26 October 2021.
[72] Young T, Tucker T, Galloway M, Manyike P, Chapman A, Myers J, Climate change and health in SADC region: Review of the current state of knowledge, 3 September 2010.

Where water is not readily available, people may decide handwashing is not a priority, thereby adding to the likelihood of diarrhoea and other diseases. This is a particular risk in the time of COVID-19 when handwashing is one the main ways of preventing the spread of the virus.

Lack of proper water and sanitation in health care facilities places patients and staff at additional risk of infection. Globally, 15% of patients develop an infection during a hospital stay, with the proportion much greater in low-income countries. Inadequate management of urban, industrial, and agricultural wastewater means the drinking-water of hundreds of millions of people is dangerously contaminated or chemically polluted.[73] These impacts are compounded women's lack of access to disaster information and low participation in decision making on climate change.

Access to information and consultation

Protocol on Environmental Management for Sustainable Development



Article 20.3 of the Protocol on Environmental Management for Sustainable Development notes that state parties shall design gender responsive capacity building, education and training on environmental management and climate change for sustainable development initiatives.

Article 20.5: State parties shall employ people-centred, equitable, gender inclusive and participatory consultations of all stakeholders in all environmental management and climate change for sustainable development programmes and initiatives

As this chapter has shown climate change impacts women in particular ways because of social and cultural norms and the role that women play in households. In particular, they feel the negative health impacts of climate change. Women's lack of voice and agency in decision-making can drive gender gaps in outcomes.

Addressing gender inequalities by enhancing women's participation in decision-making is crucial for building communities' resilience to natural disasters. Evidence demonstrates that women have an active role in disaster preparedness, response, and recovery efforts. Because women have a better understanding of what women need, their involvement and leadership in disaster decision-making is crucial.[74]

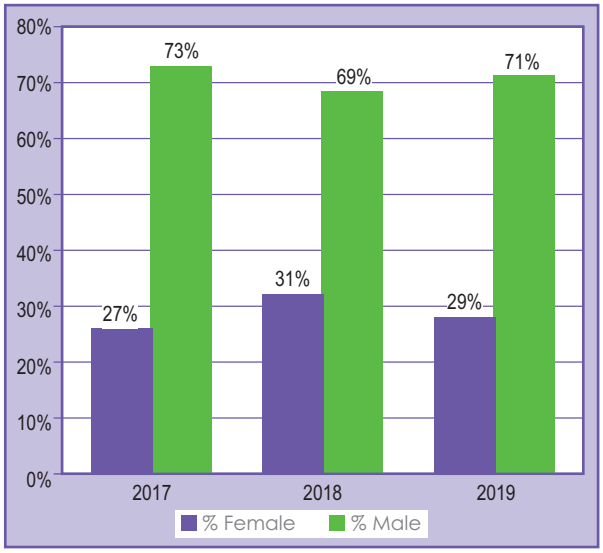
[73] WHO, Fact Sheet Drinking water, https://www.who.int/news-room/fact-sheets/detail/drinking-water accessed 15 September 2021
[74] Global Facility for Disaster Risk and Reduction (GFDRR) and World Bank Group, Gender Dimensions of Disaster Risk and Resilience, 2021

Women's Voice and Choice

The Conference of the Parties (COP 18) in 2012 agreed that additional efforts were needed by all Parties to improve the participation of women in bodies established under the Convention and its Kyoto Protocol. It decided to adopt the goal of gender balance for bodies established under the Convention and its Kyoto Protocol in order to improve women's participation and inform more effective climate policy that addresses the needs of women and men equally.

In addition, it advised Parties to strive for gender balance in their delegations to sessions under the Convention and its Kyoto Protocol. However progress has been slow, and COP 22 and 23 in 2016 and 2017 respectively noted the urgent need to improve the representation of women. Again in 2019 COP 25 recognized that the full, meaningful and equal participation and leadership of women in all aspects of the UNFCCC process and in national- and local-level climate policymaking and action is vital for achieving long-term climate goals.[75]

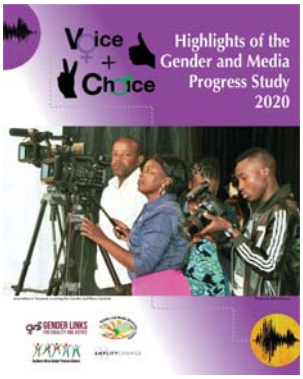
Figure 10.8: Gender composition of UNFCCC bodies



Source: UN Climate Change Secretariat (as at 12 April 2019).

