SADC GENDER PROTOCOL 2020

BAROMETER



in the time of COVID-19

Colleen Lowe Morna,
Kubi Rama and Sifiso Dube

Southern Africa
Gender Protocol Alliance

Foreword by 'Dr T'
Dr Tlaleng Mofokeng

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.

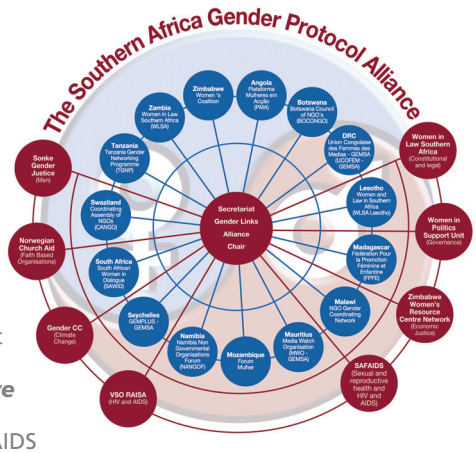
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Alliance partners
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Gender Links
Constitutional and legal rights
Women and Law Southern Africa (WLSA)
Governance
Women in Politics Support Unit (WIPSU)
Sexual and Reproductive Health and Rights
Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)
Care work
Voluntary Services Overseas - Regional Aids Initiative South Africa
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)
Lesotho
Women and Law in Southern Africa (WLSA-Lesotho)
Madagascar
FPFE Federation Pour la Promotion Feminine et Enfantine
Malawi
NGO Gender Coordinating Network (NGOGCN)
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Mozambique
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Namibia Association of Non-Governmental Organisations Trust
Seychelles
GEMPLUS
South Africa
South African Women in Dialogue SAWID
eSwatini
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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
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newventurefund

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

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EDITORIAL TEAM



Colleen Lowe Morna (Zimbabwe/ South Africa) is CEO of 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. 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 eleven Barometers.



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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.



Makanatsa Makonese (Zimbabwe) is the Deputy Chief of Party for the American Bar Association-Southern Africa Human Rights Programme based in Johannesburg, South Africa. She holds a PhD in Law from the University of Zimbabwe with a focus on women's law and rights, land law and international human rights law. She is an experienced human rights lawyer who has worked in various countries in SADC and internationally. She has worked as the Executive Secretary/Chief Executive Officer of the Zimbabwe Human Rights Commission, Executive Secretary/Chief Executive Officer of the SADC Lawyers Association (Botswana and South Africa), a Senior Environmental Lawyer and Gender Programme Coordinator for the Zimbabwe Environmental Law Association, an Advocacy Officer for the Child Protection Society in Zimbabwe and as a Magistrate in Zimbabwe.

Makanatsa has worked with the United Nations Entity on Gender Equality (UN Women) in Uganda in developing Standard Operating Procedures for Managing Gender Based Violence and Violence against Children in the Uganda Police Force. She has also worked with UN Women in Zimbabwe in developing an Investigations and Complaints Handling Manual for the Zimbabwe Gender Commission. Makanatsa is currently working with the Food and Agricultural Organisation (FAO) in formulating a National and Gender Sensitive Land Policy for Zimbabwe. Makanatsa wrote the Harmful Practices chapter of this #VoiceandChoice Barometer.



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MIET AFRICA Lynn van der Elst, Jennifer Norins and Megan Cockerill of MIET Africa (South Africa) peer reviewed the Adolescents Sexual Reproductive Health and Rights Chapter. MIET AFRICA is a forward-thinking not-for-profit African education organization that aims to improve the lives of children and youth through supporting the provision of quality education for all. We use principles of social entrepreneurship to actively identify barriers to education achievement and to conceptualize and pilot ground-breaking, replicable interventions that address these challenges. MIET AFRICA is based in South Africa with a strong presence in the Southern African Development Community (SADC) Region.



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Foreword

#VoiceandChoice resonates with the subject closest to my heart: quality sexual and reproductive health services. Without voice there is no choice. Without choice women and girls have little hope of realising their full potential in their public and private lives. Their choices must be supported with access to comprehensive services.

The 2020 Barometer, a flagship publication of the Southern Africa Gender Protocol Alliance, is being launched in the shadow of the COVID-19 pandemic. Our mental health is under severe stress. The greatest fear is that of losing the fragile gains made on gender equality twenty five years after the Fourth World Conference on Women in Beijing and the International Conference on Population and Development (ICPD) in Cairo.

Resilience and adaptation are the buzzwords of the "new normal". Will the "new normal" be business as usual with a few minor adjustments? Or will this upheaval help us to shake patriarchy at its roots and end systems of oppression so that we attain Goal Five of #GenerationEquality by 2030, the deadline of the Sustainable Development Goals (SDG's)?

The Barometer reminds us that all pandemics and emergencies prey on inequality. COVID-19 is no exception. Like HIV and AIDS, the virus that began outside of Africa, affecting middle class men, now rages like wild fire through African and mostly poor communities.

As in the case of HIV and AIDS, women are now the majority of those *infected* and *affected*. They are at the frontline of health services, carrying collapsing public health on their backs - they continue to show up for communities, soldiers in a war against an invisible and seemingly invincible enemy.



Dr Tlaleng Mofokeng

They predominate in the so called "soft" sectors of the economy like domestic work and hospitality that have some of the least protections and have now lost the most jobs. Women continue to shoulder the burden of unremunerated care work in the home. Home is not necessarily a safe space and when we were all told to "stay at home" for some women and children, this became a death sentence.

There are fears that HIV and AIDS treatment that saves thousands of lives each day will be disrupted mainly due to supply and procurement issues as well as disruption in HIV prevention and treatment and community programmes including contraceptive stock-outs.

Young people have a particular vulnerability to being raped and even those in consensual peer sexual contact are at risk of unsupportable pregnancies Access to safe abortions continues to be the biggest hurdle, fraught with complexities of access. In the case of South Africa, despite the *Choice of Termination of Pregnancy Act* this failure amounts to systemic violence.

Harmful practices that are human rights violations such as child marriages and *ukuthwala* continue to occur in our communities. So-called "key populations" such as LGBTIA+ communities and sex workers, already "locked down" in their marginalised spaces, face further stigma and discrimination.

Many of the social support and relief funds were inaccessible to sex workers as they are criminalised and not recognised in our law as workers within their own right. A lack of social support means that it is women in poorer communities again, who are made more vulnerable due to criminalisation. LGBTIA+ communities continue to be excluded from sheltering as some of the intake protocols exclude transgender women for example.

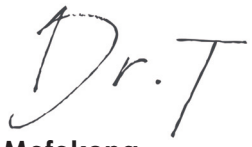
But there are silver linings to the dark cloud. The way that the Alliance networks have swung into action in defence of SRHR services under lockdown is a reminder of the power of advocacy. "Periods don't stop for pandemics" and many other home truths forced their way onto the agenda through virtual meetings, social media and community radio.

In Botswana, Minister of Health and Wellness, Dr Alfred Madigele, has suggested that safe abortion must be debated and I urge them to advance and promote law reform to ensure access to safe abortions is realised.

The Barometer abounds with views and voices from local government, the tier of government closest to the people. How heartening to see municipalities leading the march for gender responsive services!

By broadening its scope to include economic justice, political participation and climate change, the Barometer sends home the strong message that #VoiceandChoice is not just about bodily integrity, but women's rights in their totality.

An indiscriminate virus can wreak havoc, roll back progress, lock us down. The indomitable spirit of the women on whose shoulders we stand during this Women's Month in which the Barometer is being launched reminds us that we can beat COVID-19. And yes we *can* emerge as #GenderationEquality!



Dr Tlaleng Mofokeng
9 August 2020

(Dr Tlaleng Mofokeng is UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. She is also a Commissioner at the South African Commission for Gender Equality; Author: Dr T: A Guide to Sexual Health and Pleasure and member of the boards of Safe Abortion Action Fund, Global Advisory Board for Sexual Health and Wellbeing, Accountability International; Chair of the Sex Worker Education and Advocacy Taskforce and vice-chairperson Soul City Institute She runs a Reproductive Clinic in Sandton).

EXECUTIVE SUMMARY



Participants in the Economic Power to End GBV Sunrise Campaign in Madagascar regroup during the COVID-19 pandemic to re-strategise. Photo: Zoto Razanadrotefa

The 12th #VoiceandChoice Barometer reflects slow progress in advancing women's rights in the Southern African Development Community (SADC) region. The COVID-19 pandemic threatens to roll back fragile Sexual Reproductive Health and Rights (SRHR) gains made in the last decade.

The #VoiceandChoice Barometer measures 100 indicators in seven thematic areas: sexual and reproductive health; adolescent SRHR; safe abortion; GBV; HIV and AIDS; harmful practices and sexual diversity. The 2020 Barometer adds chapters on Climate Change, Economic Justice and Women's Political Participation, key components of #VoiceandChoice, and clusters of the Southern African Gender Protocol Alliance. The State of Women in SADC Report that will be published in November 2020 weighs indicators across all these sectors and ranks countries based on these.

In the tradition of the 2019 Barometer, the 2020 Barometer continues measuring progress against the 100 SRHR indicators. The SADC SRHR strategy adopted by Health Ministers in 2018 provides a progressive tool for measuring the progress of SRHR in the region. The strategy builds onto 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.

A detailed explanation of the methodology used in the SRHR scorecard is included as a technical note at Annex A. The SRHR Scorecard rates countries using an index classifying performance based on quartiles. The dataset is divided into three sections using the interquartile range. Values above the first quartile is included in the 1st quartile under GREEN, anything between the 1st and 3rd quartile will fall under the YELLOW color while those below the 3rd quartile will fall under the RED color.[1] Green denotes that countries have met the required target, yellow means efforts are needed to achieve the target and red highlights countries that need urgent action to achieve the target. The 12th Barometer includes Comoros, the 16th SADC country.

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

Table I: Overview of countries by indicators, 2020

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.	29	25	32	29	17	35	21	22	9	28	16	9	11	21	23	21	3	8	5	0
Adolescent birth rate, 10-19 years of age.	151	46	70	124	77	93	110	133	26	149	64	62	68	118	120	86	5	4	7	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).	36	14	30	27	14	16	18	16	10	24	16	n/d	14	21	18	10	6	6	3	1
Percentage reduction in new HIV infections, females 15-24.	1.2	8.9	n/d	0.5	15.9	10.8	0.1	4.3	0.2	3	4.5	n/d	11.3	2.2	4.9	5.5	9	2	3	2
Mother to child transmission of HIV.	27.8	2.5	n/d	27	7.8	12.7	39.8	7.8	13.7	15	3.9	n/d	4.9	10.5	11.2	7.6	7	5	2	2
Percentage of condom use with last high-risk sex among adolescent girls and young.	32	n/d	n/d	25	54	76	5	50	n/d	42	66	n/d	61	30	41	67	1	10	1	4
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	0	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	n/d	58	43	41	42	43	25	48	39	30	31	47	18	43	2	4	9	1
Percentage of annual budgets allocated to health sector (Abuja Declaration recommends 15%).	5.4	9.1	3.6	3.7	15.25	10.1	17.8	9.8	10	8.3	13.8	10	13.3	9.5	7.1	14.5	2	9	5	0

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.

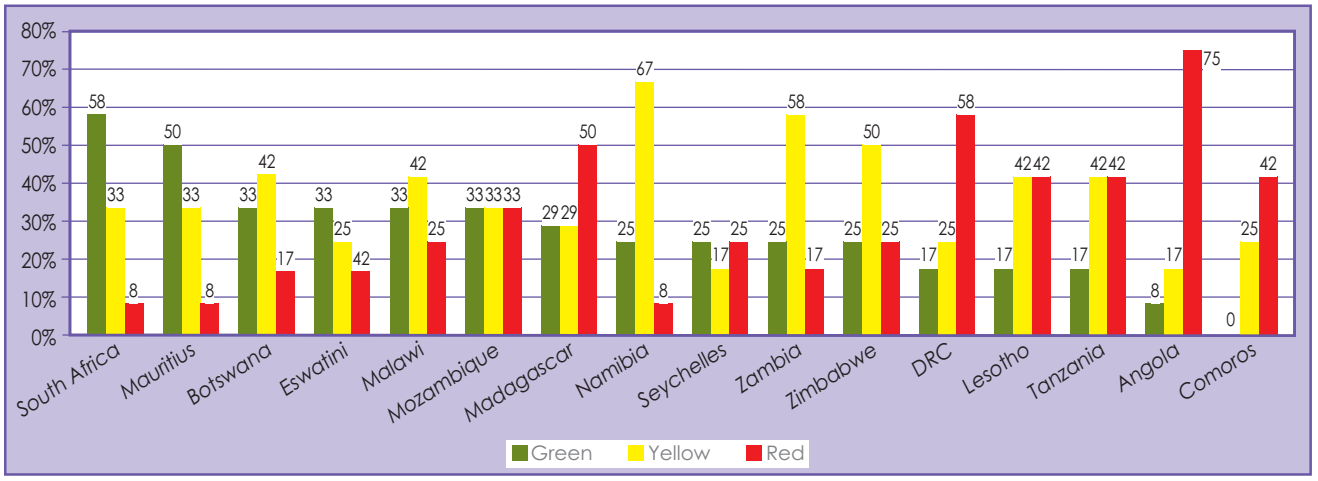
Table II: Summary of performance by indicator

Indicators	Green	Yellow	Red	No data	% Green
Percentage reduction in new HIV infections, females 15 - 24	9	2	3	2	56%
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)	6	6	3	1	38%
Minimum legal age of consent to marriage, 18 years for all irrespective	6	4	6		38%
Adolescent birth rate, 10-19 years of age	5	4	7	0	31%
Neonatal mortality, institutional	3	8	5		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	9	1	13%
Maternal mortality	2	4	10		13%
Legal status of abortion	2	13	1		13%
Percentage of annual budgets allocated to health sector	2	9	5		13%
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age	1	10	1	4	6%
Total #	***51***	***69***	***62***	***10***	
Total possible score	***192***	***176***	***192***	192	
Percentage of total	***27%***	***36%***	***32%***	***5%***	

Table II shows that:

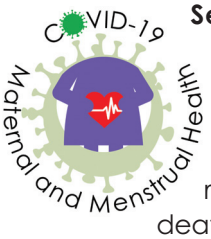
- Overall, only 27% of the 12 indicators that could be measured fall in the green category; 36% in the yellow category; 34% in the red category and 5% in the no data category.
- The largest number of greens (56%) is percentage reduction in new HIV infections among females aged 15 - 24 followed by reduction in Mother to Child transmission of HIV (50%). The region still needs to accelerate commitments to reducing HIV infections.
- 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: Overview of country SRHR scores

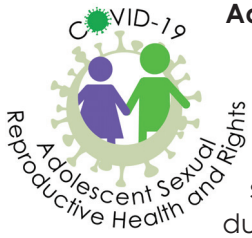


Source: Gender Links SRHR indicators table computed from global data sources.

Figure I summarises each country's performance on the basis of the 12 indicators. South Africa (58% green) is in first position followed by Mauritius (50% green) and Botswana; Eswatini, Malawi and Mozambique (33% green) tie for third place. Fourteen SADC countries have achieved less than 50% of the targets. The lowest ranking countries on the green scores are DRC, Lesotho and Tanzania (17% each) followed by Comoros (8%) and Angola (8%). Angola (75%) and DRC (58%) have the highest red score. Namibia (67%) and Zambia (58%) have the highest yellow score. Key factual highlights in each theme chapter of the Barometer include:



Sexual and reproductive health: Maternal mortality remains high across the region, despite political commitment to reduce it. Fourteen countries in SADC remain below the target of 70 deaths per 100 000 women. Of the 16 SADC countries, 14 now have stand-alone policies or guidelines on Sexual and Reproductive Health and Rights (SRHR). Only two (Angola and DRC) do not. However, many countries failed to mainstream SRHR into their COVID-19 responses, leaving women and girls without vital services and support throughout the region during the pandemic. Six SADC countries (Lesotho, Mauritius, Seychelles, South Africa, Zambia, and Zimbabwe) have removed Value Added Tax (VAT) from menstrual hygiene products and five (Botswana, Lesotho, Madagascar, Seychelles, and Zambia) now provide free sanitary pads in schools. The COVID-19 pandemic has increased the need for clean water and sanitary facilities for menstrual hygiene and highlighted the lack of clean water in many SADC communities. More women than men collect water in nine of 16 SADC countries studied. In Mozambique and Malawi, a recent study found that 84% of women and girls collect water for the household, as opposed to just 6% and 7% men and boys, respectively. In eight SADC countries (Comoros, DRC, Eswatini, Malawi Mauritius, Mozambique, Tanzania, and Zambia) more than half of women between ages 15 and 49 do not have a say in decision-making about contraceptive use. The COVID-19 pandemic highlighted many gaps in health systems in the region, underscoring the need for countries to adhere to their Universal Health Coverage commitments, with SRH mainstreamed throughout.



Adolescent SRHR: UNESCO estimates that 75 million learners enrolled in primary and secondary schools in Southern Africa (more than 70% of students) were out of school due to COVID-19 from February to May 2020. Governments have struggled to keep commitments to achieving universal access to Sexual and Reproductive Health and Rights (SRHR) due to the COVID-19 pandemic. Menstrual health and harmful practices for adolescents are not receiving sufficient attention. Better access to sex education and contraceptive information could reduce high numbers of maternal deaths due to unsafe abortion. Bowing to local and global advocacy, and in a major policy reversal, the Tanzanian government committed to providing pregnant girls with equal opportunity to education in March 2020.



Safe abortion: The Guttmacher Institute reports that 24% of all pregnancies in Southern Africa end in abortion. The 2019 Nairobi International Conference on Population and Development (ICPD25) firmly established that safe abortion services and treatment of complications from unsafe abortion represent one of nine essential elements SRHR service. ICPD25 resulted in renewed commitments from governments across Africa and the globe to the provision of SRHR to reach three overarching targets: zero maternal deaths, zero unmet need for family planning, and zero gender-based violence (GBV) and harmful practices within the next decade. A new study has shown the negative impact of the Global Gag Rule on improving legislation around abortion and provision of SRHR services. No SADC country totally bans abortion, but most conditions under which women can obtain abortions remain restrictive. Little change has occurred in legislation in the last year, but DRC and Mozambique have made strides to improve their legislative framework for abortion. Namibia's First Lady spoke out in favour of legal reforms to

improve access to abortion in July 2020 as lawmakers in that country prepared to debate the issue. Unsafe abortions affect mostly poorer, unmarried women and adolescents. As this group contributes significantly to high maternal mortality rates in the region, it will be difficult to reach the goal of eliminating maternal mortality without addressing the need for safe abortion. Emerging evidence suggests that the COVID-19 pandemic will increase the need for abortions, reduce the provision of abortion services, restrict access to abortion and SRHR services, and reduce the opportunities for advocacy for legislative reform.



HIV and AIDS: SADC, which has 4.6% of the world's population, is home to 45% of all people living with Human Immunodeficiency Virus (HIV) in the world. In 2019 SADC accounted for: 55% of new infections in young women and 35% new infections in young men globally; 48% of people on antiretroviral therapy (ART) and 55% of children on ART globally; 65% of the global number of pregnant women that were on ARTs; 67% of voluntary malecircumcisions (VMC) conducted in priority countries; 35% of all acquired immune deficiency syndrome (AIDS)-related deaths, 46% of AIDS related deaths in young people (15 to 24), 37% of AIDS related deaths in children; 50% of TB-related AIDS deaths globally and 52% of all AIDS related deaths that are estimated to have been averted by ART. Much progress has been made towards achieving the UNAIDS 2020 targets of 90% awareness of status, 90% access to treatment and 90% suppression of the virus. New infections in adolescent girls and young women have been declining steadily and the proportion of new infections in key populations (sex workers, men who have sex with men, people who inject drugs - who are especially important in the island nations, prisoners) is rising. COVID-19 is disrupting HIV services. This could lead to an additional 500,000 deaths in sub-Saharan Africa by the end of 2021 and regression of the Prevention of Mother to Child Transmission (PMTCT) programme to levels of a decade ago. Community care workers have been called into COVID-19 service to support testing and will likely support those that contract COVID-19 and not be hospitalised.



Gender-based violence: COVID-19 lockdowns could have a "catastrophic impact" on women, leading to a 20% surge in domestic violence cases. Restrictions linked to the pandemic have worsened existing gender inequalities and left many women and girls without options to escape violent settings as governments across the region shuttered clinics and shelters and limited response mechanisms. Fifty seven percent of women surveyed in Zimbabwe 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. Following a spike in violence against women during the pandemic, South Africa announced a R1.6billion Emergency Response Plan to fight GBV and femicide. Some countries still lack critical data on intimate partner violence (IPV) and violence against men. Globally, traffickers rob a staggering 24.6 million people of their freedoms and basic human dignity. In September 2019, the SADC Parliamentary Forum convened to discuss ways of harmonising and implementing GBV legislation to establish a GBV Model Law for SADC. “Hashtag advocacy” has gained tremendous momentum as a social media campaign tool across the region, although researchers warn its successes could be short-lived. A global UN Women study in 2019 found that 84% of respondents believe it is essential for society to treat women as equal to men.



Harmful practices: The Tanzania Court of Appeal upheld a 2016 High Court judgment outlawing child marriage and declaring it unconstitutional. The Government had appealed the 2016 ruling, arguing that the court should uphold Islamic and customary laws, which allowed for marriage before age 18. Civil society in Mauritius continue to lobby government to repeal Section 145 of the Civil Code, which allows children from the age of 16 years to marry if they have parental consent. Meanwhile, the government has tabled a Children's Bill, which seeks to repeal the Child Protection Act and replace it with a new legislative framework to

protect children. In South Africa, a 2019 Constitutional Court ruling gave spouses in both monogamous and polygamous customary marriages equal rights of ownership and control over matrimonial property. In Eswatini, the progressive Sexual and Domestic Violence Act continued to face resistance, mostly because it criminalises marital rape. DRC is on track to pass its Disability Rights Bill in 2020. The Act will protect children with disabilities from accusations of witchcraft. Zimbabwe gazetted a Marriage Bill to harmonise its different marriage regimes and laws and ensure that it governs all marriages under one law. Emerging harmful practices in the region, such as skin lightening/bleaching and vaginal tightening have negative impacts on women's health yet remain readily available.



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 strategies towards the attainment of universal health care.



Economic justice: SADC states need to turn global, continental and regional economic commitments into change for women on the ground. The SADC Industrialisation Strategy and Roadmap 2015-2063 needs review to integrate gender in all pillars and to prioritise Women's Economic Development Strategy. Macro-economic policy cannot continue in its current form where women are largely excluded and gender is not integrated in all aspects. SADC needs gender aware 'business unusual' policies. Levels of extreme poverty are high across the region, in the DRC and Madagascar there are 75% or more women and men living in extreme poverty. Food security is a critical area of concern that must be linked with climate change mitigation and sustainable economic growth strategies. The gender division of labour is still very evident in industry and services. Men dominate in industry and women in service. Economic power and agency are central to stopping and preventing GBV.



Climate justice: The past year witnessed increasing temperatures throughout the region, accelerating sea level rise, droughts, cyclones, and other disasters and pushing 12 million people in nine countries into a state of food insecurity. Climate change will make future disasters and epidemics, such as COVID-19 inevitable, pushing millions of women and girls even further into poverty. Globally, increasing natural disasters and weather-related emergencies have contributed to large increases in sexual trafficking and forced child marriage. The COVID-19 crisis represents an unprecedented wake-up call for the region, reminding leaders that they must prepare for more frequent emergencies linked to climate change. The COVID-19 pandemic exacerbated food insecurity and other social challenges, leaving women and girls in impoverished communities, marginalised people, refugees and other displaced people especially vulnerable. The environmental crisis in SADC has extended from directly affecting agriculture and food security to impacting healthcare across the region. In 2019, climate shocks worsened measles outbreaks and Namibia saw a spike in hepatitis E-transmissions in informal settlements due to poor access to water and adequate sanitation. The COVID-19 virus will contribute to food insecurity, conflict, and gender-based violence (GBV) for months and possibly years to come. However, it also presents an opportunity

for governments in the region to re-align their priorities and pursue the development of renewable energy and "greener" economies.

Governance: Eleven countries held elections between July 2018 and December 2019 - Botswana (national and local); Comoros (national and local), DRC (national and local), eSwatini (national and local), Madagascar (National Assembly and local), Malawi (national and local); Mozambique (national and provincial), Mauritius (national); South Africa (national and local); Namibia (national), Zimbabwe (national and local). Women's representation in parliament has increased by three percentage points over the last decade, from 25% in 2009 to 28% in 2019. There is mixed progress between countries, which ranges from an increase of 16 percentage points in Namibia and Zimbabwe to a decrease of seven percentage points in Angola, from 37% in 2009 to 30% in 2019. Women's representation in parliament in the SADC region is three percentage points higher than the global average of 25% and four percentage points higher than the Sub-Saharan average of 24%. Women's representation in cabinet in the SADC region has increased by four percentage points from 23% in 2009 to 27% in 2019. Women speakers/presidents of parliament in the SADC region have decreased from 40% in 2018 to 35% in 2019. The first-past-the-post (FPTP) electoral system is still the most popular in the region with seven countries using this system at the national level and eight at the local level. Countries with the highest number of women parliamentarians use either the PR or mixed system in conjunction with some form of Temporary Special Measure (TSM).



Young people participating in a menstrual health campaign at the Lavumisa Town Board, Eswatini. Photo: Thandokuhle Dlamini



Introduction 1



Survivors of GBV learn how to produce sanitisers during an Entrepreneurship workshop held in Kadoma, Zimbabwe in July 2020.
Photo: Tapiwa Zvaraya

KEY POINTS

- The 2020 #VoiceandChoice Barometer has been expanded to cover Sexual Reproductive Health and Rights (SRHR), Governance, Economic and Climate Justice. It also covers Comoros, SADC's newest member state for the first time.
- The Barometer is being launched virtually in the wings of the Southern African Development Community (SADC) Heads of State Summit in August 2020 under the shadow of the Corona Virus Disease- 2019 (COVID-19) pandemic.
- In August 2020, SADC accounted for 58% of the African and 3% of the global COVID-19 cases. South Africa, with 92% of all cases in the region and 53% of all cases in Africa, is the hardest hit SADC country.
- COVID-19 threatens fragile SRHR gains made in the SADC region. But the pandemic has also opened opportunities to explore multi-sector approaches for achieving gender equality by 2030. Bridging the digital gender gap will help achieve #VoiceandChoice in the time of COVID-19.
- Key global events that informed data collection of the Barometer are the 25th anniversaries of the International Conference on Population and Development (ICPD) and Fourth World Conference on Women (the Beijing conference). The Barometer also draws on the 23rd International AIDS conference and the 2020 Sustainable Development Goals (SDG) report.
- Fifty-four national and 130 local government SRHR campaigns demonstrate the need to mainstream gender in emergency responses such as the COVID-19 pandemic.
- Ninety-eight local government councils across nine SADC countries have conducted a rapid response survey of COVID-19 impact on SRHR in 2020.
- 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.



Each year since the first edition in 2009, the Southern Africa Gender Protocol Barometer has been evolving, moving with the times, and the dominant concerns of each period. Now in its twelfth edition, the 2020 #Voice andChoice Barometer is no exception. In 2019, 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 #VoiceandChoice campaign. Key themes included: maternal and menstrual health; adolescent SRHR; safe abortion; gender-based violence; HIV and AIDS; harmful practises and sexual diversity. The 2020 Barometer adds chapters on economic justice; 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 SADC. However, as in every crises the silver lining in this dark cloud is the opportunity to revision a "new normal" not just for addressing the pandemic but also gender relations.

This chapter provides crucial background information on the pandemic; its impact on Southern Africa in general and gender equality in particular. It 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 2020. 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 Southern Africa, 5 August 2020[1]

	Confirmed cases	Active cases	Recoveries	Deaths	% deaths	% SADC
South Africa	521 318	148 683	363 751	8 884	1.7%	92%
Madagascar	11 895	2 486	9 286	123	1.0%	2.1%
DRC	9 178	1 236	7 727	215	2.3%	1.6%
Zambia	6 793	1 511	5 109	173	2.5%	1.2%
Malawi	4 361	2 186	2 047	128	2.9%	0.8%
Zimbabwe	4 075	2 938	1 057	80	2.0%	0.7%
Eswatini	2 856	1 549	1 258	49	1.7%	0.5%
Namibia	2 470	2 247	211	12	0.5%	0.4%
Mozambique	2 029	1 249	765	15	0.7%	0.4%
Angola	1 280	746	476	58	4.5%	0.2%
Botswana	804	739	63	2	0.2%	0.1%
Lesotho	726	531	174	21	2.9%	0.1%
Tanzania	509	305	183	21	4.1%	0.1%
Comoros	386	49	330	7	1.8%	0.1%
Mauritius	344	-	334	10	2.9%	0.1%
Seychelles	114	75	39	-	0.0%	0.0%
Total	569 138	166 530	392 810	9 798	1.7%	100%
						SADC as %
Africa	980 616	317 277	64 245	21 094	2.2%	58%
Global	18 579 615	6 705 075	11 173 262	701 278	3.8%	3%

Source: Gender Links, with data from Wikipedia.

Table 1.1 shows that as at 5 August 2020:

- SADC accounted for 3% of all COVID-19 cases globally, but 58% of all cases in Africa. South Africa alone accounts for more than half (53%) of the cases in Africa.
- Although South Africa only accounts for 17% of the 342 million people in SADC, it accounts for 92% of all the COVID-19 cases. Like many other pandemics before it, COVID-19 preys on inequality. Twenty six years since the first post-apartheid democratic elections in South Africa, the country remains one of the most unequal nations in the world.
- Nearly 10,000 people (9,798) have died in SADC as a result of COVID-19; 8,884 (90%) of these in South Africa. However the fatality rate in South Africa and most SADC countries is less than 2%; lower than the Africa average of 2.2% and global average of 3.8%. Experts suggest that the lower death rate in Africa may be due to the more youthful population, with 60% of the population under the age of 18.

The harsh lockdown measures taken in Southern Africa since March have helped to slow down the spread of the virus so that health facilities can cope. On 26 March 2020 South Africa went on full lock down. Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, Zambia and Zimbabwe soon followed suit. The restrictions imposed in the lockdown included bans on all international travel, internal movement and gatherings. The economic impact is devastating for all SADC countries.

[1] https://en.wikipedia.org/wiki/Portal:Coronavirus_disease_2019

COVID-19 and Women's Rights

In most of the world, more men than women are infected by, and die as a result of, COVID-19. In South Africa, which accounts for 92% of the cases in SADC, a pandemic that started with these gender metrics has taken an about turn. Women are now **more infected *and* affected** by the deadly pandemic.

Initially, data in South Africa reflected the global trend, with men constituting 60% of those infected and 70% of those who died as a result of COVID-19. The Lancet Gender and COVID-19 Working Group suggested that this could be because across the globe more men smoke cigarettes than women, making them more susceptible to the respiratory complications in coronavirus. Research showed that women could have stronger immune responses to coronavirus, possibly linked to higher levels of oestrogen and having two x chromosomes.

Sex disaggregated data from 125 countries from 24 June 2020[2], shows that although the gender gap is closing, globally the male infection rate (54%) is still higher than infections in women (46%). But in South Africa, more women (57%) are infected compared to men (42%). However, the death rate for men in South Africa (51%) is slightly higher than that of women (49%).

These shifts suggest that although biologically women might be less susceptible to the virus, there are strong social reasons why the gap is closing and - in the case of South Africa - the tables have turned.[3] Across the world, women constitute 75% to 80% of **health care workers**. According to UN women COVID-19 infections among female health workers are twice that of their male counterparts, in Spain, Italy and the USA - countries with some of the highest prevalence rates.[4] Women also dominate in care occupations that have a higher level of contact such as the hospitality and retail industries; care for the elderly and domestic work.

In South Africa, women have higher levels than men of the three **comorbidities**[5] now strongly associated with those worst affected by the virus: diabetes, hypertension and obesity. Globally and in South Africa, the gender gap in the long term impact of the pandemic continues to widen. Women comprise 39% of global employment but account for 54% of overall job losses as a result of COVID-19. Women in South Africa accounted for two million (two thirds) of job losses between February and April 2020.

These and other alarming statistics can be found in the National Income Dynamics Study (NIDS) Coronavirus Rapid Mobile Survey[6], a telephone survey of 7,000 households in South Africa to measure of the impact of Covid-19 on jobs,



Nomthandazo Mankazana, Grants Coordinator of the Canadian Women Voice and Leadership (WVL) fund in South Africa, distributes food parcels to women entrepreneurs after the pandemic hit. Photo: Gender Links

2 https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters
3 https://genderlinks.org.za/news/south-africa-more-women-than-men-now-infected-by-covid-19/
4 https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters
5 State of having multiple medical conditions at the same time, especially when they interact with each other in some way.
6 https://www.dailymaverick.co.za/article/2020-07-15-overview-chapter-of-the-2020-coronavirus-rapid-mobile-survey-results-and-findings/#gsc.tab=0

hunger and poverty, which highlights the disproportionate effect this pandemic is having on women and other vulnerable groups.

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.[7]

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**.[8] 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.

Following the easing of lockdown restrictions on 1 June 2020 there has been a spike in cases of femicide in South Africa. A list of more than 400 women alleged to have been killed by their abusive partners went viral on social media. Some of the horrific murders include an eight month pregnant woman Tshegofatso Pule, stabbed in the stomach and hanged from a tree; Naledi Phangindawo, stabbed in her car by her ex-boyfriend and Sanele Mfaba, dumped by a tree in a Soweto township, to mention just a few. In his address to the nation on 17 June, President Cyril Ramaphosa dubbed GBV a "second pandemic". As the #BlackLivesMatter protests swathed across the US and major cities globally in July 2020, gender activists in Southern Africa started the hashtag #FemaleLivesMatter.



[7] United Nations, Sustainable Development Goals Report, July 2020
[8] World Health Organisation, July 2020 The effects of COVID-19 on maternal health

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.

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.

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 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. 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.

Global context



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,[9] 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

[9] Sustainable Development Goals

during the 2020 Commission on the Status of Women but postponed due to the COVID-19 pandemic aims to[10]:

- Undertake a review and appraisal of the implementation of the Beijing Declaration and Platform for Action1and 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.



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 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[11]. Gender Links, as secretariat of the Southern African Gender Protocol Alliance, is a co-leader of the feminist movement building Action Coalition.



Twenty-five years ago, the **International Conference on Population and Development (ICPD)** endorsed a Programme of Action that laid out an ambitious population and development 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.[12]

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 mobilise more financial resources to achieve SRHR.

[10] United Nations Political Declaration on the Twenty-Fifth Anniversary of the Fourth World Conference on Women, 2 March 2020
[11] UN Women, Announcement of Global Leaders to Accelerate Gender Equality, July 2020
[12] 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.

MOVING TOGETHER
TO BUILD A HEALTHIER WORLD

The **High-Level Meeting on Universal Health Coverage** held at the United Nations General Assembly in September 2019 focused on "Universal Health Coverage: Moving Together to Build a Healthier World." It brought together heads of state, political and health leaders, policy-makers, and universal health coverage champions to advocate for health for all. The meeting aimed to strengthen health systems for universal health coverage. Government contested many aspects of SRHR during the meeting. The political declaration from the meeting garnered financial and political commitments from countries to sustain health investments. The political declaration commits to accelerating progress towards universal health coverage, including access to essential health services, skilled health workers, financial risk protection and access to safe, quality, effective and affordable medicines and vaccines for all.[13] There is still need for solid political commitments to integrating SRHR into essential health services.

AIDS 2020
23RD INTERNATIONAL AIDS CONFERENCE
VIRTUAL
6 - 10 JULY 2020

For the first time, the 23rd annual **International AIDS conference** took place virtually due to the COVID-19 pandemic. The July 2020 conference highlighted the impact of COVID-19 on people living with HIV. At the time of writing there was no evidence to suggest that there is an increased risk of infection and increased severity of illness for people living with HIV (with the understanding that they are not immunosuppressed and/or have no other co-infections or co-morbidities). However, people living with HIV who are not on treatment or who are not virally suppressed may have a compromised immune system (measured by a low CD4 count) that makes them vulnerable to opportunistic infections and more severe illnesses. During lockdowns caused by COVID-19, some HIV patients could not access their medication resulting in compromised immune systems. Women are the most infected and affected by both viruses.[14]

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.[15] UN Women's Data Hub dashboard provides a compilation of indicators that will inform gender-responsive policy action on COVID-19.

[13] United Nations General Assembly Resolution 74/2 Political Declaration on Universal Health Coverage, October 2019
[14] International AIDS Society, COVID-19 and HIV, accessed from https://www.iasociety.org/covid-19-hiv on 3 August 2020
[15] UN Women COVID-19 and Gender Monitor, June 2020

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.[16]

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.

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.[17]

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's 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.

[16] Message of the Chairperson of the African Union Commission H.E. Mousa Faki Mahamat on the occasion of International Women's Day, March 2020
[17] Morna C, Dube S, Makamure L (2016) SADC Gender Protocol Barometer

SADC context

Southern Africa Gender Protocol Alliance

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 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.[18] 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.

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.[19] 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.

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

In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 SADC member states approved the ground-breaking **SADC Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030** and corresponding Score Card to measure progress. The Strategy provides a framework for the member states to fast-track SRHR in the region. It will support the vision of the SADC Regional Indicative Strategic Development Plan (RISDP) 2015-2020 of a shared future within a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom, social justice, peace and security for its peoples.[20]

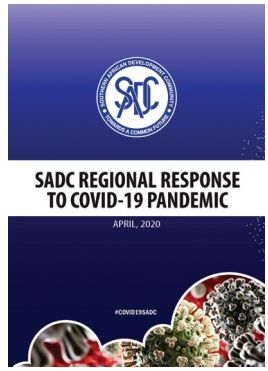
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The SADC SRHR Strategy builds on the Sexual and Reproductive Health Strategy 2006 - 2015. The current strategy moves from a service focus to a rights-based approach. This illustrates an important shift to recognising people's human rights as the centre 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.[22]



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).



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.[23] 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.

[20] The SADC SRHR Strategy, 2019 - 2030
[21] The SADC SRHR Strategy, 2019 - 2030
[22] https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval
[23] 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 stake-holders 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 ar e 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[24] and representatives from the 400 Centres of Excellence for Gender in Local Government[25] 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.

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

Table 1.2: 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		N	L
	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 1.2 shows that the #VoiceandChoice coalition has implemented 54 national and 130 local government campaigns. 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. Some examples of successes of the Alliance-led SRHR campaigns include:



Angola: The SRHR cluster of Plataforma Mulhers Emaccao (PMA) has engaged schools on sexual and reproductive rights education to raise the gender equality awareness among girls and boys alike. This raised interest for youth to demand gender responsive SRHR services in local health facilities.



Botswana: The Gender Sector of the Botswana Council of Non-Governmental Organisations (BOCONGO) worked with UNESCO in the Comprehensive Sexual Education (CSE) campaign. The campaign has led to training of teachers and health workers (nurses) on the CSE manual in an effort to integrate CSE into the school curriculum through a partnership with the Ministry of Basic Education. The ministry is working with parents using UNESCO's Parent Child Communication (PCC) manual to bring parents on board in order to address SRHR. A partnership with the Botswana Council of Churches (BCC) aims to train faith-based organisation and religious leaders on SRHR. UNPFA works on prevention of early and unplanned pregnancy among young people. This includes supporting line Ministries in ensuring young people have access to SRHR services and information and ensuring policies are aligned to global standards.



Lesotho: The Women in Law Southern Africa (WLSA) Lesotho Chapter partnered with women's rights organisations and UNFPA to popularise an app on GBV response and support. Women's rights organsiations are working with media houses

such as BAM Media to avail GBV platforms. They have decided to publish GBV stories biweekly in their Newspaper which is circulated free of charge, Karabo ea Bophelo has operationalised a GBV referral system. Gender Links has an advert on TV Lesotho that is aimed at creating awareness on GBV. WLSA also implemented the menstrual health campaign as menstrual hygiene remains a challenge for many Basotho girls and young women. Despite the scrapping of tax on sanitary pads, they still remain expensive and not accessible to most girls and young women who come from poverty stricken backgrounds. WLSA Lesotho will continue to lobby the new cabinet to ensure accessibility of sanitary pads in both urban and rural areas.



Madagascar: The Alliance focal network, Federation Pour La Promotion Feminine Et Enfantine (FPFE) has trained young people from several municipalities to raise awareness and build their capacity on young people's sexual and reproductive health. The network engaged mainstream media to highlight issues of adolescents SRHR.



Malawi: The SRHR cluster of the NGO Gender Coordinating Network (NGOGCN) implemented the Adolescent Sexual and Reproductive Health Campaign (ASRHR) included training service providers to provide family planning service provisions to the youth during the pandemic. This will also include motivating health care service providers and the youth to engage amidst COVID-19 fears. The campaign included advocating for the creation of USSDs (Unstructured Supplementary Service Data) which will capitalise on the use of phone messaging and social media among the youth. The campaign included building the capacity of people to administer health care by themselves due to the shortage of health workers during the pandemic e.g. self-injectables.



Tanzania: The Tanzania Gender Networking Program (TGNP) has done extensive research on adolescent health and specifically on menstrual health. The network identified youth champions for SRHR in coastal villages of Tanga and Bagamoyo. The network is also working with schools to form gender clubs. Young Feminist Forum Members have been participating in interactive and educative shows in five popular radio stations and one TV station: *Abood FM, Kiss FM, Ndingala FM, Divine FM, Faraja FM, EA TV* and *Katavi FM*. The talk shows have reached a combined audience of over 20,000 Tanzanians, for whom radio is a primary source of information and not less than 27% of Tanzanians who watches TV in Tanzania. The radio programs started where the world was commemorating the Menstrual Hygiene Day in May. Menstrual health is one of the components of SRHR and it is bringing back to life the major campaign of TGNP, which is the provision of free sanitary pads. The programs were part of advocating for the importance of good menstrual hygiene management (MHM).



Namibia: The Gender Sector of the Namibia Non-Governmental Organisation Forum Trust and Gender Links worked with Outapi Town Council to popularise the menstrual health campaign. The council adopted the campaign in their action plan/ budget. The campaign aims to break the silence and build awareness about the fundamental role that good menstrual health and hygiene management plays in enabling women and girls to reach their full potential. The campaign led to round table discussion among leaders and policy-makers, calling for certain items such as sanitary products to be exempted from VAT, provision of free sanitary product in schools, and increase policies on and attention to menstrual hygiene management. Young people have been championing the campaigns through social media and community outreaches aimed at creating awareness.



South Africa: The campaign against teenage pregnancy led by South African Women in Dialogue (SAWID) has contributed to a review of the Teenage Pregnancy Policy in South Africa and the South Africa School health Act. South Africa designated May 2019 as Teenage Pregnancy Month. This resulted in the establishment of a national school teenage pregnancy tracker, which also monitors re-entry back into school for teen mothers.



Zimbabwe: The menstrual health campaign led by the SRHR cluster of the Women's Coalition of Zimbabwe (WCOZ) has yielded positive results as evidenced by the removal of sanitary ware tax. The 2020 National Budget has set aside $200 million to cater for the provision of sanitary ware for rural primary and secondary learners from Grade four to Upper sixth form as a measure to enhance the dignity of the girl child. However, there is lack of political will to implement measures put in place as the school learners have not yet received sanitary ware.

Sounding the alarm - SRHR and COVID-19



When the COVID-19 pandemic broke out, the Southern Africa Gender Protocol Alliance convened virtual meetings via Zoom to assess the impact of the SRHR campaigns and the effects of COVID-19 on these campaigns. These virtual meetings assessed the impact of COVID-19 on SRHR and included youth, persons with disabilities and other key populations. The Alliance networks also held radio talk shows on community radio or other relevant media to highlight how the COVID-19 pandemic has affected the SRHR campaigns in each country.

Table 1.3 Overview of Alliance SRHR consultations and Radio Talk Shows

Country	Number of virtual consultation on SRHR campaigns	Number of SRHR Radio talk shows
Angola	2	1
Botswana	2	3
DRC	3	3
Eswatini	2	2
Lesotho	2	2
Madagascar	2	2
Malawi	2	1
Mauritius		
Mozambique	3	4
Namibia	2	2
Seychelles	1	2
South Africa	2	3
Tanzania	2	6
Zambia	2	2
Zimbabwe	2	2
TOTAL	**29**	**35**

Source: Southern Africa Gender Protocol National Reports, Gender Links Workshop Statistics, 2020.