Figure 10.8 shows that women are still under-represented on UNFCC bodies. This proportion ecreased by two percentage points to 29% in 2019. These statistics illustrate the need for more concerted effort to increase women's representation and meaningful participation in climate change negotiations.

The media also has a key role to play in reporting on climate change in a responsible manner and providing factual information. They play a key role in shaping public opinion about climate change. They have wide reach and help to explain technical jargon in simple terms. The media also portrays the human face of the climate crisis, holding those in power accountable from large corporations to public officials and policy makers.[76]



As with women in decision-making, it is vital that women be represented in the media on climate change issues. The latest Gender and Media Progress Study (GMPS) on gender equality in the news media in Southern Africa found that out of 18,630 new items monitored for a month only 3% concerned climate change.[77] It is encouraging that there are almost equal numbers of women (49%) and men (51%) reporting on climate justice.[78] However women make up just 27% of those speaking about climate change in the media.[79]

[75] UNFCC, COP, Gender Composition report by the Secretariat, 7 October 2020
[76] Kenyan Institute for Ethics, https://kenan.ethics.duke.edu/the-media-is-at-the-center-of-fighting-climate-change/ accessed 9 Sept 2021
[77] Gender Links, SADC Voice and Choice Barometer, 2021, Chapter 10, Media, Information and Communication (2021), p26
[78] Ibid p17
[79] Ibid p26

Mitigation and adaptation measures for climate change



Article 31, 1b: State parties shall conduct research to access the different gendered impacts of climate change and put in place effective mitigation and adaptation measures.

Article 20.6: Protocol on Environmental Management for Sustainable Development: State parties shall, as part of their research agenda, include all aspects of gender in environmental management, risk assessment, emergency and disaster response, and other sustainable development initiatives.

There is a need to consider the different impact of climate change on women, men, boys and girls, in designing mitigation strategies. "It is not about simply adding a 'woman's component' or a 'gender equality component' to existing interventions for combatting climate change. The process entails that the perceptions, experiences, knowledge, interests, needs and priorities of males and females are given equal weight in planning and decision-making. It is also important to note that gender mainstreaming is contextual. Different contexts need to be informed by an effective gender analysis. This process plays a critical role in ensuring that women, men, girls and boys are not disadvantaged by climate change interventions. It allows for the collection of vital gender-disaggregated data that is needed to inform the various gender mainstreaming phases."[80]

Climate change mitigation

Climate change mitigations addressed the root cause of climate change through avoiding and reducing emissions of greenhouse gases to prevent the planet from warming to more extreme temperatures. In sum this means we must transition from fossil fuels to clean, renewable energy. We need to stop deforestation and extractive industries and restore our natural habitats. And we need to reduce our production and consumption patterns.

Contraception as strategy for climate change mitigation

By 2050, "the global population is expected to have increased to about 9.7 billion people, which evidently will be one of the significant drivers of greenhouse gas emissions and global climate change. Scholars advocate for population stabilisation or control as a viable way to address climate change and the associated impacts The prediction is that population stabilisation will likely contribute to a 30% to 40% decrease in emissions and subsequent decrease in global warming."[81]

[80] Bagabura, A. Gender Equality in Combating Climate Change: The African context. August 2019
[81] Share-Net International, Linkages between climate change and sexual and reproductive health & rights: a demographic perspective, 12 November 2019

Promoting contraception as a mitigation strategy for climate change is controversial for obvious reasons. It instrumentalises women's and girls' bodies and places emphasis and responsibility for tackling the climate crisis on those least responsible for contributing to it but most severely affected by its impacts. Policies and practices driven by a desire to stem population growth have led to countless human rights violations.[82]

However, over 200 million women want, but currently lack, access to modern contraceptives. As a result, 76 million unintended pregnancies occur every year. Meeting this unmet need could slow high rates of population growth, thereby reducing demographic pressure on the environment. There is now an emerging debate and interest about the links between population dynamics, sexual and reproductive health and rights, and climate change.[83]

The debate is an important one but should not shift attention away from the primary problem of high consumption in developed countries. The emphasis on population control or family planning as a strategy for climate change mitigation may exaggerate/ emphasize population increases without addressing other factors influencing climate change, such as consumption patterns and levels of economic development.[84]

What is needed is a social justice and rights approach for climate action that protects human rights, especially for the most vulnerable populations, and promotes justice, equity, and fairness.

Promoting green principles in waste management

Waste management already represents a key challenge in the SADC region. This will be exacerbated by climate change. Contributing factors are the increase in population and growing production of industrial and agriculture products.

The SADC Climate Change Strategy and Action Plan (CCSAP) proposes three key actions to be taken to mitigate the impacts of climate change:

- Develop policies that encourage investment in alternative energy production using waste products;
- Promote waste recycling, reuse and reduction;
- Develop an enabling framework to promote waste minimisation through education and behavioural change of waste generators and the general public.[85]

While policy makers develop policy it's local councils and communities on the ground that can take concerted action in waste management.



Sorting waste in Lesotho. Photo: Trevor Davies

[82] Ibid
[83] SADC Climate Change strategy and action plan, p35
[84] Share-Net International, Linkages between climate change and sexual and reproductive health & rights: a demographic perspective, 12 November 2019 https://share-netinternational.org/linkages-between-climate-change-srhr/ accessed 8 September 2021
[85] SADC Climate Change strategy and action plan (CCSAP), 24 July 2015, pp 31



Waste Management key to a clean city - Masvingo City Council, Zimbabwe



Masvingo City women in clean up campaign. Photo: Tapiwa Zvaraya

Masvingo city community ward health clubs were formed by the city in collaboration with Oxfam to help manage the city against Cholera. After the partnership, the council took ownership of the project by supporting the health clubs to carry out their various activities including recovery and recycling of the waste.

The city has been facing challenges on waste management issues. The amount of waste generated from the community and emanated from dumpsites became a burden to the city and a time bomb to disease outbreaks. The council seeks to reduce waste through recycling, reuse and reduction in order to increase the caring capacity of the refuse compactors of the city. The council is empowering the community by building the capacity of health club members through income-generating projects so they can earn a living. The community polices themselves against littering since they manage the cleaning.

The key activities of this intervention include street cleaning, paper picking in the respective ward's defined area, waste disposal and any other waste management services required by the council. In return, the council remunerates the community cleaners. Other income-generating activities include the sale of various artefacts, 3 legged ports, oil, and paving bricks made from collected and recycled waste.

Through these activities, the council has managed to clear all the illegal dumpsites. The community is now able to manage their waste at the household level through health education from the community members. The health club members are now able to pay council rates and services for their houses thus more revenue to the council. The biggest lesson coming out of this is that waste is money.

Source: Gender Links Zimbabwe Voice and Choice Summit Climate Justice case study 2019.

Climate change adaption

Climate change adaptation relates to the process of adjusting to actual or expected impacts of climate change. This means altering our behaviour, systems, ways of life, our economies, and the environment in which we live from the impacts of climate change. It fosters resilient communities, economies, and ecosystems by considering climate risks in decision making at all levels.

Climate change adaption plans and strategies cannot be gender neutral as climate change impacts people differently based on their roles and responsibilities in families, communities and societies, defined by gender, age, class, sexual orientation. By using an intersectional approach and understanding the particular and compounded barriers that people face, and how these exacerbate their vulnerability to climate

change, adaption strategies can reduce climate risks for the most vulnerable people while also tackling systemic inequalities.