Table 1.3 shows that the Alliance held 29 Zoom or virtual consultations to analyse the impact of SRHR campaigns during the COVID-2019 pandemic. The Alliance networks collaborated with 35 community radio stations and national radio stations to hold talk shows on the impact of COVID-19 on SRHR. Tanzania held the most radio talk shows, which demonstrates the power of community radio in that country. All countries held at least two consultation meetings except Seychelles and Mauritius.

The main findings of the analysis of campaigns and talk shows are:

- Community radio is a reliable source of information during emergencies such as COVID-19, especially where internet access is likely to be limited. SRHR issues attract a wide audience on community radio including from traditional and religious leaders. Women and men participated almost equally in most call in radio talk shows.
- There are disparities in the supply of sanitary products between urban and rural schools in countries where these are free, posing challenges to the menstrual health campaign especially in times of COVID-19.
- Health recommendations such as wearing masks, washing hands, social distancing, and the use of sanitisers a challenge to some type of disabilities during COVID-19. Women with disabilities more likely to become a target for gender-based violence and sexual harassment during this period.
- Due to the closure of schools, there are high chances of child marriages because the girls are not in school, which prolongs their chances of going into marriage.
- Access to family planning services has declined as a result of COVID-19.
- The rate of unplanned pregnancies and unsafe abortions are likely to increase during pandemic.
- Funding directed to fighting the COVID-19 pandemic is being diverted from SRHR.
- SRHR campaigns have been effective where there is a multi-stakeholder involvement including government, women's rights organisations, local government and community based organisations amongst others.
- There is need to create better supply chains between menstrual health suppliers/providers for the smooth supply of the products during the COVID-19 pandemic.
- Effective use of technology safeguards support for SRHR services for youths and girls.

Local action on gender responsive approaches to COVID-19[26]



Strengthening the SRHR plan in the Mafeteng Council, Lesotho.
Photo: Tokelo Lefoka

In May 2020 Gender Links administered a questionnaire on the impact of COVID-19 to 98 Centres of Excellence for Gender in Local Government programme. In most SADC countries, local government is also responsible for primary health care in the form of clinics. Almost all councils in the survey were open and functioning to varying degrees including working from home, working on shifts, providing limited services with limited staff. Of the 98 councils who completed the survey, only 33% have a COVID-19 response plan. Only 12% have a budget to fight COVID 19.

Despite the constraints, some councils are making valiant efforts to sustain their SRHR services and action plans. Councils would welcome support in mainstreaming gender into their COVID action plans. GL has worked with councils to create a Gender, COVID-19 and Emergencies Checklist with a strong SRHR component. The examples below show the approaches being taken by local authorities:

Botswana - Okavango Sub District Council: The response plan has been devised to address all matters arising due to the COVID 19. The plan was drafted by a committee appointed by the director and includes all relevant stakeholders. The same plan allows for the easy implementation.

Eswatini - Mbabane: Council has a plan in place even though with new changes it has to be updated now in response to the pandemic.

Madagascar - Andoharanomaintso: After a consultation meeting between Mayor and councillors of the Andoharanomaitso rural council, the COVID-19 response plan was created and relies on COVID-19 budget response.

Mauritius - Municipal Council of Port Louis: The Health Department of all Councils are actively engaged in their activities which includes the provision of scavenging services and cleaning of public places such as market fairs, recreational places falling under the council.

Namibia - Tses Village Council: The council came up with a response plan to respond to emergencies and community education.

Zambia - Chipata Municipality: An emergency plan has been developed and approved by full council.

Zimbabwe - Bikita Rural Council: The Council quickly came up with a COVID - 19 response plan as soon it was declared a national disaster. Local action plans on COVID-19 include raising awareness of the pandemic as highlighted in the case of Murewa district council below:

Zimbabwe: Murewa Rural District Council action plan guards SRHR[27]

Murewa as a district is not left behind in this situation and the Council in conjunction with key stakeholders came up with a Gender responsive plan in relation to SRHR. Murewa RDC is also a key member of the Murewa COVID-19 Gender Sub-Committee.

[26] Gender Links, June 2020, Gender and Local Government COVID-19 Rapid Response
[27] Excerpt from the Murewa Rural District council COVID-19 and SRHR response plan, June 2020

The rural district council's action plan's overall objective is to ensure that access to SRHR services by women and girls prevail during the lockdown/COVID-19 pandemic period. The strategic priorities of the action plan are:

- ***Personal Protective Equipment (PPE) at Council Rural Health Centres*** - To ensure that health workers at council clinics are protected and willing to provide all essential services like SRHR services - Council is providing PPE material to its clinics during the period.
- ***Ensuring access to contraceptives and reproductive health services*** - All Murewa Rural District Council 16 Rural Health Centres are operational and contraceptives are available at all centres. Council has liaised with the District Medical Officer to ensure that there is adequate supplies at all clinics and health centres in the district.
- ***Ensuring that menstrual education and sanitary ware is accessible to women and girls*** - Due to the COVI-19 restrictions many women and girls will find it difficult to access sanitary ware and menstrual health education. Murewa RDC will continue distribution of sanitary ware and provision of menstrual health education/awareness.
- ***Making sure that maternal health services (including waiting mothers homes) are accessible to Murewa community*** - Maternity services i.e. pre and post antenatal care services shall be available at all council clinics and waiting homes shall be fully operational during the COVID-19 pandemic period.
- ***To ensure that cervical cancer screening, STI treatments and HIV/AIDS services exist during the period*** - The COVID-19 Gender sub-committee liaised with the District Medical Officer so that cervical cancer screening services resume at health centres. STI treatment is being done at all Council clinics. ART services are also available at all Council clinics.
- ***Ensuring continuity of public awareness on SRHR and GBV issues*** - Public awareness on SRHR and GBV issues continue to be a priority. The District COVID-19 Gender sub-committee is raising awareness on SRHR and GBV (child marriage, sexual violence etc). Councillors who are close to the communities are now regarded as referral points for GBV cases for onward reporting to relevant offices.
- ***Rapid response services for GBV cases and provision of shelter to victims*** - The RMT centre continues to provide shelter to GBV victims in the district during the COVID-19 pandemic period. A District COVID-19 Gender committee was set to ensure that they rapidly respond to reported cases of GBV.

Methodology

Table 1.4: Structure of the #Voice and Choice Barometer

Chapters	Relation to previous Barometer Chapters
1 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. Economic justice	Economic justice
10. Climate Justice	Climate Change
11. Gender and Governance	Gender and Governance

Table 1.4 summarises the eleven chapters of the 2020 Barometer. The first eight chapters are the same as 2019. Chapters that have been added, and correlate to chapters in the original Barometer include Economic Justice; Climate Justice; Gender and Governance. The 2020 #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 in the chapter.
- 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.
- New SADC Protocol@Work case studies highlighting various aspects of #Voiceand Choice and collected through the learning aspects of the annual summits.

Normative frameworks

The provisions of the SADC Protocol guide the chapters on Gender and Development. However, to strengthen the arguments, the #Voice andChoice 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 2020 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.[28] 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.
- **Public attitudes:** Each year Alliance partners administer the Gender Progress Score (GPS) or Attitudes Survey that gauges prevailing gender attitudes amongst the public using a 25-question survey. Eight of these questions are relevant to SRHR. They help to gauge public attitudes on topic issues such as safe abortion and sexual diversity that in turn play a critical role in driving or deterring reform agendas. For the period 1 August 2018 to 31 July 2019 GL gathered 11 124 surveys, 6013 women and 5111 men.
- **The Gender Responsive Assessment (GRA) of Constitutions and Laws:** The GRA is a peer review of Constitutional rights, special measures, domestic legislation, equality in accessing justice, marriage and family rights, persons with disabilities, widows and widowers' rights, the girl and the boy child (Articles 4 to 11 of the SADC Gender Protocol). A group of legal and subject area experts meet and score the country using a standardised score sheet. These are acknowledged in the contributors section of the Barometer.

Table 1.5: Classification of 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 1.5 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.

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

- 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 also being gathered through the case studies presented at the #Voiceand Choice SADC Protocol@Work summits (in progress at the time of writing).

Table 1.6: 2019/2020 SADC Protocol@Work summit entries

Country	SRHR	Economic justice/ Education	Drivers of Change	Media	Climate change	Local government COEs	Entrepreneurship	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 1.6 shows that Alliance partners collected 1,168 case studies between 2019 and 2020. 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 and in April 2019, an in-country 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.

Political Discourse on SRHR - these are political statements analysed by researchers in different countries. Many times political statements tend to translate into policies. The Barometer has mainstreamed the analysis of political discourse in the SRHR chapters. This is an important indicator of changing attitudes and mindsets.

Rapid response on SRHR

Gender Links conducted an Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment undertaken in Botswana, Eswatini, Lesotho, Madagascar, Zambia and Zimbabwe from November 2019 to April 2020. The study will be rolled out to Mauritius, Mozambique, Namibia and South Africa between by end of August 2020. The preliminary findings of the assessment are highlighted in the ASRHR chapter of this Barometer.

Limitations

The COVID-19 pandemic posed constraints on the processes linked to the Barometer. SADC Protocol@work summits have been postponed in four SADC countries (Lesotho, Eswatini, Zambia and Zimbabwe). These have not yet been adjudicated. These summits will be held towards the end of 2020 where COVID-19 regulations allow. The regional SADC Protocol@Work summit scheduled for May 2020 has been indefinitely postponed. Regional, continental and global meetings of importance to the Barometer were held virtually or cancelled due to the pandemic.

Data on Comoros, SADC's latest member, is limited. An Alliance national network will be identified for the island by early 2021. #VoiceandChoice campaigns have not been held in Comoros due to the lack of an Alliance focal network.

Some case studies related to economic justice and HIV could not be used in the research for ethical reasons. The two subjects involve vulnerable women namely survivors of GBV in economic justice and people living with HIV. Case studies used in the research are accompanied by full consent from the subjects.

Sexual and Reproductive Health 2



Thabo Morena distributing sanitary pads after a council meeting in Mamantso, Lesotho, in November 2019. Photo: Ntolo Lekau

KEY POINTS

- Maternal mortality remains high across the region, despite political commitment to reduce it. Fourteen countries in SADC remain below the target of 70 deaths per 100 000 women.
- Of the 16 SADC countries, 14 now have stand-alone policies or guidelines on Sexual and Reproductive Health and Rights (SRHR). Only two (Angola and DRC) do not.
- However, many countries failed to mainstream SRHR into their COVID-19 responses, leaving women and girls without vital services and support throughout the region during the pandemic.
- Six SADC countries (Lesotho, Mauritius, Seychelles, South Africa, Zambia, and Zimbabwe) have removed VAT from menstrual hygiene products and five (Botswana, Lesotho, Madagascar, Seychelles, and Zambia) now provide free sanitary pads in schools.
- The COVID-19 pandemic has increased the need for clean water and sanitary facilities for menstrual hygiene and highlighted the lack of clean water in many SADC communities.
- More women than men collect water in nine of 16 SADC countries studied. In Mozambique and Malawi, a recent study found that 84% of women and girls collect water for the household, as opposed to just 6% and 7% men and boys, respectively.
- In eight SADC countries (Comoros, DRC, Eswatini, Malawi Mauritius, Mozambique, Tanzania, and Zambia) more than half of women between ages 15 and 49 do not have a say in decision-making about contraceptive use.
- The COVID-19 pandemic highlighted many gaps in health systems in the region, underscoring the need for countries to adhere to their Universal Health Coverage commitments, with SRHR mainstreamed throughout.



Introduction

Sexual and Reproductive Health (SRH) represents both a human right and a significant aspect of public health that requires constant attention. Globally, more than 350,000 women still die annually while pregnant or within 42 days of giving birth - "maternal deaths." Almost all (99%) of these occur in the developing world, with 87% of maternal deaths in Sub-Saharan Africa and South Asia.[1]

SRH becomes especially important in emergencies like the COVID-19 pandemic, given that women make up 70% of the global health workforce, representing a majority of frontline health workers, nurses, midwives, and community health workers.[2]

In 2019, global leaders gathered in New York during the annual United Nations (UN) General Assembly for a summit focused on universal health coverage. They agreed to a political declaration, adopted in October 2019. This committed to: universal access to SRH care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes. Countries had already committed to universal access to SRHR in the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action.[3]

According to the United Nations Population Fund (UNFPA), good SRH comprises complete physical, mental, and social wellbeing in all matters relating to the reproductive system. It implies that people can have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.[4] The COVID-19 pandemic poses challenges in achieving SRH. Lockdown regulations and the increased burden of COVID-19 patients at health institutions resulted in limited access to SRH for women and girls. Despite governments' commitment to universal access to SRH at the 2019 UN General Assembly, COVID-19 exposed a lack of political will in many Southern African governments to mainstream SRH.



A woman nurses her one-year-old child in Sinazongwe, Zambia, in 2020.
Photo: Albert Ngosa

Key elements of realising SRH include:[5]

- Access to accurate information and the safe, effective, affordable, and acceptable contraception method of choice;
- Information availability that empowers people to protect themselves from sexually transmitted infections (STIs);
- When women decide to have children, they must have access to services that can help them have a healthy pregnancy, safe delivery, and strong baby; and
- The right to make one's own choices about SRH.

[1] World Health Organisation, Fact Sheet on Sexual and Reproductive Health accessed 30 June from https://www.who.int/hac/events/drm_fact_sheet_sexual_and_reproductive_health.pdf?ua=1
[2] WHO (2019). Gender equity in the health workforce: Analysis of 104 Countries: https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?ua=1
[3] United Nations Resolution 74/2 Political declaration of the high-level meeting on universal health coverage, October 2019
[4] United Nations Population Fund, sexual reproductive health overview, accessed from https://www.unfpa.org/sexual-reproductive-health on 30 July 2020
[5] UNFPA, News on Sexual Reproductive Health, accessed on 27 June 2020 from https://www.unfpa.org/sexual-reproductive-health

Table 2.1: SRH indicators in 2020

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
SRHR policy and legislative framework																
Existence of SRHR policies/ guidelines[6]	No	Guide-lines	2018 Stand-alone SRHR policy	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2015-2019 Policy	2011-2015 Guide-lines	2008 Policy	2010-2015 Policy
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation[7]	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 Stra-tegy	No
Menstrual health																
Provision of free menstrual ware in schools[8]	No	Yes	No	No	No	Yes	Yes	No	No	No	No	Yes	No	No	Yes	No
Removal of Value Added Tax (VAT) on menstrual ware[9]	No	No	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes
Basic drinking water status (%)[10]	41	79	84	42	68	72	51	67	100	47	79	96	85	50	61	67
Access to basic sanitation (%)[11]	39	60	34	20	58	44	10	44	93	24	34	100	73	24	31	39
Contraception																
Contraceptive preva-lence rate amongst women aged 15-49 (%)[12]	17	60	27	25	66	62	47	62	67	30	60	49	57	43	50	67
Unmet need for contraception amongst women aged 15-49 (%)[13]	36	14	30	27	14	16	18	16	10	24	16		14	21	18	10
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[14]	62		21	31	49	61	74	47	49	49	71			47	47	60
Age of access to contraception[15]	16	12		18	15		12	16	16	16	12	15	12	12	16	16
Maternal mortality																
Maternal mortality ratio (per 100 000)[16]	241	144	273	473	437	544	335	349	61	289	195	53	119	524	213	458
Antenatal care visits (at least one visit) (%)[17]	82	94	49	88	99	95	82	98		87	97		94	98	97	93
Antenatal care visits (at least four visits) (%)[18]	61	73	11	48	76	74	51	51		52	63		76	62	64	76
Skilled attendance at birth (per 100)[19]	50	99	82	80	99	78	44	90	100	54	88	99	97	64	80	78
Postnatal care coverage (%)	23		14	44	88	62		42			69		84	34	54	57
Neonatal mortality (per 1 000)[20]	29	25	32	29	17	35	21	22	9	28	16	9	11	21	23	21
Nursing and midwifery personnel per 10 000 of the population[21]	4	54	6	11	41	33	2	4	35	7	20	80	13	6	13	19

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Universal health coverage																
Proportion of population receiving essential health services (%)[22]	40	61	52	41	63	48	28	46	63	46	62	71	69	43	53	54
Health budgets																
Health expenditure as proportion of GDP (%)[23]	2.9	5.5	7.6	3.9	7.7	8.1	6	9.8	5.7	5.1	9.1	3.9	8.1	4.1	4.5	9.4
Health expenditure as proportion of total government expenditure (%)[24]	5.4	9.1	3.6	3.7	15.25	10.1	17.8	9.8	10	8.3	13.8	10	13.3	9.5	7.1	14.5

Table 2.1 shows that:

- Except for Angola and DRC all countries now SRHR policies and/or guidelines. However, only six (DRC, Lesotho, Madagascar, Malawi, South Africa, and Zambia) allow adolescents to access SRH services without third party authorisation.
- Maternal mortality rates improved from 2019 to 2020 in Angola, DRC, Lesotho, Madagascar, Mozambique, and Namibia. However, they worsened in Eswatini, South Africa, and Tanzania, while remaining comparable to previous years in all other countries.
- Despite some improvement in maternal mortality rates, more than 250 women (of every 100 000) still die during pregnancy, childbirth, or in the first 42 days after childbirth in nine of 16 SADC countries.
- Five countries now provide free menstrual ware in schools (up from four in 2019) and six countries have removed taxes on menstrual products.



Justice Pour Elles members take part in a "silent march" against delays to justice and poor SRHR in the Democratic Republic of the Congo (DRC) in February 2020.
Photo courtesy of UCOFEM

- Access to basic drinking water and sanitation remains inconsistent across the region, with a majority of people in Angola, DRC, and Mozambique still going without both, while almost all citizens in Mauritius and Seychelles have access.

6 Gender Links Audit of SRHR Policies and Laws, June 2020
7 aho.afro.who.int/profilesinformation/index.php/
8 GL Audit of SRHR Policies and Laws in SADC, 2019
9 IBID
10 WHO/UNICEF (2017) Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline
11 IBID
12 https://www.unfpa.org/data/world-population/
13 IBID
14 https://www.unfpa.org/data/world-population/
15 GL Audit of SRHR Policies and Laws
16 Maternal and Newborn Health Coverage Database, UNICEF, 2019
17 IBID
18 IBID
19 IBID
20 https://childmortality.org/data
21 http://apps.who.int/gho/data/view.main.HWFNURv
22 http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv
23 https://databank.worldbank.org/data/source/world-development-indicators#
24 IBID

- Access to contraception is still poor across the region, with a high of only 67% in Zimbabwe and a dismal low of 17% in Angola.
- Most countries spend between 4-8% of their GDP on health care, with some outliers, including Malawi at the high end (9.8%) and Angola at the low end (2.9%).
- Most women in the region now have between one and four antenatal care visits but postnatal care remains patchy, with a high of 88% in Eswatini and a low of 14% in Comoros.

COVID-19 highlighted roadblocks to some of these goals, including limited access to antenatal facilities, limited access to SRHR services, disruption to provision of contraception methods, and lack of emergency contraception, among others. While most Southern African Development Community (SADC) member states declared a state of national disaster during the pandemic, many lacked critical and robust strategies to mainstream SRH into COVID-19 responses.

Civil society organisations have actively led SRH campaigns that integrate COVID-19 responses. The Southern Africa Gender Protocol Alliance (the Alliance) championed SRHR campaigns through online platforms and community radio under the banner #VoiceandChoice throughout the pandemic.[25] Other campaign hashtags of note during this period included #SheDecides, #Femalelivesmatter, #MyBodyMyChoice, #GenerationEquality, and the #TotalShutDown campaign in South Africa.

Gender activists release this 2020 SADC #VoiceandChoice Barometer against the backdrop of key political events linked to SRH. These include the declaration by all SADC countries that the COVID-19 pandemic represents a regional disaster; South Africa's chairing of the African Union; the tenth anniversary of UN Women; the UN General Assembly High Level meeting on Universal Health Coverage; the establishment of Generation Equality Action Coalitions by UN Women; and the Beijing Declaration and Platform for Action 25th anniversary. All these political milestones affected global and regional SRH in 2019 and 2020.

This chapter focuses on SRHR policies and frameworks - the 2016 SADC Protocol on Gender and Development, the Sustainable Development Goals (SDGs), and the SADC SRHR strategy - as well as three key areas of SRH: menstrual health; family planning and maternal health. These are analysed against the backdrop of the COVID-19 pandemic and its profound effects on the sector.

SRH and the COVID-19 pandemic

The novel coronavirus (SARS-CoV-2) that causes COVID-19 spread rapidly after emerging in late 2019, leading the World Health Organisation (WHO) to declare the disease a global pandemic on 11 March 2020.[26] The pandemic has massively strained SADC's already under-resourced health institutions (only two countries - Eswatini and Madagascar - meet the target of 15% minimum for health expenditure). Regional responses to the pandemic also affected SRH, in particular lockdown measures that classified some health services as non-essential.[27]

The COVID-19 pandemic presents both opportunities and challenges to SRH. While the pandemic affects all people, it has highlighted glaring gendered dimensions around SRH for women and girls. Women seek medical help more often because of their reproductive role in society. Prenatal visits expose pregnant women to an elevated risk of contracting the virus as expectant mothers frequently seek medical help in crowded health facilities. The Guttmacher Institute estimated that a 10% reduction in the proportion of women receiving SRH services

[25] Gender Links, SADC Gender Protocol Alliance SRHR and COVID-19 consultations guide, May 2020
[26] Guttmacher Institute, April 2020, Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries.
[27] World Health Organization, COVID-19: operational guidance for maintaining essential health services during an outbreak, 2020, https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak.



Parishioners wash their hands as a preventive measure against the spread of COVID-19 in Lilongwe, Malawi, in April 2020. Photo courtesy of BBC

would have major impact on unintended pregnancy and maternal and newborn mortality over a 12-month period. The institute further states that, during the COVID-19 pandemic, a modest decline of 10% in coverage of pregnancy-related and newborn healthcare will have disastrous implications for the lives of women and their newborns.[28] Other ways the pandemic has adversely affected SRHR include:

- Affected the supply chain of contraceptive products, resulting in reduced availability.
- Diverted equipment and staff dedicated to SRHR to fulfil COVID-19 care needs.
- Stigmatisation of the pandemic has made people reluctant to visit hospitals. For example, in South Africa 11 000 people living with HIV and AIDS did not collect their monthly medication in health facilities in May.[29]
- Classification of some lifesaving SRH services as non-essential, such as abortion care.[30]
- Worsened levels of gender-based violence (GBV).[31]
- Limited access to skilled care for childbirth, including care for obstetric and neonatal complications.[32]
- Increased maternal and neonatal mortality, largely due to poor access to skilled healthcare workers for childbirth and the difficulties faced in referring for obstetric and neonatal complications.
- Increased the risk of morbidity and mortality for women and their newborns due to loss of support and reduction of access to health facilities. Trauma, malnutrition, disease, and exposure to violence compound this.
- Closure of some family planning services, thereby increasing the risk of unwanted pregnancies.
- Increases in sexual violence and domestic abuse.

In any emergency, including COVID-19, one in five women of childbearing age is likely to be pregnant



In June, WHO technical experts arrived in **Comoros** to assist with the country's COVID-19 response. The expert team of epidemiologists, laboratory experts, pulmonologists, and others will support Comorian technicians in their efforts to fight the virus. At the time of writing, the island had 311 confirmed cases, seven deaths, and 266 recoveries.[33] Practitioners in the country's struggling and under-resourced health system welcomed

[28] Guttmacher Institute, Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries, accessed on 5 July 2020 from https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health#fn1
[29] TimesLive, Almost 11,000 HIV-positive patients in Gauteng have skipped ARV collection during lockdown, 19 May 2020
[30] UNFPA, "Women are the Fabric: Reproductive Health for Com-munities in Crisis". UNFPA, http://www.unfpa.org/public/publications/pid/1348
[31] Wenham C et al., COVID-19: the gendered impacts of the outbreak, Lancet, 2020, 395(10227):846-848, http://dx.doi.org/10.1016/S0140-6736(20)30526-2.
[32] World Health Organisation (2020); Packages of interventions for family planning, safe abortion care, maternal, newborn and child health
[33] Government of Comoros, accessed from on 2 July 2020 https://stopcoronavirus.km/

the additional support. Women struggled to access pre- and postnatal care in Comoros even before the advent of COVID-19.



In the **DRC**, UN Women worked with local organisations to distribute COVID-19 resilience kits to women. Each kit contains ten kilos of food and essential hygiene products, such as sanitary pads, water purification tablets, and bleach. Kits also include soap, alcohol-based sanitary gel, and tissues,



Women distribute COVID-19 resilience kits in Kinshasa in April 2020.
Photo courtesy of UN Women

which enable women to protect themselves when caring for sick family members. Lessons from the Ebola outbreak point to the harmful impacts during a health epidemic in the absence of focused responses from governments to protect SRHR gains (such as contraceptive use and availability). Union Congolaise des Femmes de Médias (UCOFEM), an Alliance partner in DRC, has been collaborating with community radio stations and women's rights organisations to integrate SRHR into their COVID-19 response since the DRC declared the virus a pandemic on 10 March 2020.[34]



In **Madagascar**, huge gaps exist in delivery of, and access to, water and sanitation in both rural and urban councils. Water shortages have a massive impact on menstrual health in the country. COVID-19 has increased household need for water. One pack of ten sanitary pads costs almost a dollar, which is the equivalent of one day's pay in rural areas. Therefore, women cannot prioritise menstruation hygiene during the pandemic over other daily necessities like food.[35]

SRHR policy and legislative framework

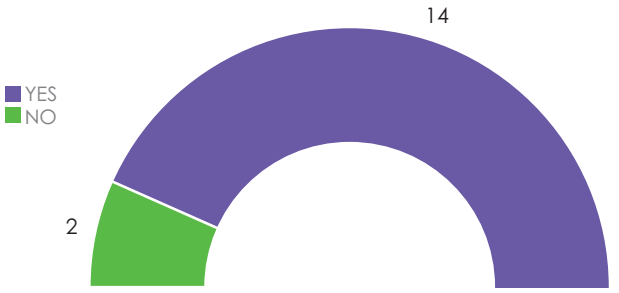
Article 6.1 (a) of the SADC SRHR Strategy obliges member states to establish a multisectoral coordinating entity that includes civil society, networks of youth, adolescents and key populations, and development partners, to domesticate, implement, monitor and evaluate their national SRHR strategies.

Stand-alone policies on SRHR underscore political commitment to realise the rights of women and girls as well as to domesticate regional, continental, and global SRHR instruments. However, the COVID-19 pandemic presented a new challenge in the region: how to integrate SRHR into state of emergency responses. SADC countries that have made strides in SRHR will find it easier to do this as part of their COVID-19 response. Strong SRHR policies and guidelines with disaster response will be a necessity as the SADC region continues to adapt to the pandemic.

[34] Anna Mayimona Ngemba, June 2020, Report on the impact of COVID-19 on SRHR
[35] Via Yolande, June 2020, Madagascar report on the impact of COVID on menstrual health.

Status of SRHR policies and laws in SADC

Figure 2.1: Countries with standalone SRHR policies or guidelines



Source: Audit of SRHR policies and laws Gender Links, 2020.

Figure 2.1 shows that 14 out of 16 SADC countries have stand-alone policies or guidelines on SRHR. Of these, 11 have SRHR policies while Botswana, Comoros, and Tanzania have SRHR guidelines. Angola and the DRC do not have stand-alone policies or guidelines.

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Older than five 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
Seychelles	Reproductive Health Policy for Seychelles	2012
Adopted in the past five years		
Eswatini	National Policy on Sexual and Reproductive Health	2013
South Africa	Sexual and Reproductive Health and Rights: Fulfilling our Commitments and "National Adolescent Sexual and Reproductive Health and Rights Framework Strategy"	2014 - 2019
Madagascar	Reproductive Health and Family Planning Law	2017
SRHR guidelines		
Botswana	Policy guidelines and service standards for sexual and reproductive health	2015
Tanzania	SRHR guidelines and National Adolescent Reproductive Health Strategy	2011 - 2015
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 Laws and Policies in SADC, Gender Links, 2020.

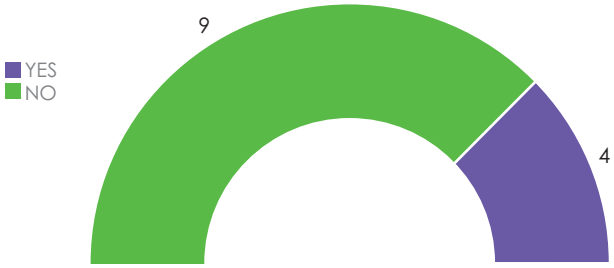
Table 2.2 shows that eight SADC countries have SRHR policies that go back five years or more. Namibia's SRHR policy is 18 years old. These policies need urgent review and revision. Eswatini, Madagascar, and South Africa have newer policies. The new Madagascar SRHR Policy, adopted in 2017, represents a welcome deve-

Comoros finalised an adolescent and youth health strategy in 2018

lopment, however it is important to note that it prohibits abortion under any circumstances.

Botswana and Tanzania need to review their guidelines and lobby for relevant longer-term SRHR policies. The UNFPA notes that Comoros finalised an adolescent and youth health strategy in 2018.[36] Angola and DRC do not have SRHR policies and both countries urgently need them given their unique post-conflict SRHR challenges.

Figure 2.2: Number of countries reviewing SRHR policies



Source: Audit of SRHR policies and laws Gender Links, 2020.

Figure 2.2 shows that, out of the 13 countries that have stand-alone SRHR policies or guidelines (excluding Comoros), five (South Africa, Botswana, Namibia, Zambia and Seychelles) have these under review. Tanzania has the newest policy: the Adolescent and Health Development Strategy 2018-2022.

Moving forward, all SADC countries should align their SRHR policies with the provisions of the SADC Protocol on Gender and Development and the SADC SRHR Strategy 2019-2030. SRHR policies should also consider issues of access under restricted movement orders, such as those implemented during the COVID-19 pandemic.

"In many countries, there's already stigma associated with sexual and reproductive health services," says Abebe Shibru, country director for Marie Stopes International in Zimbabwe. "For this reason, women often seek out these services in secret. Lockdowns have made it harder for women in Zimbabwe to discreetly access sexual and reproductive care... because now family members may want to know where they're going. Women may also face harassment from police officers enforcing stay-at-home orders."[37]



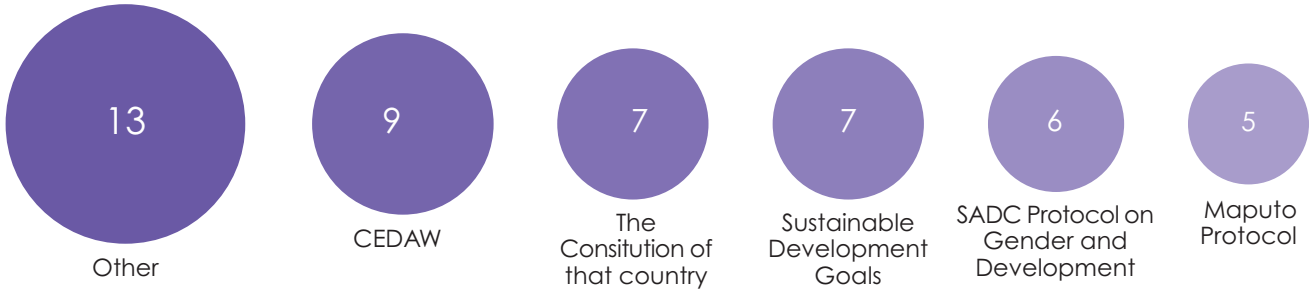
Abebe Shibru, country director for Marie Stopes International in Zimbabwe, says lockdowns made it harder to access SRHR services.
Photo courtesy of Marie Stopes International

Linking SRHR policies with regional and global instruments

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

[36] https://www.unfpa.org/data/transparency-portal/unfpa-comoros
[37] Accessed from https://www.npr.org/sections/goatsandsoda/2020/06/08/864970278/lockdown-limits-access-to-legal-abortion-in-colombia-telemedicine-is-now-an-option on 25 May 2020

Figure 2.3: Global and regional instruments referenced in SRHR policies



Source: Audit of SRHR policies and laws, Gender Links, 2020.

Figure 2.3 shows that countries reference several global and regional instruments as overarching frameworks in their SRHR policies and guidelines. Five include the Maputo Protocol; six countries reference the SADC Protocol on Gender and Development, and seven countries refer to the SDGs and national constitutions. Thirteen countries cite other sources. These include the Millennium Development Goals (MDGs); Cairo 1994 ICPD; the SADC minimum package for SRHR services; the global Family Planning 2020 framework; and the Beijing Platform for Action.

Menstrual health

Menstruating women face exclusion from public and family life for a combination of reasons. These include lack of access to affordable sanitary products and sanitation facilities, cultural and religious myths and misinformation around menstruation, and absence of menstrual hygiene education that would support safer practices and reduce stigma. One in ten girls in Africa miss school for up to four days during their period, according to the United Nations Children's Fund (UNICEF) and the WHO. This affects performance in school and many girls drop out of school due to lack of sanitary pads. Although girls and women sometimes find resourceful ways to improvise sanitary pads, some of the materials they use offer limited absorbency, making it challenging to participate in school activities. Menstrual health relates to human dignity and it is a fundamental right for every girl and woman to live a healthy life during menstruation. Southern Africa's economic and patriarchal structures sometimes exclude or shame women because of menstruation. UNICEF has predicted that 1.8 billion girls, women, and gender non-binary persons menstruate, yet millions of them across the world cannot manage their monthly cycle in a dignified, healthy way.[38] COVID-19 posed many challenges for menstruating women and girls, highlighting the urgent need for safe bathing facilities and safe and effective means of managing menstruation.[39] The poorest countries and those most vulnerable to economic and social shocks have also been the most affected by the pandemic.[40]

Provision of free sanitary pads to all rural schoolgirls would demonstrate that governments understand the necessity for sanitary wear as a right for all women and girls. Improving access to sanitary wear for rural schoolgirls ensures that they will not miss lessons and sporting activities during menstruation. Long-term, it will improve educational performance. Schoolgirls will also stop using leaves, cloth, and other unsafe methods of menstruation management, which will advance their overall health.

[38] UNICEF, May 2020, Country Data on Menstrual Hygiene
[39] UNICEF Brief April 2020, Mitigating the impacts of COVID-19 and menstrual health and hygiene
[40] Ibid



Zimbabwe: Advocacy pays off for menstrual health



Girls from Hwange receive sanitary pads in February 2020.
Photo: Tapiwa Zvaraya

In a major political shift celebrated by gender activists in the country, Zimbabwe parliamentarians dedicated US$12.5 million in the country's 2020 budget to provide free sanitary pads for rural schoolgirls.

The commitment comes after persistent lobbying by opposition politicians, civil society, the media, and religious organisations to amplify the voices of women and girls on the issue.

Research in Zimbabwe shows that menstrual health issues remain deeply embedded in a culture of silence that includes lack of men's involvement; limited availability of information, and inadequate access to menstrual hygiene products.[41]

For two decades, the country has imported most sanitary ware from neighbouring countries as local production stopped during the economic collapse in the 2000s. Women in rural communities bore the brunt of the country's challenges related to this issue.

Perennial droughts in agriculturally dependent rural communities meant families often had to choose food above other necessities. The prohibitive cost of sanitary wear and the dearth of it in rural areas also exacerbated the problem, forcing many rural schoolgirls to miss school during menstruation and use cow dung, clothes, and other unhealthy items as a substitute for pads and tampons.

Since 2014, when opposition Movement for Democratic Change (MDC) MP Priscilla Misihairabwi-Mushonga moved a motion to remove import duties on sanitary wear, civil society organisations, media, and religious organisations have joined the chorus to lobby the government. To date, lack of political will represented the biggest stumbling block to change. Four years after the initial call, the government responded by removing duty on sanitary wear, but the move did not change the plight of many women and girls, especially those in rural areas.

Non-governmental organisations reacted by distributing free sanitary pads in rural areas and introducing projects to produce reusable sanitary pads in rural schools. Over the years, Misihairabwi-Mushonga consistently raised the issue in Parliament up until the recent announcement of dedicated funds.

Citizens and local governments can take some credit for the decision thanks to their advocacy, including 13 local authorities that developed SRH plans and six local authorities (Chinhoyi Municipality; Epworth Local Board; Rusape Town Council; Guruve Rural District Council; Murewa Rural District Council, and Umguza Rural District Council) that conducted SRH campaigns on menstrual health and child marriage, led by junior councils.

Councils like Masvingo City Council and Mvurwi Town have also offered SRHR services during the COVID-19 pandemic, and Zibagwe Rural District Council's junior council raised funds to buy sanitary pads for underprivileged

[41] Menstrual hygiene - A salient hazard in rural schools: A case of Masvingo district of Zimbabwe



In October 2019, the NGO Katswe Sistahood initiated the Happy Flow campaign in Harare. Photo courtesy of Katswe Sistahood

adolescent girls in their community during the lockdown.

Gender activists continue to call on the government to reduce the cost of sanitary pads, including by submitting what they dubbed a "Heavy Flow" petition, signed by more than two million Zimbabweans, to the health and child welfare minister.

Source: Thabani Mpofu, Media Lecturer at National University of Science and Technology - submitted to Gender Links as part of the Political Discourse Analysis

Table 2.3: Menstrual products in SADC

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

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

Table 2.3 shows that six SADC countries have now removed VAT on menstrual products. Tanzania had removed VAT on menstrual products in its 2018/19 budget but reversed this decision in the 2019/20 fiscal year. Removal of VAT is an important first step towards providing affordable menstrual products.



In 2017, **Botswana** became the first SADC country to provide free sanitary products to all schoolgirls after its parliament adopted a motion in a move that deputy basic education minister, Moisiraela Goya, said would give "dignity to the girl child."[42] The new law attempts to address the problem of access and information for young girls in remote schools, as well as prevent them from dropping out of school. Ashley Moyo, the gender focal point for Tsabong Sub District Council, presented on the issue at the SADC Protocol Summit in June 2019, noting that her council worked with the Tsabong Primary Health Hospital to advocate on the issue and provide pads to schools in her district.



An advert for a menstrual care bank distributed by Shamwari Yemwanasikana, an SRH agency in Zimbabwe. Photo courtesy of Women's Coalition of Zimbabwe

[42] https://www.africanews.com/2017/08/02/botswana-to-offer-free-sanitary-pads-to-girls-as-part-of-school-supplies//

Covid-19 and menstrual hygiene management

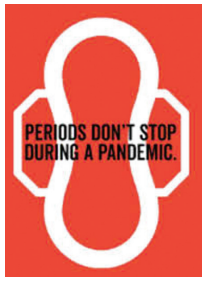
The coronavirus pandemic has reduced supplies of sanitary products in many countries, worsening an access issue that activists bemoaned long before the first case of COVID-19 hit the region.

Globally, about 500 million girls did not have access to what they need to manage their menstruation before this crisis.[43] Emerging evidence suggests that the pandemic, which has increased unemployment and poverty, will also exacerbate challenges linked to menstrual health. The 2020 theme for Menstrual Hygiene Day, "Periods in Pandemic," recognised this impact and encouraged women and men around the world to rally around this cause. The campaign noted that the pandemic led to suspension of many subsidised supply schemes, for example free distribution of menstrual products in schools. The economic impact of COVID-19 will also force many women and girls to prioritise other basic needs over safe menstrual products. Disrupted supply chains drive prices up, making menstrual products even more unaffordable than before.[44]



Malawi: Schoolgirls demand free pads

Schoolgirls in Malawi have a message for their leaders: periods do not stop for pandemics.



Joana Banda (a pseudonym) who attends a secondary school in Blantyre, Malawi's commercial capital, joined other students to call on leaders to provide free sanitary products in schools as the country marked Menstrual Hygiene Day during the COVID-19 pandemic on 28 May 2020.

"I know a number of girls in my school who cannot afford sanitary pads because they are expensive," said Banda, noting that the pandemic made the situation worse. "They use pieces of cloth as a substitute to sanitary pads. I suggest that schools should start distributing sanitary pads free of charge. It is possible."

Banda said monthly periods lead to anxiety for the girls in her school: "When you do not have sanitary pads you end up absenting yourself from classes. It is common for girls not to attend classes during monthly periods."

Gender activists hope that sharing stories like Banda's will push leaders to prioritise menstrual hygiene management in national and local policies. Authorities must also help to address taboos surrounding menstruation and raise awareness about the importance of good menstrual hygiene management in schools, hospitals, and elsewhere.

The indifference of authorities to this issue stands in sharp contrast to their commitments under the SDGs to ensure good health and wellbeing for all.

Source: Gender Links News Services accessed from https://genderlinks.org.za/news/periods-do-not-stop-for-pandemics-mhd2020/ on 10 June 2020

[43] https://menstrualhygieneday.org/
[44] https://menstrualhygieneday.org/wp-content/uploads/2020/05/mhday2020-covid19-and-periods-logo.pdf

During the early days of the COVID-19 pandemic, media reports regularly noted the lack of personal protective equipment (PPE) for health workers, which increased risks in their work during COVID-19. However, female health workers and patients also lacked menstrual products during this time. Lack of access to water, health, and sanitation (WASH) services at healthcare facilities prevents women from managing basic hygiene while at work. Some SADC countries still have hospitals with no running water, especially those in rural areas. Girls and women hospitalised or in quarantine centres for COVID-19 went without WASH services and menstrual health supplies in many cases.



Women in the DRC participate in a UCOFEM campaign for SRHR in Kinshasa during the 16 Days of Activism campaign in 2019.
Photo: Anna Mayimona Ngemba

Quarantine facilities must provide these to give dignity to their female patients. There is a need to train quarantine centre workers to assist girls and women with personal hygiene if needed. Governments must also consider creating separate WASH facilities in hospitals for girls and women with COVID-19, and for those without.

Water and sanitation

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

Access to WASH services represents a crucial aspect of achieving SRHR. Reliable WASH facilities in both private and public areas help save lives, especially during a pandemic, natural disaster, or drought. Before the pandemic hit, many SADC countries faced drought in 2019/20, resulting in huge water shortages for both rural and urban areas. Some cities resorted to water rationing measures to conserve scant water resources. However, these measures affect women and girls' SRHR as they rely on water for menstrual health, maternal hygiene, and other SRHR needs.

Table 2.4: Access to basic drinking water in SADC

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

Source: Progress on Drinking Water, Sanitation and Hygiene: 2019 Update and SDG baseline, WHO/UNICEF, 2019.

As shown in Table 2.4, four SADC countries - Angola, DRC, Mozambique, and Tanzania - have 50% coverage or less for basic drinking water. Meanwhile, Eswatini, Madagascar, Malawi, Zambia, and Zimbabwe have between 50-68% coverage across urban and rural. Only Mauritius, Seychelles and South Africa provide basic drinking water coverage to more than 80% of citizens.

Citizens in rural areas remain at a disadvantage in most countries, with access to water provision as low as 21% in rural areas in the DRC, followed by 23% in Angola. Madagascar, Mozambique, Tanzania, and Zambia have between 32% and 44% coverage for basic drinking water in rural areas. South Africa, a well-resourced country, has failed to deliver the basic need for clean water to many of its citizens in rural areas, even as it does so for the vast majority of urban dwellers.



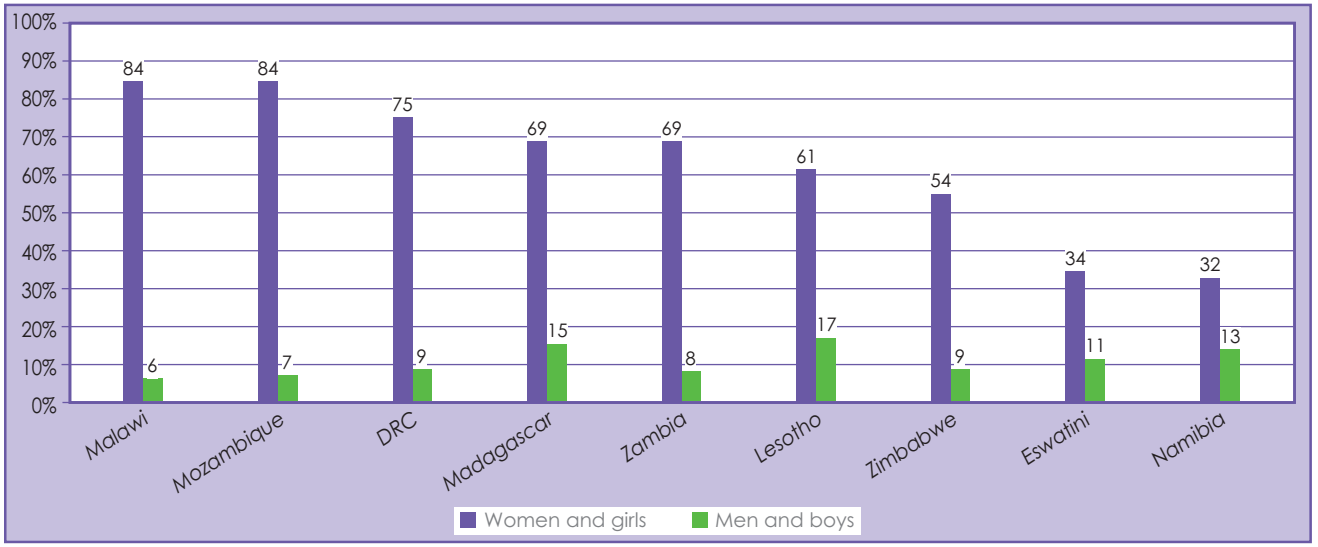
Students use a new tippy tap wash station to prevent the spread of COVID-19 in Botswana in May 2020. Photo courtesy of JG Afrika

Leaders across SADC prioritised water provision as part of their COVID-19 response, with many scrambling to send water tankers to drought-stricken areas, as well as build new boreholes and repair existing infrastructure. When the pandemic hit, several parts of the region had not yet recovered from droughts that had left many without access to water. Lack of proper water infrastructure has long been a challenge in most SADC countries, even in good times. A May 2020 report by the Partnership for Evidence-based Response to COVID-19 (PERC), a consortium of global public health organisations, found that almost 70% of Africans would struggle to access food and water if governments enforced lockdowns for two weeks.[45]

As governments advised citizens to wash their hands frequently to prevent the spread of COVID-19, many took to social media to remind their leaders that they had no water with which to do so. "We're calling for the government to do more because at the moment there are few boreholes," Khulekani Ncube, head of Gongu village in Zimbabwe, told the Thomson Reuters Foundation.[46]

[45] https://reliefweb.int/updates?advanced-search=%28S50291%29
[46] https://www.reuters.com/article/us-health-coronavirus-safrica-water-feat/in-parched-southern-africa-coronavirus-spurs-action-on-water-supply-idUSKBN22I0DY

Figure 2.4: Gender division of labour for water collection in nine SADC countries



Source: Safely managed drinking water, UNICEF, 2017.

Figure 2.4 shows 2017 data from a report by UNICEF on safely managed drinking water, disaggregated by sex. It measured access to water in countries in which at least one in ten households access water off premises. In Mozambique and Malawi, it found that 84% of women and girls collect water for the household as opposed to 6% of men and boys in Malawi and 7% in Mozambique. The numbers do not improve much for women and girls in all the other countries, with men in Lesotho collecting more water than their male SADC counterparts at 17%.

This situation affects women and girls' time, safety, health, and general wellbeing, and these findings provide yet another urgent impetus for accelerated safe water provision across the region. A clear link exists between water, sanitation, and gender equality. Limited access to water compromises the provision of sanitation. The lack of sanitation in communities, and particularly schools, impacts quality of education, girls' attendance, hygiene, and health.

Table 2.5: Status of access to basic sanitation in SADC

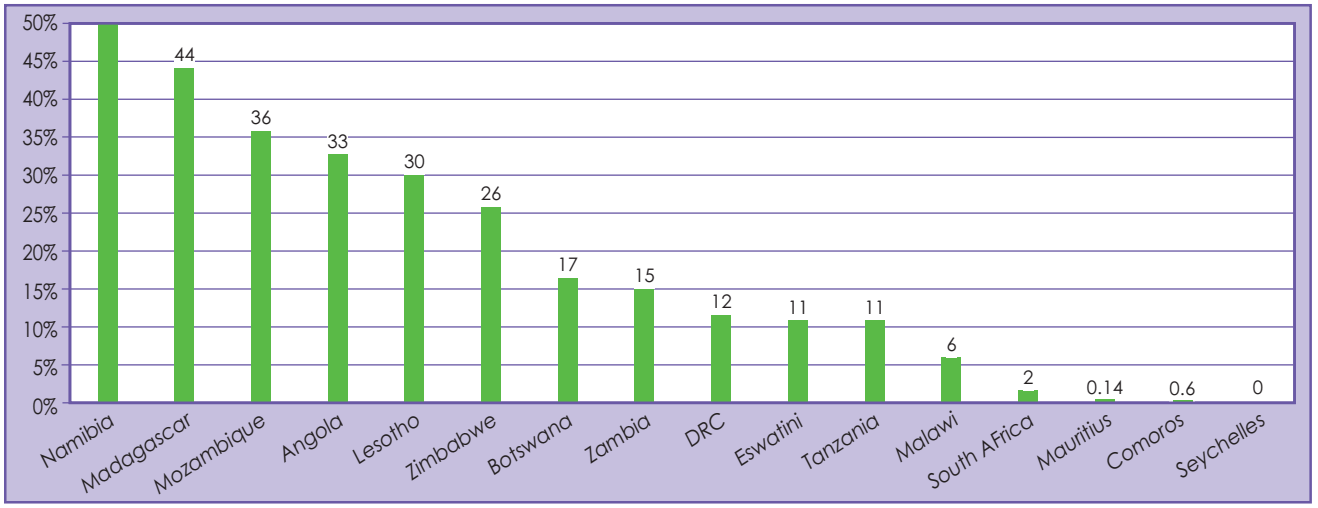
Country	National access to basic sanitation (%)	Urban access to basic sanitation (%)	Rural access to basic sanitation (%)
Seychelles	100	-	-
Mauritius	93	94	93
South Africa	73	76	69
Botswana	60	75	39
Eswatini	58	58	58
Lesotho	44	46	43
Malawi	44	49	43
Angola	39	62	21
Zimbabwe	39	54	31
Namibia	34	55	15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

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

Table 2.5 shows that ten SADC countries provide basic sanitation for less than half of their citizens. Madagascar, with 10% coverage, sits at the bottom in the region, while Seychelles, with 100%, sets a gold standard. Governments clearly prioritise sanitation services in urban areas. Four countries (DRC, Madagascar, Mozambique, and Tanzania) provide basic sanitation to less than 25% of the population.

Governments may balk at the cost of sanitation provision but a crisis such as the COVID-19 pandemic provides a good reminder of why sanitation is so important. Poor hygiene and lack of sanitation facilities both contributed to the rapid spread of the virus in the region.

Figure 2.5: Percentage population practicing open defecation



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

Figure 2.5 shows that, at 50%, Namibia has the highest proportion of people practicing open defecation in the region, followed by Madagascar at 44%. Open defecation increases the risk of communicable diseases such as cholera and typhoid. Many people also still practice open defecation in Angola, Lesotho, Mozambique, and Zimbabwe. While the levels drop in other countries, the practice of open defecation remains a concern in the absence of proper sanitation facilities. COVID-19 worsened the situation, as lockdown measures forced many SADC citizens to defecate outdoors.

Access to contraception

SDG 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

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

Ensuring access for all people to their preferred contraceptive methods advances several human rights, including the right to life and liberty, freedom of opinion and expression, and the right to work and education, as well as bringing significant health and other benefits.



A health provider trains women on maternal health at a workshop in Eswatini in November 2019. Photo: Thandokuhle Dlamini

Use of contraception prevents pregnancy-related health risks for women, especially for adolescent girls. When women separate births by fewer than two years, the infant mortality rate is 45% higher than when they separate births by two to three years, and 60% higher than births four or more years apart.[47]

The WHO estimates that, among the 1.9 billion women of reproductive age (15-49 years) world-wide in 2019, 1.1 billion need family planning. Of these, 842 million use contraceptive methods, while 270 million have an unmet need for contraception.[48]

The COVID-19 pandemic disrupted provision of basic contraceptive methods and reduced the availability of emergency contraception. Activists worried that this would lead to increased risk of unplanned pregnancy and increased unsafe abortions. Lockdown measures during COVID-19 also reduced access to contraception for women who rely on public transportation to fetch their monthly allocations.

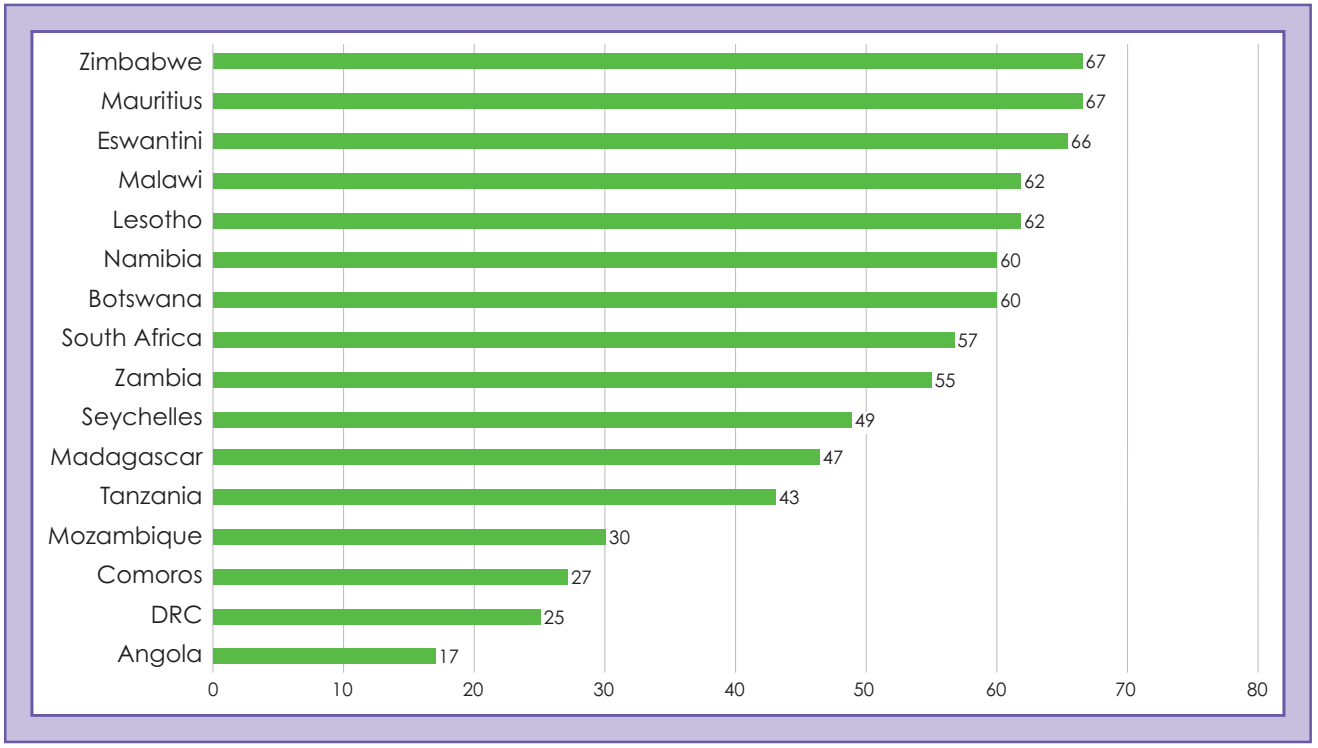
The WHO estimates that, among the 1.9 billion women of reproductive age (15-49 years) world-wide in 2019, 1.1 billion need family planning

Contraceptive prevalence rates

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

[47] WHO, June 2020, Family Planning and Contraception Facts.
[48] World Health Organisation, June 2020, Key Facts - Family Planning and Contraception Methods
[49] https://www.africanhealthstats.org/cms/?pagename=indicator&indicator=RMNCH3

Figure 2.6: Contraceptive prevalence in SADC



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

Figure 2.6 shows wide disparities in contraceptive prevalence rates across the SADC region. The CPR is highest in Zimbabwe and Mauritius (67%) and lowest in Angola (17%).



Zambia: Exceeding family planning targets

Despite a challenging year marred by droughts, flooding, food insecurity, and COVID-19, Zambians have at least one reason to celebrate.

The country plans to increase access to modern contraceptives by another 17% in 2020, providing them to 82 000 more citizens than in 2019 and ensuring it meets a family planning target its leaders set eight years ago.

The country's Family Planning Scale-Up Plan 2013-2020, launched in 2012, ends later this year. It aimed to increase the contraceptive prevalence rate (among married women) for modern methods from 33% to 58% by 2020 in line with the government's regional and international commitments.

One in every two Zambian women aged 15 to 49 currently use a modern contraceptive, which demonstrates the impact of deliberate government intervention. In 2017 alone, this enabled the country to prevent an estimated 600 maternal deaths; 10 000 unintended pregnancies and 6000 unsafe abortions.



Members of Zambia's Alliance SRHR cluster discuss SRHR campaigns in May 2020 in Lusaka. Photo: Bessa Mwale

The move to continue investing in contraception access represents just the latest positive step the Zambian government has taken to improve family planning services over the past decade.

These include the introduction of innovations and capacity development for healthcare providers and encouraging family planning among poor and marginalised groups in the country.

The 2018 Zambia Demographic Health Survey also found that most women now give birth in a health facility (84%), although rural women still report issues accessing health care. The most common challenge involves long distances between facilities, which may also contribute to the country's high maternal mortality rate (213 per 100 000 live births).

Zambian lawmakers recently created several policies, guidelines, and laws to guide SRH with an aim to continue to increase access to contraceptives and family planning. These include Adopting Contraception in Zambia: the 2013-20 plan; Zambia Family Planning Guidelines and Protocols; and Zambia Family Planning Services Health Policy Project.

Research suggests that a choice among several contraceptive methods, rather than between two methods, is more likely to result in the use of contraception.

Source: Gender Links Political Discourse Analysis, June 2020, Zambia set to increase access to contraceptive and family planning Services.

Lockdown measures during COVID-19 have activists worried about an increase in pregnancies, highlighting the critical need for easier access to contraceptives. Limited transportation facilities and services in health institutions could also worsen the unmet demand for contraception. Some countries have initiated mobile facilities for the distribution of contraceptives while others have explored the use of other technologies for ordering and distribution. The economic challenges posed by the pandemic will also reduce access, as many people will struggle to pay for contraceptives.

There is a need to prioritise contraception access as an essential service during the COVID-19 pandemic. Governments should invest in innovation and technology that allows provision of contraception while limiting exposure to the virus.

Some countries have initiated mobile facilities for the distribution of contraceptives

DRC and Malawi: Family planning doorstep dialogue

Local organisations in the DRC and Malawi have been piloting new ways to reach people through family planning that goes back to the basics and door-to-door.

Both countries have family planning challenges, with high birth rates, conservative attitudes towards contraception, and poverty rates that keep women close to home with no time to access most family planning outreach.

Through its work in the Nsona Kulu district of Mbanza Ngungu in the DRC, Action for Integral Health of Women and Girls (ASIFF) decided to meet women where they live and work. In the process, they have changed the lives of at least 12 families, helping keep mothers healthier because they now wait longer between pregnancies.

Many women in the area struggle with birth spacing, which affects their health, the health of their families, and their development.

ASIFF found that ignorance of contraceptive methods and poverty are at the root of the issue, so they began travelling door-to-door as part of their work to raise awareness about the importance of birth spacing, good nutrition, sexual health, and hygiene.

Their strategy has paid dividends, allowing relationships to develop between families and health workers over several years. Local community radio stations also help get the message out to families in the region, buttressing the important family planning messages delivered in person.

In Malawi, the team at Art and Global Health Centre Africa (ArtGlo) also uses community dialogues to improve family planning for girls at Ntiya Village in Zomba.



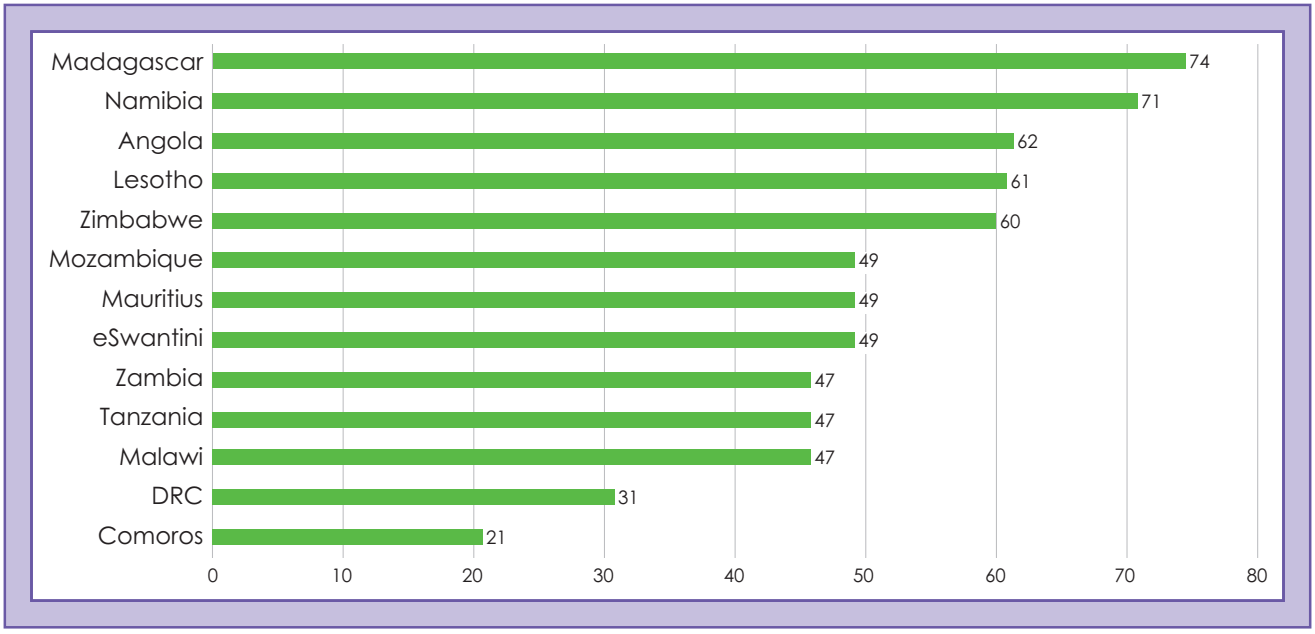
Betty Nzayambela, DRC coordinator at Action for Integral Health of Women and Girls, on a monitoring visit in the Nsana Kulu district in January 2019.
Photo courtesy of UCOFEM

Through its community-based programme, girls express their views and thoughts about family planning in front of their chiefs and religious leaders, including some who limit their access to sex education. This unique strategy breaks down barriers and allows community leaders, especially religious leaders, to remain involved in family planning instead of excluding them, which could result in girls' continued lack of access to family planning.

So far, both projects have seen some successes, opening dialogue, sharing important health knowledge in traditional ways, and helping cultural and religious leaders realise their vital role in normalising family planning.

By Betty Nzayambela, DRC Coordinator at Action for Integral Health of Women and Girls, ASIFF, and Sylverster Chiweza, intern with the Girl Rising IN Potential (GRIP) Malawi as part of the SADC Protocol Gender Links Summit June 2019 for SADC Protocol@Work

Figure 2.7: Women in contraceptive decision-making (15-49)



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 15 May 2020.

Figure 2.7 shows that Madagascar has a high proportion of women involved in decision-making about contraceptive use at 74%, even though the country also has a high unmet need for contraception and low rates of contraception use (47%). In eight SADC countries (Comoros, DRC, Eswatini, Malawi Mauritius, Mozambique, Tanzania, and Zambia) more than half of women between ages 15 and 49 do not have a say in decision-making about contraceptive use. Comoros, at 21%, ranks as the lowest in the region. No data exists for Botswana, Seychelles, and South Africa.

Maternal health

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

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

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

a) The right to control their fertility;

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

c) The right to choose any method of contraception.

Maternal mortality

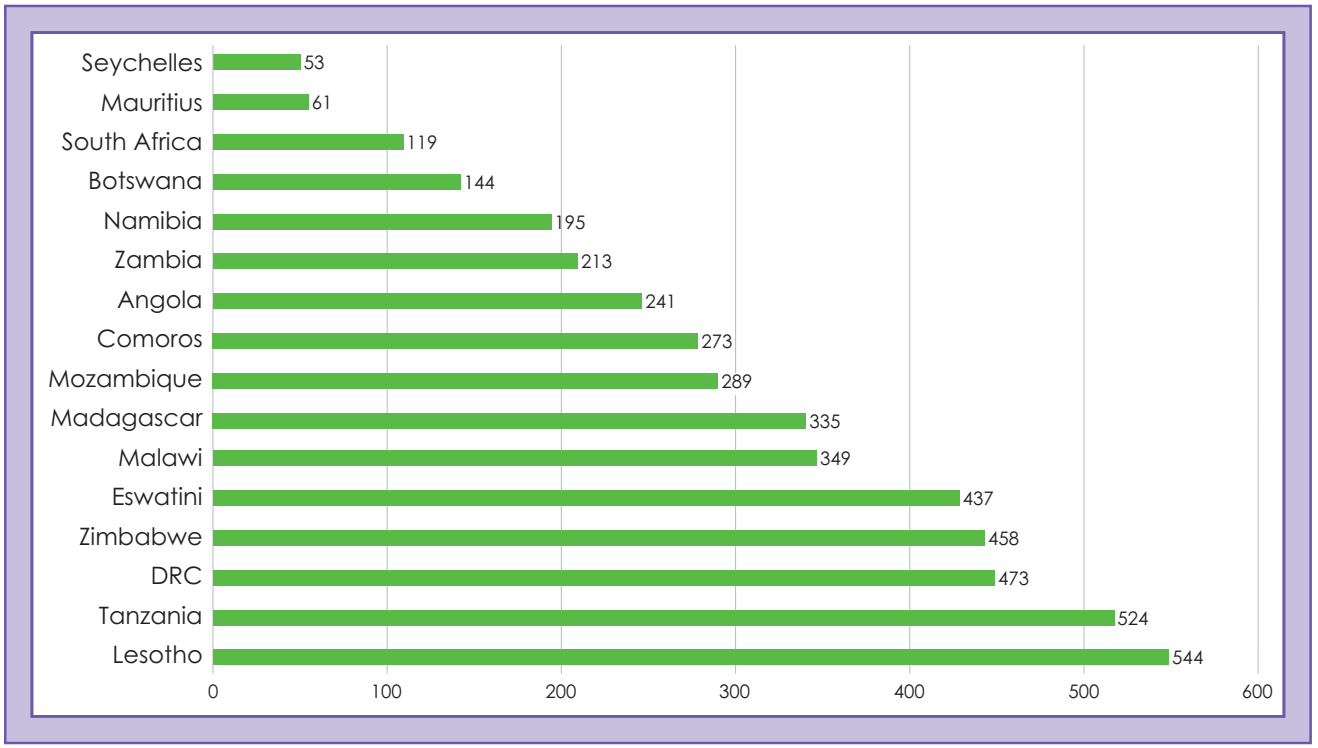
The WHO defines maternal health as the health of women during pregnancy, childbirth, and the postpartum period.[50] The Maternal Mortality Ratio (MMR) represents the number of women of childbearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy and from any cause related to, or aggravated by, the pregnancy or its management (but not from accidental or incidental causes) per 100 000 live births.[51] Most often, women die because of lack of access to proper reproductive health care.

COVID-19 poses challenges to maternal and child health. Poor access to skilled care for childbirth, including care for obstetric and neonatal complications, sits high on the list of SRH health risks during the pandemic. Indeed, such skilled care remains hard to find across much of the region in normal times.

Most maternal and neonatal deaths occur around the time of labour, childbirth, and in the immediate postnatal period.[52] Maternal and neonatal mortality is higher in developing countries than in developed countries, largely due to poor access to skilled health care workers for childbirth and the difficulties faced in referring for obstetric and neonatal complications. COVID-19 exacerbates these conditions, as countries have shifted most skilled healthcare workers to responding to the pandemic.

The pandemic may also create a loss of support and reduction of access, compounded in many cases by trauma, malnutrition, disease, and exposure to violence. All pregnant women, including those with suspected or confirmed COVID-19, should continue to attend antenatal care visits and deliver with a skilled health provider to ensure healthy outcomes for both themselves and their newborns.

Figure 2.8: Maternal Mortality Ratio per 100 000 in SADC



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

[50] https://www.who.int/maternal-health/en/
[51] UNICEF MMR definition
[52] WHO (2019). Packages of interventions for family planning, safe abortion care, maternal, newborn and child health www.who.int/making_pregnancy_safer/documents/fch_10_06/en/index.htm

Figure 2.8 shows that MMR varies considerably by country: from a low in Seychelles at 53 and highest in Lesotho at 544 per 100 000 live births. Poor investment in health facilities, especially in rural areas, keeps MMR high in other countries, which has also given rise to expensive private maternal health care. Fourteen countries in SADC remain below the MMR target of 70, with five countries (DRC, Eswatini, Lesotho, Tanzania, and Zimbabwe) much higher. Achieving universal health coverage includes reducing maternal mortality in each country. Political commitment remains critical to ensure thriving maternal health care systems in the region.



South Africa continues to work on its National Health Insurance (NHI), a health financing system designed to pool funds to provide access to quality affordable personal health services for South Africans based on their health needs, irrespective of their socio-economic status.[53] The NHI, which South Africa has been phasing in since 2012, seeks to realise universal health coverage for all citizens. It means every South African will have a right to access free comprehensive healthcare services at the point of use at accredited health facilities such as clinics, hospitals, and private health practitioners. It represents a big change in the country, which currently has an over-burdened health system and poor infrastructure that is known for its overworked health workers. The current system benefits those with private medical aid, but most others can hardly afford to buy medication or seek SRHR in health facilities.



MMRs in **Tanzania** have remained stubbornly high over the last decade, at around 400-500 per 100 000 live births.[54] Previous research indicates large variations across regions in the country. The health system currently fails to meet the needs of women in the country, which a doctor at the government regional hospital of Temeke municipality confirmed in a recent interview. The most recent Tanzania Demographic Health Survey (TDHS) 2015/16 and National Census 2012 provide an overview of MMRs at a regional level, highlighting the high rates across the country. Politicians regularly comment on the situation, noting they encourage maternal health campaigns with "multi-stakeholder approaches."



In **Zimbabwe**'s National Strategy document for 2016-2020, the Ministry of Health and Child Care acknowledged a decline in MMR from 960 to 614 out of 100 000 live births from 2011 to 2015. It also found child mortality to be at 29 per 1000 for neonatal mortality and 75 out of 1000 live births for under-fives. The WHO, on the other hand, put Zimbabwe's MMR at 443 in 2015. All 92 local authorities offer maternal health services. These include antenatal and postnatal care, family planning, and contraception services. All 92 local authorities have also developed gender action plans, which include actions on reducing maternal morbidity. Thirteen local authorities have developed specific maternal health campaigns to raise awareness on maternal health, with messages like "Early booking for safe delivery," "Zvarira kuchipatara," and "Book early, save lives." Activists continues to advocate for a review of the Termination of Pregnancy Act, as well as the enactment of several laws to improve maternal health, including the National Maternal and Neonatal Roadmap.

Council clinics in Zimbabwe all provide maternal health services. These include access to contraception and provision of shelters for pregnant girls and mothers. Local authorities like Kadoma City Council also provide comprehensive sex education to adolescents, while Chegutu Municipality provides antenatal and postnatal care to increase community involvement in maternal health care. In rural areas, where most pregnant women must walk long distances to clinics, several local authorities have shelters for expectant mothers so pregnant women can have a place to stay prior to, and after, giving birth.

The COVID-19 lockdowns, with their stringent measures and accompanying statutory instruments aimed at stemming the spread of the

[53] Government of South Africa, Department of Health accessed on 1 July 2020 from https://www.gov.za/about-government/government-programmes/national-health-insurance-0
[54] Gender Links Political Discourse Analysis, June 2020, Maternal Health Services and Information still a major Problem to the Society

virus, has affected the right to movement and the right to health. Reports from the first week of the lockdowns noted that many clinics stopped antenatal and postnatal services and turned pregnant and new mothers away. Others discharged women too early following delivery, well before the recommended three days. Health experts worry this could lead to missed post-delivery complications and other health challenges.

Access to health services

Table 2.6: Provisions for antenatal and postnatal care, and skilled birth attendants

Country	Antenatal care (%)		Post-natal care (%)	Skilled birth attendants (%)
	At least one visit	At least four visits		
	2010 - 2015			
Angola	82	61	23	50
Botswana	94	73		99
Comoros	49	11	14	82
DRC	88	48	44	80
Eswatini	99	76	88	88
Lesotho	95	74	62	78
Madagascar	82	51		44
Malawi	98	51	42	90
Mauritius	-	-		100
Mozambique	87	52		54
Namibia	97	63	69	88
Seychelles	-	-		99
South Africa	94	76	84	97
Tanzania	98	62	34	64
Zambia	97	64	54	80
Zimbabwe	93	76	57	78

Source: Gender Links.

Table 2.6 shows that most pregnant women and girls (between 82% and 99%) in SADC now have at least one antenatal visit. However, a much lower proportion of women have at least four antenatal visits. Encouraging figures in Botswana, Eswatini, Lesotho, South Africa, and Zimbabwe show that three quarters of pregnant women and girls have at least four antenatal visits in these countries.

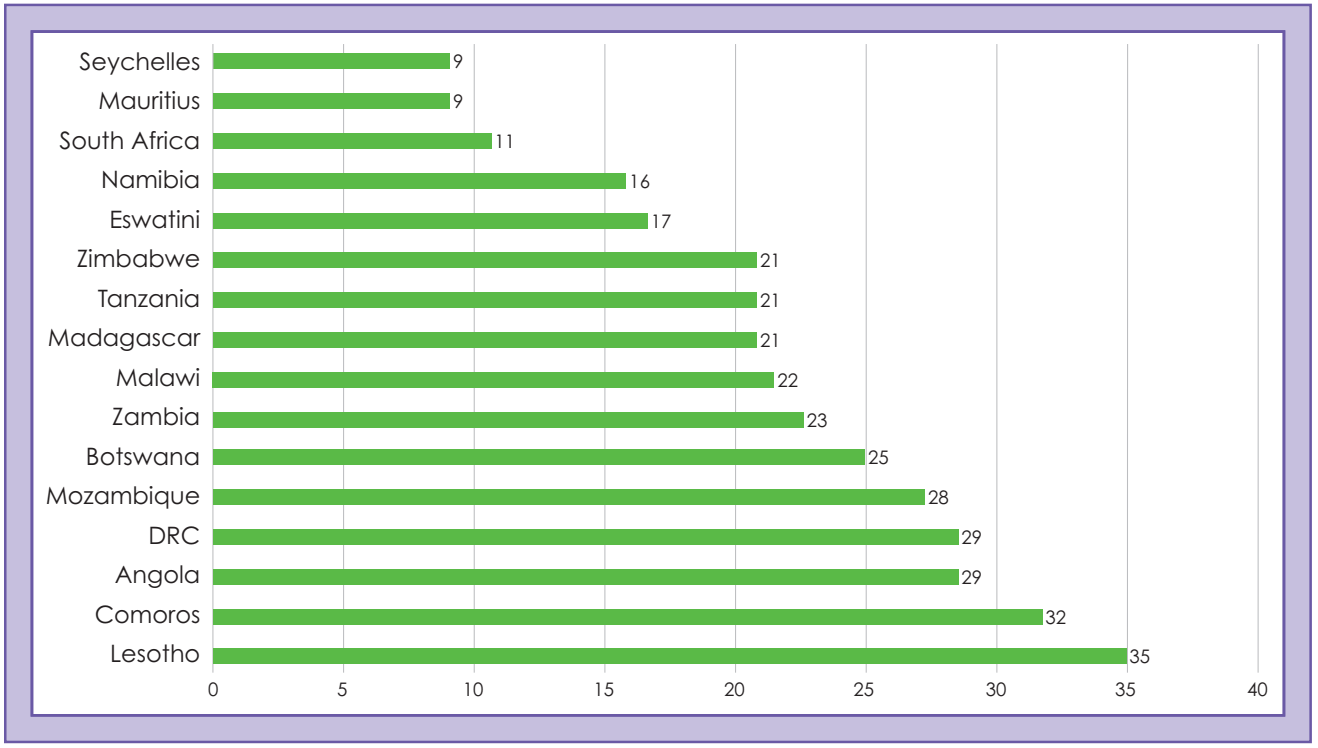
Exceptionally low proportions (between 44% and 54%) of women and girls receive care from skilled birth attendants during delivery in Angola, Madagascar, and Mozambique. Five SADC countries (Botswana, Malawi, Mauritius, Seychelles, and South Africa) now provide skilled birth attendants to more than 90% of pregnant women and girls.

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. Neonatal deaths subdivide into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.[55]

[55] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf

Figure 2.9: Neonatal mortality per 1000 live births



Source: http://apps.who.int/gho/data/view.main.HWFNURv. Accessed 15 May 2020.

Figure 2.9 shows that Lesotho has the highest rate of neonatal deaths in the region at 35 out of 1000 live births. Many other countries fall between 21 and 32 neonatal deaths per 1000. Health experts attribute high neonatal mortality in SADC to low levels of antenatal and postnatal care for pregnant women and newborns.

With health facilities overburdened during the COVID-19 pandemic, many clinics sent mothers home with babies earlier than usual to free up capacity for COVID-19 patients. Others neglected to provide vaccination and medical care for newborns, which should remain essential, even during a pandemic. It is always critical to keep dedicated facilities available to support neo- and postnatal care.



A health worker inspects a storage facility for neonatal vaccines in Andoharanomaitso, Madagascar, in May 2020.
Photo: Zotonantenaina Razanadratefa

Universal health care

Universal health coverage (UHC) ensures that all people have access to effective and needed health services (including prevention, promotion, treatment, rehabilitation, and palliation), while also ensuring that the use of these services does not expose the user to financial hardship.[56] UHC includes the realisation of SRHR.

[56] World Health Organisation, accessed on 5 July 2020 from https://www.who.int/healthsystems/universal_health_coverage/en/

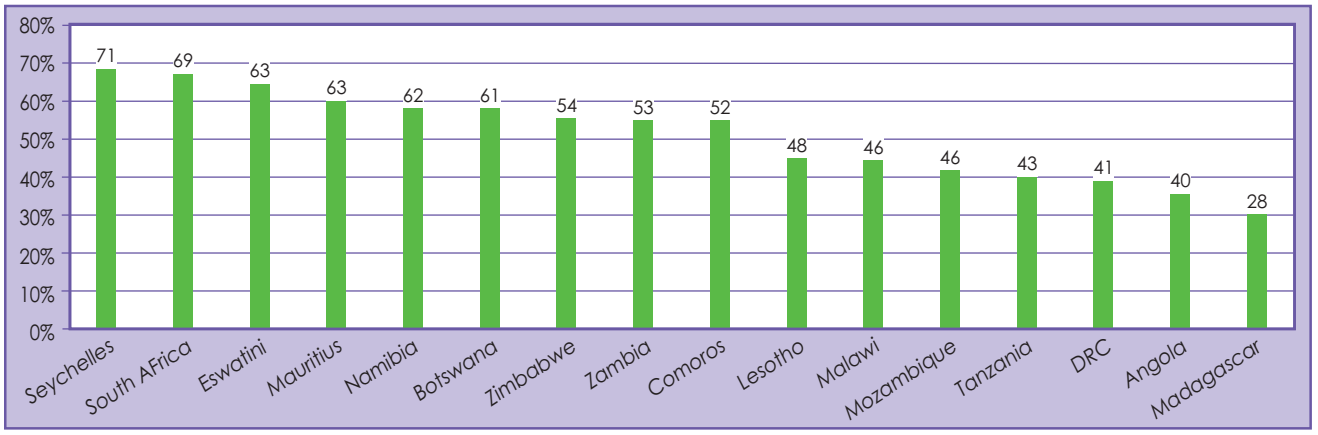
In September 2019, global leaders held a high-level meeting on UHC during the UN General Assembly. Section five of the political declaration from the meeting recognises that UHC is fundamental for achieving the SDGs, including those related to health and wellbeing, eradicating poverty in all its forms and dimensions, ensuring quality education, and achieving gender equality and women's empowerment.[57]

The UN Political declaration on UHC commits to ensuring, by 2030, universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health in national strategies and programmes. The declaration ensures universal access to SRHR as agreed in the Programme of Action of the ICPD and the Beijing Platform for Action.[58]

UHC also improves countries' ability to deliver effective and comprehensive responses to health events like COVID-19. Achieving SRHR and other health goals during a pandemic will require health systems to have the ability to ensure high rates of recovery to the virus, infrastructure for quarantine and treatment, and highly capable health workers.

Civil society should remain vigilant as watchdogs to remind SADC governments of commitments made on UHC. At times of crisis, governments often neglect the needs and rights of women and girls. So far, this pandemic suggests more COVID-19 deaths among men. Countries should report sex-disaggregated data on testing, confirmed infections, and deaths. There is need to be sensitive to gender throughout any government's response to COVID-19.[59]

Figure 2.10: Percentage of the population receiving essential health services



Source: http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv. Accessed 15 May 2020.

Figure 2.10 shows that nine countries provide essential health services to at least 50% of their citizens. A majority of citizens in Angola, DRC, Lesotho, Madagascar, Malawi, Mozambique, and Tanzania do not receive essential health services. As the COVID-19 pandemic ravages the region, these findings should worry leaders in these countries and will hopefully lead to new action for a concerted push to meet the political commitments made to bring in UHC. UHC coverage must include SRHR services, including during the COVID-19 pandemic. Covering SRHR indicates progress towards achieving UHC commitments as well as the SDGs.

[57] United Nations Resolution 74/2, October 2019, Political declaration on Universal Health Coverage
[58] Ibid
[59] World Bank, April 2020, Universal Health Coverage in times of COVID-19 accessed on 6 July 2020 from https://blogs.worldbank.org/health/covid-19-coronavirus-universal-health-coverage-times-crisis



Zambia: Sounding the alarm on chronic SRH constraints

Zambian mothers have been speaking out about the dismal state of healthcare in the country as their leaders look to meet SDG targets linked to health and wellbeing.

Expectant mothers in Lusaka recently told Radio Lusaka, an adult contemporary station that hosts SRHR programming, that while government has improved some services, the country has a long way still to go.

One report found that some clinics do not have medical supplies, and another highlighted the issue of travel in a country where many women must walk long distances to reach a hospital or health centre.

The women interviewed said they want easier access to health services, something they know will prevent maternal deaths. They also noted the inhabitable state of many existing shelters for expectant mothers at hospitals and clinics.

The report comes during a time when Zambia's leaders look to pave the way for attainment of the SDGs by 2030, especially the goals linked to ensuring health and wellbeing for all and achieving universal health coverage.



Women from Luangwa District in Zambia attend a neonatal class in October 2019. Photo: Albert Ngosa

Many women in Zambia still die from preventable causes while giving birth. The WHO indicates that 99% of all maternal deaths worldwide occur in Africa.

Maternal health problems in Zambia range from negligence of health personnel to a lack of advancement in health technology. Poor road networks add to the problem, causing lengthy delays when transporting women to clinics.

Story by Christopher Chisi - A Journalist with Chawama Catholic Church, Regina Pacis Parish - as an entry into the GL Zambia 2020 Summit Media Entry

Fertility

Fertility is one of the least talked about SRH subjects. Deeply entrenched patriarchy in Southern Africa often blames the woman when families do not have biological children when in fact biologically this is usually caused by men. The economic situation of many SADC countries limits expensive fertility treatment for most citizens.

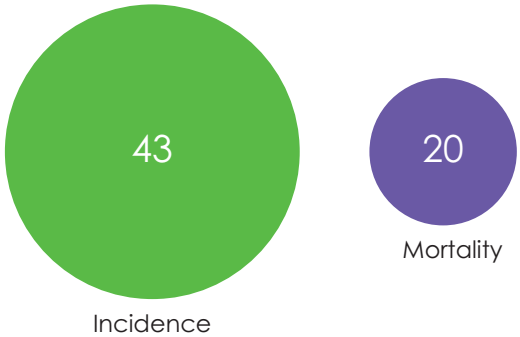
Health insurance seldom covers these trial and error treatments. So far, scientific studies have not proven the efficacy of traditional fertility treatments. Infertility has ripple effects on one's mental wellbeing. Stigmatisation associated with infertility leaves women more vulnerable to polygamy, abuse, and harmful practices.

COVID-19 has significantly impacted availability of fertility treatment around SADC. The Southern African Society of Reproductive Medicine and Gynaecological Endoscopy (SASREG) provides the following guidelines on fertility and COVID-19:[60]

- Undergoing fertility treatment does not increase the risk of contracting COVID-19 (beyond the risk that any individual takes by venturing into public space);
- For women who are trying to conceive, or who are in early pregnancy, there is no evidence to suggest an increased risk of miscarriage with COVID-19;
- At the moment, pregnant women do not appear to be more severely unwell if they develop COVID-19 infection than the general population;
- Women who have severe COVID-19 infection during pregnancy could be at increased risk of miscarriage or early labour;
- There is no evidence that the virus can pass to the developing foetus (vertical transmission); and
- Newborn babies and infants do not appear to be at increased risk of complications from the infection.

Knowing that COVID-19 poses no special risk to women undergoing fertility treatment, to the developing foetus, or to newborn babies will certainly provide peace of mind for those seeking these services. Women everywhere should have an affordable choice of fertility treatment free from fear of stigmatisation.

Figure 2.11: Cervical and uterine cancer prevalence and mortality rates per 100 000 in SADC



Source: http://gco.iarc.fr/today/data/factsheets/cancers/23-Cervix-uteri-fact-sheet.pdf. Accessed 15 May 2020



Youth lead on SRHR campaigns in Zimbabwe.
Photo courtesy of Women's Coalition of Zimbabwe

Figure 2.11 shows the current incidence rates of cervical and uterine cancer at 43 per 100 000 women of all ages. These cancers have emerged as a leading cause of death amongst women. The mortality rate for these cancers in SADC sits at 20%. It is critical to raise awareness of these cancers even during COVID-19. Governments must ensure accessible and affordable testing. UHC provides for relevant cancer treatments and testing.

Health expenditure analysis

Experts use two measures to assess health financing: the level of health spending as a proportion of the total government spending and health spending as a proportion of 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.[61] Health experts view health expenditures as an important indication of a government's commitment to UHC.

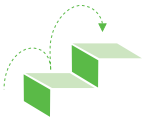
[60] SASREG COVID-19 and COVID-19 Guidelines, April 2020
[61] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038

Table 2.7: Health financing analysis

Country	Health expenditure as % of total government expenditure	Health expenditure as % of GDP
Madagascar	17.8	6.0
Eswatini	15.25	7.7
Zimbabwe	14.5	9.4
Namibia	13.8	9.1
South Africa	13.3	8.1
Lesotho	10.1	8.1
Seychelles	10.0	3.9
Malawi	9.8	9.8
Mauritius	10.0	5.7
Tanzania	9.5	4.1
Botswana	9.1	5.5
Mozambique	8.3	5.1
Zambia	7.1	4.5
Angola	5.4	2.9
DRC	3.7	7.6
Comoros	3.6	3.9

Source: https://databank.worldbank.org/data/source/world-development-indicators#. Accessed 15 May 2020.

Table 2.7 shows that only Eswatini and Madagascar meet the recommended Abuja Declaration goal of 15% expenditure on health.[62] Zimbabwe comes close at 14.5%. DRC and Comoros allocate the least to health at 3.7% and 3.6% of their respective budgets. All SADC countries spend less than 10% of their GDP on health. This poses a regional challenge to realising SRHR and achieving universal health coverage. Most countries will have increased health expenditures during the COVID-19 pandemic. It would be wise for governments maintain these higher allocations in years to come.



Next steps

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

- Develop and review national SRHR policies and guidelines to align to global, continental, and regional instruments on SRHR. The review of policies must include health disasters.
- Mainstream SRHR in all COVID-19 responses, including policy and guideline development.
- Ensure that price increases do not offset gains made in removing VAT from sanitary pads. Governments must make sanitary pads essential commodities, removing barriers to manufacturing and supply.
- Prioritise investment in clean water provision for both urban and rural areas.
- Raise public awareness on sanitation, including building the capacity of community-led sanitation coverage.
- Support continuity of WASH services in the home when possible or ensure regular deliveries of essential WASH supplies during the COVID-19 pandemic.
- Support health workers' menstrual health and WASH needs to prevent heightened risk of COVID-19 infection and other infections.
- Improve access to contraception for women and girls, including during the COVID-19 pandemic and other health disasters.
- Build capacity in communities to expand pools of health workers to achieve UHC, which is especially critical in emergencies such as the COVID-19 crisis.
- Keep sex disaggregated data on access to SRHR services, including during national health disasters such as COVID-19.
- Develop programmes and policies on reproductive cancers and share these with different target groups at community level.
- Prioritise investment in health systems in national budgets and plans to achieve the Abuja Declaration commitments.