Gender equality should be at the centre of analyses and policy decisions, programmes, financing, institutional structures and processes, implementation and monitoring and evaluation. "It is not about simply adding a 'woman's component' or a 'gender equality component' to existing interventions for combatting climate change. The process entails that the perceptions, experiences, knowledge, interests, needs and priorities of males and females are given equal weight in planning and decision-making. It is also important to note that gender mainstreaming is contextual. Different contexts need to be informed by an effective gender analysis. This process plays a critical role in ensuring that women, men, girls and boys are not disadvantaged by climate change interventions. It allows for the collection of vital gender-disaggregated data that is needed to inform the various gender mainstreaming phases."[86]

An important part of this process is to examine how norms and traditional beliefs related to gender have been institutionalised. "By acknowledging and confronting gender-related biases and barriers institutions, decision-makers can take an important step toward creating the conditions for gender equality and social inclusion in the policies, programs, and services that they deliver."[87]

No SADC country in the region has yet submitted a National Adaption Plan (NAP) established under the Cancun Adaptation Framework (CAF). The NAP process is about identifying medium- and long-term adaptation needs and developing and implementing strategies and programmes to address those needs. However ten countries have developed National Adaptation Programmes of Action (NAPAs) for climate change.

Climate adaption plans and programmes of action should cover a range of sectors including agriculture, water, biodiversity, fisheries, health, security, settlements and infrastructure, tourism and mining and other extractive industries. Each of these issues affect women in particular ways and adaption strategies should address these different needs and circumstances.

Involving women and men in climate adaption, from planning to implementation is essential to ensuring that the final solutions will benefit the entire community. Women have a lot of knowledge and experience that is important and useful for adaption because of the roles they play in society and interaction with the environment.[88]

"Recent estimates suggest that implementing adaptation measures in the health sector could reduce the number of children at risk from chronic under-nutrition by 10 million in Sub-Saharan Africa, through improved disaster risk reduction measures that reduce vulnerability to extreme events such as flooding and droughts. A particular challenge from a climate perspective for the sector is the scant data available on the links between climate variables and disease patterns, which makes it difficult to design appropriate intervention and surveillance methods. Nevertheless, the most effective measures to reduce vulnerability to climate in the health sector in the near term are (a) promoting programs that implement and improve basic health system measures, such as the provision of safe water and improved sanitation, (b) securing essential health care, (c) increasing capacity for disaster preparedness and response, and (d) alleviating poverty.[89]

There is no explicit mention of SRHR in any of the health sections of the NAPAs, which focus on the spread of waterborne and vector diseases that are exacerbated by climate change. This is an obvious gap. While states must develop and implement gender aware NAPs, local communities have a key role to play in adaption efforts.

[86] Bagabura, A. Gender Equality in Combating Climate Change: The African context. August 2019
[87] Ibid
[88] Gender CC, Gender and Climate, https://www.gendercc.org.za/gender-climate/ accessed 20 September 2020
[89] USAID, Regional Factsheet, Climate Risk Profile Southern Africa, 2016

Madagascar: Climate change adaption means every day simple gestures

Fitobea Edwin won the 2019 Voice and Choice Summit award in the climate change category in Madagascar for an agricultural project he is implementing in a rural Fort-Dauphin council called Somangymiavotse. The project is in southern Madagascar where there is a growing hunger crisis because of climate change. Amboasary Sud is also included in the project.

The project promotes women's involvement in the male-dominated agriculture sector through market gardening as an income generating venture. This empowers them financially and ensures food security for families.

This project touches on three climate change rights, which are:

- The equal right between men and women to access land.
- The right to food and
- The right to food production.

The project involves three steps:

- A General Assembly conducted with traditional leaders to explain the importance of the work,
- Sensitisation and home visits to identify households able to engage in the process.
- Agricultural training on the leafy vegetable plantation.



Fitobea Edwin, National Summit Climate Change Category Winner 2019, Hotel le Pave, Madagascar. Photo: Zoto Razanandratefa

Women's groups in the Lutheran and Catholic Churches are partners in raising awareness. Men prepare the planting beds and dig the well required for the irrigation of the plantation. Women participants are empowered financially to solve their economic challenges in households. They also participate in environmental conservation and nutrition. Edwin's plan for the future is to expend the project within the association and to neighbouring villages.

Source: Gender Links Madagascar Voice and Choice, Summit Climate Justice case study 2019.