Doctor Angele Mabiala distributes menstrual hygiene products to adolescents in Boma, DRC, in February 2020. Photo: Anna Mayimona Ngemba

[62] https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf

Adolescent Sexual and Reproductive Health and Rights (ASRHR) 3



Students in Seychelles take part in the 2019 launch of the Orange Campaign, a government effort to raise awareness about gender-based violence (GBV) in primary schools.
Photo: Sharon Thelemaque Ernesta

KEY POINTS

- UNESCO estimates that 75 million learners enrolled in primary and secondary schools in Southern Africa (more than 70% of students) were out of school due to COVID-19 from February to May 2020.
- Governments have struggled to keep this commitment internationally binding, commitments to achieving universal access to Sexual and Reproductive Health and Rights (SRHR) due to the COVID-19 pandemic.
- Menstrual health and harmful practices for adolescents are not receiving sufficient attention.
- Better access to sex education and contraceptive information could reduce high numbers of maternal deaths due to unsafe abortion.
- Bowing to local and global advocacy, and in a major policy reversal, Tanzania's government committed to provide pregnant girls with equal opportunity to education in March 2020.

Introduction

Youth in Southern Africa face many sexual and reproductive health challenges, such as unintended pregnancies, Sexually Transmitted Infections (STIs), limited youth-friendly health facilities, and sexual exploitation. Adolescents represent more than half of Sub-Saharan Africa's population (United Nations, 2018), including in Comoros, the newest member of the Southern African Development Community (SADC). This chapter on Adolescent Sexual Reproductive Health Rights (ASRHR) will look at progress in the 16 SADC countries in implementing the SADC Gender Protocol articles that focus on Comprehensive Sex Education (CSE), access to Sexual Reproductive Health and Rights (SRHR) services for young people, and teenage pregnancy.

The COVID-19 pandemic has impeded progress on some of these issues. The pandemic has crippled major economies around the world. SADC states have an obligation to ensure access to sexual and reproductive healthcare services during a crisis. Twelve SADC member states implemented lockdown measures, allowing only essential services to remain open. Namibia and Eswatini declared partial lockdowns, while Tanzania and Zambia imposed curfews and movement restrictions instead of a full lockdown. These restrictions have seen schools closed across the region. This has implications for adolescent health that we have yet to fully understand as the crisis continues.

Over the past years, the region has made tremendous strides in CSE, aligning with international agreements such as the International Conference on Population and Development (ICPD, 1994), which formally introduced the concepts of sexual and reproductive health and reproductive rights. In 2019, stakeholders took stock of 25 years of progress towards agency, education, and access to critical health services in 179 countries that signed on to the global commitment (ICPD, 2019).[1] SRHR services sits alongside four other key thematic areas highlighted as part of the 2019 ICPD, also known as the Nairobi Summit. These renewed commitments agreed to by governments, members of civil society, and other key stakeholders include a pledge to incorporate CSE in national plans and strategies. These commitments, if implemented, will ensure improved sexual and reproductive health outcomes including a reduction of adolescent STI rates, HIV infection and unintended pregnancy (Sexual and reproductive health and rights: an essential element of universal health coverage).[2]

In addressing ASRHR, it is important to emphasise that adolescents are not "little adults" or "big children." They are individuals existing in the important years when reproductive growth occurs, and foundational sexual socialisation takes place. Adolescents face the pull of both negative and positive behaviours and influences, and thus need access to health education, counselling, and services. Administering of CSE in schools is the ideal entry point for reaching adolescents. CSE administered through community projects can reach those youth and adolescents who do not attend school.

CSE helps empower young people because it is grounded in human rights

[1] https://www.nairobisummiticpd.org/content/about-nairobi-summit [accessed 18 April 2020]
[2] https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_2020_online.pdf [accessed 18 April 2020]

ASRHR and COVID-19

As much of the world shut down because of the COVID-19 coronavirus in early 2020, governments in SADC also closed and regulated schools, retails outlets and non-essential services. According to the United Nations Educational, Social and Cultural Organisation (UNESCO), as of 12 June 2020, 144 countries had implemented nationwide school closures.[3]

Government also cancelled non-emergency health services because of the large number of COVID-19 cases in many parts of the region. This put access to SRHR on the back burner, as governments also closed public community-level youth centres and public and academic clinic facilities to prevent the spread of the deadly virus. The 16 SADC countries have all responded to the global call for isolation, physical distancing, and variations of lockdown scenarios under which citizens have been regulated and obliged to remain at home. These actions mean governments must find new ways to provide information and support to adolescents and young people so they can continue to realise their sexual and reproductive health and rights (UNFPA, 2020).[4] Activists have expressed concerns about the gendered nature and impact of COVID-19, including on ASRHR, with some worried about increased vulnerability of women and girls and a potential spike in teenage pregnancies.

School closures due to COVID-19 widen education inequalities and affect vulnerable girls and youth disproportionately. Adolescent girls who already face domestic and family-related violence may experience even higher levels due to isolation and quarantine. Out of the total population of students enrolled in educational programmes, UNESCO estimates that more than 70% are currently out of school due to the pandemic, representing 75 million primary and secondary learners over the period February to May 2020[5]. Drawing lessons from the 2014-2016 Ebola outbreak in West Africa, during which similar quarantines took place, experts and activists have warned that school closures expose girls to sexual violence and unintended/unwanted pregnancy (Peyton, 2020).[6] When forced to remain at home, girls become vulnerable to sexual predation from relatives, neighbours and others.

The SADC Secretariat and UNESCO have launched initiatives to ensure continuity, inclusion and equity for all.[7] Using the hashtag *#Learning NeverStops*, SADC governments and development agencies have mobilised resources to provide online distance learning and television education programmes as part of the Global Education Coalition. They have also made several investments to reduce the pandemic's impact on ASRHR.



In **South Africa**, Harambee, an agency that champions local human resources, is working with partners to provide trusted and accurate information to young people (Southern Africa Trust, 2020). Meanwhile, UN Women and civil society organisations have been providing online webinars and WhatsApp outreach programmes for reporting violence and mental health needs in the Eastern Cape. They have also accelerated service delivery for GBV survivors, especially women in the informal economy, as well as young girls and women affected by HIV and AIDS.[8]

Throughout the COVID-19 pandemic, the Media in Education Trust (MIET) Africa in **Lesotho, Malawi,**

3 https://en.unesco.org/covid19/educationresponse [accessed 19 April 2020]
4 https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Preparedness_and_Response_-_UNFPA_Interim_Technical_Briefs_Adolescents_and_Young_People_23_March_2020.pdf [accessed 19 April 2020]
5 https://en.unesco.org/covid19/educationresponse [accessed 19 May 2020]
6 https://news.trust.org/item/20200319115906-eieyl/?utm_source=Global+Health+NOW+Main+List&utm_campaign=d0c2ace1c0-EMAIL_CAMPAIGN_2020_03_19_03_46&utm_medium=email&utm_term=0_8d0d062dbd-d0c2ace1c0-3019493 [accessed 19 April 2020]
7 https://en.unesco.org/news/sadc-and-unesco-sign-agreement-ensure-learning-never-stops [accessed 20 May 2020]
8 https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006 [accessed 19 May 2020]

Zambia, and **Zimbabwe** has embarked on SMS engagement with beneficiaries of the FutureLife-Now! programme, a regional school-based initiative aimed at reducing HIV infections and increasing anti-retroviral adherence amongst young people in SADC. Twenty-five thousand beneficiaries receive four messages per month over the course of the COVID-19 engagement.



Zambia: COVID-19 may reverse SRHR gains

Zambian activist and counsellor Nsofwa Petronella Sampa worries that the restrictions placed on young people due to COVID-19 will impede their access to SRHR services. Legislators in Zambia, which is currently under a partial shutdown to fight COVID-19, have brought in measures that include the mandatory use of face masks in public and closures of all social spaces including restaurants, bars, gyms and sporting facilities.

Sampa, who is blind, says she feels more vulnerable because of her disability. "I had to wash my hands at every shop I entered. But I also had to endure some acts that are totally unfriendly to persons with disabilities like I am. Zambia is also enforcing physical distancing rules, which means its citizens cannot shake hands with one another. For Sampa, this makes her feel like she does not exist, and she says she feels more susceptible to contracting the deadly virus. "When it comes to physical distancing being talked about, that doesn't exist with us. Those of us that are blind, we normally hold our guides as we walk. So, I don't know how physical distancing would work," Sampa explains.



Zambian activist and counsellor Nsofwa Petronella Sampa.
Photo courtesy of Fortress Media

She also worries about what these measures will mean for accessing SRHR services with restrictions placed on youth-friendly facilities. Sampa, who is a 2017 Mandela Washington Fellow, notes that "some facilities are not allowing everyone to go in... even safe spaces for young people where they access SRHR services are closed due to [the] 'stay home' emphasis by authorities. So, some facilities would obviously tell young people to go and access, for example condoms, at pharmacies where they have to buy them," Sampa says.

This story by Arthur Sikopo is part of the Gender Links News Service's series on Gender and COVID-19.

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 that reflects international standards[9]	Partial	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Partial	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)[10]	18	16[11]	13[12]	18	16	16	14[13]	16	16	18	14	18	16	18	16[14]	16
Legal age to consent to sex (F)[15]	16	16	13	14	16	16	14	16	16	18	14	18	16	15	16	16
Adolescent fertility rate (births per 1000 women, 15-19 years of age)[16]	151	46	70	124	77	93	110	133	26	149	64	62	68	118	120	86

Source: Gender Links 2018 updated 2020.

Table 3.1 shows that:

- Of 16 SADC countries, only seven have CSE programmes that fully meet international standards.
- Countries that make it difficult for younger adolescents to access contraceptives, specifically DRC, Mozambique, and Zambia, have higher adolescent fertility rates.
- Experts calculate the adolescent fertility rate as the annual number of live births to women aged 15 to 19 years, divided by the number of women aged 15 to 19 years, expressed as births per 1000 women.
- The legal age of consent to sex in three SADC countries is quite young (13-14 years), which is a concern because many adolescents in this age group do not have the education and experience required to make safe sexual choices.
- Researchers documented increases in adolescent fertility ratios in 2018/2019 in Malawi, Namibia, South Africa, and Zambia. While efforts to incorporate sex education into school curriculum have increased, this raises concerns about access to family planning and contraception, including in schools.

The 2019 SADC Gender Protocol SRHR Barometer highlighted high rates of teenage pregnancies in Malawi, Tanzania, and Zambia, with more than 50% of female school dropouts due to pregnancy (EUP, 2018).[17] The 25-year progress marker at ICPD in November 2019 noted that, while there has been progress, millions of women in the SADC region still do not have access to, or use, modern contraceptives to prevent unintended and unwanted pregnancies. Additionally, unsafe abortions continue to contribute to high maternal death rates in the region (UNFPA).[18]

Unsafe abortions continue to contribute to high maternal death numbers in the SADC region

[9] UNESCO, Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education, a Global Review, 2015
[10] https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf [accessed 21 April 2020]
[11] https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf [accessed 21 April 2020]
[12] https://www.ageofconsent.net/world/comoros [accessed 21 April 2020]
[13] https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf [accessed 21 April 2020]
[14] https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf [accessed 21 April 2020]
[15] https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf [accessed 21 April 2020]
[16] 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 21 April 2020]
[17] https://www.youngpeopletoday.org/wp-content/uploads/2019/04/Unesco_EUP_Report_2018_LOW_RES.pdf [accessed 22 April 2020]
[18] https://www.unfpa.org/resources/supplement-background-paper-sexual-and-reproductive-health-and-rights-essential-element [accessed 22 April 2020]

Comprehensive Sex Education (CSE)

SDG-4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. SDG 5.6.2 indicator 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."

ICPD paragraphs 4.29, 7.37, 7.41, and 7.47: Sexuality education to promote the well-being of adolescents and 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 East and Southern Africa (ESA) Ministerial 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 stakeholders should explore creative approaches to build the capacity of media, including radio, to reach out-of-school youth.

CSE is a rights-based approach to adolescent sex education that seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality. While some SADC CSE programmes align with international standards, country-specific cultural interpretations exist, with universal sexual rights-based lessons on understanding the physical, emotional, and individual aspects of sex and relationships. CSE views sexuality holistically, as

part of young people's emotional and social development. It provides young people the opportunity to acquire essential life skills and develop positive attitudes and values (UNESCO, 2018).[19]

CSE curriculum in schools and in out of school programmes is meant to provide accurate information on sexual and reproductive rights in a neutral manner that dispels myths and traditionally limiting or erroneous approaches to SRHR. Through these programmes, young people receive education on STIs and HIV and AIDS and can develop critical thinking and decision-making skills that provide a sense of self and confidence. Cultural and religious traditions that pose a threat to sexual rights and ethical barriers to exercising SRH still hold sway in the SADC region. Thus, the role of regional and national policies, laws, and structures becomes paramount in navigating the understanding that sexuality and culture are diverse and dynamic. Policies and laws safeguard choice and civil protections, this includes underscoring the importance of consent and the right for adolescents to have sex only when they feel ready to do so. This also includes the sometimes-contentious right to freely express and explore one's sexuality in a safe, healthy, and pleasurable way.

As part of education and literacy obligations, CSE commitments appear in many international agreements and normative frameworks, including those listed above. The Sustainable Development Goals (SDGs) monitoring framework under SDG target 3.7 states that by 2030 there must be "universal access to sexual and reproductive health care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes" (UN, 2015).[20] Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (The Maputo Protocol) enshrines sexual reproductive health and



'Restless development' girls in Chipata. Photo: Gender Links

reproductive rights (SRHRR).[21] This includes adolescent sexual and reproductive health (ASRH); family planning; prevention and management of STIs including HIV and AIDS; safe abortion care; health and development; and health education (The Operationalisation Of The Continental Policy Framework For Sexual And Reproductive Health And Rights, 2016).[22]

These show strong convergence with the Continental Policy Framework on Sexual and Reproductive Health and Rights which calls for increasing resources to SRHR programmes, translating the International Conference on Population and Development (ICPD) and Beijing+20 commitments into national legislation, and SRHR policies, including continuing to reduce HIV and AIDS, expanding contraceptive use, reducing levels of unsafe abortion, and ending early and child marriage. All of these form part of CSE when educators administer it accurately.

Like these global frameworks, the SADC Gender Protocol Article 11 also enshrines SRHR education, requiring state parties to adopt laws, policies, and programmes that ensure the girl and boy child have equal access to information, education services and facilities on SRHR and that state parties shall develop concrete measures to prevent teenage pregnancies (Morna, C., Rama,

[19] UNESCO. 2018 Global CSE education campaign; https://en.unesco.org/news/unesco-launches-its-global-comprehensive-sexuality-education-campaign [accessed 21 May 2020]
[20] https://sustainabledevelopment.un.org/sdg3 [accessed 22 April 2020]
[21] The Operationalisation Of The Continental Policy Framework For Sexual And Reproductive Health And Rights: https://au.int/sites/default/files/documents/30358-doc-mpoa_7-_revised_au_stc_inputs_may_se-rob-director_002.pdf [accessed 22 April 2020]
[22] Ibid.

K., Chigorimbo, S., 2019). This Protocol article also calls on member states to "ensure that the girl and the boy child have equal access to education and health care, and are not subjected to any treatment which causes them to develop a negative self-image."



United Nations Population Fund (UNFPA) research on ASRHR notes that **Comoros** has been improving health care services and decreasing maternal mortality. UNFPA programmes there provide emergency obstetric care and family planning (UNFPA, 2019).[23] CSE education in Comoros includes the Adolescent and Youth Health Strategy, developed as part of the National Plan for Sexual and Reproductive Health and the National Youth Policy. According to 2019 UNFPA data, Comoros's education empowers adolescents, and specifically girls, with access to sexual and reproductive health and reproductive rights, in all contexts, with consideration for their active participation and leadership.[24] The UNFPA, however, notes that Comoros still provides inadequate CSE curriculum in some areas, as it has no legal framework for adolescent SRHR services. Comoros has been rolling out youth-friendly centres to provide CSE and other SRHR services as a response to high levels of unprotected sexual activity, which results in unwanted pregnancies, STIs and increased rates of HIV and AIDS.[25]

Cultural and religious traditions that pose a threat to exercising SRH still hold sway in SADC

#VoiceandChoice ASRHR campaigns



The #VoiceandChoice campaign, coordinated by Gender Links (GL) and partners, has been running since 2018, with seven partner countries working specifically on ASRHR campaigns that have been documented on the GL website and social medial (Gender Links, 2019).[26] In the **Democratic Republic of the Congo (DRC)**, the campaign's initiatives and strategies have most commonly focused on reduction of risky sexual behaviours and decreasing the proportion of early marriage. Joint campaign activities align with regional initiatives, such as #OurGirlsMatter, that focus on preventing early pregnancy. Union Congolaise des Femmes de Médias (UCOFEM), GL's partner in DRC, has been part of an effective campaign that has attracted media attention because of its SRHR training.



In **Namibia**, the office of the first lady has spearheaded efforts to reduce teenage pregnancy by providing SRHR information and education in schools. The campaign extends to local communities and Namibian media has also featured it, with messaging on improving access to available health services by removing cost-related barriers. Prior to the ESA-CSE commitment, a programme called Life Skills Education mainly delivered sex education in Namibia's schools.

[24] https://www.unfpa.org/sites/default/files/KM_UNFPA_Results_07_27.pdf
[25] https://www.unfpa.org/sites/default/files/portaldocument/DP.FPA_.CPD_.COM_.6Finalcountryprogrammedocumentfor theComoros.pdf [accessed 15 April 2020]
[26] https://genderlinks.org.za/what-we-do/sadc-gender-protocol/voicechoice/cse-and-teenage-pregnancy/

Similarly, in **South Africa**, the #VoiceandChoice teenage pregnancy campaigns have seen the development of Information, Education and Communication (IEC) messaging and community drama road shows in several provinces. These campaigns first started in Limpopo province, where the Capricorn Municipality and school collaborations led them.

On 12 March Youth Day 2020 in **Eswatini**, Nhlangano Town Council conducted the #VoiceandChoice sex education and management of menstrual health campaign through dialogue and youth drama sessions. The council worked with three schools: Evelyn Baring High School, Nhlangano Central High School, and Nhlangano Primary School. Ten councils implemented the #VoiceandChoice menstrual health campaign along with two national campaigns with youth alliance focal points. The campaigns included local marches to spread awareness, and the councils distributed toiletries and women's hygiene products to the schools. In the same campaigns, #VoiceandChoice and #SheDecides partnered to engage and sensitise youth through dialogues on the topic of early child marriage. Faith-based organisations in Manzini hosted the Early Child Marriage campaign and took the lead on these initiatives.

In **Malawi** the Phalombe Youth Arms Organisation has been disseminating specific SRH information for local youth. The group is also working with the district health office on issues of SRHR and youth-friendly health services. Next up, they want to expand efforts to work with youth champions to sensitise the community on COVID-19 and family planning.

In **Zimbabwe**, GL has partnered with the Kadoma City Council to raise awareness of COVID-19, with youth at the forefront of the campaign. Using digital technology and mainstream media, the youth in Kadoma municipality have led the fight against the pandemic, which has affected their access to SRHR services. The municipality's health department works at the local level to deliver messages about COVID-19 through drama, videos, and other publicity materials.[27] The Kadoma City Council and junior councillors have been using WhatsApp, Smartphones, and TV campaigns to share animated and sign language videos that raise awareness about COVID-19 prevention. The council has mostly distributed the video messaging in three local languages to hard-to-reach communities and disabled people. Kadoma junior councillors showed initiative and determination in presenting the project idea to the City Council, which joined together with Gender Links Zimbabwe to find resources for the messaging.



[27] Kadoma Municipality Health Department video on COVID-19 awareness

Policies and practice

Recognition of SRHR is a precondition for the growth of social capital, an outcome indicator linked to all aspects of sustainable growth and development. Many national policymakers and civil society leaders who invest in policy review and implementation agree that the SDGs cannot be achieved "without focusing on six aspects of adolescents' SRHR: pregnancy, HIV, child marriage, violence against women and girls, female genital mutilation, and menstruation".[28]

There has been considerable progress made in many of these areas and increased funding for programmes and research targeting adolescents. This includes significant growth in the number of evidence-informed policies, normative documents, and guidelines on adolescent-responsive SRHR programming. Despite progress, several critical gaps remain.

Table 3.2: Breakdown of CSE in 13 SADC countries[29]

Country	National policy	CSE place in the curriculum	Reflects international standards	Offered at		Mandatory or optional	Teacher training
				Primary	Secondary		
Angola	Yes	In progress - stand-alone	Under review to meet standards	Yes	Yes	Mandatory	Yes
Botswana[30]	Yes	Integrated	Under review to meet standards	Yes	Yes	Integrated into mandatory subjects	Yes
Comoros[31]	No	Integrated in other lessons[32]	Yes	Yes	Yes	Unknown	Unknown
DRC	Yes	Integrated	No	Yes	Yes	Mandatory and examinable	Yes
Eswatini	Yes	Stand alone	Yes	Yes	Yes	Mandatory and examinable	Yes
Lesotho	Yes	Integrated - primary Stand-alone - secondary	Yes	Yes	Yes	Mandatory	Unknown
Malawi	Yes	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes
Mozambique	Yes	Integrated	Under review to meet standards	Yes	Yes	Mandatory and examinable	Unknown
Namibia	Yes	Stand-alone	Yes	Yes	Yes	Mandatory and assessment	Yes
South Africa	Yes	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes
Tanzania	Yes	Integrated	Yes	Yes	Yes	Mandatory and examinable	Yes
Zambia	Yes	Integrated	Yes	Yes	Yes	Mandatory and examinable	Unknown
Zimbabwe	Yes	In progress	Under review to meet standards	Yes	Yes	Mandatory and examinable	Yes

Source: Emerging evidence, lessons, and practice in comprehensive sexuality education: A global review, 2015 and specified data sources referenced in footnotes.

[28] Volume 65, Issue 6, Supplement, S1-S2, December 01, 2019. Adolescents' Sexual and Reproductive Health and Rights: What Has Been Achieved in the 25 Years Since the 1994 International Conference on Population and Development and What Remains to Be Done? Caroline W. Kabiru, Ph.D. https://www.jahonline.org/article/S1054-139X(19)30468-9/pdf
[29] https://unesdoc.unesco.org/ark:/48223/pf0000243106 emerging evidence, lessons and practice in comprehensive sexuality education o a global review 2015 [accessed 21 April 2020]
[30] https://www.youngpeopletoday.org/wp-content/uploads/2018/06/CSE_Scale_up_in_practice_JUNE_2017_FINAL.pdf
[31] https://www.afro.who.int/sites/default/files/2019-08/39%20Comoros%20AH24022019.pdf [accessed 21 April 2020]
[32] https://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive_health_policies_2017_data_booklet.pdf [accessed 22 April 2020]

Table 3.2 shows that:

- Thirteen SADC countries have CSE offered in both primary and secondary schools, which is crucial to equip learners with knowledge, skills, values, and positive attitudes about their reproductive health and sexuality.[33]
- Most schools in the region now make CSE mandatory.
- Comoros, a new addition to the list, has no national ASRHR or CSE policies. However, it does have health ASRHR strategies in place that adopt concrete measures to administer CSE nationwide.
- Madagascar, Mauritius and Seychelles provide school-based sex education in other subjects such as biology, life-skills and other civics education initiatives.[34]

Many teachers require training, support, and a coordination mechanism to ensure that they cover the full curriculum across all subjects.[35] Research suggests that when larger numbers of staff take part in CSE, it results in more holistic "whole school" approach.

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.



In **Eswatini**, the Child Protection and Welfare Act of 2018 enables young people 12 years and older to access SRHR information and services, including contraceptives. However the Sexual Offences and Domestic Act (SODV) of 2018 states that the age of consent for any sexual practice is 18 years and older. This points to the need for policymakers to ensure consistency in rights and overall ASRHR outcomes through policy alignment when reviewing and enacting new laws and policies.[36] Eswatini is one of four countries with a standalone CSE curriculum. It includes HIV prevention, delayed sexual debut, and preventing, identifying and reporting abuse (UNESCO and UNFPA, 2012). In 2017 and 2018, the Eswatini Ministry of Education engaged primary and high school pupils on Comprehensive Sex Education and Information (CSE&I) aimed at promoting access to SRHR information and services. The joint initiative between the government and other civil society organisations, specifically UNICEF and Save the Children, strengthened nationwide capacity to jointly collaborate on CSE matters for young people. With specific objectives for effective ASRHR outcomes, the Maternal Newborn Child Health (MNCH) programme, which houses ASRHR responsibility, aims to reduce teenage pregnancy and positively influence adolescent sexual behaviour.[37]

Eswatini is one of four countries in SADC with a standalone CSE curriculum

[33] https://unesdoc.unesco.org/ark:/48223/pf0000247268 [accessed 23 April 2020]
[34] Reproductive health policies 2017 - https://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive_health_policies_2017_data_booklet.pdf [accessed 23 April 2020]
[35] https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf [accessed 23 April 2020]
[36] https://genderlinks.org.za/news/the-sexual-offences-domestic-violence-act-analysis/
[37] http://www.gov.sz/index.php/departments-sp-654042511?id=473 [accessed 24 April 2020]



Eswatini: CSE emphasises abstinence

The Eswatini CSE curriculum includes abstinence as the key method for preventing early pregnancy. One young woman, who prefers to use only her first name, says she accidentally became an advocate for teenage pregnancy prevention through abstinence.

Enhle, at 24, says she remains a virgin, even though she knows that it is generally assumed that most women will have become sexually active by the time they reach her age. Sexual debut is around the age of 16 for many girls in the region. Enhle says she has been able to avoid sex despite societal pressure to enter into sexual relationships.

Teenage pregnancy prevention is especially relevant in Eswatini, which has some of the world's highest rates of HIV and AIDS. Abstinence offers a solution to the scourge, especially because young women represent the most vulnerable group for contracting HIV. A focus on abstinence as a preventative measure is one way to advocate about SHRH issues. Yet it is also uncommon, and many young women who choose this route are ignored because



Eswatini youth came together in 2019 to sign a pledge that they will contribute to a GBV-free nation. Photo: Gender Links

many assume that all young people are sexually active.

This myth means many young people do not hear about abstinence as an option. Educational emphasis is often placed on correct and consistent condom use and family planning provision. By raising awareness of stories such as Enhle's, some educators hope that abstinence may be "cool" again.

Source: Bongiwe Zwane, independent journalist with The Times of Swaziland, as part of a submission for the SADC Protocol @ Work Gender Links Summit case study 2020.



A recent CSE highlight in **Lesotho** occurred at a February 2020 sharing meeting with the Lesotho Ministry of Education and Training. Participants noted that Lesotho introduced "Life Skills Education" at the time of the ESA-CSE commitment. The customised content includes the reduction of (i) HIV infection, (ii) early/unwanted pregnancy and (iii) child marriage. In 2019, educators began developing scripted lesson plans for Grade 12. Education Management Information Systems (EMIS) data shows that more than 90% of primary and high schools offer life skills in curriculum, though it remains unclear why the remaining 10% do not.

Lesotho's Ministry of Education has adopted training materials for teachers, which has improved their confidence in teaching the subject, although many acknowledge there is still a long way to go. Specifically, teachers would like a guide to provide them with scientifically accurate information (MIET, 2020). This aligns to the findings of a 2012 UNESCO review in Lesotho schools.

The Government of Lesotho, through the Ministry of Education and Training (MOET) is a signatory to the SADC Comprehensive Education Policy. Its curriculum review included the launch of a

textbook that addresses Sesotho cultural norms and encourages diverse learning related to sex and sexuality using the country's mother tongue. To ensure that CSE becomes effective and productive, the MOET has included psychosocial support services for schools (training teachers in lay counselling). This component ensures that schools accommodate those learners who do not receive support at home (Adesina & Olufadewa, 2019).

The Child Friendly School Standards Policy of 2012 guides Lesotho's child friendly school programmes. One of the main strategic goals in this policy includes, "mainstreaming HIV and AIDS prevention and awareness into all aspects of school life, making schools centres for sexual and reproductive health education." Hopefully, the long-term impact for CSE in Lesotho schools will be a demystifying of sex and sex education.

Most educators prefer the integration and infusion of CSE into other subjects. CSE is integrated into one or more subjects in Madagascar, Mauritius, Mozambique, and Zambia (UNESCO HIV and Health Education Clearinghouse, 2016). In the integration scenario, course material in relevant classes covers specific CSE topics on subjects already taught in the curriculum, for instance teachers cover topics around pubertal changes and reproduction in biology classes. Likewise, teachers speak about values and norms in religious education classes.



In **Zambia**, integration has the advantage of removing the perceived additional strain that a standalone subject might otherwise add to both learners and teachers. Integrating CSE into other classes decreases the pressure to create space in the school day to teach a new subject and removes the need to bring on board a dedicated, specially trained instructor. The downsides of integration include the need to train an increased number of teachers to deliver CSE schools and the potential for the quality of the CSE to be compromised or watered down.[38]

Cultural, religious and traditional practices may negatively impact CSE

According to the UNFPA 23 country review of the Legal Environment for Adolescent Sexual and Reproductive Health and Rights (Africa, 2017): "The application of customary and religious laws over statutory policies is a barrier to the acceptance and uptake of ASRHR." The report notes that this "is further impacted by the lack of accessible youth-friendly health centres across some SADC countries. Acceptance of adolescent sexual and reproductive health and rights is slowly improving but cultural beliefs and taboos are still barriers to ensuring young people have adequate access to information and services."[39]

Most educators prefer the integration and infusion of CSE into other subjects

[38] https://aphrc.org/wp-content/uploads/2019/12/comprehensive-sexuality-education-in-sub-saharan-africa-1.pdf [accessed 24 April 2020]
[39] https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf

Teaching and talking about sexuality can be challenging in social and cultural contexts with negative and contradictory messages about sex, gender, and sexuality. However, most good teachers and educators have the skills needed to build rapport with learners, actively listen, identify needs and concerns, and provide information. Training in this vein can make up part of the curriculum at educator training institutes (pre-service) or as in-service teacher training. Societal changes due to modernisation and urbanisation have led to changes in traditional family structures, leaving many young people unable to rely on parents or guardians for information and guidance about responsible sexual behaviour. As such, the need for teacher training in CSE content through participatory methodologies is essential. This does not mean all teachers must be experts on sexual health and sexuality.



CSE helps Tanzanian communities address harmful gender stereotypes

In Tanzania, a recent CSE education awareness drive on SRHR among women and teenagers aged 13 to 45 years took CSE to community leaders in the Bagamoyo and Pangani districts in Tanga Region. The project's leaders hope to drive community participation and change in coastal villages, where participants will become "agents of change" by using the knowledge they acquire about reproductive health and tools.

The programme aims to help youth develop knowledge and skills, such as communication and decision making, to help them transition to adulthood in good health. It also provides access to satisfactory sexual and reproductive health education, including information about teenage pregnancies and the spread of HIV and AIDS, and addresses emotions involved in sexual experiences.

The training approach uses a participatory and animation methodology, experience-sharing forums for village leaders about sexual reproductive health education, and drama and song as tools to communicate sensitive issues and demonstrate the disadvantages of perpetuating negative perceptions, norms, behaviours, and attitudes about SRHR.

Facilitators found parts of the project challenging because of inadequate and unequal access to sexual reproductive health education in different villages. Traditional beliefs also posed a challenge, as men in some villages believe it is not part of their culture to listen to women. Thus, the team worked hard to change this perception held among a majority of men.



The Gender Hub at Tanzania's Antakae primary school in Antakae village in 2018. Photo: Gender Links

Facilitators worked with Muheza District Commissioner Mwanaisha Tumbo and ward representative John Kiko to overcome these challenges. The long-term impact included a better understanding of SRHR among community members, including youth, and greater awareness about harmful gender stereotypes. These communities also say they have seen a decrease in early pregnancy, school dropouts, early marriages, and the spread of HIV and AIDS since the project started.

Source: Janeth John, Binti Makini Foundation, SADC Protocol @ Work Summit 2019.



In 2019, the **South Africa** Department of Basic Education (DBE) introduced "scripted lesson plans" for CSE. This is a structured lesson plan with educator guides in a process that includes parent orientation as a critical element for successful implementation. The new structured lesson plans are tailormade to help learners build an understanding of concepts, content, values, and attitudes around sexuality, sexual behaviour, and leading safe and healthy lives. The DBE has worked hard to develop a comprehensive curriculum that will address challenges and issues faced by learners in their daily lives.[40] International agencies have been intricately involved in the process, including UNESCO and UNFPA, and the United States Agency for International Development (USAID). They provided technical and financial support to develop scripted lesson plans on SRHR education. However, the newly scripted CSE met with some controversy following its public launch, as some expressed discomfort with the curriculum. The department has argued that its lesson plans are not overtly sexual and are appropriate for the classroom. DBE Minister Angie Motshekga said parents can opt out of the life orientation curriculum for their children, provided that they can produce an alternative curriculum that meets the required national criteria.[41]



The **Botswana** Christian AIDS Intervention Programme (BOCAIP) and the District Health Management Team (DHMT) have conducted activities aimed at reducing teenage pregnancy, new HIV infections, and GBV in Botswana. Policy and legal frameworks, such as the Ministry of Education and Skills Development HIV and AIDS Strategic Framework (2011-16) and the National Strategic Framework for HIV and AIDS (2009-2016) guide this work, which has prioritized the prevention of new infections, especially among young people.

Monitoring and evaluation of CSE[42]

Assessing the impact of CSE in promoting improved SRH outcomes for young people requires a monitoring and evaluation (M&E) system based on an agreed set of targets and goals. In collaboration with numerous agencies - including UNFPA, UNESCO, World Health Organisation (WHO), International Planned Parenthood Federation (IPPF), the SRHR Africa Trust (SAT), Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDs) and Media in Education Trust (MiET Africa) - SADC governments have developed various monitoring systems to assess progress, such as the SADC SRHR Strategy and the ESA Commitment Accountability Framework.

Assessing the impact of CSE in promoting improved SRH outcomes for young people requires an M&E system based on an agreed set of targets and goals

[40] https://www.education.gov.za/Home/ComprehensiveSexualityEducation.aspx [accessed 23 April 2020]
[41] https://www.parent24.com/Learn/Learning-difficulties/parents-can-opt-out-of-new-cse-lessons-says-dbe-minister-20191112 [accessed 23 April 2020]
[42] https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf [accessed 24 April 2020]

Table 3.3: Monitoring and Evaluation strategies across SADC[43]

Country	Approach to CSE	M&E and CSE strategies
Botswana	Integrated	• CSE content is age-appropriate and taught within the context of culture.[44] CSE is compulsory and examinable, although examination tends to concentrate on core subject competency requirements.[45]
Comoros	Integrated	• Integrated provision for CSE,[46] 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.
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 SODV enactment in 2018 supports better outcomes in reduced GBV among adolescents, mostly advocated by youth.
Lesotho	Integrated	• The Ministry of Education and Training introduced the Curriculum and Assessment Policy of 2009 in Lesotho schools.[47] • 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.[48]
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."[49]
Mozambique	Intergrated	• The Department of School Health (Departamento de Saúde Escolar) has ensured widespread dissemination of SRHR and HIV and AIDS materials.
Namibia	Stand alone	• Progress has been slow 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 within DBE 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. • Stakeholders hold inter-provincial meetings twice a year to share information and best practices, and to assess progress and gaps on implementation.
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.[50]
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).
Zimbabwe	In progress	• Guidance and Counselling (G&C) has M&E tools to monitor implementation of life skills, which include the evaluation of the National Adolescent Sexual and Reproductive Health Strategy (2010-2015).

[43] 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. [accessed 25 April 2020]
[44] MIET together with SADC Secretariat as its implementing partner, Review Meeting of Future Life Now, CSTL project 2020.
[45] 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.
[46] https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf [accessed 25 April 2020]
[47] https://genderlinks.org.za/casestudies/lesotho-demystify-sexual-education-in-secondary-schools/
[48] 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
[49] https://www.hivsharespace.net/resource/evaluation-one-community-malawi
[50] Ibid

Table 3.3 provides an update on recent measures taken in SADC countries to monitor CSE. According to UNFPA, proper evaluation of CSE should assess monitoring and evaluation on three levels, including regionally, through laws and policies relating to CSE indicators. Because a central regional body does not collect data, an overview of monitoring and evaluation in SADC requires analysis from different data sets and sources to get this regional overview. Thus Table 3.3 describes how various countries conduct monitoring and evaluation and assess the impact of specific SRHR health indicators, for example on new HIV infections, child marriages, and other areas.

Engaging out-of-school youth

Most SADC countries have diverse policies that integrate CSE in "out-of-school" youth programmes. The ministers of health and education in Botswana, Lesotho, and Malawi have endorsed the East and Southern African Commitment, which has time-bound targets to scale up CSE and SRHR services for young people (UNFPA - Africa, 2017).[51]



Mozambique uses a multi-sectoral initiative called Programa Geração Biz as part of out-of-school CSE curriculum. It adopts a three-pronged approach to reaching out-of-school young people with SRH interventions in health clinics, schools, and the community (UNESCO, 2017).[52]



CSE requires community mobilisation and a safe space for girls to meet. In **Namibia**, the Ministry of Sports, Youth and National Services provides CSE to out-of-school youth. With support from UNFPA, the ministry developed its out-of-school CSE curriculum, and several NGOs support sector efforts to strengthen the delivery of CSE and SRHR services to these youth (UNESCO, 2017). For example, a partnership between the Namibia Planned Parenthood Association (NAPPA), the Ministry of Sports, Youth and National Services, and the Ministry of Health and Social Services, provides out-of-school youth with services at NAPPA youth-friendly clinics that operate in several youth centres.



Young women participate in an SRHR workshop in Mogovolas in north-eastern Mozambique in 2019. Photo by Graca Maria

The COVID-19 pandemic has seen most schools closed due to lockdown. While this presented challenges and opportunities to home school youth on CSE, many young people do not have access to online courses because they do not have internet access at home. In many communities in SADC, access to technology remains a luxury. Therefore, parents or guardians must home school youth on CSE. However, in many parts of SADC, home-schooling on CSE is taboo.

[51] https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf
[52] https://hivhealthclearinghouse.unesco.org/library/documents/cse-scale-practice-case-studies-eastern-and-southern-africa.
[53] 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.

CSE and youth-friendly services

One of the key calls in the ESA-CSE Commitment - and from youth organisations - relates to the need for youth-friendly services to address adolescents' sexual and reproductive health questions and needs. The focus on providing youth-friendly services, including mobile health services and youth corners, means that sexual and reproductive health service providers have to remember that sex and sexuality means different things for different young people. Service providers often have assumptions about the sexual behaviours of young people which are not always in line with reality. For example, the assumption that young people have sex frequently; only engage in heterosexual sex; take risks; or are egoistic pleasure-seekers. Existing gender inequalities that stem from rigid gender norms and harmful beliefs lead to some of these assumptions. Service providers who are involved in youth-friendly services need to think about and discuss these issues for instance. It is important to note that sexual and reproductive health services for young people must address issues of sexuality, sexual desires, and sexual enjoyment alongside education on sexual health and treatment and prevention of STIs.

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 is also based 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 sexual and reproductive health services, including:

- Sexual and reproductive health counselling.
- Contraceptive counselling and provision (including emergency contraception).
- Abortion services.
- Prenatal and postpartum services.
- Prevention, testing and counselling services for HIV and other STIs.
- Sexual abuse counselling.
- Relationship and sexuality counselling.

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

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

There is unmistakable evidence that CSE has a positive impact on SRHR, including a notable reduction in STIs

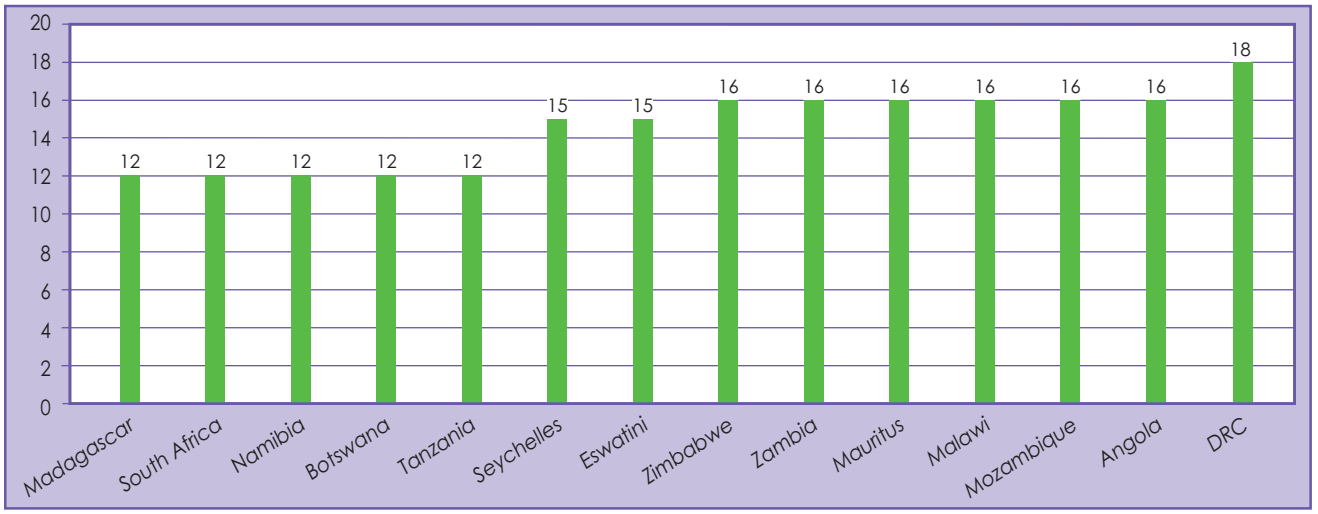
Ensuring that educators address the unique SRH needs of young men and adolescent boys is also part of a comprehensive gender-transformative approach. In applying this approach to SRHR, service providers should note that, in many contexts, women do not control decision making, including SRHR choices, yet they bear a significant burden linked to contraceptive use and childbearing (UNFPA and UNICEF, 2020).[54] Thus, promotion of safer sex activities remains critical for all adolescents, including young women and girls. Safer sex includes much more than protected sex; it is also about feeling safe and at ease with your partner, trust, communication, well-being, and happiness. These are often missing due to the skewed power dynamics in some sexual relationships.

Following the release of the SADC SRHR Strategy, several agencies have been working together to address these challenges and increase the range and quality of youth-friendly SRHR services. These groups place emphasis on tailoring services to embrace sexuality as a part of SRHR education and including initiatives for clinical staff to question personal standards of "normal" and "responsible" sexual behaviour for young people. A clear age of consent to access treatment and service remains important in improving adolescent access to SRHR services.

There is unmistakable evidence that CSE has a positive impact on SRHR, including a notable reduction in STIs, HIV transmission, and unintended pregnancy. CSE also improves knowledge and self-esteem, changes attitudes and harmful gender social norms, and builds self-efficacy. Curriculum that includes content about gender and rights, and access to a full range of high-quality, youth-friendly SRH services and commodities, makes it even more effective (UNESCO, 2015a; UNFPA, 2014). In many SADC countries, young people have their first sexual experiences while they are still in school, making the setting even more important for early access to contraceptives.

The COVID-19 period has restricted youth access to SRH services as stakeholders consider these services to be non-essential. In most cases, health facilities that would normally conduct outreach programmes on SRH ceased to do so during the lockdown period as COVID-19 awareness programmes took priority. This underscores the need to find ways to address the SRHR needs of youth during disasters and crises to prevent a regression on progress in this area.

Figure 3.1: Age of access to contraceptives across SADC



Source: Gender Links 2020.

[54] https://www.unfpa.org/resources/technical-note-partnering-men-and-boys-end-child-marriage-global-programme-end-child.pdf [Accessed 27 April 2020]

Figure 3.1 shows that five countries (Botswana, Madagascar, Namibia, South Africa, and Tanzania) provide contraceptives from the age of 12. Meanwhile, Eswatini and Seychelles start at age 15 and five countries allow for contraception from age 16, with the DRC only providing contraceptives at age 18. Researchers were unable to find information for Comoros or Lesotho.

Table 3.4: SADC countries with adolescent and youth SRHR policies[55]

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

Source: African Health Observatory.

Table 3.4, shows that ten out of 16 SADC countries do not have stand-alone ASRHR policies. However, all countries do have well developed policy frameworks, which guide the delivery of ASRHR, CSE, and provision of youth-friendly health services. The National Adolescent Friendly Clinic Initiative (NAFCI) effectively implements **South Africa**'s Adolescent and Youth Health Policy.





Malawi's National Youth Friendly Health Services Strategy 2015-2020 recognises that the health of young people is a key component of public health and ensures the provision of comprehensive sex education. The policy provides a framework for addressing threatening factors in adolescent growth, such as STIs, including HIV and AIDS, teenage pregnancies, unsafe abortion complications, nutrition inadequacies, alcohol and drug abuse, and mental health problems. Initiatives like #SheDecidesMalawi work to raise awareness about the harms of child marriages and unsafe abortion.

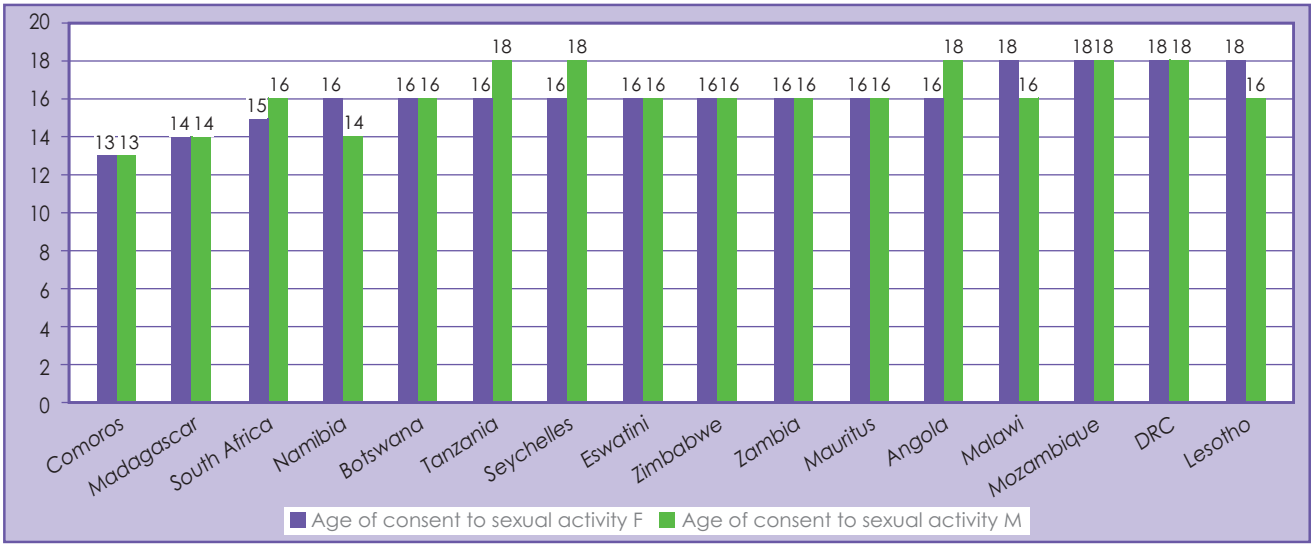


Malawi activist and sexual health champion Tikhala Itaye.
Photo courtesy of SheDecides

In an interview, Malawi activist and sexual health champion Tikhala Itaye notes, "there is a 'he' in 'She' Decides. It is not only about girls and women but men and young boys need to be part of this movement and we need equal empowerment of young people to ensure that we create a future where they are equal partners in the workplace, at home, and in leadership" (She Decides, 2019).[56]

[55] aho.afro.who.int/profiles information/index.php/ [accessed 28 April 2020]
[56] https://www.shedecides.com/champions/tikhala-itaye/ [accessed 28 April 2020]

Figure 3.2: Age of consent to sexual activity by sex



Source: GL Mapping of SRHR Policies and Laws 2018 updated 2020.

Figure 3.2 shows that the legal age of sexual consent remains high at 18, and equal for young men and women, in DRC and Mozambique. In several countries, the age of consent is different for men and women. These differences have unintended consequences, including leaving young girls vulnerable to abuse.



Mozambique passed a bill in July 2019 criminalising the marriage of citizens younger than 18 and proposing penalties for offenders and enablers of the practice. Laws in many countries do not explicitly provide for the ages of consent to sexual intercourse, they are rather inferred through provisions criminalising sex with an individual below a specific age, regardless of consent. This creates confusion about the age of consent to sex between, and with, young people and creates potential access barriers to appropriate services.

The regional trend of liberalisation of abortion laws continues. Since the ICPD, 50 countries have enacted laws expanding the grounds upon which abortion can be legal. However, barriers such as parental consent for minors remain in many countries. As is the case in DRC, Lesotho, and Tanzania, differences in male and female age of consent to sex have dire consequences.

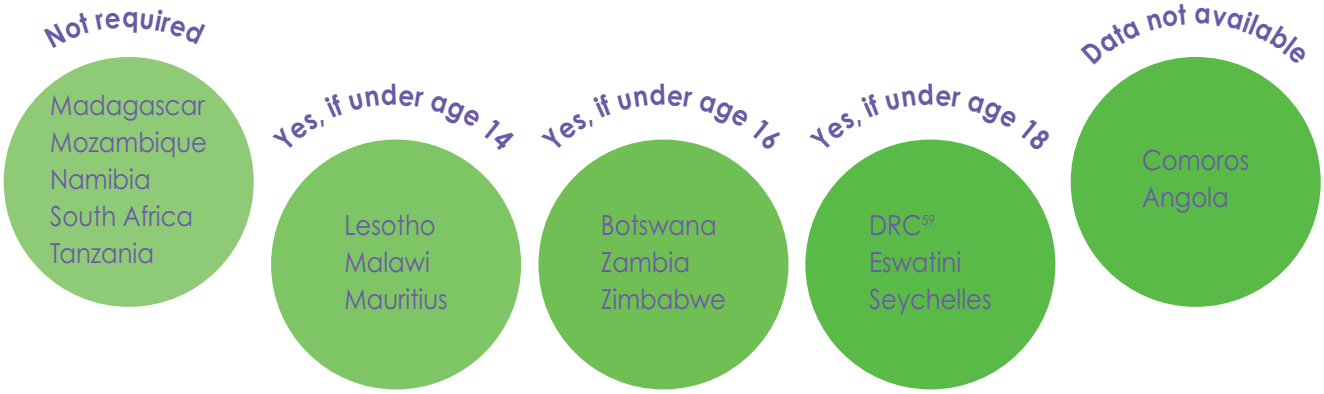
Laws in many countries do not explicitly provide for the ages of consent to sexual intercourse



In one court case that affects age of consent in **Zimbabwe**, the *State v. B Masuku*, the High Court reviewed the case of a 17-year-old boy who had consensual sexual intercourse with his 15-year-old girlfriend and was consequently convicted of the offense of having sexual intercourse with a young person (High Court Ruling, 2015).[57] In her decision, Justice Amy Tsanga commented on the question of criminalisation of adolescent consensual sexual conduct. The various laws and policies in Zimbabwe criminalise adolescent consensual sex for both male and female adolescents younger than 16.

[57] http://zimlii.org/zw/judgment/harare-high-court/2015/106/ [accessed 28 April 2020]

Figure 3.3: Requirements for Parental consent for ASRHR in SADC[58]



Source: UNAIDS, 2020.

Figure 3.3 illustrates laws in all SADC countries on age of parental consent for adolescents to access SRH services. Two of the 16 countries have no data available on parental consent to SRHR: Angola and Comoros. Meanwhile, DRC, Eswatini and Seychelles require parental consent to access SRH services if children are younger than 18. In many cases, these countries discourage adolescent girls from accessing these important services (Vandermorris & McKinnon, 2018).

The **South Africa** Children's Act of 2005 provides that a child aged 12 years or older may consent to medical treatment without parental consent if he/she is of sufficient maturity and stage of development. South Africa also does not require parental consent to abortion, irrespective of the age of the child. Sections 129 to 134 of the South African Children's Act contain these comprehensive provisions, which experts consider best practice within adolescent SRHR. Laws and policies that require parental consent to access SRH services discourage adolescent girls from accessing the services they need to stay healthy (UNFPA - Africa, 2017).[60]



Junior Councillors at Harare City Council assisted with the ASRHR research. Photo: Colleen Lowe Morna

[58] http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf [accessed 28 April 2020]
[59] https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html [accessed 28 April 2020]
[60] https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf [accessed 28 April 2020]

ASRHR services still a challenge in many countries

Nearly two fifths of young people who sought Sexual and Reproductive Health (SRHR) Services in six 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 89% of those who accessed services said that health personnel treated them with respect. 81% said they were accorded privacy and confidentiality.

These are among the preliminary findings of the Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment undertake in Botswana, Eswatini, Lesotho, Madagascar, Zambia and Zimbabwe from November 2019 to April 2020. The total number of respondents from the six countries is 9984, 5170 (52%) young women and 4808 (48%) young men and five people identifying as gender non-confirming (GNC). The study will be rolled out to Mauritius, Mozambique, Namibia and South Africa between June and August 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 9984 adolescents between ages 10 and 19 in six countries, 5170 (52%) females and 4808 (48%) males. The survey is being carried out with the Centres of Excellence for Gender in Local Government with the support of Hivos and Amplify Change. Other key preliminary findings include:

- 70% of the sample had a health facility within 10km of their homes while 29% did not have a health facility within 10km of their homes
- 64% of the respondents reported meeting peer counsellors in the health facilities they visited.
- 32% of the sample requested contraception and 84% of these received contraception.
- 6% of the female respondents requested a pregnancy test and 6% requested post-natal care.
- 42%, of respondents requested an HIV test and 16% 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.
- 51% of the sample received follow up appointments and 56% received a referral to another facility.

Currently five countries (Botswana, Lesotho, Madagascar, Zambia and Zimbabwe) have ASRHR policies in place, Eswatini does not have an ASRHR policy. Botswana's policy ended in 2016 and all the other countries' ASRHR policies expire in 2020. There is need to lobby for ASRHR policies that are youth friendly in all five countries.

At a policy and legislative level, it must be clear that young people can access SRH services without third party authorisation. Health workers insisting on a parent or family member being present will mitigate against young people going to health facilities. Only Madagascar provides for adolescent access to SRHR services without parental consent.

Source: Gender Links ASRHR Rapid Response Survey Preliminary Results 2020

Teenage pregnancy

While 12-year-olds can legally access contraceptives in many countries, adolescents face more obstacles than adults in obtaining contraceptives because of restrictive laws and policies, concerns about confidentiality, and stigma associated with sex at an early age (United Nations Population Fund ESA Regional Office, 2019). As a result, teenage pregnancy remains high in the region. Pregnancy among adolescent girls, particularly young adolescent girls, carries profound consequences for their physical health, the health of the child, and their future well-being. Pregnancy contributes to further excluding young women from school due to health issues, stigma, social roles and expectations for young women, and punitive regulations governing pregnancy and school attendance. In addition, unintended teenage pregnancies expose girls to other risks, such as HIV transmission (UNAIDS, 2015).

> During health emergencies, young girls face an increased risk of sexual exploitation and abuse

The SADC region has many policy documents, guides, and resources to support the reduction of teenage pregnancy. CSE plays a critical role in both preventing teenage pregnancy and supporting those who become pregnant at an early age. CSE should provide information about the physiological and emotional experiences during pregnancy as well as what is involved in child-rearing. It should also note that teenage pregnancy compromises women's educational, social, and economic prospects and advise adolescents to postpone pregnancy until they are better prepared.

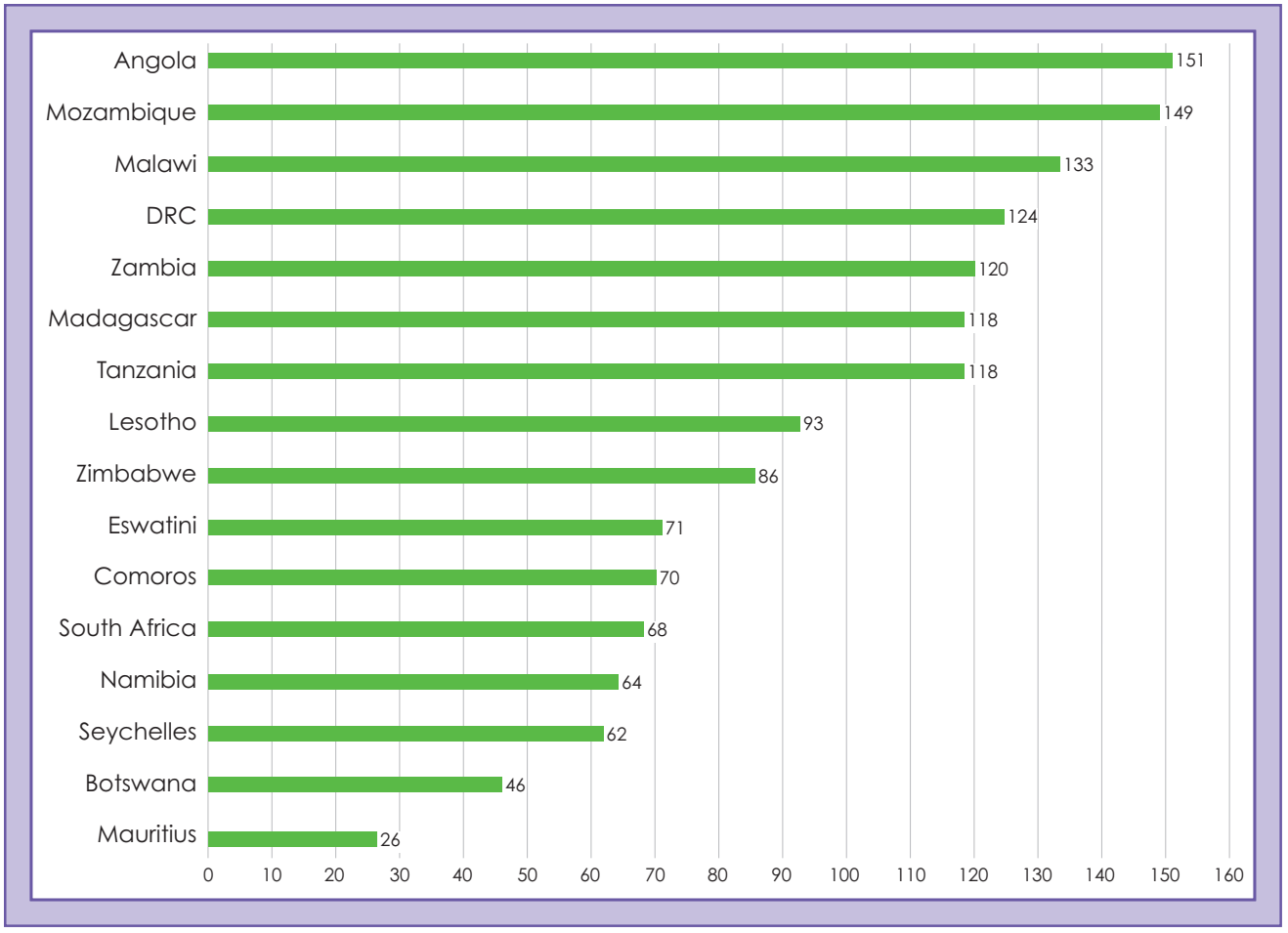
While the region continues to grapple with high rates of teenage pregnancy in non-disaster environments, experts worry that the COVID-19 crisis will exacerbate sexual exploitation of young girls and possibly lead to a spike in new teenage pregnancies. Homes are already unsafe places for too many young women in the region. Data shows that, during health emergencies, young girls face an increased risk of sexual exploitation and abuse.[61] Additionally, abusers may feel emboldened to act with increased impunity as access to social services dwindle and lockdown laws restrict external interactions. In the current situation, these laws have curtailed girls' ability to seek refuge outside the home, which may make it more difficult to escape from an abuser.[62]

Having the information, power and means to decide whether, when, and how often one becomes pregnant is a universal human right. That is what 179 governments agreed at ICPD and it remains a universal right that applies to all women and adolescent girls (United Nations Population Fund ESA Regional Office, 2019).[63] Governments should support this right by ensuring adequate access to necessary contraception and education on abstinence and safer sex practices, as well as appropriate support for young women who do become pregnant at a young age. This must include education, training and employment opportunities for young fathers (UNFPA ESARO, 2019).

[61] Foluyinka "Yinka" Fakoya, COVID-19 and Young Girls: Expect Increases in Child Marriage and Teen Pregnancy, April 2020
[62] Ibid
[63] https://esaro.unfpa.org/en/news/lesotho-youth-commitment-accelerating-promise-icpd-road-nairobi-0

The number of adolescent live births per 1000 population rates indicates early and unintended pregnancy, child marriages, and sexual violations against adolescent girls. The latter can result in increased baby dumping (UNESCO HIV and Health Education Clearinghouse 2017). It is paramount that relevant ministries follow national policies and advocate to end child marriages, support school re-entry, and ensure that girls forced by pregnancy to drop out of school can re-enter education after delivery. Other recommendations for reducing teenage pregnancy include ensuring readily available access to youth-friendly counselling and services, particularly availability of condoms and contraceptives.

Figure 3.4: Adolescent live births per 1000 population



Source: Southern Africa Gender Protocol Alliance mapping of SRHR Policies and Laws, 2018 updated 2020.

Figure 3.4 suggests that teen pregnancy strongly links to poverty, as the region's low- and lower-middle income countries (Angola, DRC, Malawi, Mozambique, and Zambia) have higher adolescent birth rates than middle income countries like Botswana, Mauritius, and South Africa. Additionally, the figures for Comoros, Eswatini, Lesotho, Namibia, Tanzania, and Zimbabwe, remain concerningly higher than average rates for the African continent rates.

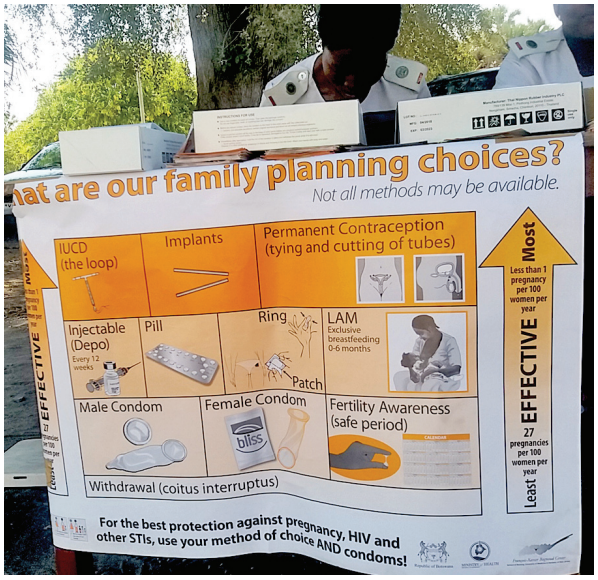
Botswana: Okavango community tackles high teenage pregnancy rates

In Botswana's Okavango community, cultural barriers continue to contribute to high teenage pregnancy, which explains why stakeholders have begun using community-wide approaches to educate people on the topic.

As part of this approach, the Botswana Christian AIDS Intervention Programme (BOCAIP) in collaboration with the District Health Management Team, and the District Multi-sectoral Committee conducted community conversations in Xakao and Shakawe village on from 28 April to 2 May 2019. The communities shared their thoughts on high numbers of teenage pregnancy in the region, as well as the consequences faced by the young mothers, and the community at large. The communities then created action plans to address teenage pregnancy in their locality.

For the past three years, teenage pregnancy cases have been escalating in the district. Stakeholders in Botswana believe that changing community norms requires combining effective programmes aimed at eliminating harmful practices and advocacy that engages all community members.

BOCAIP chose this strategy to stimulate critical thinking and holistic and inclusive collective action that focuses on the root causes. Part of this solution requires engagement with men, women, boys, and girls in strengthening communities and reaching young people before it is too late. This means raising ideas during discussions that can be supported, and acted upon, by many different individuals and diverse groups.



SRH activists in Kgotla, Botswana, distribute teenage pregnancy and parent child materials at an event in 2018. Photo: Kgalalelo Gambule

Conducting different conversations with distinct groups - men only, females only, girl children only, community leaders and stakeholders etc. - enhanced the involvement of all the people that surround the girl child.

Source: Kgalalelo Gambule from Okavango Sub District Council as submission for the SADC Protocol @ Work Summit Application (Gambule, 2020).

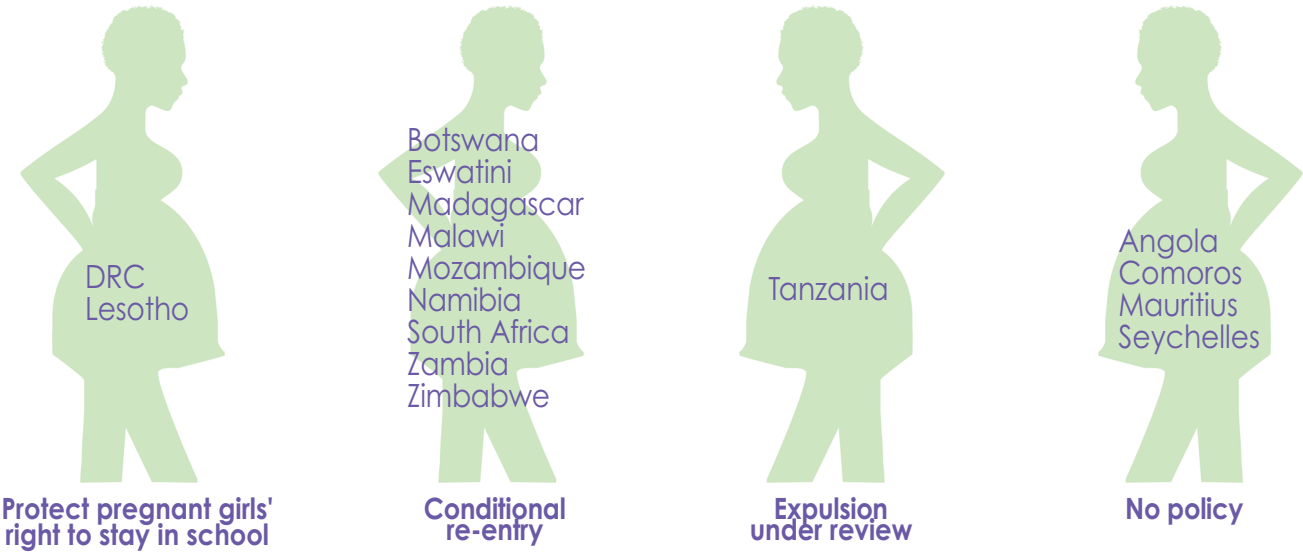
Policies on teenage pregnancy

Laws and policies can reflect or reinforce discriminatory norms and attitudes that block adolescent girls' access to re-entry into school or formal education after they fall pregnant and give birth. Conditional policies and laws can often further prevent adolescent mothers from

working or restrict their access to certain types of jobs due to their lack of completed educational qualifications.

In the SADC region and other developing countries, only a fraction of boys and girls complete upper secondary schooling: 20% of boys and 15% of girls (Human Rights Watch Report, 2018). As such, the South African government has focused on providing social and financial support for adolescent mothers. Meanwhile, in Zambia, teen mothers receive a choice of access to morning or evening school shifts, and in Malawi, pregnant girls and adolescent mothers can access school-based counselling services.

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



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

As noted in Figure 3.5, as of April 2020, Tanzania's government has been feeling the pressure to review its policy of expelling pregnant girls from school. Human Rights Watch reports that, following the approval of a World Bank education loan under the country's Secondary Education Quality Improvement Project (SEQUIP), the Tanzania government will be required to alter its policy of discriminating against pregnant students, adolescent mothers, and married girls. Following threats of arrest and detention, women's rights organisations in Tanzania have been working quietly on assisting pregnant teenage youth without public recognition and mention. The matter remains extremely sensitive among Tanzania's civil society and in its engagement with government.

Meanwhile, DRC and Lesotho protect pregnant girls' right to stay in school. In Lesotho, the Education Act of 2010 contains a re-entry provision. In DRC, while policies and laws exist to protect pregnant adolescents, the post-conflict reality means that vast gender and economic inequities still keep pregnant teenagers out of school. In the past five years, the number of programmatic initiatives to address adolescent and young people's sexual and reproductive health has steadily increased in the DRC, largely in urban areas such as the capital, Kinshasa.[64] Increasingly, decision-makers in the DRC have come to accept the importance of providing SRHR services and information to young people. The continued expansion of the DRC National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020 is a crucial step toward that goal.

[64] USAID. Evidence to action (E2A): sexual and reproductive life stages Framework. 2017. [accessed 29 April 2020]

Lesotho's legislators rally to address worrisome levels of teenage pregnancy



Some of the contraceptive methods provided in Lesotho. Photo: Ntolo Lekau

At 17, Lerato Molise found herself pregnant by her ex-boyfriend, who then turned his back on her. Raising the child, Molise says, was one of the toughest experiences because she had no income. Using her hard-earned money, Molise's mother decided to take Molise to a catering school so that she could generate some income for her child.

Lesotho has many challenges linked to teenage pregnancy, and schools and parents force many young girls to drop out of school to raise their children. The highlands of the country, where health services are a distant cousin, remain the most affected by this issue. 'Mathato Nkuatsana, the adolescent health programmes manager at the Ministry of Health (MoH), says her ministry has established programmes to tackle the issue of teenage pregnancy in the country.

Such programmes include the Anti-Child Marriage Campaign outreach programme meant to scale up family planning services for adolescents and young people. Nkuatsana says her ministry also advocates for social behavioural change messages and condom distribution by civil society organisations. She says it has also established adolescent health corners in all hospitals in the country, except in Quthing district.

Chief Ntsane Makopela of Ha Makopela in Ts'anatalana Community Council says teenage pregnancy beleaguers the area, especially among girls aged between 13-14 years old. Makopela says some girls leave their children with their parents and go to South Africa to hunt for jobs as domestic workers. Because of this, his community holds pitsos (traditional meetings) to sensitise parents about teenage pregnancy. He added that once girls get impregnated, their education journey usually comes to a screeching halt.

Chair of Ts'anatalana Community Council Emile Tekane says teenage pregnancy also plagues his council. It has formed support group committees in different villages to sensitise young girls about the issue. Tekane says they also hold pitsos during which they talk with children together with their parents, urging them to avoid teenage pregnancy because it hinders hinder their academic journey. "We work closely with the Ministry of Health so that we can pass the message to youngsters," he says. Tekane says school-going children stay in rented homes, where they often have no adult supervision, to be closer to their schools. "Teachers have asked us to visit the children in their rented homes unannounced so that we could see what we can find," he says.

Source: Gerard Molupe as part of the Gender Links Media Articles (Molupe, 2020).[65]

[65] https://genderlinks.org.za/news/lesotho-teenage-pregnancy-growing-concern-in-tsanatalana/ [accessed 20 April 2020]

DRC has the fourth highest rate of teenage pregnancy in SADC



DRC has the fourth highest rate of teenage pregnancy in SADC. In 2017/2018, UNICEF reported that 27% of girls in DRC between ages 15-19 were pregnant (USAID, 2018).[66] Therefore, it is important that legislators reinforce the country's re-entry education policy and continue to expand provision of adolescent SRHR services and education.[67] According to a 2019 Guttmacher Institute report, of an estimated 563 100 total pregnancies in Kinshasa in 2016, 61% were unintended, corresponding to a rate of 147 unintended pregnancies per 1000 (Lince-Deroche et al., 2019).[68] This means the 2020 rate of 124 is an improvement. Young people and SRHR activists in the DRC have genuine concerns with the current situation, including fear of pregnancy, judgmental attitudes of health providers, and fear of side effects from teenage pregnancies.

As noted earlier, UNESCO has found that CSE expands education opportunities, challenges gender norms, and promotes gender equality, resulting in more responsible sexual behaviours and fewer teenage pregnancies. For these reasons and the findings above, it is more important than ever for lawmakers to implement the renewed commitments coming out of the ICPD 2019 conference: comprehensive and age-responsive information, education and adolescent-friendly comprehensive, quality, and timely SRHR services.[69] These basic policies will enable adolescents and youth to make free and informed decisions and choices about their sexual and reproductive lives, which will protect them from unintended pregnancies and facilitate a safer transition into adulthood (Nairobi Statement on ICPD25: Accelerating the Promise, 2019).[70] The region's lawmakers must continue to implement better policies to protect and assist in implementation of their universal health commitments.



Zambia has a conditional policy that allows pregnant learners to re-enter the same or any other school after they give birth (Southern Africa Gender Protocol Alliance SRHR Policies and Laws Survey, 2018). However, government bodies have reportedly not upheld the 1997 re-entry policy, which lawmakers meant to be a positive step toward upholding girls' basic right to education by expanding their future job options. According to a 2018 *Lusaka Times* investigation, "school officials are not trained on the policy guidelines and some have never even seen a copy of the policy. Government does not monitor school compliance and there are no consequences if they do not respect girls' right to be in school."[71] Many Zambians consider early unintended pregnancies a public health issue, which occurs because of gendered sexual norms which make young girls vulnerable to sexual relationships due to lack of resources, among many other factors. Interestingly, the number of girls marrying before age 15 has declined, yet the levels of teenage pregnancies has remained stable during the same period.[72]



Zimbabwe's 2019 Education Amendment Bill has a provision in clause 68D of the Education Bill stating that girls shall not be expelled from school for falling pregnant. It says: "No pupil shall be excluded from school for non-payment of school fees or on the basis of pregnancy."[73] The Gweru local government and junior councillors employ a participatory approach, whereby they

[66] https://www.unicef.org/drcongo/en/what-we-do/child-protection [accessed 20 April 2020]
[67] https://www.hrw.org/news/2019/06/16/africa-pregnant-girls-young-mothers-denied-school
[68] https://www.guttmacher.org/report/unintended-pregnancy-abortion-kinshasa-drc [accessed 25 April 2020]
[69] In line with international technical guidance; ref https://unesdoc.unesco.org/ark:/48223/pf0000260770
[70] http://www.nairobisummiticpd.org/content/icpd25-commitments [accessed 30 April 2020]
[71] https://www.lusakatimes.com/2018/08/07/zambian-goverment-failing-to-implement-the-re-entry-policy-for-young-mothers/ [accessed 25 April 2020]
[72] Population Council, UNFPA and Government of the Republic of Zambia 2017
[73] https://zimfact.org/factsheet-corporal-punishment-pregnancy-and-the-new-education-bill/ [accessed 25 April 2020]

consult youth in different decision-making processes. Junior councillors carry out activities, including interacting with vulnerable children to document needs. They also run donate a pad campaigns, advocate for girls' rights to freedom workshops, and other campaigns that promote hygiene, STI awareness and overall SRHR concerns affecting youth.[74]

Mozambique is one of two countries in SADC that has decriminalised abortion



Progress in **Mozambique** has led to increased awareness among girls and young women about mental health, psychological, and other consequences of teenage pregnancy and unsafe abortions. Advocacy initiatives have included raising awareness among youth about policy and law provisions and procedures so that they can demand justice in cases of abusive processes in communities. Mozambique is one of two countries in SADC that has decriminalised abortion[75] and yet teenage pregnancy remains high due to delayed implementation of youth-friendly SRHR spaces where adolescents could seek safe abortions. Mozambique has also rolled out civil society campaigns and mandatory sex education in schools and created a network of youth-friendly sexual health clinics across the country to curb ASRHR challenges.



Botswana's re-entry policy stipulates that pregnant girls must withdraw from school and later seek re-admission in the same school or to a different school. Other initiatives in the country include provision of reusable menstrual pads and discussions of power relations in relation to sexual consent. These strides have been possible due to the provision of sex education that encourages young people to delay their first sexual experience and helps them understand the risks of HIV and early pregnancy. UNDP asserts that CSE also builds communication skills, making it easier for young people to talk about sex and decide when and with whom to have sex, and to confidently say if they do not want to have sex.[76]

If the Ebola pandemic is any indicator, the COVID-19 pandemic may cause an upsurge in teenage pregnancy. Complications during pregnancy and childbirth are the leading cause of death for 15-19-year-old girls globally.

Studies from the Ebola response indicate that school closures and increased barriers to accessing contraception among adolescents resulted in increased sexual activity and unplanned pregnancies. UNFPA warns that the pandemic may result in 13 million more child marriages between 2020 and 2030 as poverty increases and programs designed to prevent them are scaled back due to lack of funds or restrictions on gatherings and movement[77]. For girls living in poverty, the breakdown of basic services in many communities may also lead to heightened pressure to engage in transactional sex with older men in exchange for financial or in-kind support, such as transportation, food or clothing.[78]



The Kenya Health Information System survey shows that a total of 3,964 girls aged 1 9 years and below were reported pregnant in Machakos County during the lockdown. Children Officer Salome Muthama said: "Most of these cases you will find involve children who were taken from urban centres in the wake of Covid-19 and left in the hands of their grandmothers in the countryside as the parents returned to the towns."[79]

[74] SADC Gender Protocol Application 2019 by Blessing Dumu
[75] GL Audit of SRHR Laws and Policies 2018: https://reproductiverights.org/worldabortionlaws
[76] https://botswana.unfpa.org/sites/default/files/pub-pdf/Investing%20in%20Young%20People%20UNFPA%20Botswana.pdf
[77] http://news.care.org/article/motherhood-too-soon-child-early-and-forced-marriage-and-adolescent-pregnancy-in-covid-19/
[78] https://msmagazine.com/2020/04/20/covid-19-and-young-girls-expect-increases-in-child-marriage-and-teen-pregnancy/
[79] https://www.africanews.com/2020/06/17/close-to-4000-school-girls-impregnated-in-kenya-during-covid-19-lockdown//

Seychelles grapples with rebellious educators who refuse to teach sex education



Teenage pregnancy is on the rise in Seychelles, partly because many teachers refuse to teach sex eduation, according to ministry officials.
Photo: Gender Links

The rate of teenage pregnancy in Seychelles has increased steadily over the years. Despite the inclusion of sex education in the school curriculum under the Personal, Social and Citizenship Education (PSCE) programme, the small island nation has yet to address the issue. The problem, says Jacques Koui of the Ministry of Education, is that teaching professionals often overlook sexuality and topics pertaining to sex and gender, which they dismiss as "vulgar."

Koui, who is the curriculum development officer for PCSE, explains that it encapsulates family life and health education, careers guidance and careers education, moral education, religious education, and citizenship education. The programme is available at primary and secondary levels, while Seychelles offers Citizenship Education (CE) as a standalone programme at post-secondary level.

"Sexuality is addressed as a vast spectrum under family life and health education and this covers puberty, adolescent sexual and reproductive health, sexually transmitted infections amongst others," Koui says. "PSCE is allocated two 40-minute periods per week at primary level and secondary level and considering all the elements that have to be covered, we cannot explore them all as broadly as we want."

He says the ministry struggles with teachers who refuse to acknowledge and teach sexuality-related topics because of their religious beliefs or simply because they do not feel comfortable to do so. Koui notes that parents often do not talk about sex, limiting young adults' access to vital information and contraception. Seychelles law dictates that individuals aged 15 can access contraception with the consent of their parents. According to IPPF, it is unethical to give information and education on SRH without providing access to appropriate services, including contraceptives and counselling (2008).

Dean Padayachy, the founder of Brother Dudes, an NGO dedicated to helping young mothers in need of guidance and support, says lawmakers must revise the Seychelles curriculum to include broader CSE, and a rights-based and gender-focused approach to sex education, to empower young women.

Padayachy assists young, homeless and jobless mothers with shelter, finding employment, and other necessities. He notes that he encounters many underage girls who face hardship because they became mothers at a young age. One young mother Padayachy is assisting, who wished to remain anonymous, recounted her experience of her first pregnancy, at the age of 16. "Before my pregnancy, I led an active lifestyle, played a lot of sports and socialised with my friends. When I found out I was pregnant, I was lucky to have the support of my mother, but the baby's father cut me off. Neither he nor his family made any effort to be there for me or my child," she said.

"I'm not enthusiastic about making contraceptives available to young people as it might serve to encourage them to engage in sexual activities but improving sex education in schools is a good idea," she asserts. "The more informed someone is, they can act more responsibly."

Source: Laura Pillay as part of Gender Links #VoiceandChoice series.

Next steps

The global COVID-19 pandemic has affected everyday life across the SADC region, including schooling. This severely affects CSE given the many competing priorities in this regional state of disaster. Policy response and regulatory response will need to be even more intentional as the new stresses on health systems will disrupt the delivery of SRH services and information to young people. There is need to refocus and strengthen ASRHR strategies. Key next steps include:

- ***Intensify healthcare post-COVID-19:*** SRHR considerations must be embedded into national and local responses to COVID-19 and then continued post-pandemic.
- ***Governments need to ensure minimum interruption of CSE provision:*** It is important to respond to COVID-19 but government must also continue to provide access to CSE, contraceptives, safe abortion and sexual health - including menstrual health.
- ***Implementation of planned SRH programmes remains crucial to tackling the region's challenges and inequalities:*** It is necessary for lawmakers and other stakeholders to continue to develop programmes that effectively engage men to advance gender equality, challenge inequities, and promote access to SRHR services. It is crucial to increase men's knowledge of gender so they can reflect on gender norms in their own context.
- ***Increase availability of contraceptives:*** As governments continue to expand implementation of SRHR programming and youth-friendly services, it is vital they also address the persistent needs and challenges of adolescents and young people in both rural and urban areas, including access to modern contraception and other ASRHR services.
- ***Expand legal frameworks for CSE:*** Lawmakers must strengthen and enforce legal frameworks in health and education systems. This includes ensuring sufficient infrastructural and financial supports for SRH interventions.
- ***Enhance education and legislation to secure brighter futures for adolescents:*** If lawmakers fail to address teenage pregnancy and concerns about girls' inability to re-enter school following pregnancy, young women's future income earning prospects will continue to be lower than those of young men. This will negatively affect the region's economies and increase inequalities and wage gender gaps that will continue into future generations.

Safe Abortion 4



KEY POINTS

- The Guttmacher Institute reports that 24% of all pregnancies in Southern Africa end in abortion.
- The 2019 Nairobi International Conference on Population and Development (ICPD25) conference firmly established that safe abortion services and treatment of complications from unsafe abortion represent one of nine essential elements of comprehensive sexual and reproductive health and rights (SRHR) service.
- ICPD25 resulted in renewed commitments from governments across Africa and the globe to the provision of SRHR to reach three overarching targets: zero maternal deaths, zero unmet need for family planning, and zero gender-based violence (GBV) and harmful practices within the next decade.
- A new study has shown the negative impact of the Global Gag Rule on improving legislation around abortion and provision of SRHR services.
- No SADC country totally bans abortion, but most conditions under which women can obtain abortions remain restrictive.
- Little change has occurred in legislation in the last year, but DRC and Mozambique have made strides to improve their legislative framework for abortion.
- Namibia's First Lady spoke out in favour of legal reforms to improve access to abortion in July 2020 as lawmakers in that country prepared to debate the issue.
- Unsafe abortions affect mostly poorer, unmarried women and adolescents. As this group contributes significantly to high maternal mortality rates in the region, it will be difficult to reach the goal of eliminating maternal mortality without addressing the need for safe abortion.
- Emerging evidence suggests that the COVID-19 pandemic will increase the need for abortions, reduce the provision of abortion services, restrict access to abortion and SRHR services, and reduce the opportunities for advocacy for legislative reform.



Introduction



Adverts for abortions can be found on street poles throughout South Africa, even though activists warn that most of these services are unsafe.
Photo courtesy of Amandla.mobi

Deciding whether and when to have children, and being able to act on that decision, is a fundamental human right. Men and women should share in the decision to conceive a child. Unplanned pregnancies have repercussions, such as forcing young women to drop out of school, lose employment, or experience delayed progress in their career paths. Women can also experience health challenges, struggles accessing material and emotional resources to care for and feed a child, shame, stigma, and discrimination. Risk factors that affect health and wellbeing increase if a woman is too young or too old to have a child - or having another child too soon after the last. If a woman has been raped and becomes pregnant as a result, she may face enormous psychological trauma if forced to carry the pregnancy to term.

Between 2010 to 2014, Africa's unintended pregnancy rate stood at 89 out of 1000 women aged 15-44. Each year, approximately 38% of unintended pregnancies in Africa end in abortion.[1] While the Southern African Development Community (SADC) Sexual and Reproductive Health and Rights Strategy notes that 24% of all pregnancies in Southern Africa end in abortion, the Guttmacher Institute found that the region's abortion rate per 1000 women stood at 34% between 2010-2014.[2]

Article 26 (a) of the revised SADC Gender Protocol commits all member states to work to eliminate maternal mortality. Though the region's governments have made progress on this around four causes of maternal mortality (severe bleeding, severe infection, blood pressure disorders, and obstructed labour), they have largely neglected unsafe abortion, which represents the only fully preventable cause.[3]

The World Health Organisation (WHO) defines unsafe abortions as pregnancies that get terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Impact of COVID-19 on safe abortion services in SADC

This chapter delves further into this topic, highlighting the high rates of unsafe abortions in SADC and the challenges this presents for the region's development. It also outlines the legal, moral, and religious environment that allows for this situation and the steps that the region's leaders must take to reduce the need for abortion and encourage safe abortion.

While many health practitioners worry that COVID-19 will limit women's options for SRH support, including abortion and post-abortion care, the pandemic has also created some promising innovations linked to telehealth and telemedicine. Both employ telecommunication technologies to deliver health-related information and services. Indeed, some health facilities have offered medication abortion to women during the pandemic via telehealth systems. Despite these advances, activists predict that the sudden global restrictions imposed to curb the spread of COVID-19 will mostly have negative implications on women's health issues, including access

[1] Guttmacher Institute. 2018. Fact Sheet: Abortion in Africa. New York, NY.
[2] https://www.guttmacher.org/fact-sheet/abortion-africa#
[3] Africa: Unsafe Abortion - Neglected Emergency. 4 March 2019.

to safe abortion. These include reduced supply of, and access to, contraception services, which leads to increased unintended pregnancies and demand for abortions, as well as reduced access to safe abortion services.

Reduced supply of contraception: Many reports, from as early as March 2020, point to interruption of the supply chain for contraception commodities. Devex[4] attributes the delays to a few key factors:[5]

- The slowdown of manufacturing in Asian countries, which supply the raw materials, as well as reduction in manufacturing of final products. One example of this included a report from DKT[6], a family planning agency, of a two-month delay in delivery of condoms to Mozambique.



Reports point to interruption of the supply chain for contraception due to COVID-19. Photo: Ntolo Lekau

- Shipping and clearing approval processes and increased attentiveness of oversight bodies with regards to the import and export of goods (including contraceptives) coming from other countries led to delays in the already lengthy processing of paperwork.
- Many countries have stringent regulatory body requirements, particularly about health services. These processes include factory visits and approvals, which regulators will have to revisit given ongoing travel restrictions.

Reduced access to contraception: The United Nations Population Fund (UNFPA) estimates that, due to the pandemic, 47 million women across 114 low- and middle-income countries will not be able to access critical family planning services, resulting in increases in unwanted pregnancies.[7] Drawing on evidence from other pandemics, such as Ebola in West Africa, the Guttmacher Institute and others raised the alarm that the pandemic will dramatically impact SRH service provision. Guttmacher points out that the first step in ensuring continuation of SRH services during various levels of lockdowns means making them essential services, which SADC countries did.[8] However, the pandemic has curtailed access to all health services as providers focus on responding to COVID-19 and clients fear visiting health centres.

In late May, the acting administrator of USAID called on the UN to "stay focused on life-saving interventions" such as food insecurity, essential health care, malnutrition, shelter, and sanitation. In a letter to the UN, John Barsa also wrote, "I ask that you remove references to 'sexual and reproductive health,' and its derivatives from the Global [Humanitarian Response Plan], and drop the provision of abortion as an essential component of the UN's priorities to respond to the Covid-19 pandemic."[9]

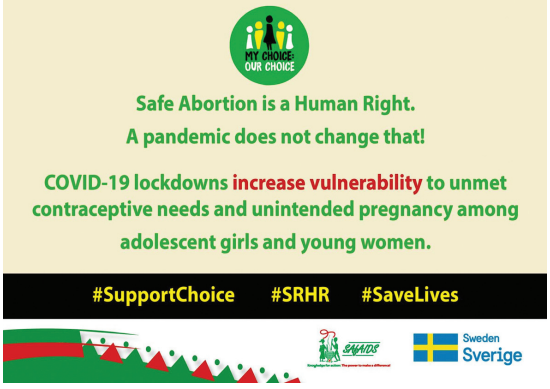
The implication of this is an increased demand for abortion services at a time when many remain inaccessible due to curfews and limitations of movement. The hardest hit will be in countries that criminalise abortion, or where it is only legal on limited grounds. The situation will also hurt women who cannot travel to major centres to access termination services and those who cannot access termination of pregnancy medication due to manufacturing delays.