As the level of government closest to the people who are most vulnerable to and impacted by climate change, local government councils should be leading climate change adaption measures.



Lesotho: Council empowers women to address climate change

The land in Mafeteng Lesotho is naturally dry which means it is vulnerable to extreme climate change-related disasters such as strong winds, drought, flood and wildfires.

The council has encouraged its populace, especially women to form cooperatives; solicit external funding and use greenhouses to produce food as a climate change adaptation measure to ensure food security, reduce the number of people exposed to climate-related risks and susceptible to poverty. The council also aims to fight gender based violence through empowering women to provide food for their families and making them less vulnerable to abuse.

The council has introduced hail nets and greenhouses, economically empowering women and equipping them with agricultural skills; helping women ensure food security and curb malnutrition. The council helps project beneficiaries find market for their products.

In the face of declining water supplies, reduced agricultural yields, health impacts and erosion the council is working to curb overgrazing and burning. The council is also working with the ministry of water to fix old village taps and add more taps to reduce the water stress especially for women. The council is also working closely with the ministries of agriculture and of trade to encourage women to adopt innovative agricultural projects to mitigate the effects of climate change.



One of the greenhouses provided by the Mafeteng Urban Council.
Photo: Palesa Moleli

Source: Submitted by Mafeteing Urban Council as one of their projects, 2019.

Youth participation

Sixty percent of Africa's population is under 24 years old, making Africa the world's youngest population.[90] As the inheritors of the climate crisis youth have a crucial role to play in climate action, mitigation, adaption and policy-making. Governments should be working with youth-led and youth-focussed organisations to enhance effective participation of youth in climate change policy decision-making processes. This key constituency is however often neglected in policy processes and designing climate change responses.

The voice of youth has only recently become more prominent in the global response to climate change. Protest-oriented programmes, such as Fridays for Future, Earth Uprising and the Extinction Rebellion, have some key aims, which are, to

[90] United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, Key Findings and Advance Tables. Working Paper No. ESA/P/WP/248.

enhance the voice of youth on climate change; address intergenerational climate justice and hold political leaders accountable for insufficient progress in addressing climate change.

Young people are establishing networks in schools, universities and communities, using social media, and a range of innovative communication strategies to raise awareness and better coordinate action and shape climate responses.[91]

While the representation of youth in formal negotiations is growing there is need to increase young people's participation in strategy formulation and implementation. More work is needed to understand what intergenerational equity and meaningful youth participation means and how it can be practised.



Zambia: Action and youth involvement in climate change



Sr Chanda Nsonfwa, Lungu Collins, Fr Chris Kunda and Mwansa Muhandu at Radio show to raise awareness on climate change and Environmental issues in Zambia. Photo: Albert Ngosa

Zambian youth are working with the media to raise awareness about climate change and the environment to change the mind-set of the general public.

Often people do not know of the effects of our human actions have on climate change. People also do not know the ways in which they can take part of the solution to restore the earth and make a better future. For people to change they need to change their mind-set first, they need to realize the problem and work towards solving it. This is why the focus of the action is knowledge creation and awareness raising.

The Global Catholic Climate movement Zambia Chapter is raising awareness through the radio programs aired on Radio Maria Yatsani voice 99.3FM every Thursday. The radio programme had a major impact because it started at a time of COVID-19 when people were listening to radio more because they were often at home. The programme started as a recorded programme and then became a live show in which people would phone in and give their ideas.

They also have a weekly TV Show that airs every week at Wednesday 18:30hrs. This show has from March featured different guests who have discussed topics all related to climate change and the environment. We have conducted trainings for Youths at Cicetekelo Youth Project in Ndola and St Francis of Assisi School.

The Lumen TV programme on climate change has since grown through a "See, Judge, Act" method which makes people see the problem, judge the extent of the problem and take action. It draws examples from the community, globally and locally. Individuals and organisations discuss their role in climate action and bringing about change.