4 Devex is a social enterprise and media platform for the global development community. Devex aims to connect and inform development, health, humanitarian, and sustainability professionals through news, business intelligence, and funding & career opportunities in international development.
5 https://www.devex.com/news/opinion-how-will-covid-19-affect-global-access-to-contraceptives-and-what-can-we-do-about-it-96745
6 DKT International is named after D.K. (Deep) Tyagi, who was assistant commissioner of Family Planning for the Government of India from 1966. He pioneered an extensive communication and behavior change program that introduced modern methods of family planning to hundreds of millions of Indians, successfully bridging the gap between the traditional aspirations of rural Indians and national family planning goals.
7 https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf
8 https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health
9 US demands removal of sexual health reference in UN's Covid-19 response
https://www.theguardian.com/global-development/2020/may/20/us-demands-removal-of-sexual-health-reference-in-un-covid-19-response accessed 6 June 2020



Reports from **Malawi** note that women have been struggling to access contraceptives from local health centres.[10] This leads to stress as women grapple with the worry of a possible unwanted pregnancy. In an interview with the journalist Penelope Paliani-Kamanga, one woman expressed frustration, noting that responding to COVID-19 seemed to be the Malawian government's only priority at this time.

Reduced access to abortion services: According to *Foreign Policy*, COVID-19 has had a serious negative impact on organisations such as Marie Stopes International (MSI) and DKT, which deliver crucial family planning and other SRH services to many African countries.[11] MSI, which operates in several SADC countries, temporarily reduced many activities in the region. When programmes restarted, however, some challenges remained. In Zimbabwe, for instance, even though the government had deemed post-abortion care and contraception as essential services, reports emerged of women who had been turned back at a roadblock because the police did not view contraception as an acceptable reason for them to travel. In response, and in collaboration with the Swedish International Development Cooperation Agency (SIDA), MSI set up emergency remote services for rural communities to meet the needs of 3500 women.



A safe abortion and COVID-19 flyer by Southern Africa HIV & AIDS Information Dissemination Service (SAfAIDS). Photo courtesy of SAfAIDS

In April 2020, International Planned Parenthood Federation (IPPF) closed 5633 static and mobile clinics and community-based care stations globally, accounting for a total of 14% of IPPF outlets.[12] More than 100 IPPF centres reportedly closed in both Zambia and Zimbabwe. Outcome of this include a scaling down of HIV testing, GBV services, abortion care, and contraceptive services. This will be more pronounced in poorer communities. All national members and partners reported challenges in moving goods within countries, as well as shortages of HIV-related medication and contraceptives.



In **Zimbabwe**, the onset of COVID-19 resulted in border closures that meant many Zimbabwean women could no longer access a safe abortion in South Africa. The alternative is to try to obtain a clandestine abortion in Zimbabwe. The border closures also resulted in a scarcity of the abortion pills misoprostol and mifepristone, driving prices up and making the drugs inaccessible to most Zimbabwean women.[13]

Telehealth options for abortion in South Africa

Medical practitioners have been looking into ways of reaching more people faster through telehealth and telemedicine for some years. The COVID-19 pandemic revived this discussion, along with the topic of self-managed abortion at home. On 3 April 2020, the Health Professions Council of South Africa (HPCSA) amended its telemedicine guidelines during the COVID-19 pandemic to allow telehealth even where an established practitioner-patient relationship does not exist, as long as it is in the best clinical interest of patients.[14] This has eased the conditions under telehealth for safe abortion, leading to more successful terminations. Patients receive a delivery of pills and experts guide them through the procedure over the phone, providing medical advice throughout. Though this is available to women in South Africa who can afford the drugs, many women cannot access these services because of the price tag.[15]

[10] https://genderlinks.org.za/news/109754/
[11] https://foreignpolicy.com/2020/05/04/coronavirus-africa-abortion-access/
[12] https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world
[13] https://genderlinks.org.za/news/lockdowns-may-increase-unsafe-and-illegal-abortions/
[14] https://www.hpcsa-blogs.co.za/notice-to-amend-telemedicine-guidelines-during-covid-19/
[15] https://www.safeabortionwomensright.org/blog/south-africa-a-space-of-many-contradictions-and-now-covid-19/



Table 4.1: 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	Penal Code 2014	Penal Code 1991	Penal Code 1995	Penal Code 2004	Consti-tution 2005	Penal Code 2010	Penal Code 1998, Criminal Procedure Law	Penal Code	Criminal Code 2012	Penal Code 2013	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
Abortion on request	Yes	Not specified	No	No	No	No	No	Not specified	No	Yes	No	Not specified	Yes	Not specified	Not specified	No
Conditions																
Save the woman's life/preserve health	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Economic or social reasons	No	No	No	No	No	No	No	Not specified	No	No	No	Yes	Yes	Not specified	Yes	No
Foetal impairment	Yes	Yes	No	No	Yes	Yes	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Rape	No	Yes	No	Yes	Yes	Yes	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Incest	No	Yes	No	Yes	Yes	Yes	No	Not specified	No	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Intellectual disability	No	Not specified	No	No	Yes	No	No	Not specified	No	No	Yes	Yes	Yes	Not specified	Yes	No
Mental health	Yes	Yes	No	Yes	Yes	Yes	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	No
Physical health	Yes	Yes	No	Yes	Yes	No	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Response																
Improve access to contraceptives		Yes			Yes				Yes							
SRH education		Yes			Yes			Yes		Yes	Yes		Yes			Yes
Decriminalise abortion	Yes					Yes	Yes						Yes			
Safe abortion health				Yes		Yes				Yes		Yes		Yes	Yes	
Comprehensive post-abortion care guidelines		Yes					Yes	Yes		Yes			Yes	Yes	Yes	Yes
Attitudes																
% who say a woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy	48	24		10	31	51	11	37	35	16	14	41	28	15	47	28

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 4.1 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 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 almost 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 28% of those polled agree with this statement. However, attitudes on this controversial topic have been changing, illustrated by the fact that 51% of respondents in Lesotho agreed with the statement, as did 48% in Angola and 47% in Zambia.

Normative frameworks

Beijing Declaration and Platform for Action (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 disproportionate 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.[16]

Nairobi Statement on ICPD25: Accelerating the Promise[17]
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.[18]

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

14.2. States Parties shall take all appropriate measures to:
c) Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

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

[16] 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
[17] https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf
[18] https://www.nairobisummiticpd.org/content/icpd25-commitments
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.

ICPD25

In November 2019, the world reviewed progress towards attaining the goals of the 1994 International Conference on Population Development at the ICPD25 conference in Nairobi. The UNFPA briefing paper for the conference outlined the following essential SRHR interventions as part of a comprehensive, life course approach to SRHR:

- Comprehensive sexuality education - in and out of schools;
- Counselling and services for a range of modern contraceptives, with a defined minimum number of types of methods;
- Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care;
- Safe abortion services and the treatment of the complications of unsafe abortion;
- Prevention and treatment of HIV infections and other sexually-transmitted infections (STIs);
- Prevention and detection of, and immediate services for sexual and GBV, including referrals for all cases;
- Prevention, detection, and management of reproductive cancers, especially cervical cancer;
- Information, counselling, and services for subfertility and infertility; and
- Information, counselling, and services for sexual health and well-being.

The report points out that low cost options as part of Universal Health Care can provide most of these interventions, including prevention of unwanted pregnancies and provision of safe abortion. The conference emphasised the imperative to commit to three zeros: zero preventable maternal mortality; zero unmet need for family planning; and zero GBV and harmful practices.

All states represented at the conference made commitments to improved SRHR provision and reduction in maternal mortality, including:

- Improved youth-friendly SRH services with a focus on those living with disabilities;
- Improved capacity to deliver comprehensive sexuality education in primary and secondary education;
- Capacity building and allocation of financial and human resources for SRHR;
- Strengthen access to family planning information and services, especially for girls and young women, married and unmarried, in and out of school at all health facilities;
- End child marriage, sexual and GBV, and all forms of discrimination against all women and girls;
- Improve data collection including identifying causes of mortality;
- Support adolescent and youth leadership and participation;
- Improve antenatal care and postnatal services in all heath centres;
- Establish more one-stop centres and review marriage acts;
- Domesticate instruments such as the Convention on the Elimination of all forms of Discrimination against Women and Girls (CEDAW), Maputo Plan of Action, SADC Protocol on Gender and Development, and SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage; and
- Develop comprehensive national SRHR packages and integrate them into the UHC strategies, policies, and programmes.

The Global Declaration on Abortion calls on world leaders to legalise abortion

Global Declaration on Abortion

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.

Factors contributing to the demand for abortion

Most abortions occur because of an unintended pregnancy. Some reasons for unintended pregnancies include unmet need for contraception; failure of contraception; coerced or forced sex (rape); and unplanned sex. Contraceptive supply can be limited in areas with poor services, such as rural areas. Some women cannot access it because they cannot afford the ancillary costs like transport. Women with lower levels of education may not have access to information about contraception.

Table 4.2: Contraceptive prevalence rate, unmet need for family planning, and decision-making on SRHR

Country	Contraceptive prevalence rate (CPR) (%)				Unmet need for family planning, women 15-49 (%)	Proportion of demand satisfied, women 15-49 (%)	Decision-making on SRHR (%)
	Women aged 15-49, any method	Women aged 15-49, modern method					
	2019	1970	1994	2019	2019	2019	2007-2008
Angola	17	0	3	16	36	33	62
Botswana	60	3	38	58	14	82	N/A
Comoros	27	1	10	22	30	48	21
DRC	25	2	4	12	27	49	31
Eswatini	66	2	25	65	14	83	49
Lesotho	62	1	22	61	16	79	61
Madagascar	47	0	7	41	18	72	74
Malawi	62	0	11	61	16	79	47
Mauritius	67	17	46	44	10	87	N/A
Mozambique	30	0	5	29	24	56	49
Namibia	60	3	31	59	16	79	71
Seychelles	N/A	N/A	N/A	N/A	N/A	N/A	N/A
South Africa	57	16	52	57	14	80	N/A
Tanzania	43	1	12	37	21	67	47
Zambia	55	1	12	51	18	75	47
Zimbabwe	67	5	43	66	10	87	60

Source: UNFPA, World Population Dashboard: https://www.unfpa.org/data/world-population-dashboard. Accessed 28 May 2020.

Table 4.2 shows the contraceptive prevalence rates (CPRs) in SADC, which represents the percentage of women of reproductive age who use (or their partner uses) a contraceptive method at a particular point in time, usually reported for married women or women in sexual unions. Angola has the lowest rate at 17%, with Mauritius and Zimbabwe sharing the top spot at 67%.

In 2019, the rate of unmet need for family planning - the percentage of married or in-union women aged 15 to 49 who want to stop or delay childbearing but do not use contraception - ranged from 36% in Angola to 10% in Mauritius and Zimbabwe. Meanwhile, the percentage of married or partnered women aged 15-49 years who make their own decisions on three areas - sexual intercourse with their partner, use of contraception, and their healthcare - ranged from a low level of 21% in Comoros to 71% in Namibia and 74% in Madagascar.



In **South Africa**, the 2020 Individual Deprivation Measure study found that 79% of a sample of urban and rural citizens fall under the least deprived group in terms of access to contraception, which means either an individual had no need for contraception or they use a modern method. Meanwhile, 3.3% of the sample fall under the category of somewhat deprived (they did not use a method themselves, but their partner used a modern method); 13.3% use a traditional contraception method, known in the study as the "deprived" group; and 4.3% fall in the grouping of "most deprived," which means they do not use contraception or their partner uses a traditional contraceptive method.[19] However, 90% of respondents categorised as deprived refused to answer questions about their use of contraception to delay or avoid having children. Questions about contraception represented the only series of questions in the broad survey that had a high proportion of refusals to answer (a combined rate across the series of questions of 10.7%).

Similar proportions of men and women fell into the least deprived and most deprived categories. The report notes, "The implications of this unmet need for contraception - of up to around one-fifth of respondents - should not be minimised, particularly for women who may be left to deal with unwanted and unplanned pregnancies alone."



In **Malawi**, as in other SADC countries, overall rates of unmet need for contraception hide marked disparities in access, especially for adolescents and unmarried women. For example, more than half of women in the country use a modern method of contraception, such as injectables, implants, or external condoms. However, the unmet need for family planning for married women is about 19% while it rises to 40% for unmarried, sexually active women.[20] Factors such as stigma, lack of support from family, partners or health providers, and low self-esteem contribute to reduced access to contraception for young and unmarried girls and women.

More than half of women in Malawi use a modern method of contraception

UNFPA reports that African countries represent 24 of the 26 countries in the world with adolescent fertility rates higher than 100 per 1000 girls between the ages of 15 and 19.

[19] Suich, H., Pham, T., Hunt, J., Yap, M., Hasan, M. and Bessell, S. (2020) 'The Individual Deprivation Measure South African Country Study.' Canberra: ANU, Crawford School of Public Policy. https://www.individualdeprivationmeasure.org/wp-content/uploads/IDM-South-Africa-Report_Final.pdf

[20] National Statistical Office (NSO) [Malawi] & ICF, Malawi Demographic and Health Survey 2015-16 94 (2017), available at https://dhsprogram.com/pubs/pdf/FR319/FR319.pdf.

Table 4.3: SADC countries with high adolescent fertility rates

Country	Adolescent fertility rate (births per 1000 girls aged 15-19)
Mozambique	167
Angola	163
Madagascar	152
Zambia	141
DRC	138
Malawi	136
Tanzania	132
Zimbabwe	110

Source: UNFPA, World Population Dashboard https://www.unfpa.org/data/world-population-dashboard, accessed 28 May 2020.

Table 4.3 shows the eight countries in SADC with extremely high adolescent fertility rates, ranging from 110 in Zimbabwe to 167 per 1000 girls in Mozambique.



Zimbabwean youth learn about safe abortion at a Marie Stopes International clinic in 2020. Photo: Tapiwa Zvaraya

Women seek abortions because of socio-economic concerns linked to the ability to care for a child, or an additional child; lack of support from the male partner; and, particularly for unmarried women, when the pregnancy deviates from the expectations their family has for them. Stigma about abortion traces back to religious attitudes about the sanctity of life, attitudes about the morality of sex outside of marriage, and social norms of womanhood which perceive a women's role as being primarily to reproduce. Stigma can result in women confiding in very few people about an abortion, which leaves them more vulnerable to complications especially in cases where they do not immediately seek help.



The pope's visit to **Madagascar** in 2019 provided the backdrop for a story about illegal and unsafe abortions.[21] One woman, a mother of six, told journalists how she had aborted up to eight foetuses, highlighting the need for contraception in the country. The story noted that the woman's husband did not support the abortions and expected her to have sexual intercourse every time he wanted it. Because the woman works as a domestic helper, she could not afford contraception. Nifin'Akanga, an abortion rights group whose name derives from a powerful blue-flowered herb used as part of unsafe traditional abortions, estimates that one in four women in Madagascar have terminated between two and eight pregnancies. Illegal abortionists - locally known as angel makers - use a variety of infusions and medications. MSI provides post-abortion care to 200 000 women a year in the country and estimates that three women die per day as a result of abortions or miscarriages. Parliament has delayed an attempt to decriminalise abortion first put forward in 2017.



The government of **Angola** has a programme of integrated healthcare for adolescents for the years 2016-2021. Half of girls have already been pregnant by the time they turn 18, which restricts their education and opportunities. The risk of maternal death from pregnancy complications in girls younger than 20 is four times greater than in adult women in Angola.[22] A study of 715 patients with post-abortion complications in a hospital in Huambo found 75% did not use

[21] https://www.news24.com/Africa/News/madagascars-angel-makers-flourish-in-ban-on-abortion-20190906
[22] Angola - integrated health care programme for adolescents launched. https://www.safeabortionwomensright.org/angola-integrated-health-care-programme-for-adolescents-launched/ accessed 27 April 2010.

contraception even though 79% had previously undergone an abortion. In the study, 30% of women were aged 20-24; 46% had a primary education; 41% were single; and 27% were employed in the informal sales sector. First sexual intercourse had occurred as early as 13-15 years for 40% of respondents and 8% had experienced serious complications, with six maternal deaths (0.8%).[23]



In **Botswana**, the Ministry of Local Government and Rural Development has acknowledged that GBV causes many unplanned pregnancies in the country, resulting in women opting for unsafe abortions, which endangers their lives. Minister Botlogile Tshireletso said she prefers a situation that allows women to terminate pregnancies legally and safely, noting this would also help women who face desperation stress and anxiety due to unplanned pregnancies.[24]



Researchers estimated in 2016 that unintended pregnancies account for 71 out of 1000 pregnancies in **Zimbabwe** in women ages 15-49. During that same year, an estimated 25 245 women received post-abortion care. Activists have lauded Zimbabwe as having one of the highest contraceptive prevalence rates in the region. The Zimbabwe National Family Planning Strategy 2016-2020 shows that the country has almost achieved universal knowledge of family planning, but it accepts that gaps still exist in delivering family planning methods to some segments of the population. These gaps continue to leave many unmarried women and adolescents at risk of unwanted pregnancies, with little recourse from the law or the medical system.[25]

Unintended pregnancies account for 71 out of 1000 pregnancies in Zimbabwe

Legal and policy provisions for abortion in SADC

In most SADC countries, penal codes cover abortion, often in ways that date back to the region's colonial past. Most legislation is very conservative, though most member states have some exceptions that allow abortion. It is important to note that when a woman or girl is determined to end her pregnancy she will do so, even in instances when the only option is a risky, unsafe, or illegal procedure. Abortions occur as frequently in countries that ban abortion or allow it only to save a woman's life (37 per 1000 women) as in countries that have legalised it (34 per 1,000 women). Where abortions remain illegal, many women risk their lives to have unsafe abortions. Thus, the proportion of unsafe and dangerous abortions (defined by the WHO as involving ingestion of caustic substances or untrained persons using dangerous methods such as insertion of foreign bodies, or traditional concoctions) remain high in the region.[26]

[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: Legal provisions regarding abortion in SADC[27]

Country	Law	Abortion on demand (yes/no)	Conditions under which an abortion may be granted					Gestational limits	Consent	Provided by	Penalties for an illegal abortion
			Rape/ incest	Mothers life at risk	Mothers mental state compro-mised	Child's life at risk	Other				
ABORTION AVAILABLE ON DEMAND											
South Africa	Choice of Termination of pregnancy Act (92/1996) amended in 2008[28]	Yes - specifies available to any woman who wants to terminate out of choice, including counselling						Within the first trimester	Right to termi-nate without consent of other parties apart from medical practitioners		Yes, for the woman, provider, and person who helps a woman obtain abortion
Mozambique	Amended Penal Code	Yes						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[29]	A certified practitioner must perform termination at designated facilities[30]	Yes, for the woman, provider, and person who helps a woman obtain abortion
ABORTION AVAILABLE IN CERTAIN CIRCUMSTANCES											
DRC	Penal Code 2004, super-seded by Maputo Protocol, 2018	No	Yes	Yes	Yes	Yes	Sexual assault		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[31]	No	In cases of incest or rape, but not marital rape	Only 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
Zambia	Termination of Pregnancy Act,	No		If the preg-nancy will	If the pregnancy will	If the child is at risk of mental			Once three medical		Seven years for person who

	13 October 1972, amended in 2005 and Penal Code			cause death	cause mental or physical damage to the woman	and physical deformities			practitioners have agreed		administers; seven years for woman who administers own abortion
Botswana	Penal Code (Amendment) Act, 1991 - Section 160	No	Rape or incest	If the mother's life is at risk or the pregnancy may cause mental harm	Yes	If unborn child will suffer or later develop physical or mental abnormality	Yes, in cases of defilement	Termination must be performed before 16 weeks[32]	Consent of parent or next of kin for minors; two doctors	Licensed facility	Three years for procurement; seven years for aiding
Lesotho	The Penal Code (2012)[33]	No	If pregnant due to incest or rape	To save the life of a pregnant woman		To prevent birth of a child who will be seriously physically or mentally handicapped			Performed by a registered medical professional, with the written opinion of another registered medical professional		A fine of M5000-M10 000 or imprisonment of up to three years
Mauritius	Penal Code 1983; Criminal Code Amendment Act 2012[34]			To save the life of a pregnant woman; or prevent permanent physical damage		If the foetus may suffer severe malformation or abnormalities	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	No	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	If the woman is deemed to be an idiot or imbecile as per the Immorality Act 1957, which criminalises sex with her[35]	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 pregnancy is a risk	Licensed facility	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both

Country	Law	Abortion on demand (yes/no)	Conditions under which an abortion may be granted					Gestational limits	Consent	Provided by	Penalties for an illegal abortion
			Rape/ incest	Mothers life at risk	Mothers mental state compro-mised	Child's life at risk	Other				
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	No		If the woman's life is deemed to be in dan-ger 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[36]			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[37]			If a woman is at risk of death, or the pregnancy 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 Consti-tution			Only if the life of the woman is in danger[38]			Unlawful intercourse with mentally retarded female		One doctor		Life imprisonment
Malawi	Penal Code	No		Only to save a woman's life							14 years for having an abortion; three years for supplying instruments to conduct an abortion

Angola	Penal Code 2017[39]			Yes, 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
Comoros	Comoros-Penal-Code-1995	No	Yes		Yes	Yes	For a very serious medical reason	Not specified	Two doctors	One doctor	Penalties for the woman and provider
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

Source: Gender Links, with data from UNAIDS 2019.

Activists worry that SADC could see higher rates of unplanned pregnancy because of COVID-19, increasing the demand for abortions

[27] 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.
[28] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[29] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[30] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[31] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[32] 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
[33] https://lesotholii.org/ls/legislation/num-act/6
[34] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[35] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[36] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[37] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
[38] http://srhr.org/abortion-policies/country/swaziland/
[39] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf

In detailing the current legal provisions in SADC regarding abortion, Table 4.4 illustrates that legal change, especially for an issue as emotive and contentious as abortion, remains slow and varied across the region. However, most SADC countries now provide for abortion in some circumstances. This ranges from South Africa and Mozambique, where abortion is available on demand, to Angola, Eswatini, Malawi, and Tanzania, where abortion is only available in extremely limited circumstances. Penalties for an illegal abortion also vary widely.



Activists in Malawi take part in the launch of a music album to mobilise support for law reform on abortion in Mangochi in 2015. Photo courtesy of Luke Tembo

Many factors mediate the relationship between legislation, policy, and practice, including moral and religious contestations, patriarchal attitudes, control of policy and legal processes and, in some cases, pragmatism. Foreign aid restrictions, such as the Global Gag Rule, also known as the Mexico City Policy, block funding for organisations that provide abortion counselling or referrals, or lobby to decriminalise it. The Trump administration in the United States has reinvigorated this approach in its distribution of USAID and the President's Emergency Plan for AIDS Relief (PEPFAR) funds. SADC also has instances of progressive legislation around abortion that lawmakers do not fully implement and other cases where seemingly conservative legislation does not prevent many women from seeking abortions.

Lawmakers in the region adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, often referred to as the Maputo Protocol, in July 2003 in Mozambique. It entered into force after 15 countries ratified it in 2005. The Maputo Protocol covers a wide range of women's rights provisions. Article 14 on health and reproductive health rights empowers women to control their fertility, decide whether to have children or not and the number thereof, to choose their preferred contraception, and to be protected from STIs. Additionally, women have the right to know their own and their partner's health status; to family planning education; affordable and accessible health services; and pre- and post- natal, delivery and nutritional services. Finally, it granted women the right to medical abortions in cases of sexual assault, rape, incest, and in the event that the pregnancy endangers the mental and physical health of the mother, or the life of the mother or unborn child.



The **Democratic Republic of the Congo (DRC)** signed the Maputo Protocol in 2003 and ratified it in 2008. After months of advocacy initiatives by civil society groups in conjunction with the Ministry of Gender, the DRC finally published the ratified Maputo Protocol in the nation's legal gazette on 14 March 2018. According to the DRC's monist legal system, international and domestic law form part of one integrated system. Thus, gazetting the Protocol means that its provisions become legally binding. Abortion is now legal in cases of rape, incest, assault, and mental and physical endangerment of the woman and/or her child and all medical facilities must provide termination of pregnancy.

The DRC has high rates of unintended pregnancy because of both poor access to contraception and high levels of sexual assault, especially in the eastern parts of the country. In 2016, researchers estimated that 61% of all pregnancies in Kinshasa were unintended. Approximately 43%, or 147 000, of those pregnancies led to induced abortions and nearly 38 000 women sought treatment for abortion complications. Meanwhile, 27% of women in the DRC report experiences of sexual assault; many of these result in pregnancy. Due to fear of death or

complications, 47% of women who became pregnant because of assault did not attempt to abort.[40] Gazetting of the Maputo Protocol was the first step in making abortions more available to women who need them. However, many women still struggle to access abortion because:

- Many Congolese legal experts and medical providers do not know about the change or choose not to follow the law;
- The legal establishment and law enforcement's inconsistent understanding and application of the law;
- Slow integration of Maputo Protocol language into national laws; and
- Crippling stigma against women who seek or have had abortions.

Several NGO programmes now support government efforts to train health professionals to provide safe abortions, especially in regions of the DRC where men use rape and sexual assault on women as weapons of war in the ongoing unrest. One of these is Si Jeunesse Savait (SJS, "If Young Women Knew" in French), which has organised online communication as well as face-to-face workshops to sensitise healthcare providers on the need to provide quality care without stigmatisation of women. SJS has also educated young women about their rights, how to exercise them, and the means available to them. The association estimates that it reached more than 5000 people in one year. It also offers referral services to appropriate health structures.

Many factors mediate the relationship between abortion legislation, policy, and practice in SADC

[40] Se Jeunesse Savait, Safe Engage & Population Reference Bureau. 2018. Fact Sheet: Expanding Access to Safe Abortion in DRC. https://www.prb.org/wp-content/uploads/2019/04/SAFE-ENGAGE-DRC_Medical-Fact-Sheet.pdf Accessed 2 May 2020.

[41] Blystad et al. International Journal for Equity in Health (2019) 18:126, The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia. https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1024-0 accessed 23 April 2020.



Mozambique amended its Penal Code in 2015, decriminalising abortion as part of a comprehensive legal review. The revisions allow women to terminate their pregnancies during the first 12 weeks or, in the case of rape, up to 16 weeks. The amended law stipulates that qualified practitioners must conduct abortions in approved health centres as a free service. Girls younger than 16 require consent from someone 21 (age of majority in Mozambique) or older to have an abortion - either a parent or trusted adult. There is a 48-hour waiting period before a woman receives an abortion.

However, several bottlenecks to full implementation of these new rules exist, including delays in defining clinical standards for safe abortion, institutional opposition, resistance from health workers, and gaps in the knowledge of decision-makers. Consequently, many women still cannot, or do not know how to, access abortion services.

NGOs such as Associação Moçambicana de Obstetras e Ginecologistas (AMOG), the country's association for gynaecologists, has tried to improve the situation, including by:

- Sensitising girls and women on the provisions of the law, especially time limits for an abortion, and where they can receive them;
- Sensitising communities to reduce the high levels of stigma that may prevent a woman from seeking an abortion;
- Sensitising doctors and health providers on the provisions of the law and their responsibility to provide abortions; and
- Training qualified health providers on safe abortion in line with the law.

A study of the interplay between legislation, attitudes, policy and practice in Zambia and Tanzania found that many factors besides the actual legislation influence access to safe abortion.[41] The study also assessed Ethiopia and noted that all three countries have high fertility rates (the average number of children a woman gives birth to in her childbearing years), and high maternal mortality ratios: 224 per 100 000 live births in Zambia and 398 in Tanzania. Meanwhile, the contraceptive prevalence rate at the time researchers conducted the study stood at 41% in Zambia and 25% in Tanzania - and 28% among

teenage girls in Zambia and 15% among Tanzanian teens.

The study, conducted between 2016 and 2018 and published in 2019, also examined implementation of abortion legislation in Zambia, which appears to allow abortion on many grounds, but remains hampered by a requirement for three doctors to authorise any abortion in the country. This provision has stymied implementation of the law, especially in rural areas where it is almost impossible to find the three doctors in any one community. Lack of coherent implementation guidelines has exacerbated the situation. In Tanzania, on the other hand, quite conservative legislation includes an explicit exemption of providers from punishment if they perform an abortion to save a woman's life. The law allows a single health practitioner - a doctor or a midwife - to make this determination.

Records from five major hospitals across Zambia between 2003 and 2008 suggest that almost one-third of all women admitted for gynaecological reasons came in due to complications of unsafe abortions, and researchers estimate that six in every 1000 of these women died as a result of complications. In Tanzania, where abortion is highly restrictive, researchers struggle to estimate incidences of unsafe abortions. However, a 2013 study found that clandestine abortions represent a major contributor to maternal death and injury in the country.



Despite much consultation and a critical need for abortion review in **Malawi**, progress has been very slow. A CHANGE fact-finding mission found that one contributing factor for this is the Protecting Life in Global Health Assistance (PLGHA) policy in all USAID health assistance, also known as the Global Gag Rule, which blocks aid for organisations that provide abortion counselling or referrals.[42] Malawi depends on foreign aid from a range of bilateral and multilateral donors. In 2017, US$1.5 billion in aid to the country accounted for more than one quarter of its gross national income (GNI).

USAID disbursed more than US$215 million in global health assistance for programming in Malawi from 2017-2019. In comparison, the UK's Department for International Development (DFID), disbursed about US$84 million during the same period. The CHANGE study found that the Malawi government could not afford to directly contradict the USAID policy, resulting in delays in the passage of the Termination of Pregnancy Bill.



Malawi: coalition that includes faith leaders pushes for abortion reform



Chisale Mhango, a gynaecologist with the College of Medicine, writes a column about safe abortion in The Daily Times. Photo courtesy of Nyasa Times

An advocacy network called Coalition for the Prevention of Unsafe Abortion (COPUA) has brought together leaders from various sectors including media, health, legal, gender and women's rights, academia, students, faith communities, and traditional leaders to push for law reform on abortion.

Many Malawians, including faith and traditional leaders, now openly talk about the danger of unsafe abortion and the need for a modernised termination of pregnancy policy and legal framework.

[42] CHANGE, op cit.

Since 2015, Malawi's lawmakers have avoided debate of a draft bill from the Malawi Law Commission that would expand the grounds under which women can access abortion.

These include: when the continued pregnancy will endanger the life of the pregnant woman; when termination is necessary to prevent injury to the physical or mental health of the pregnant woman; when there is a severe malformation of the foetus, which will affect its viability or compatibility with life; and when the pregnancy occurred because of rape, incest, or defilement.

Maternal health statistics indicate the critical need for abortion reform in Malawi. Unintended pregnancies represent more than half of all pregnancies, with 30% of these ending in unsafe abortion. Indeed, research has found that more than 78 000 Malawian women undergo unsafe abortions annually, with more than 50 000 experiencing complications that necessitate post-abortion care (PAC).[43] Complications from unsafe abortion rank among the top five direct causes of maternal deaths in the country, which has one of the highest global maternal mortality rates, estimated to be 439 maternal deaths per 100 000 live births in 2019.[44]

Malawi's Centre for Solutions Journalism (CSJ) has been disseminating research from the College of Medicine at the University of Malawi on maternal and sexual and reproductive health that highlights the gravity of unsafe abortion. Through a multimedia programme, CSJ hopes to reach a million people. A local radio show in Chichewa, *Uchembere ndi Ufulu* ("motherhood and rights"), engages experts to raise awareness on issues of safe abortion.

Chisale Mhango, a gynaecologist with the College of Medicine, writes a column about safe abortion in *The Daily Times*. Mhango covers topics such as the proposed bill, whether abortion is a religious or a health issue, and the health system's capacity to deliver safe abortion. Faith-based leaders also play a role in the discussion. Pastor Esitedi Chikopa wrote of how his interest in unsafe abortion stems from the death of two members of his congregation. "As master condemners, we have no compassion for many women who induce abortion in Malawi," he wrote. "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 (or interpretation)."

Political turbulence in Malawi following the nullification of the May 2019 elections created a hostile environment for the enactment of the draft bill, as MPs worried about discussing abortion issues in fear of losing their political support bases. The COVID-19 pandemic also resulted in a reduction of awareness campaigns as social distancing measures and restrictions prohibited mass gatherings.

Source: Extract from Luke Tembo, "Malawi: Moving the Needle on Comprehensive abortion Care," entry into the SADC Gender Protocol @ Work Summit 2019 and Gender Links, Malawi: Political Discourse, Safe Abortion Care.

Abortion incidence

The Guttmacher Institute uses the best available data to estimate abortion rates per 1000 women aged 15 to 44 for different regions and times (in a series of five-year intervals). It estimates that 58 million women in Africa have an unmet need for contraception, which results in 21.8 million unwanted pregnancies per year and 8.2 million abortions. This is an increase from 4.6 million in 1990-1994, mainly because of the increased number of women of reproductive age.[45]

[43] CHANGE. 2020. A Powerful Force: U.S. Global Health Assistance and Sexual and Reproductive Health and Rights in Malawi. https://srhrforall.org/a-powerful-force-u-s-global-health-assistance-and-sexual-and-reproductive-health-and-rights-in-malawi/
[44] USAID: Maternal, neonatal and child health. Accessed 2 July 2020 https://www.usaid.gov/malawi/global-health/maternal-neonatal-and-child-health#:~:text=Malawi%20has%20one%20of%20the,and%2015%25%20of%20maternal%20deaths.
[45] Guttmacher Institute, 2018. Fact Sheet: Abortion in Africa. Guttmacher Institute. New York, NY.

Table 4.5: Abortion rates in Africa

Region	Abortion rate per 1000 women of reproductive age (15-44)		% of all pregnancies that end in abortion
	1990-1994	2010-2014	2010-2014
Africa	33	34	15
Southern Africa	32	34	24
Eastern Africa	32	34	14
Central Africa	32	35	13
West Africa	28	31	12
North Africa	41	38	23

Source: Derived from Guttmacher Institute, 2018. Fact Sheet: Abortion in Africa. Guttmacher Institute. New York, NY.

Table 4.5 shows that estimated abortion rates in Southern Africa increased from 32 per 1000 women in the 1990s to 34 between 2010 and 2014. This compares to a decrease of 40 to 35 globally, a decrease of 39 to 37 in developing countries, and a decrease from 46 to 27 in developed countries over the same period. The SADC region has the highest percentage of pregnancies that end in abortion compared to other African regions (24%). Globally, the institute estimates that 25% of pregnancies end in termination.[46] It recognises comprehensive safe abortion care (including post-abortion care), as a key element of SRHR.

In 2019, MSI conducted a survey with 1929 of its clients across Latin America, Africa, and Asia.[47] The organisation wanted to ascertain whether their abortion services were meeting the needs of their clients.

Table 4.6: Age of women seeking abortions

Percentage	Age
9.5	33
25.9	32
28.5	32
19.8	32
12.5	28
3.9	41

Source: Marie Stopes International, 2019.

Table 4.6 illustrates that MSI found that most women seeking abortions fall into the 25-29 age group and the 20-24 age group. However, the study also found that teenagers account for almost 10% of those seeking abortions.

Table 4.7: Marital status of those seeking abortion

Percentage	Status
28.7	Single (not living with a partner) and do not have children
23.8	Single (not living with a partner) and have children
8.2	Married or living with a partner and do not have children
39.3	Married or living with a partner and have children

Source: Marie Stopes International, 2019.

Table 4.7 shows that married and partnered women with children comprise a majority of those seeking abortions. This points to a need for better family planning services to assist women who already have children, so they do not have to deal with unwanted pregnancies.

Table 4.8: Employment status of those seeking abortion

Percentage	Employment status
18.4	Students
45.4	Employed
33.5	In paid work

Source: Marie Stopes International, 2019.

Table 4.8 illustrates that most women seeking abortions have paid work. However, at 18.4%, students account for one in five abortions.

[46] Singh, S. et al. 2017. Abortion Worldwide 2017. Guttmacher Institute. New York.
[47] Marie Stopes International. 2019. My Body, My Voice: Women's views on abortion care. www.mariestopes.org accessed 2 May 2020.

Overall, 23% of women reported that they faced some stigma in choosing to have abortions: from a partner, their community, and even from providers. MSI found single women five times likelier to experience stigma than married women. The study also noted that safe abortion services remain difficult for most women to access. Women travelled further and found it more difficult to gather funds to access safe abortion care than they did for contraceptive services.

MSI concluded that there is a need to deliver safe abortion through a variety of channels, such as those that reach low-income women in rural settings, including via outreach teams. It also found that knowledge of safe services remains limited: 54.7% of women who visited MSI did not know of an alternative abortion provider and 28.9% accessed information on safe abortion care via the internet and social media.

> It is important that programmes offer integrated safe abortion care, including access to a wide range SRHR services

Half of clients planned to receive a contraceptive method with MSI as part of abortion care. It is important that programmes offer integrated safe abortion care, including access to a wider range of SRH services, such as cervical cancer screening and counselling on post-abortion contraception, if desired.

Finally, 31.2% of women found out about MSI from a government or private facility, underscoring the importance of creating partnerships with the public and private sectors.



The **Seychelles** Penal Code criminalises abortion, except in cases of foetal impairment, rape, incest, intellectual disability and to preserve a woman's mental and physical health. In 2018 Seychelles reported 473 abortions, the equivalent of 22% of pregnancies.



In 2016, Guttmacher Institute reported that 60% of women in **Tanzania** who suffer post-abortion complications do not receive medical care. Researchers conducted the most recent study of abortion in Tanzania in 2013, finding that, of one million pregnancies reported, women underwent 405 000 abortions, the vast majority considered unsafe by WHO standards. Of these, only about 66 600 women received post-abortion care.[48]

Safe abortion

Overall, as this chapter has illustrated, most legal frameworks in Africa do not accept abortion, which drives women to unsafe methods and providers. Of all abortions:[49]

- Experts consider only 55% to be safe (i.e. conducted using a recommended method and by an appropriately trained provider);
- 31% are less safe. This means they meet one of either the method or provider criterion, or are conducted using outdated methods like sharp curettage even if the provider has been trained, or if women use tablets but do not have access to proper information or to a trained person if they need help;
- 14% are least safe, which means employing neither a recommended method nor a trained provider, or they involve ingestion of caustic substances, or untrained persons use dange-

[48] https://www.guttmacher.org/news-release/2016/unsafe-abortion-common-tanzania-and-major-cause-maternal-death
[49] World Health Organisation, https://www.who.int/health-topics/abortion#tab=tab_1

rous methods such as insertion of foreign bodies or use of traditional concoctions.



In terms of actual numbers, experts believe an estimated 25 million unsafe abortions take place each year worldwide, of which eight million fall in the category of least safe.[50] In Africa, three of every four abortions fall into the unsafe group. In 2008, women in the 15-24 age group comprised 51% of those accessing the least unsafe abortions in Africa. The more restrictive the legal setting, the higher the proportion of unsafe abortions. Less than 1% of the least safe abortions occur in the least restrictive countries while 31% occur in the most restrictive countries. While unsafe abortion declined between 1990 and 2008 in most regions, it remained constant in Africa at a rate of 28 per 1000 women in reproductive age years (15-44). Africa accounts for 29% of global unsafe abortion but suffers 62% of unsafe abortion-related mortality.[51]

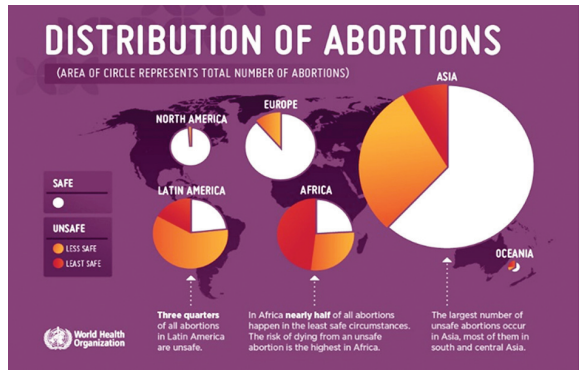
In developing countries, where unsafe abortion remains prevalent, up to 40% of women who have an abortion develop complications, including severe bleeding, uterine perforation, tearing of the cervix, severe damage to the genitals and abdomen, internal infection of the abdomen, and blood poisoning. Long-term complications include increased risks of infertility and ectopic pregnancies, as well as miscarriages or premature deliveries in subsequent pregnancies. Some of the least safe methods of abortion include inserting dangerous objects such as knitting needles, or even glass, into the vagina. Globally, unsafe abortion ranks as the third major cause of maternal death after haemorrhage and sepsis in childbirth.

The WHO has developed guidance to support countries to provide safe services. Its recommendations for safe abortion can be found in the following publications:

- Safe abortion: technical and policy guidance for health systems;
- Clinical practice handbook for safe abortion; and
- Health worker roles in providing safe abortion care and post-abortion contraception (2015).

Impact of the Mexico City Policy

A review of the implications of the Mexico City Policy (MCP), which US Republican administrations since Nixon have enacted - and every subsequent Democrat president has rescinded - found many unintended consequences.[52] The policy aims to reduce abortions by limiting US funding to organisations that provide information, counselling, abortions, or advocacy for abortion. However, some organisations that suffered funding cuts because of this policy also provide SRH services, including access to contraception. Thus, these organisations also lose funding for other SRH services.



Researchers conducted the review for the period from 1991 to 2019, covering the Clinton, Bush, and Obama administrations, which made the policy inactive, then active and then inactive

[50] WHO, 2018: Preventing unsafe abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion. Accessed 10 June 2019.
[51] https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion, 19 February 2018. Accessed 10 June, 2019.
[52] Brooks N, E Bendavid, G Miller, USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy. Lancet Global Health. 2019; 7: 1046-1053. https://doi.org/10.1016/S2214-109X(19)30267-0 accessed 30 May 2020.

again. It looked at 13 African countries classified as having high exposure to the MCP as they receive above average annual per-capita development assistance for family planning and reproductive health from USAID (in SADC, this included Madagascar, Malawi, Tanzania, and Zambia) and 13 classified as having low exposure to the MCP (including Eswatini, Lesotho, Mozambique, Namibia, and Zimbabwe in SADC).

The study found a reduction in modern contraceptive use (14% less), an increase in pregnancies (12%), and an increase in abortions (40%) among women living in countries highly affected by the policy during periods when administrations enacted the MCP. It is highly likely that these increased abortions would rank as unsafe. The review also showed that these outcomes reversed after the policy's repeal (2009-14).



Namibia: Unsafe abortion and baby-dumping



Namibia police investigate a case of unsafe abortion in Arandis, Namibia, in June 2019. Photo courtesy of Monalisa Hoaes

Namibia inherited its Abortion and Sterilisation Act from South Africa in 1975. Since then, abortion has been illegal in Namibia for women and girls (except in cases of rape, incest, or endangerment of the mother's or child's life).

Almost 50 years on, however, terminations by other means continue. "It is naive to assume that abortions are not already taking place in Namibia," said Andrea Thompson, communications lead at Marie Stopes in South Africa. "They are, and they are happening through backstreet means."

In 2013, the Namibia Press Agency (NAMPA) published a report stating that Namibians dump or flush 40 babies and foetuses down the toilet every month. A 2010 UNICEF report likewise found that "13 dead babies are found every month at the sewage works in Windhoek."

Shaun Whittaker, a clinical psychologist in Windhoek who counsels post-abortion women, says these stories may be hard to stomach, but women in Namibia have few other options. "When someone is confronted with an unwanted pregnancy, they are in a state of panic. Usually these are young women, from a working-class background, with little or no financial means. They are desperate," he said.

Sacky Shangala, of the Law Reform and Development Commission, agrees, noting it is time for the country's leaders to address the issue. "There have been many baby dumping incidents in Namibia to warrant a discussion on whether or not abortion should be legalised," he said.

Namibian women who choose "backstreet" solutions break the law in doing so and face risk of complications, including haemorrhage, septicaemia, internal organ damage, tetanus, sterility, and even death. Failed procedures remain common.

"The current situation allows people with means to go to another country, such as South Africa, to access safe, legal abortions," said Dianne Hubbard, coordinator of Gender Research and Advocacy at the Legal Assistance Centre. "While our restrictive laws expose the poorest and most vulnerable members of society." Crossing the border to visit a clinic in South Africa is an expensive trip for most Namibians.

Private doctors regularly charge more than R10 000, whilst non-profit organisation prices start at R3 000. This does not include travel, accommodation, and other expenses.

Even some religious leaders in Namibia say they are open to talking about the current laws. "In the light of ongoing gender-based violence, teenage pregnancies and baby dumping, these tragic events necessitate a fresh discussion," said Ernst//Gamxamub, deputy bishop of the Evangelical Lutheran Church in the Republic Namibia.

Any change in policy could have a profound positive effect on women's health, as occurred in South Africa. In 1997, South Africa legalised abortion, and the same year the annual number of abortion-related deaths fell by 91%.

Source: Monalisa Hoaes from Arandis Namibia as part of SADC Gender Protocol Summit @ Work application 2019.

Access to post-abortion care services

Some countries have begun to develop guidelines for post-abortion care, a key part of comprehensive abortion care that has five essential elements:

- Treatment of incomplete and unsafe abortion as well as complications;
- Counselling to identify and respond to women's emotional and physical health needs;
- Contraceptive and family planning services to help women prevent future unintended pregnancies;
- Reproductive and other health services that they receive on site or via referrals to other accessible facilities; and
- Community and service provider partnerships to prevent unintended pregnancies and unsafe abortions, to mobilise resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.[53]

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.
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.

[53] IPPF. Op Cit

Table 4.9 outlines available guidelines on post-abortion care in seven SADC countries. Many countries have explicit guidelines that lawmakers have recently updated, while others look to standards set out in lists of essential medicines or standard treatments. To reduce maternal mortality, it is essential that all countries provide easily accessible post-abortion care. There is an urgent need therefore for comprehensive post-abortion care guidelines in all countries. However, activists note that provision of post-abortion care in cases of unsafe abortion is much costlier than providing legal access to safe abortion.



Zimbabwe's 2gether4SRH programme combines interventions from UNAIDS, UNFPA, UNICEF, and WHO to combat maternal mortality due to abortion and take more direct action to achieve SDGs 3 and 5. Zimbabwe's Ministry of Health and Child Care partners with these groups, implementing the initiative in 12 districts.[54] All 18 health facilities assessed provide post-abortion care to women through manual vacuum aspiration, dilation and curettage, medical abortion and electric vacuum aspiration, with dilation and curettage, a procedure to remove tissue from inside the uterus, most common. However, researchers found that 79% of these centres do not provide counselling to their clients, which illustrates a gap if the aim is to deliver a complete package of post-abortion services.

Other gaps identified include too few professionals trained in post-abortion care, as well as limited post-abortion care courses for health care workers, such as pre-service medical professionals and midwives. Zimbabwe also has a shortage of supplies such as sterile water, manual vacuum kits, and aspirin, which limits the quality of services rendered to clients.[55] A study conducted by Guttmacher Institute found that staff at 55% of health facilities in 2016 said they had run out of misoprostol[56] within the last three months at the time of the study, and no central hospitals had the drug at that time. The research also found that 93% of primary health care centres, 75% of all provincial hospitals, and 50% of all district hospitals did not have misoprostol. Hospital staff also reported they did not have blood transfusion services, IV antibiotics, and MVA kits.

Increasing access to post-abortion care saves lives

Regardless of Zimbabwe's stringent laws on abortion, many women still risk their lives to terminate unwanted pregnancies. Government leaders knows abortions occur daily and, even though it is illegal, they know they have a duty to preserve life and treat women when they arrive in health facilities. While there is nationwide awareness of family planning, access to it remains spotty. Legislators need to do more to make it available to all women in the country.

Access to safe abortion services

Safe abortion care is a package of essential health services: safe termination of pregnancy, management of post-abortion complications, and provision of contraceptives. The services must be timely, reliable, confidential, compassionate, and provided by well-trained professionals.

Termination of pregnancy is a safe and effective medical act, carried out using tablets, known as "medical" or "medication" abortion, or through a minor procedure using local anaesthesia, known as manual vacuum aspiration (MVA). Medical abortion involves five tablets of two drugs, mifepristone and misoprostol - both listed

[54] https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-death
[55] https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-deaths
[56] https://journals.plos.org/plosone/article/file?type=printable&id=10.1371/journal.pone.0205239

as WHO essential medicines. Misoprostol is widely available and inexpensive but only results in a complete first trimester abortion 75-90% of the time if used correctly.

When combined with mifepristone, which is less widely available and more expensive, effectiveness for complete abortion at nine weeks of pregnancy improves: between 95-98% when used correctly.[57] Women usually prefer medical abortion as it is less invasive and can be started as an outpatient and completed in the privacy of one's home. Skilled midwives and nurses can provide both methods in hospitals and health centres.[58] Abortion is safe when service providers use safe methods.



Activists gather for a safe abortion roundtable meeting in Namibia in 2019.
Photo: Kaino Kamweka

Southern Africa Gender Protocol Alliance

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

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

Contraception and safe abortion care are critical components of any strategy to reduce unwanted pregnancies, unsafe abortions, and maternal deaths. Increasing access to modern contraception is essential to reduce unintended or unwanted pregnancies and abortions or unplanned births. However, contraception alone is not enough.

Provision of safe abortion services is a powerful indicator of relative gender equality. Countries that score high on the UN Gender and Develop-



[57] IPPF. 2018. Her in charge: Medical abortion and women's lives - A call for action. London. https://www.ippf.org/herincharge/downloads/IPPF_Her_In_Charge_Report_2018.pdf accessed 10 June 2019.
[58] Africa: Unsafe Abortion Neglected Emergency, MSF Opinion https://allafrica.com/stories/201903040646.html

ment Index (GDI) tend to provide good access to safe abortion services, while countries with low GDI scores often have higher levels of unsafe abortion. Further, safe abortion services are part of a package of improved SRHR services, including good access to contraception and sex education. Thus, countries with more liberal abortion legislation do not have increased demand for abortion as they also have reduced rates of unintended pregnancy.



In **Lesotho**, CNN spoke with nine women between age 17 and 30 who had contacted people on social media who claimed to be doctors for the purpose of an abortion. All nine women told the journalists they felt they had undergone an unsafe procedure. They all experienced extensive bleeding and faintness following use of the pills provided. None of the women sought medical attention.[59]



In providing safe and legal abortion for its citizens, South Africa has also seen an increase in women arriving for abortions from neighbouring countries, including Botswana, Eswatini, Lesotho, Namibia, and Zimbabwe. Although these countries all have conservative legislation around abortion within their own borders, a quick Google search in any of them highlights providers with South African numbers. Unfortunately, even though abortion is legal and can be safe in South Africa, searching for providers via social media, such as WhatsApp or Facebook, puts women at risk of finding unsafe and unscrupulous providers.

Safe abortion campaigns

Gender Links (GL) has collaborated with SAfAIDS to champion campaigns across the SADC region and raise awareness of available services for abortion and post-abortion care. Many women, especially young, poor, and rural women, do not always know about availability of safe services and therefore do not access them. The campaigns also highlight the need for legislation, policy, and provision of services that support women.

Voice and Choice campaign

GL launched the #VoiceAndChoice campaign in 2018 with the aim of campaigning for the increase of abortion services in Mozambique and South Africa. The campaign also advocates for decriminalisation of abortion in the SADC region. Because abortion laws differ from one country to the next, each country's campaign highlights different priorities and gaps within policies.

There is need to align as a region and ensure that all women have access to safe abortions. Women take different risks across the region, contributing to high maternal mortality across Southern Africa every year. Angola and Madagascar receive particular attention because abortion remains illegal in both countries under most circumstances and both have extreme punishments for those who undergo abortions. The campaign aims to amplify the voices of women across the region who seek to take ownership of their bodies and exercise their rights to safe SRH, including abortion. GL's campaign looks to ensure that leaders hear all voices in the region.

The #VoiceAndChoice campaign also connects global policy to those on the ground through tangible activities to share contextualised information for local communities. On 28 September 2019, Gender Links, through the Southern African Gender Protocol Alliance, joined SafAIDS and dozens of organisations across the globe in observing the International Safe Abortion Day.

[59] https://edition.cnn.com/2018/03/07/health/lesotho-abortions-asequals-intl/index.html

Through simultaneous round tables hosted in Angola, Botswana, DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe, organisations set out to understand the ramifications of the Global GAG Rule while advocating for its reversal. They also undertook to increase national and regional advocacy to reduce stigma, remove policy restrictions, and increase access to safe and legal abortions. The Alliance undertook seven national and 17 local campaigns on safe abortion with support from Amplify Change. The case study that follows is an example of a local-level campaign led by a male councillor.



Anushka Virahsawmy, Gender Links' country manager in Mauritius, speaks about abortion at an International Women's Day event in 2020.
Photo: Sheistah Bundhoo



Lesotho: Councillor campaigns for safe abortion



The Gender Hub at Tanzania's Antakae primary school in Antakae village in 2018.
Photo: Gender Links

"Our girls' future, health, and safe life is in our hands and knowledge is power," says Mohlomi Setlaba.

The Mamants'o councillor and member of the social services committee wants Lesotho's councils to work together with traditional and community leaders to campaign for safe abortion.

In 2018, Setlaba participated in an SRHR action planning workshop with a focus on safe abortion for councillors from ten councils. He was the first person in the meeting to support safe abortion.

Afterwards, he held public gatherings in his village, at which he talked to teenage girls about safe abortion and tried to gather evidence to support legalisation in Lesotho.

He organised a big public gathering during the 16 Days of Activism campaign, themed "Safe abortion." He has also promised to encourage all councillors to get involved and campaign for safe abortion.

Abortion in Lesotho remains criminalised under Section 45 of the Penal Code Act of 2010. However, illegal sales of misoprostol for abortion is a lucrative business. Black market dealers have found a way to smuggle the pills out of hospital pharmacies and clinics to sell them at a street value of M400 for three pills.

"Most of the customers now are from referrals of friends who have accessed our services," says one seller. "For each abortion, a female

client is given three pills, two which she swallows while the third one she places inside the vagina. It succeeds mostly when the foetus is less than two months but can still work up to five months although the risks are high at the time. However, it is not our problem if something goes wrong, I always tell customers that they do it at their own risk."

Desperate young women in rural areas often do not have access to these pills so they resort to using traditional practices including herb mixtures to abort the foetus. One woman from Tlhanyaku, a rural village, said although she eventually lost the baby, she also nearly died in hospital. "I got pregnant in 2016... by my teacher. We could not risk people finding out. He gave me money to go and see a lady who was popular for abortions in the area. She gave me a bitter concoction to drink and gave me three pads, one to put on three hours later and others to change."

The young woman discovered serious bleeding from her vagina in the middle of the night and her neighbour then rushed her to the hospital three hours away. "I was bleeding heavily when I got to the hospital and the last thing I remember were nurses shouting at me asking what I had consumed. I could not respond but was only focusing on the unbearable pain in the stomach. I passed out and only woke up the following day when I was told by a nurse I had lost a baby."

Although statistics are not readily available, Mothepane Thahane, public relations officer at Lesotho's Queen Mamohato Memorial Hospital, said most maternal deaths there occur because of failed abortions.

Source: Adapted from Lesotho SRHR summit case study and Gender Links news services accessed from: https://genderlinks.org.za/casestudies/lesotho-male-councillor-campaigns-for-safe-abortion/ and https://genderlinks.org.za/news/lesotho-unsafe-abortions-leading-to-high-maternal-mortality/

Safe abortion campaign Zimbabwe[60]

Zimbabwe's Safe Abortion Coalition has developed an advocacy tool named Safe Engage to collect data, package evidence and summaries, and provide facts on abortion. Nationally, and despite restrictive laws in Zimbabwe regarding the termination of pregnancy, the coalition remains determined to engage women and girls about their rights. This includes letting them know when they can access abortion services and empowering them to use this right free of stigma. The coalition also aims to empower women and girls with knowledge on the right to post-abortion care and equip them with necessary information on how to access these services.

Women in Zimbabwe worry that the law does not refer to marital rape or statutory rape, which means they cannot be grounds for termination.

After meetings with multiple stakeholders, the coalition determined that many women in Zimbabwe want access to safe abortion, specifically to reduce the number of deaths that result from clandestine abortions. Thus, they have called on the authorities to broaden the circumstances that allow for it.

Government has made strides in protecting women through legal post-abortion care. The Ministry of Health and Child Care conducted training on MVA and added misoprostol to the essential drugs list in 2011. They introduced training on the use of misoprostol for post-abortion care in 2013 and amended the National Guidelines for Comprehensive Abortion Care in Zimbabwe in 2014 to ensure that primary care and public facilities provide post-abortion care.

[60] https://genderlinks.sharepoint.com/:w:/r/programmes/alliance/_layouts/15/Doc.aspx?sourcedoc=%7B3AB23149-A6F2-4DD9-94E7-4F2E28FF6FB2%7D&file=Zimbabwe%20Safe%20abortion%20campaign%20report.docx&action=default&mobileredirect=true

Statement on International Safe Abortion Day (ISAD) by SAfAIDS

On 1 October 2019, SAfAIDS released the following statement on ISAD:
"As we commemorate ISAD 2019, SAfAIDS urges policy makers to exercise their obligation of ensuring policy spaces facilitate access to safe abortion by ALL women. Policy makers have an enshrined duty to enable adolescent girls and young women to enjoy their fundamental right to freedom of choice, autonomy, and physical and psycho-social wellbeing. Beyond moralization and judgement; denial of access to safe, legal and unrestricted abortion services is a direct contradiction to the pursuit of Saving Lives, Preserving Dignity and the Human Development agenda of all States. A win-win is enjoyed by both States and their communities and populace, where safe abortion access, and contraceptive access, is effected. More girls and young women completing their education, less women dying due to unsafe abortion related complications, lowered burden on health economies, and increase in young women contributing to socioeconomic development of their communities - are among the bigger picture wins, pivotal to this SRHR advocacy agenda.

A regional rapid assessment conducted by SAfAIDS (2019) in 16 SADC Member States illustrates that 14 out of 16 States have restricted laws for provision of safe abortion, and in the same States maternal deaths due to unsafe abortion are as high as 30%. This year's ISAD theme, "Abortion is Healthcare," is timely and fitting, to emphasise and reaffirm the global sexual and reproductive health and broader public health sector's commitment to effectively addressing consequences of unsafe abortion including high incidence of maternal mortality, morbidity and disability. This year's theme is relevant to the global efforts aimed at advancing SRH rights though Universal Health Coverage, Sustainable Development Goals, and ICPD25. At the SADC level, the theme



Rouzeh Eghtessadi is the executive director of SAfAIDS.
Photo courtesy of Twitter

aligns with the SRHR Strategy (2019-2030). Providing access to safe abortion has a direct benefit of keeping the girls in schools and achieving SDG4, reducing inequality and contributing to national development. Provision of safe unrestricted abortion services has proven to contribute to macro-economic development.

SAfAIDS joins like-minded stakeholders in commemorating ISAD 2019, by calling on SADC Member States to address restrictive policies for provision of safe abortion services. SAfAIDS has amplified this advocacy agenda for adolescent girls and young women, through a Regional "My Choice: Our Choice" Campaign on Ending Unsafe Abortions. To commemorate ISAD 2019, SAfAIDS is collaborating with Gender Links under the banner of the SADC Gender Protocol Alliance to amplify and increase national and regional deliberative advocacy for removal of policy restrictions to access safe and legal abortion SADC.

Source: Rouzeh Eghtessadi, Acting Executive Director, SAfAIDS, 2019

My Body My Choice campaign

In 2018, activists launched phase one of the My Body My Choice campaign in South Africa to advocate for abortion rights.[61] Despite the fact that South Africa has one of the most liberal abortion laws in the world, more than 50% of the 260 000 abortions performed every year remain illegal and probably unsafe. Activists designed the campaign to raise mass awareness about issues facing women and girls who seek abortion, such as stigma, poor infrastructure, and refusal of health care professionals to perform abortions.

Together with partners - including Gender Links, Marie Stopes SA, Section 27, Sonke Gender Justice, Amnesty International South Africa, the South African Human Right Commission, Health-e News, Ibis Reproductive Health, Ipas, Médecins Sans Frontières, Nalane for Reproductive Justice, Sexual and Reproductive Justice Coalition, and Treatment Action Campaign - the campaign mobilised experts in the industry to raise their voices, spread the word on abortion practices, and call for reforms and an end to abortion stigma.

Employing a multimedia approach, the campaign made use of the voices of influencers, subject matter experts, and the public to generate mass awareness. In the first phase, the campaign reached 1.4 million people through a short documentary aired on eNCA. The campaign then reached more than 36 million people through messaging across numerous social media platforms. The first phase also included the production of radio, TV and print media spots, including ads, a docu-drama series, and talk show appearances on community radio.

On International Safe Abortion Day, the campaign ran activities such as a youth panel discussion, a theatre production, and a solidarity march to raise awareness of abortion and reproductive health justice with 600 participants. In a major development, South Africa's health department developed comprehensive guidelines on abortion care.



Women enjoy the artwork at the My Body My Choice Safe Abortion Exhibition in South Africa in 2019. Photo: Thato Phakela

The campaign also took off in Botswana, where youth mostly connect and interact using Facebook, Twitter, and WhatsApp. National and local level administrators run the campaign in collaboration with local councils. The activists hope that with increased youth involvement they can explore peer education as a sustainable way to create change.



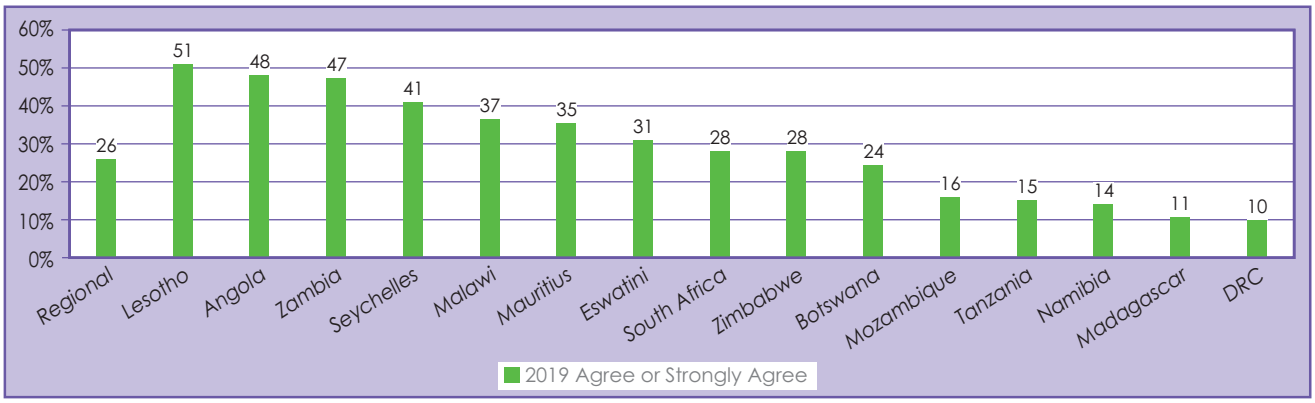
In **Madagascar**, the National Human Rights Commission hosted a conference on the theme "safe abortion in healthcare" at the University of Antananarivo. Other NGOs, such as the Institut Pasteur, joined in coordinating it. Even though abortion remains illegal and tightly restricted in the country, the university often uses its platform to host debates on contentious topics. The conference emphasised that the ultimate aim is to see Madagascar reach zero abortions: that is, all pregnancies would be wanted, and all children born desired by their parents. In the meantime, it remains necessary to draw attention to the high number of unsafe abortions in the country and the high cost in women losing their lives.[62]

[61] https://globalhealthstrategies.com/blog/impact/my-body-my-choice-campaign/
[62] https://www.safeabortionwomensright.org/madagascar-national-debate-on-abortion-law-reform-has-resumed/ accessed 26 April 2020.

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.

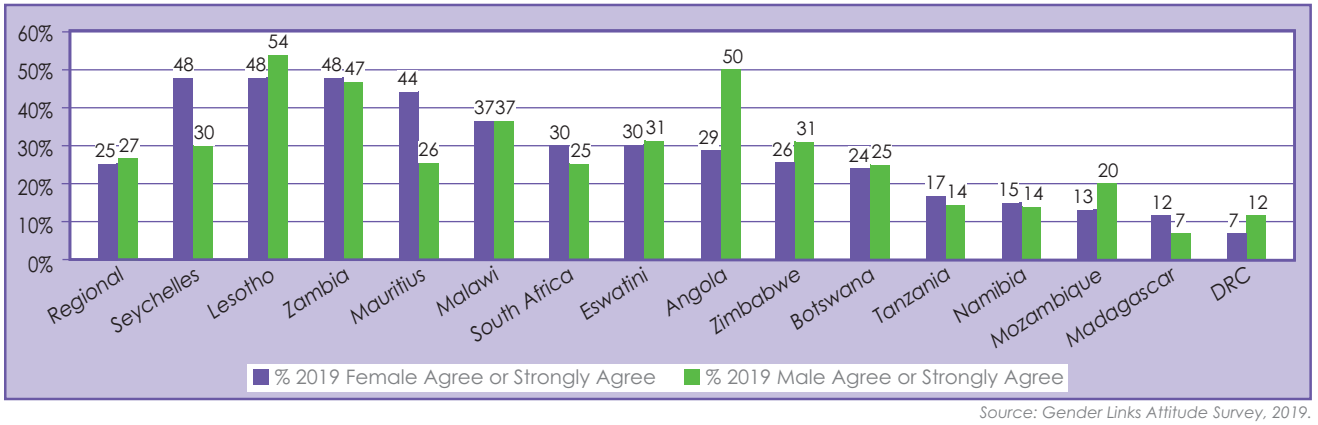
Figure 4.1: A woman should be able to choose to terminate a pregnancy



Source: Gender Links Attitudes survey, 2019.

Figure 4.1 shows that the 2019 regional average of those who agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months sits at just 26%. This ranges from highs encompassing half of people in Lesotho (51%), Angola (48%), and Zambia (47%) to lows of 14% in Namibia, 11% in Madagascar and 10% in DRC. This is a strong indication of the high levels of stigma that still exist in relation to abortion.

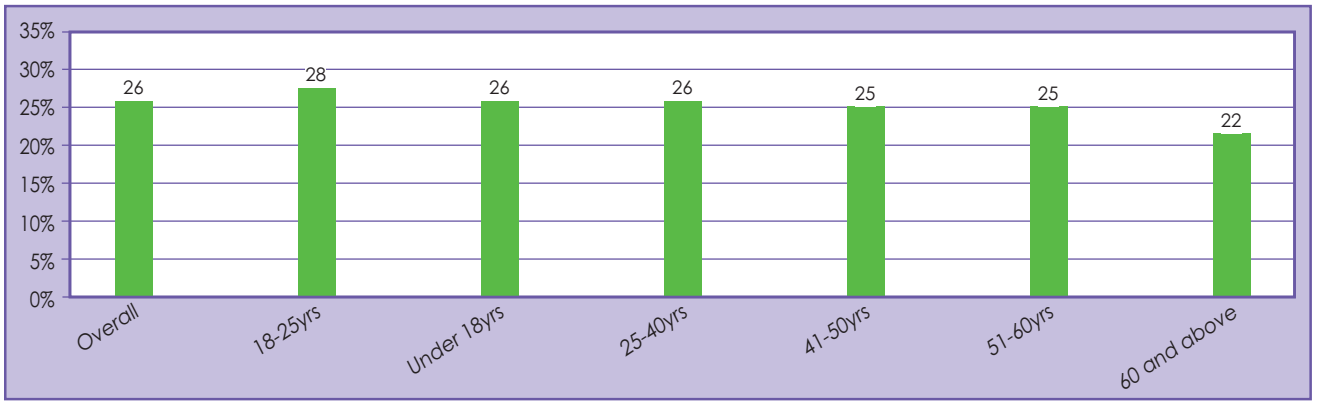
Figure 4.2: Attitudes on abortion by sex



Source: Gender Links Attitude Survey, 2019.

Figure 4.2 shows the differences in attitudes between men and women in 2019 in relation to the same question. Women are more likely to agree or strongly agree that a woman has a right to terminate a pregnancy in the first three months in Madagascar, Mauritius, Namibia, Seychelles, South Africa, and Tanzania. In other countries more men agreed or strongly agreed, particularly in Angola, DRC, Mozambique and to a lesser extent in Lesotho and Zimbabwe.

Figure 4.3: Safe Abortion Score 2019



Source: Gender Links Attitudes survey, 2019.

Figure 4.3 shows the regional responses to the same question on abortion, disaggregated by age. Interestingly, little distinction exists between age bands, with the highest agreement being in the 18-25 age group at 28% and the lowest in the 60 and older group at 22%. This underscores the point that conservative views remain entrenched in all age groups. Research in the SADC region consistently shows that conservative cultural, moral, and religious attitudes continue to fuel abortion stigma.

SADC: Thawing of attitudes on safe abortion in political discourse

There is however growing evidence of changing political discourse on safe abortion. Social media has aided this process, expanding access to information, and providing new opportunities for civil society engagement and campaigning that advocates for SRHR and legalised abortion.

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

service; enabling environment for adolescent and youth access to SRHR; and removing all policy, cultural, social and economic barriers.

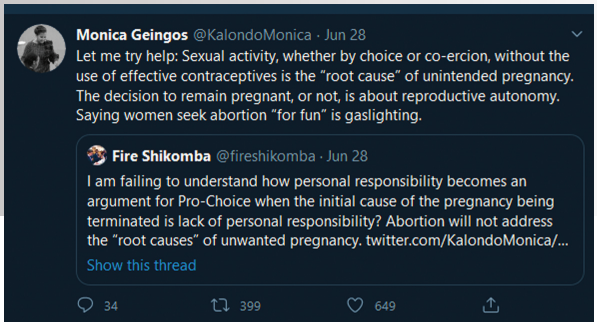
Programmes such as the SADC Parliamentary Forum SRHR project encourage increased political discourse on SRHR, although this remains largely driven by a genuine commitment to reducing maternal mortality. Often, instead of tackling the topic of abortion, discourse tends to focus on addressing unintended pregnancy, particularly for adolescent girls and young women, by expanding access to SRHR information and contraception.

But examples from several countries show that an increasing number of SADC leaders have come out in favour of reform to the region's existing abortion laws. This gives activists hope that consensus may be building for real change on this issue across the region.



Competing petitions from advocates for and against abortion stoked debate in **Namibia** in July 2020. The issue has divided lawmakers, forcing discussion on the issue in a country long known for its conservative views on abortion.

Parliamentarians in Namibia debated the issue in July 2020 after receiving petitions from both pro- and anti-abortion advocates. Activist Beauty Boois submitted an open letter to the government on 29 June 2020 in support of legalising abortion signed by 35 000 Namibians. Boois called on the government to take the issue forward by focusing on facts and human rights. Namibia's First Lady, Monica Geingos, also tweeted out her support, noting that "this discussion needs evidence-based arguments."



Namibia's First Lady, Monica Geingos, joined the debate on Twitter, writing: "Sexual activity, whether by choice or coercion, without the use of effective contraceptives, is the 'root cause' of unintended pregnancy. The decision to remain pregnant, or not, is about reproductive autonomy. Saying women seek an abortion 'for fun' is gaslighting." *Geingos is UNAIDS Special Advocate for Young Women and Adolescent Girls; a qualified lawyer and a businesswoman.*

Meanwhile, parliamentarian Mandela Kapere used Facebook to air his thoughts, noting in June that "access to safe abortion should be an option available for any woman in this day and age, not only the wealthy." Esther Muinjangue, Namibia's deputy health minister, said she wants to see parliament have a debate on the issue and "make informed decisions." Parliament planned to debate her motion in mid-July, even as the country's gender minister, Doreen Sioka, came out against legalisation.[63]



In **Botswana**[64], groups have been advocating for policy and legal reforms for the decriminalisation of abortion to curb the avoidable death toll resulting from these illegal abortions. A 2018 *Sunday Standard* article attempted to sensitise policymakers on this issue and the need for safe abortion facilities. The article noted that women seeking abortions have often been swindled; sold placebos and vitamins under the pretext that they are buying antibiotics. The article targeted ministry of health officials, eager that they understand the urgent need for safe abortion in public health institutions.

Botswana law currently specifies that women can only terminate pregnancies deemed harmful to the mother, or those that result from rape, defilement, or incest. The health ministry has said it will launch an inquest on how to approach the abortion issue as well as run a national referendum to find out what the public wants and needs. Alfred Madigele, minister of health and wellness, stated "The Ministry is

[63] https://www.we.com.na/news/focus-abortion-debate-on-rights-not-religion2020-06-30
[64] Excerpt from a submission for the SADC Protocol @Work Summit 2019 by Ruth Kedikilwe a Journalist who writes for Sunday Standard Botswana.

considering having a conversation around legalising selective abortions. This is because we record a number of unsafe abortions and we will have to turn that around."



Abortion pills on display in Botswana. Photo: Keletso Serowe

In response to high maternal mortality due to unsafe abortion in **Lesotho**, the government has been consulting with schools, religious leaders, communities, and civil society involved in health. These discussions led to a partnership with UNFPA to teach rural women to administer their own injectable contraceptives. The government is also advocating for the free distribution of contraceptives in high schools and sex education for students. Activists have pushed the government to go further, however, noting that these steps will reduce the demand for abortion but not eliminate it. In September 2018, the Lesotho Times reported that the government had been consulting religious leaders since 2007 to get their support in relaxing Penal Code specifications on abortion. This dialogue led to the 2010 amendment allowing a woman to terminate a pregnancy to save her life. Since then, the government has continued to push religious leaders to accept further amendments to the code. The article quoted a minister who noted that legalising abortion remains "tricky because of resistance" from the country's churches.

In **Zimbabwe**, several parliamentarians have spoken in favour of relaxing abortion regulations and addressing the negative effects of current laws on the country's women and girls. This includes Jessie Majome, who advocates for reform, noting to Reuters that "I am concerned about the practical difficulty which often makes it impossible to access termination on legal grounds, especially for low-income victims."[65] The head of the parliamentary committee on women and youth, Priscilla Misihairabwi-Mushonga, has also toured the country to hear first-hand accounts from teenagers who wanted an abortion but could not access it. Though this is not conclusive, it illustrates that lawmakers have been looking into the matter and understand that there is a need to reassess the existing laws, with particular emphasis on preventing teenage maternal mortality.

Advocacy and campaigns during COVID-19

Advocacy and campaigns during COVID-19 The advent of COVID-19 has meant that governments and organisations have diverted resources usually used for SRHR to tackle the pandemic. The Alliance had to postpone all 2020 #VoiceAndChoice summits due to COVID-19. This is especially problematic because of fears that more women than ever will have no choice but to access unsafe abortions during the pandemic due to closures of other health facilities and safe abortion clinics in many parts of the region.

[65] https://www.reuters.com/article/us-zimbabwe-abortion-law/as-teenagers-die-zimbabwean-lawmakers-call-for-abortion-reform-idUSKBN1IA00J

Next steps

Urgently addressing the factors that continue to fuel demand for abortion is the only way to reduce maternal mortality linked to it. This includes increasing access to safe abortion. Especially during the COVID-19 pandemic, this means ensuring that governments define access to comprehensive SRH services as an essential service for all, irrespective of age, socio-economic status, or any other factor.

Key recommendations and next steps include:

- SADC governments must acknowledge 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 sex 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 people and other marginalised women from accessing SRH services. These groups must find better ways of engaging with those who need services, including by reviewing legislation and provision of services to make safe abortions more readily available.
- All SADC member states should ensure they have adequate guidelines for health practitioners that clearly outline the conditions under which safe abortions can occur.
- SADC governments should make conditions for accessing safe medical abortion easier by, for instance, relaxing the required number of doctors for sign-off from three to one and ensuring that women who report having been raped can access safe abortion without needing to prove they have been raped.
- To save lives, SADC member states should provide post-abortion care to all women with abortion complications.
- All SADC governments should increase the number of health facilities that offer safe abortion.
- Activists and political leaders need to work together to address negative attitudes about abortion in the region, especially among health personnel, whose role legally obliges them to provide abortion or post-abortion care services.
- 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.

Alliance networks met virtually throughout April and May 2020 to discuss SRHR in the context of the COVID-19 pandemic. Due to social distancing, it is imperative that they continue to find new measures to keep youth engaged and educated. This includes looking into training service providers to interact with youth, investigating self-administration of contraceptives, and migrating advocacy campaigns online and to social media where youth interact.

Longer term actions could include:

- Utilising established traditional institutions in communities such as chiefs and *anamkungwi* (older women and instructors) to convey campaign messages;
- Develop hotspots in communities for youth and service providers to interact to reduce hospital visits and public transport use during the pandemic; and
- Advocate for decentralisation of abortion care services, which many systems currently only provide in district hospitals.

HIV and AIDS 5



Kabwe City Council AIDS committee commemorates World Aids Day, December 2019. Photo: Albert Ngosa

KEY POINTS

- SADC, which has 4.6% of the world's population, is home to 45% of all people living with HIV in the world.
- In 2019 SADC accounted for: 55% of new infections in young women and 35% new infections in young men globally; 48% of people on antiretroviral therapy (ART) and 55% of children on ART globally; 65% of the global number of pregnant women that were on ARTs; 67% of voluntary male circumcisions (VMC) conducted in priority countries; 35% of all acquired immune deficiency syndrome (AIDS)- related deaths, 46% of AIDS related deaths in young people (15 to 24), 37% of AIDS related deaths in children; 50% of TB-related AIDS deaths globally and 52% of all AIDS related deaths that are estimated to have been averted by ART.
- Much progress has been made towards achieving the UNAIDS 2020 targets of 90% awareness of status, 90% access to treatment and 90% suppression of the virus.
- New infections in adolescent girls and young women have been declining steadily and the proportion of new infections in Key populations (sex workers, men who have sex with men, people who inject drugs - who are especially important in the island nations, prisoners) is rising.
- COVID-19 is disrupting Human Immunodeficiency Virus (HIV) services. This could lead to an additional 500, 000 deaths in sub-Saharan Africa by the end of 2021 and regression of the Prevention of Mother to Child Transmission (PMTCT) programme to levels of a decade ago.
- Community care workers have been called into COVID-19 service to support testing and will likely support those that contract COVID-19 and not be hospitalised.



Introduction

Although tremendous progress has been achieved in all aspects of HIV prevention and management, the Southern African Development Community (SADC) is still the epicentre of the HIV epidemic. The global average prevalence is only 0.7% and most regions of the world have prevalence below 1%. Three SADC nations (Eswatini, Lesotho and Botswana) have prevalence above 20%; five more between 10 and 20% (South Africa, Zimbabwe, Mozambique, Namibia and Zambia). There are over 17 million people living with HIV in SADC which is 45% of the global total of 38 million.

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

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



The ten targets of the five-year plan include:

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

The SDGs do not place as much emphasis on HIV as the MDGs did but do include target 3.3: "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases." Ending AIDS as

a Public health threat will contribute to good health (SDG 3); reduce inequalities (SDG 10); the achievement of gender equality (SDG 5); promotion of just and inclusive societies (SDG 16). Ending HIV and AIDS is closely linked to revitalised global partnerships (SDG 17), ending poverty (SDG 1) and ensuring quality education (SDG 4).

Table 5.1: Key HIV data 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 (%)	1.9	20.7	<0.1	0.8	27	22.8	0.3	8.9	1.2	12.4	11.5		19	4.8	11.5	12.8
Women who are HIV positive as a % of total	65	55	<50	63	60	56	44	55	31	59	62		63	58	59	54
Women aged 15 to 49 HIV prevalence rate	2.6	25.1	<0.1	1.2	35.6	27.9	0.2	10.8	0.8	15.2	14.5		25	6	14	15.4
Men aged 15 to 49 HIV prevalence rate	1.2	16.5	<0.1	0.4	18	17.9	0.3	7	1.7	9.5	8.4		12.9	3.6	8.9	10.1
HIV prevalence among young women (15-24)	1.2	9.3	<0.1	0.5	12.3	10.1	<0.1	4.2	0.2	7.1	4.8		10.2	2.2	5.5	5.9
HIV prevalence among young men (15-24)	0.4	5	<0.1	0.2	4.1	4.5	<0.1	2.1	0.3	2.8	2.7		3.4	1.2	2.6	3.3
Sex workers																
HIV prevalence (%)	8	42.2	0.3	5.7	60.5	71.9	5.5	55	15		40.7	4.6	57.7	15.4	48.8	42.2
Condom use (%)	71.7	75.7	26	69	82.9	62.3	62.8	65	67.2			16	86.1	72.4	78.5	74.9
Men who have sex with men																
HIV prevalence (%)	2	14.8	0	3.3	12.6	32.9	14.9	6.8	17.2			13.2	18.1	8.4		21.1
Condom use (%)	59.1	77.5	56.2	77.4	57.6	46.4	57.2	44	53.1				97.9	13.9		69.2
Prevention																
Proportion of people age 15+ who know their HIV status																
Women age 15+ who know their HIV status	69	95	>95	53	>95	95	18	94	59	86	>95		94	85	93	95
Men age 15+ who know their HIV status	62	91	74	72	>95	92	13	86	73	66	92		91	81	87	86
Condom use at last high risk sex																
Condom use at last high risk sex - women	32	N/A	28	23	54	76	5	50		31	66		61	30	35	67
Condom use at last high risk sex - men	63	N/A	60	31	67	77	13	76		30	80		73	47	56	85
Elimination of mother-to-child transmission																
Coverage of pregnant women who receive ARV for PMTCT (%)	63	>95		45	>95	84	24	>95	>95	>95	>95		>95	92	86	91
Mother to child transmission rate	19	2		25	2	9	35	6	13	14	4		3	11	11	8
Knowledge																
Comprehensive knowledge of HIV and AIDS	32.2	47.2	20	20	50	36	24	42	32	31	58		46	43	42	46
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.	55%	26%		11%	53%	61%	67%	58%	36%	17%	18%	50%	50%	63%	60%	59%
Treatment - Antiretroviral therapy (ART)																
% of those living with HIV who are on ART	27	82	60	53	>95	65	13	79	25	60	85		70	75	85	85
Women aged 15 and over receiving ART	29	93	81	51	>95	71	15	87	25	67	89		75	83	90	89
Men aged 15 and over receiving ART	27	71	44	72	90	57	12	67	25	46	76		63	63	79	80
Children aged 0 to 14 receiving ART	16			28	84	71	9	74	68	63	>95		47	66	76	71

Source: Gender Links computations and UNAIDS data, 2020.

Table 5.1 shows that:

- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.
- Women are much more likely than men to be aware of their HIV status.
- Prevention of Mother to Child Transmission (PMTCT) is high but still lacking in poor, post conflict countries such as Angola and DRC, and is not a priority in the islands, since this is not a primary means of transmission.
- The response among women to the question "a woman has the right to insist on a man using a condom" varies widely, from 11% in DRC to 67% in Madagascar.
- Coverage of adults and children receiving Antiretroviral Therapy has improved dramatically, but ranges from 13% in Madagascar to 85% in Namibia, Zambia and Zimbabwe. In all SADC countries (except the islands) women are more likely than men to be on ART.

Many gains have been made in the fight against HIV over more than three decades, and especially in this century. The chapter expands on many of the 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 in the first six months of 2020.

> Every epidemic thrives on inequalities. *Winnie Byanyima, Executive Director, UNAIDS*

Experts from HIV epidemiology, research, vaccine development, community mobilization 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. 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

Although there has been much concern, to date there is limited data on the **impact of HIV on COVID-19 outcomes**. A few small studies from China and Europe appeared to show no correlation.



The report of the largest cohort of people living with HIV to also be impacted by COVID-19 is from the Department of Health in the Western Cape, **South Africa**. This centres on 12,522 COVID-19 public sector patients and 453 deaths. COVID-19 death was associated with being male; increasing age and diabetes, hypertension and chronic kidney disease, as well as previous and current tuberculosis. There was an increased risk of COVID-19 death in people living with HIV compared to HIV negative patients of 2.75. The increased mortality risk does not appear to be related to being on ART, or adhering to ART.[1]

[1] Davies, M and A. Boulle. "Risk of COVID-19 death among people with HIV: a population cohort analysis from the Western Cape province, South Africa". National Institute for Communicable diseases. Vol 18.2. 22 June, 2020. https://www.nicd.ac.za/wp-content/uploads/2020/06/COVID-19-Special-Public-Health-Surveillance-Bulletin-22-June-2020.pdf

There are distinct differences in the impact of COVID-19 across **socio-economic, gender and other societal fault lines**, with the weakest and most marginalised being the most affected. Available data suggests that men experience higher mortality as a result of COVID-19, but women are impacted in numerous other ways. Women and girls experience increased gender based violence, inadequate access to health care, economic insecurity and much increased unpaid and unrecognized care work.

Further, women constitute almost 70% of the health workforce worldwide, but they are mainly employed in lower-level positions with less pay. Women make up around 85% of nurses and midwives, as well as the majority of cleaning, laundry and catering staff, where they are more likely to be exposed to the virus. Some women have less access than men to personal protective equipment (PPE). Women health-care workers report challenges around the use of PPE when they are menstruating, including inadequate flexibility or facilities to manage menstruation with dignity.

As the economic effects of COVID-19 continue to worsen, so too are the social effects on women and girls. HIV programmes are set to be negatively affected due to countries' lack of access to drugs, causing gaps in ART delivery to those already on it, and those still to begin. It is anticipated that the economic turmoil that most people will find themselves in will propel more women into the sex work market where they are likely to experience higher levels of sexual exploitation. This is likely to result in an increase in HIV infections, unwanted pregnancies and Gender Based Violence. Additionally, drug use and abuse will not end, but rather become hidden due to restrictions of lockdowns - making communities unreachable, and exposing people to infection. There are fears of viral rebound occurring in People Living with HIV (PLWHIV) due to inaccessibility of medication for various reasons.

These range from not being able to physically access health facilities to fearing stigma once PLWHIV disclose their statuses to those they live with to explain their needing to access health facilities. Botswana was the first SADC country to introduce universal ART to citizens, a goal which will be reversed. The current reality will affect initiatives such as male circumcision, Pre-exposure prophylaxis (PrEP)[2] and testing drives. Those who were lucky enough to receive ART found it was reduced from a three month supply, to a two month supply to ensure that as many people as possible are able to access treatment in the short term. Due to this negative impact, there is more need than ever to adapt quickly and find solutions to inhibit further negative effects. A multiple stakeholder approach will be more necessary than ever to beat both the HIV and COVID-19 pandemics.[3]



Mum Rose Thamae from Let Us Grow, a community -based HIV and AIDS support group in South Africa, prepares to distribute food parcels in the wake of COVID-19
Photo: Gender Links

[2] Pre-exposure prophylaxis (or PrEP) is when people at risk for HIV take daily medicine to prevent HIV. PrEP can stop HIV from taking hold and spreading throughout your body.
[3] https://genderlinks.org.za/news/botswanas-hiv-response-impacted-by-covid-19/

COVID-19 has affected HIV services in several ways:

- Health resources, including research capacity, are being redirected from HIV to COVID-19 with serious disruptions.
- Lockdowns have introduced barriers to accessing prevention, testing, treatment and care.
- Those most vulnerable to HIV infection are experiencing heightened stigma, persecution and economic hardship. Sex workers, for instance, have not been able to work and seldom qualify for, or are able to access, any social assistance.
- Supply chains have been adversely impacted by COVID-19 disruption to economic endeavour and transport.

Between April and June 2020 the World Health Organisation (WHO) undertook a survey with 144 country offices to determine the extent of disruption of 25 essential health services by COVID-19. Preliminary results of the survey with respect to HIV services were presented at the International AIDS Conference in July 2020, which was held virtually for the first time in its history.

WHO issued guidance to countries on maintaining essential health services, including reducing disruption of HIV services by adopting multi month dispensing (MMD) policies of up to six months' supply of ARVs. To date, 129 countries of the 144 surveyed have adopted such a policy. Twelve percent are providing one-month supply; 6% two months; 63% three months; and only 8% have extended to six months' supply. Unavailability of drugs due to transport problems, delays in the manufacturing process, the need to pay for supplies before they are delivered and other issues have forced some countries to reduce the number of months of supply rather than increase it.

Thirty-six countries who support 45% of the global population that is on ARVs have reported that they have experienced some disruption of supply. In SADC, Malawi and Namibia have increased the number of months' supply, while Botswana has reduced it. Thirty-two of 39 countries in the Africa region have adopted a three months' supply, while seven have adopted six months. Twelve of 19 African countries that reported on their stocks had at least three months' supply of ARVs, while the other seven had less than three months' supply. Supplies to many countries are from India, which barred exports of drugs for about two weeks in March - April. India has subsequently relaxed restrictions. India is currently reeling from the world's third largest COVID-19 outbreak which may have implications for supply of ARVs.