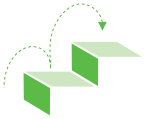
The aim is to help people understand that there is something they can do to bring about change. They stream all their TV shows through Facebook page reaching a wider audience. The Global Catholic Climate Movement Zambia

[91] Benkenstein A, Chevallier R, Kosciulek D, Lebea, D & Worth K, Youth Climate Advocacy, Special Report November 2020

Chapter has contributed to the development of the Climate Change Bill which The Ministry of Lands and Natural Resources had asked for inputs. "We put our ideas together and sent a document to the Ministry for the consideration. This has helped us take part in lobbying with the government to being issues that affect climate to consideration in Policy and Law making" says Collins Lungu of the Global Catholic Climate Movement Zambia Chapter

Lungu adds, "There is much need for our movement to come up with ways of sustaining our programs and bringing more awareness through community work and community physical awareness building. We have learnt that advocacy is more impactful through videography and Photography and people pay more attention to audio-visual content and other forms of technology. We intend to enhance our viewership on social media and mainstream media by use of these two means. We will enhance our content to being more and more awareness to the communities to see the change we desire."

Source: Gender Links Voice and Choice Zambia Summit entry, 2019.



Next steps

- It's time for action, while policy is important to guide adaption action, and States should comply with international regulations, it is now time for governments and communities to step up the action and commitment to addressing climate change.
- Gender should be a key consideration in setting policy and strategy on climate change, as responses cannot be gender neutral and must address women's specific needs and circumstances by addressing structural barriers to gender equality in climate change policies and actions.
- Strengthen evidence base on the links between SRHR and climate change. This is key to creating effective adaption and mitigation strategies that meet the particular needs of women.
- Make specific provision for SRHR in adaption and mitigations strategies ensuring universal access to SRHR services should be part of a comprehensive health response to the climate crisis.
- Gender mainstreaming in adaption and mitigation strategies should address women's needs across all sectors - agriculture, water, energy etc.
- Improve women's access to land, by adopting gender-responsive land reforms and ensure equal access to productive resources, finance and technology.
- Invest in and increase women's representation and effective participation in climate change decision-making from local to global level. As the most impacted by climate change it is essential that they are represented and fully participate in all aspects of climate change action from community involvement to global negotiations and policy making. Instead of being seen as victims of climate change impacts, they should be seen as part of the solution, with specialised knowledge and capacities to influence and shape effective gender-responsive climate change actions.
- Invest in health systems that address the underlying causes of vulnerability to climate change.
- Promote and strengthen community involvement in climate response ensuring gender balance, multi sector participation and collaboration between the climate change, health, and women's rights advocacy and humanitarian communities.
- Enhance education and awareness-raising at all levels in relation to climate change impacts and adaption approaches. Governments, in partnership with civil society organisations,

should create greater awareness and understanding of the relevance of gender equality in the fight against climate change.
- Increase advocacy and campaigning and maximize this through different communication channels including online social media platforms, using material that is appropriate for different demographics, specifically on language.
- Build and strengthen capacities on climate change issues at all levels from accessing and harnessing capacity building programmes at the international level to outreach programs on climate change for citizens in both urban and rural areas; empowering regional networks and facilitating sharing of experiences, information and documenting best practices on climate change responses in SADC countries.



Community members test a solar powered cooker in South Africa. Photo: Gender Links

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these instruments through a Monitoring, Evaluation and Reporting Framework.

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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

As the COVID-19 pandemic struck in 2020, the Barometer pivoted to tracking the impact of the pandemic on sexual and reproductive health, GBV, economic justice, political participation and climate change. While the evidence of this impact is still being gathered and analysed, this barometer provides a wealth of anecdotal evidence showing the devastating impact that COVID-19 has had on lives and livelihoods.

It is fitting that the Barometer foregrounds #VaccineGenderJustice. As I speak only 2% of the 360 million people in SADC have been fully vaccinated against COVID-19 compared to half or more in most developing countries, and 14% across the globe. *Vaccine apartheid is there for all to see!* We still do not have sex disaggregated data on vaccine roll out. What we do know for sure is that if not the majority of those infected, women are the worst affected by this pandemic.

Hon. Dr Patricia Kaliati
Minister of Gender, Community Development and Social Welfare

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