Other services which have also experienced disruption include: PMTCT HIV/ Early Identification Contraceptive/Family planning; Harm reduction needle and syringe exchange for PwID; Hepatitis C treatment; initiation Pre-exposure prophylaxis (PrEP); Enrolment on ARVs; Sexually transmitted infection (STI) services; Hepatitis B testing; Condom provision; Voluntary medical male circumcision (VMMC); Key population services; HIV Viral load monitoring and HIV testing.

HIV service disruptions could add 500000 deaths due to AIDS in Sub Saharan Africa by 2021

Modelling done by UNAIDS shows that if the service disruptions that are being experienced in Sub Saharan Africa continue for the next 6 months this could result in 500,000 additional AIDS-related deaths between 2020 and 2021 and reversal of the gains achieved in PMTCT

programmes to levels experienced ten years ago. Other modelling suggests that just a three-month disruption in Malawi would lead to a 25% increase in the number of infected children.[4]

Some national responses to keep services available are:



Malawi: "Regular communications from Ministry of health - HIV department in the form of circular letters to all service providers, toll free phone lines for consultations and support, flexed criteria for six months dispensation, running HIV clinics every day to reduce congestion, suspension of non-essential HIV services that need frequent visits to the facility.[5]



Namibia: "Implemented intensified MMD for both adults and paediatrics. Decongesting ART facilities, Establishment of a hotline for PLWHIV, community dispensing at existing DSD model sites and primary health care outreach points, Hiring of short term staff to ensure service continuity."



On 19 May, 2020, the Gauteng Department of Health, **South Africa**, reported developing a system to trace 1090 patients that had not collected their TB medication (representing a 1,4% reduction) and 10 950 people living with HIV that had not collected their ARVs (a 19,6% reduction) since the lockdown began on March 27 2020.[6]

Recommendations made by the International AIDS Society and WHO for **continuity of HIV services, including prevention, during COVID-19**[7] are:

- Reduce the frequency and duration of health facility visits.
- Implement extended refills of ARVs.
- Support out of facility pick up points for refills.
- Adapt health facilities to support core COVID-19 control measures.
- Move adherence support to virtual platforms such as Whatsapp and SMS.
- Adjust HIV prevention - to provide messaging through virtual platforms; and provision of prevention materials and testing outside health facilities. This should include, for instance, expanded use of self-testing.
- Assure linkage and ART initiation for those that test positive.
- Continue to test for and treat HIV co infections and co morbidities, including NCDs such as hypertension.
- Ensure that all SRHR services are accessible.
- Ensure that women and girls at higher risk of gender based violence receive support.
- Harness low cost, accessible technologies.



The Global Fund[8] has allowed countries to reprioritise some funds from HIV activities to very urgent demands for COVID-19, such as Personal Protective Equipment (PPE). This process is termed "grant flexibility". All SADC nations, with the exception of Angola, Mauritius and Seychelles, were allowed this flexibility, for a total of $33,895,501 (out of a total of $162,289,024 that was made available). The Global Fund has also made additional funding available for the COVID-19 response. Four SADC countries had been allocated funds from this mechanism by mid-June, 2020. Angola, Eswatini, Namibia and Zimbabwe were allocated $23,305,829 of the $134,959,496 (17%) of the funds awarded.[9]

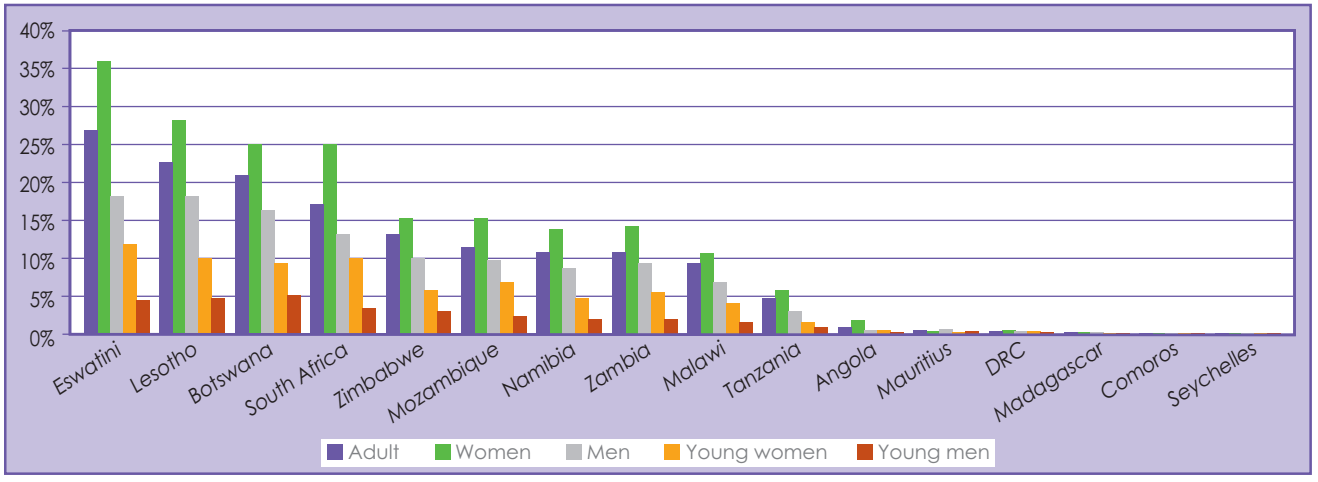
4 UNAIDS. 2020. Progress towards the Start Free, Stay Free, AIDS Free Targets. 2020 report. Geneva UNAIDS.
5 https://www.who.int/docs/default-source/hiv-hq/presentation-disruption-in-services-international-aids-conference-2020.pdf?sfvrsn=d4bf1f87_7 Accessed 11 July, 2020.
6 https://www.timeslive.co.za/news/south-africa/2020-05-19-almost-11000-hiv-positive-patients-in-gauteng-have-skipped-arv-collection-during-lockdown/
7 International AIDS Society. 2020. COVID-19 and HIV: a tale of two pandemics.
8 The Global Fund partnership mobilises and invests more than US$4 billion a year to support the end of AIDS, tuberculosis and malaria as epidemics programs run by local experts in more than 100 countries.
9 Global Fund. 16 June, 2020. Funding Approved for COVID-19 Response. https://www.theglobalfund.org/en/covid-19/

HIV Prevalence

SADC is home to 4.6% of the world's population; and 45% of all people living with HIV in the world

SADC is still the epicentre of the HIV epidemic. In 2019, UNAIDS estimated that at least 17,140,000 people living with HIV were in SADC. This is 45% of the 38 million people living with HIV globally. SADC's total population of 353,940,000 is only 4.6% of the global population.

Figure 5.1: HIV Prevalence in SADC



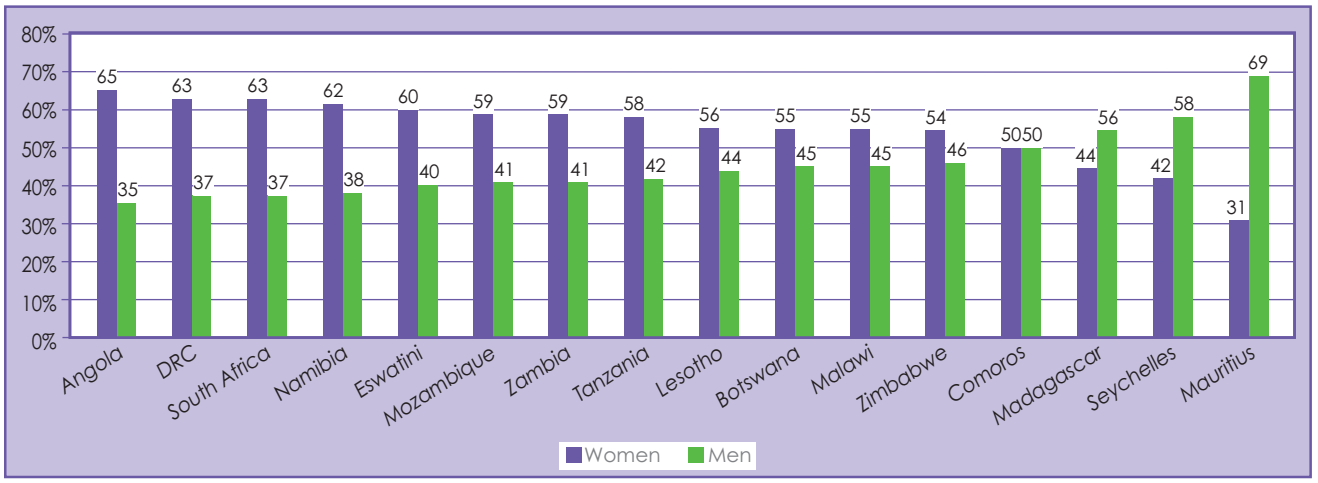
Country	Adult	Women	Men	Young women	Young men	Ratio Young women: young men
Eswatini	27	35,6	18	12,3	4,1	3,00
Lesotho	22,8	27,9	17,9	10,1	4,5	2,24
Botswana	20,7	25,1	16,5	9,3	5	1,86
South Africa	17,3	25	12,9	10,2	3,4	3,00
Zimbabwe	12,8	15,4	10,1	5,9	3,3	1,79
Mozambique	12,4	15,2	9,5	7,1	2,8	2,54
Namibia	11,5	14,5	8,4	4,8	2,7	1,78
Zambia	11,5	14	8,9	5,5	2,6	2,12
Malawi	8,9	10,8	7	4,2	2,1	2,00
Tanzania	4,8	6	3,6	2,2	1,2	1,83
Angola	1,9	2,6	1,2	1,2	0,4	3,00
Mauritius	1,2	0,8	1,7	0,2	0,3	0,67
DRC	0,8	1,2	0,4	0,5	0,2	2,50
Madagascar	0,3	0,2	0,3	0,1	0,1	1,00
Comoros	0,1	0,1	0,1	0,1	0,1	1,00
Seychelles	0,1	0,1	0,1	0,1	0,1	1,00

Compiled from UNAIDS 2020 Data https://aidsinfo.unaids.org/

Figure 5.1 and the data table that informs it shows wide variations in the HIV pandemic across SADC. The data shows that:

- Adult prevalence rates range from 0.1% in Seychelles to 27% in Eswatini. Eight SADC countries (Zambia, Namibia, Mozambique, Zimbabwe, South Africa, Botswana, Lesotho and Eswatini) have adult prevalence rates of higher than 10%.
- Seychelles, which only has a total population of 97,741 and a very low prevalence, has such small total numbers of people living with HIV that percentages are of little value. Thus, very little data is available and Seychelles is missing from much discussion in this chapter. Comoros and Mauritius have higher populations of 850,891 and 1,269,670 respectively and thus have more data available
- The island nations have pandemics that are largely driven by injecting drug use while most of SADC has a heterosexual pandemic.
- In all countries except the islands women constitute the majority of those living with HIV. For example in Eswatini, 35.6% of women live with HIV, compared to 18% of men.
- The differences in prevalence rates are particularly high for young women as compared to young men. Figure 5.1 shows that HIV prevalence is three times higher in young women than young men in Eswatini, South Africa and Angola and at least double in Mozambique, DRC, Lesotho, Zambia and Malawi.

Figure 5.2: Proportion of Women and Men Living with HIV



Source: Gender Links, derived from UNAIDS Data 2020 https://aidsinfo.unaids.org/



Demonstrating condom use in Mokhotlong, Lesotho, November 2019.
Photo: Ntolo Lekau

Figure 5.2 shows the proportion of women and men living with HIV across SADC. As expected from the differences in prevalence there are more women living with HIV in most of SADC with marked differences in Angola and DRC, which have newer epidemics as well as South Africa, and Namibia. The differences are less extreme in countries with more mature epidemics.

Table 5.2: Number of people living with HIV, different groups

Country	Total	Children 0 - 14	Adolescents 10 -19	over 50
South Africa	7,500,000	340,000	360,000	1,200,000
Mozambique	2,200,000	150,000	140,000	260,000
Tanzania	1,700,000	93,000	99,000	340,000
Zimbabwe	1,400,000	84,000	85,000	25,000
Zambia	1,200,000	66,000	68,000	230,000
Malawi	1,100,000	65,000	78,000	200,000
DRC	520,000	68,000	47,000	79,000
Botswana	380,000			90,000
Angola	340,000	31,000	22,000	39,000
Lesotho	340,000	12,000	15,000	77,000
Namibia	210,000	10,000	12,000	51,000
Eswatini	200,000	10,000	11,000	32,000
Madagascar	39,000	1,700	900	3,400
Mauritius	11,000	100	150	3,100
Comoros	100			20
SADC Total	**17,140,100**	**930,800**	**938,050**	**2,629,520**
Global Total	**38,000,000**	**1,800,000**	**1,700,000**	**7,900,000**
SADC % of Global	**45%**	**52%**	**55%**	**33%**

Source: Gender Links with data from UNAIDS, 2019.

Table 5.2 shows the total number of people living with HIV in different age categories in SADC, as compared to the global totals. South Africa has the largest HIV epidemic in the world with a total of 7.5 million people living with HIV which is 44% of the SADC total and 20% of the global total number of people living with HIV. Mozambique has 13% and 6% respectively. SADC has even higher proportions of the global burden of HIV in children 0 to 14 years old (52%) and adolescents 10 to 19 years old (55%). While the DRC has only 3% of the SADC total number of people living with HIV, it has 7.3% of SADC's children living with HIV.

SADC has 2,629,520 people over the age of 50 living with HIV (33% of the global total). This is generally a result of wider access to ARVs and more people living longer with HIV. There is growing attention to the issues of older people living with HIV as they are prone to other non-communicable diseases which are more common in older people such as hypertension and diabetes.

SADC accounts for 52% of global population of children living with HIV, 55% of adolescents and 33% of people over 50

Table 5.3: New Infections and HIV incidence

Country	New infections						HIV incidence per 1000 population	
	All	Target 2020	Adults	Women over 15	Men over 15	Children 0-14	Adults 15 - 49	All ages
South Africa	200,000	88,000	190,000	120,000	66,000	10,000	6,9	3,98
Mozambique	130,000	30,000	120,000	69,000	49,000	15,000	8,94	4,68
Tanzania	77,000	14,000	68,000	40,000	29,000	8,600	2,57	1,46
Zambia	51,000	14,000	45,000	26,000	19,000	6,000	6,03	3,17
Zimbabwe	40,000	16,000	34,000	20,000	15,000	5,200	4,87	2,81
Malawi	33,000	11,000	30,000	17,000	13,000	2,500	3,71	1,94
Angola	26,000	5,000	21,000	15,000	6,400	4,600	1,45	0,84
DRC	23,000	3,000	15,000	11,000	3,700	7,700	0,31	0,22
Lesotho	11,000	5,000	10,000	5,600	4,500	1,000	11,35	6,43
Botswana	9,500		9,300	5,100	4,200		8,23	4,78
Namibia	6,900	5,000	6,400	3,900	2,500	400	5,34	3,1
Madagascar	5,900		5,400	2,500	2,900	500	0,4	0,23
Eswatini	4,500	3,000	4,200	2,700	2,500	300	9,77	4,9
Mauritius	750		720	170	550	30	0,96	0,57
Comoros	50		50	20	30		0,01	0,01
TOTAL	**618,600**	**192,000**	**559,070**	**337,990**	**218,280**	**61,830**		
				55%	**35%**			

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

The total number of new infections is declining slowly (from 645,700 in 2018, with 355,900 adult women and 241,500 adult men to 618,600 in 2019; 337,990 women and 218,280 men). SADC's total number of new infections (618,600) is 36% of the global total of 1,700,000 new infections. This is still three times higher than the target for 2020 at global and SADC level which would lead to ending AIDS by 2030. All countries are far off course in terms of meeting targets for reduction in new infections. The largest number of new infections is in South Africa, which comprises 12% of new infections globally while Mozambique contributes 8%. Lesotho, Eswatini, Mozambique and Botswana have the highest incidence rates per 1000 population.

HIV Transition Metrics

The incidence to prevalence ratio comprises 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 5.4: Transition Metrics

Country	2000	2019
Angola	19,68	7,56
Botswana	9,34	2,49
Comoros	22,86	4,65
DRC	9,01	4,37
Eswatini	13,37	2,23
Lesotho	13,33	3,22
Madagascar	20,78	15,14
Malawi	9,75	3,1
Mauritius		
Mozambique	17,9	5,92
Namibia	12,84	3,29
South Africa	16,76	2,63
Tanzania	10,2	4,52
Zambia	9,27	4,08
Zimbabwe	7,12	2,92
Global	**11,32**	**4,37**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Between 2000 and 2019 the global incidence to prevalence ratio decreased from 11.3% to 4.4%. By 2019, 25 countries reached the 3% milestone, which indicates that they are on the way to ending their AIDS epidemics.[10] As shown in Table 5.4, these include four SADC countries: Botswana, Eswatini, South Africa and Zimbabwe.

Botswana, Eswatini, South Africa and Zimbabwe have reduced new infections sufficiently to be on the way to ending AIDS

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.

[10] UNAIDS. 2020. 2020 AIDS Data Book. Geneva. UNAIDS. https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf accessed 6 July, 2020.

Table 5.5: Most recent HIV and AIDS policy or strategy

Country	Most recent HIV strategy	Year
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, the Republic of Mauritius	2017
Mozambique	Plano Estratégico Nacional de Resposta ao HIV e SIDA 2015 - 2019	2015
Zimbabwe	Extended Zimbabwe National HIV and AIDS Strategic Plan III (ZNASP3) 2015 - 2020	2015
Malawi	National Strategic Plan for HIV and AIDS 2015 - 2020	2015
Angola	Plano Estratégico Nacional de Resposta ao HIV e SIDA 2015 - 2018	2015
DRC	Plan Strategique National de lute contre le VIH et le SIDA 2014 - 2017	2014
Madagascar	National strategic plan in response to sexually transmitted infections and AIDS in Madagascar 2013 - 2017	2013
Comoros	National Strategic Plan 2011 - 2015	2011

Source: GL Audit of SRHR Policies and Laws 2020.

Table 5.5 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. For a region which is at the forefront of fighting HIV an up to date plan for every country is critical. In five of the SADC countries HIV and AIDS policies and strategies are out of date and need to be updated. This is critical in view of the rapid changes in the sector, as well as the "shadow" COVID-19 pandemic threatening many of the gains on HIV and AIDS.

Table 5.6: SADC HIV and AIDS laws scorecard

Country	Criminalising transgender people	Criminalising sex work	Criminalising same sex sexual acts	Drug use/ possession an offence	Parental consent for adolescents HIV test	Spousal consent for married women to access SRHR	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

Source: UNAIDS. 2020. Global AIDS Update 2020: Seizing the moment - Tackling entrenched inequalities to end epidemics". https://aids2020.unaids.org/report/

Table 5.6 shows that the legal framework in SADC is generally retrogressive in terms of protecting the rights of members of key populations such as sex workers and people in same sex relationships. There are some notable achievements, such as the decriminalisation of same sex sexual activity in Botswana in 2019 (that may still be appealed by the Attorney General, see Chapter Eight).



Launch of Botswana Relationship Study, Botswana. Photo: Keletso Metsing



Comoros passed a law in 2014 that strengthens the protection for people living with HIV and AIDS. In light of this progressive development, the UNAIDS encouraged, "More countries to follow the bold and inclusive example of the Comoros, ensuring that no one is denied opportunities because of their HIV status."[11]



With the support of civil society, legal action has been taken in **Botswana** to address the discrimination that lesbian, gay, bisexual, transgender and intersex (LGBTI) persons face when seeking health-care services.



In **Eswatini**, standard operating procedures for reducing stigma and discrimination in health-care facilities have been developed to promote key population-friendly services.[12]



The enactment of the Child Care and Protection Act in **Namibia** in January 2019 has allowed the lowering of the age of consent from 16 to 14 years for sexual and reproductive health services and for HIV testing.



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

- Achieve universal access to comprehensive HIV prevention, programmes, treatment, care and support to all women and girls and achieve universal health coverage.
- Enhance the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and reduce costs of lifelong chronic care,

[11] Gender Links. Audit of SRHR Policies and Laws. 2020.
[12] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

- 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.

Although global statistics point to many gaps in reaching the goals to eradicate HIV, there has been much progress in SADC despite diverse economic backgrounds. All the countries who have achieved great progress towards the eradication of HIV over the last decade have shown strong political will and leadership, strong community engagement, reliable and consistent scientific evidence that guides decision making and a focus on rights-based multi-sector approaches to addressing the spread of HIV.

Table 5.7: Progress towards achieving the 90-90-90 goals in SADC

	Progress to 90 90 90 goals All						Progress to 90 90 90 goals Women						Progress to 90 90 90 goals Men					
Goal 1	90 Percent of those living with HIV know their status																	
Goal 2	90 Percent of people who know their status are on ART																	
Goal 3	90 Percent of people on ART achieve viral suppression																	
Year	**2015**			**2019**			**2015**			**2019**			**2015**			**2019**		
Goals	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**
Eswatini	89	76		>95	>95	>95	92	76		>95	>95	>95	90	71		>95	93	>95
Namibia	89	73	>95	95	90	91	93	71	>95	>95	93	93	87	74	>95	92	83	91
Lesotho	84	70		93	71	93	89	71		95	75	93	82	66		92	63	94
Botswana	82	84		92	89	>95	86	91		95	>95	>95	81	75		91	78	>95
South Africa	85	62	86	92	75	92	89	64	87	94	80	92	81	57	86	91	69	92
Zambia	78	87		90	95	90	82	85		93	>95	91	74	87		87	90	90
Zimbabwe	80	80		90	94	86	87	79		95	94	88	76	77		87	92	86
Malawi	78	77	88	90	88	92	86	80	90	94	93	94	74	68	87	86	78	93
Tanzania	65	75		83	90	92	69	81		85	>95	93	62	60		81	78	92
Comoros	34	>95		82	73	86	45	>95		>95	84	84	30	>95		74	60	90
Mozambique	61	62		77	77	75	70	61		86	79	78	50	57		66	70	75
Mauritius				69	37	68				59	42	68				73	34	68
Angola	51	48		62	44		58	46		69	42		50	49		62	44	
DRC	24	>95		54	>95		25	>95		53	>95		30	92		72	>95	
Madagascar				15	90					18	88					13	93	

KEY 90+% 80-89% 70-79% 60-69% Below 59%

Source: Gender Links, with data from UNAIDS Data 2020, https://aidsinfo.unaids.org/, accessed 8 July, 2020.

Table 5.7 shows that:

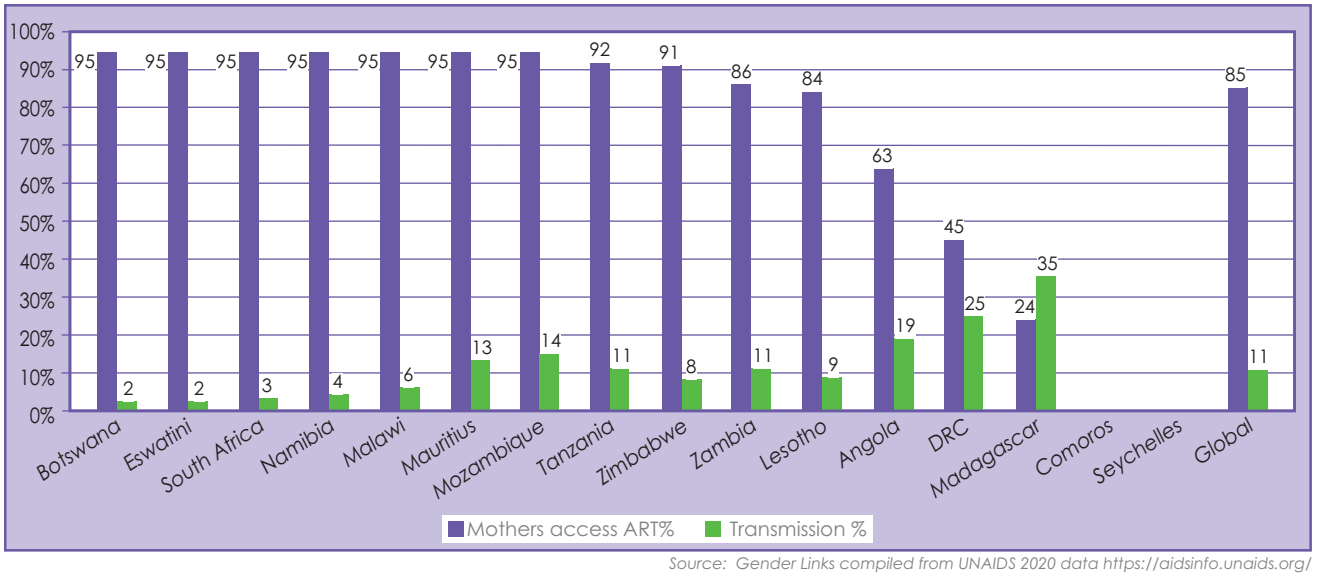
- There has been great progress in SADC towards meeting the 90-90-90 goals between 2015 and 2019, both in terms of collecting data as well as in achieving the goals of testing, access to ARVs and adherence to ARVs to suppress viral load.

- Three SADC countries (Eswatini, Namibia and Zambia) have achieved the UNAIDS 90-90-90 targets (percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression). Eswatini has achieved the 2030 goal of 95 - 95 - 95.
- Six more (Lesotho, Botswana, South Africa, Zimbabwe, Malawi and Tanzania) have achieved two targets.
- Madagascar has a very high testing gap.
- The criminalisation of key populations (Table 5.6) drives many people away from health services and makes it very difficult to reach the levels of testing, access to treatment and adherence that are required for epidemic control.
- Achievement for women is higher than for men in all countries except Mauritius and DRC.

Elimination of Mother to Child Transmission

Twenty-one countries in Africa have been targeted for support to eliminate mother to child transmission of HIV including Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe in SADC. PMTCT programmes targeted: (i) primary prevention of HIV infection of mothers, (ii) access to ARVs for mothers living with HIV and (iii) prevention of transmission after birth and during breastfeeding. Despite remarkable progress in rapidly expanding access to ARVs by pregnant mothers, this has not always resulted in corresponding decline in transmission. Thus, of the 21 focus countries, only eight (of which seven - Botswana, Eswatini, South Africa, Namibia, Malawi, Zimbabwe, Lesotho - are in SADC) have a final transmission rate that is less than 10%.

Figure 5.3: Elimination of Mother to Child Transmission



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.3 reflects tremendous progress, with nine countries having achieved at least 90% coverage of pregnant mothers living with HIV on ART. Ten countries are at the global average or better. Angola, DRC and Madagascar lag far behind, with much higher levels of transmission.

Table 5.8: Number of Pregnant Women on ART 2010 - 2019

Country	Number of pregnant women on ART 2010	Transmission 2010	Number of pregnant women on ART 2019	Transmission 2019	% increase in number of pregnant women on ART 2010 - 2019
South Africa	209,668	16	302,936	3	44%
Tanzania	40,938	18	74,596	11	82%
Zambia	35,494	19	48,342	11	36%
Mozambique	22,344	32	112,282	14	403%
Zimbabwe	21,139	22	57,609	8	173%
Malawi	13,967	28	43,269	6	210%
Botswana	10,999	12	12,728	2	16%
Eswatini	8,295	12	10,433	2	26%
Lesotho	8,047	20	7,589	9	-6%
Namibia	7,695	14	12,522	4	63%
Angola	3,652	31	15,030	19	312%
DRC	2,166	36	13,878	25	541%
Mauritius	64	18	133	13	108%
Madagascar	17	43	339	35	1894%
Comoros					
Seychelles			**19**		
SADC Total	**384,485**		**711,705**		
Global Total	**600,000**	**23**	**1,100,000**	**11**	**83%**
SADC % of global	**64%**		**65%**		

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.8 shows the actual numbers of pregnant women who accessed ART in 2010 and 2019. There has been a marked increase in the numbers of women accessing ART from a total of 384,485 in 2010 to 711,705 in 2019. The percentage increase is highest in those countries with the lowest rate of coverage (Madagascar, DRC, Mozambique and Angola), indicating an awareness of the need to improve services and action being taken to achieve this. There has also been decline in the overall rate of transmission from mother to child in all countries. The number of pregnant women that accessed ART in SADC is approximately 64% of the global total in both 2010 and 2019.

During 2019, about 150,000 children acquired HIV globally, far more than the global 2020 target of 20,000. Mozambique accounted for 14%; South Africa 9% and Tanzania 8% of children who became HIV positive in 2019. The number of adolescent girls and young women acquiring HIV declined by 19% globally from 350,000 in 2015 to 280,000 in 2019. This is still higher than the target of less than 100,000 by 2020. Three gaps that are contributing to continued transmission are:

1. Women living with HIV did not receive antiretroviral therapy during pregnancy resulting in 38,000 new infections in the focus countries;
2. Women dropped out of antiretroviral therapy either during pregnancy or breastfeeding contributing 29 000 infections.
3. Women acquired HIV while pregnant or breastfeeding, after their initial test result was negative. This added 30,000 infections.

The treatment coverage indicator does not capture whether women were retained on treatment and adherent throughout pregnancy, delivery and breastfeeding. Some countries are beginning to measure viral load suppression at delivery as a more accurate indicator to predict vertical transmission. There is evidence that young women aged 15-24 years have higher viral loads, with a higher risk of vertical transmission.

Programmatically, more attention is being given to:

- Measures to improve adherence during pregnancy and after delivery such as facility and community-based peer support; to support within a woman's network, including male partners to support maternal retention on antiretroviral therapy and to reduce the number of HIV-exposed infants acquiring HIV. Innovations to increase retention in care of both the mother and the baby depend on active follow up until breastfeeding ends, when the child's HIV status can be confirmed.
- Increasing access to viral load testing for pregnant and breastfeeding mothers living with HIV, especially adolescent girls and young women, to enable faster action in response to poor viral load results.
- Reaching 130,000 uninfected women with combination prevention support, such as prevention education, condoms, partner testing (including treatment initiation for those who test positive) and pre-exposure prophylaxis (PrEP). Particular emphasis needs to be placed on young women ages 15-24 years as 43% of those that seroconverted were in this age range. Retesting during pregnancy must be part of the prevention strategy particularly for women most at risk of HIV infection.[13]

Prevention

In 2016, the 26 countries that are contributing the highest number of new infections globally, including ten countries in SADC[14] formed A Global Partnership on Prevention. The Coalition's report in 2019 indicated:

- HIV prevention and leadership structures are being rejuvenated, with new plans.
- HIV related stigma, discrimination and legal barriers stymie efforts to enhance HIV prevention
- Though the critical role of NGOs is recognised, insufficient resources have been invested in community led response.



NGOs play a vital role in the prevention of HIV and AIDS.
Photo: Colleen Lowe Morna

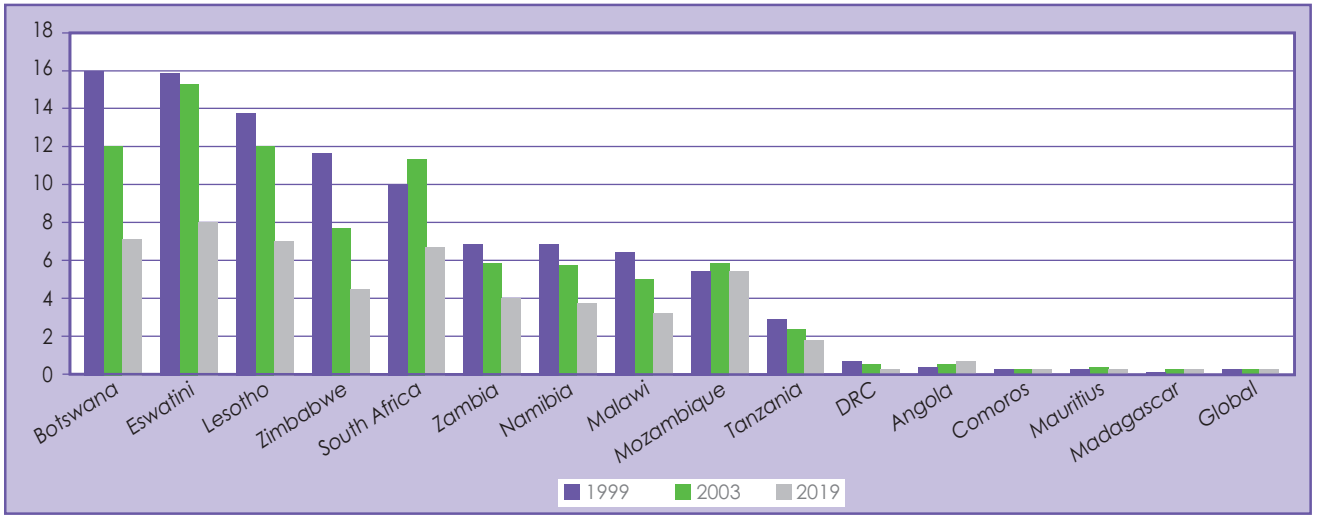
- More emphasis is still needed for the world to achieve prevention targets.[15]

Keeping young women in school prevents HIV

Globally, the HIV pandemic is largely driven by new infections in certain key populations - sex workers, people who use drugs, men who have sex with men, transgender people and prisoners and their partners. Key populations account for 28% of new HIV infections in east and southern Africa with the rest of the population accounting for 72%. The epidemic in east and southern Africa is still mainly driven by new infections in adolescent girls and young women.

[13] UNAIDS. 2020. Progress towards the Start Free, Stay Free, AIDS Free Targets. 2020 report. Geneva UNAIDS.
[14] South Africa, Mozambique, Zambia, Tanzania, Zimbabwe, Malawi, Angola, Lesotho, Namibia and Eswatini
[15] Global HIV Prevention Coalition. 2019. Implementation of the HIV Prevention 2020 Road Map: Third progress report October, 2019. Geneva. UNAIDS.

Figure 5.4: HIV prevalence rates in young people 15 - 24 (1999 - 2019)



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Prevalence rates in young people have been declining slowly from 1999. Figure 5.4 illustrates the decline from 1999 to 2003 to 2019. Some of the steepest declines are in Botswana (16, 12, 7); Eswatini (16, 15, 8); and Zimbabwe (11, 8, 5). Except for DRC, Angola, Comoros, Mauritius, Madagascar and Seychelles, all the countries in SADC still have HIV prevalence rates in young people aged 15 - 24 that are much higher than the global average (0,4; 0,3; 0,3)

Declining HIV infection rates in young people correlates with an increasing rate of women and girls aged 15 - 24 completing high school. Keeping girls in school increases their chance of using condoms, reducing their chances of contracting HIV. Keeping girls in schools is an important opportunity to teach comprehensive sexuality education and also to increase girls' agency. Cash transfers can keep young people, particularly girls, in school, improve their academic outcomes, increase their use of health services, delay their sexual debut, reduce early marriage and teen pregnancy, and promote safer sexual behaviours. A major concern with the COVID-19 pandemic is the effect that days and months out of school will have on teenage pregnancies as well as HIV and AIDS.

Keeping girls in school is important to reduce HIV transmission

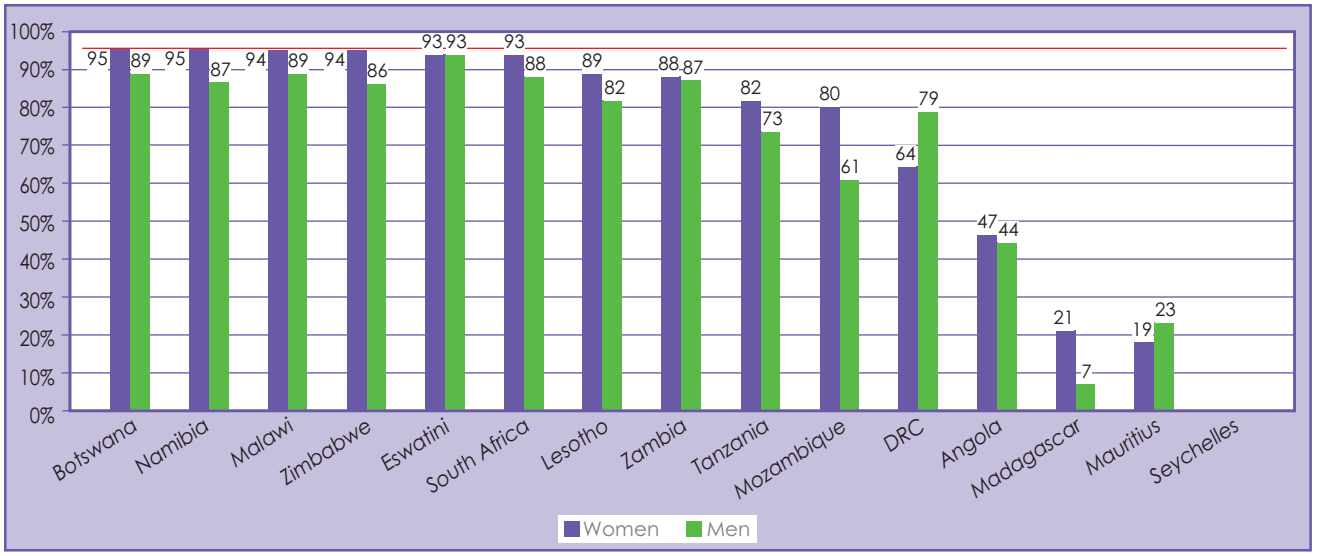


Eswatini a new study has shown that financial incentives to stay in school significantly reduced HIV incidence among adolescent girls and young women, adding to knowledge about the protective value of education for young women and the role of cash transfers and educational incentives in reducing their HIV risk.[16]

[16] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

Knowledge of HIV status

Figure 5.5: Women and men living with HIV who know their status



Source: Source: UNAIDS Special analysis 2019.

Figure 5.5 shows that six SADC countries (Botswana, Namibia, Malawi, Zimbabwe, Eswatini, and South Africa) have succeeded in expanding coverage of testing to at least 90% of those that are living with HIV, with Lesotho, Zambia, Tanzania and Mozambique not too far behind. This is a particularly noteworthy achievement in South Africa, which has the largest population of people living with HIV of any country in the world. Low coverage of testing in the islands is understandable, due to low prevalence, but is a concern, as testing is one of the most powerful prevention tools.



The Girl Power project in **Malawi** used a youth friendly model that offered HIV testing, family planning and STI services in combination. Adolescent girls using the integrated services were 23% more likely to take an HIV test, 57% more likely to receive condoms, 39% more likely to access hormonal contraception and 16% more likely to use services for STIs.[17]



GL Programme officer Thandokuhle Dlamini taking an HIV test, Eswatini.
Photo: Zethu Shongwe

[17] UNAIDS. 2020. Global AIDS Update 2020: Seizing the moment - Tackling entrenched inequalities to end epidemics". https://aids2020.unaids.org/report/

South Africa: Mobile testing clinics go to the youth

Mossel Bay: HIV testing is a critical first step to both prevention and accessing treatment. Many of those that are most affected, such as youth and males, do not access testing. One strategy to increase access is to bring services to the people, rather than waiting for people to come to access services.

In response to high rates of teenage pregnancy and HIV infections, Mossel Bay municipality has introduced mobile testing clinics for ABC Health Care for Adolescents. The Piet Julies AIDS Action Group and Mossel Bay Taxi Associations combined resources with the Health Department and Mossel Bay Municipality, to enable social change for people who are affected by HIV, TB and STIs due to their higher risk behaviours as well as legal and social issues that increase their vulnerability to health problems. The plan for the initiative taken by the Mossel Bay Municipality and the various stakeholders is to educate communities about HIV, TB, STI's, Road Safety and the Road Traffic Act as well as the National Land Transport Act.

The programme hopes to reduce the rates of new infection and teenage pregnancy by reaching adolescents directly through schools and community facilities. Youth are more likely to use mobile facilities that are specifically for them to avoid discrimination, stigmatisation or judgement when they go to regular health facilities for contraception or HIV treatment. Through regular testing, the programme hopes to identify adolescents already living with HIV and onboard them to ARV treatment

The mobile outreach testing unit targets youth between the ages 12-24. The unit provides many services including HIV testing, prevention, HIV and AIDS education and care in schools and community or outreach centres. The process is:



Mossel Bay Mobile HIV Outreach conduct HIV testing in the community.
Photo courtesy of David Marcus

- A trained nurse conducts a physical examination of the patient.
- The trained health care professional offers contraception advice, options and treatment which includes pregnancy support, male circumcision and referrals for administration of ARVs.
- The administration of ARVs is conducted offsite and includes counselling and referral services.
- In certain circumstances, the trained staff also advise on adoption options for young mothers.

To overcome fears of coming to the come to the mobile clinic, the schools agreed for the project to use the library during breaks. Adolescents can also access the services after school in privacy.

Adolescents take responsibility for their own health and make use of services at the site that is best for their needs (school, health services, or community centre). Teenage pregnancies have decreased from 14% to 10%. STI and HIV infections as well as statutory rape cases have also decreased. Currently two of seven high schools are part of the programme. Mossel Bay is seeking buy-in from the other five.

Source: David Marcus, with Piet Julies AIDS Action Group (PJAAG) Mossel Bay South Africa, submitted the case study for the SADC Protocol@Work Summit application 2019

In all SADC countries (except DRC and Mauritius), knowledge of HIV status is higher among women than men. According to the UNAIDS 2019 report, globally uptake of the three 90s is much higher among women than men: "This is in line with numerous studies showing that men are less likely than women to take HIV tests and to initiate and adhere to HIV treatment, which results in poorer clinical outcomes and a greater likelihood that they will die of AIDS-related causes."[18]

New approaches to men's health-seeking behaviour

There is growing recognition of the need to focus differently on men's health. A supplement of the Journal of the International AIDS Society which focused on this issue in 2020[19] found:

- It is time to move from a narrative that blames men for poor health-seeking behaviour and focuses on men only to improve the health of their partners and children. Engaging men in health services for their own health can provide an entry point for programmes that may also have a positive impact on the health of their families and communities.
- The current system is not working for anyone. All populations (men, adolescent girls and young women key populations) are negatively impacted by prevailing gender norms.
- HIV programmes may be able to drive a larger men's health agenda. Worse outcomes for men compared to women are found in other diseases where mortality is "stagnant or increasing."



Men need to be integral to HIV and AIDS solutions. Photo: Gender Links

Themes which emerged from the articles included in the supplement are:

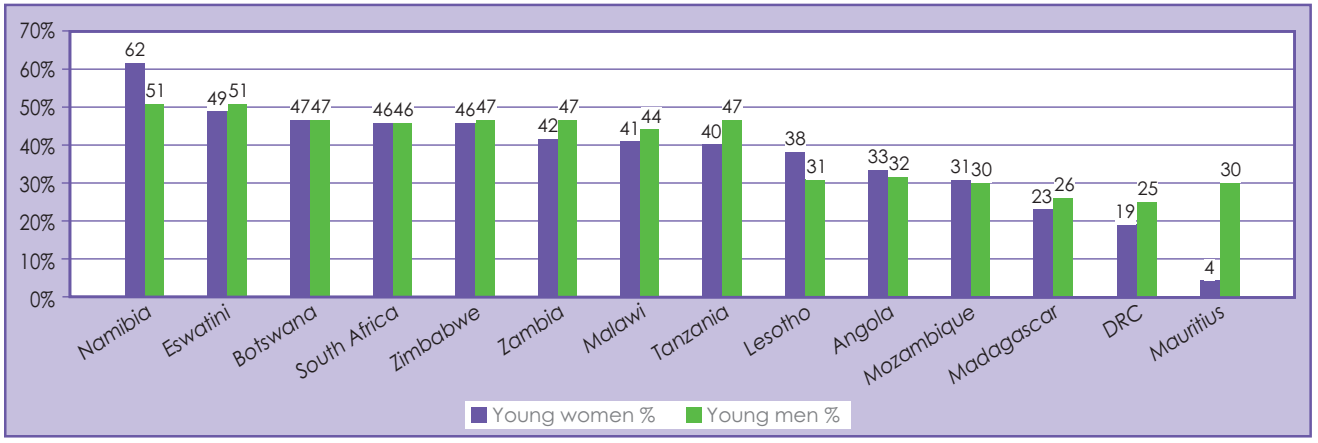
- Health systems are structurally gendered to address women's health needs.
- While there are considerable efforts to reach younger men, there are many "older" men (over 35 years old) who require HIV services.
- Programmes need to be more creative and strategic to access and test men who truly do not know their HIV status. Testing interventions must reach those unaware of their status and corresponding services must be adapted so men start and stay on treatment.
- It is time for a narrative shift away from "men as the problem" to "men as a group that is interested in health and able to be part of the solution" where health systems adapt to meet men where they are.

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.

[18] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p85
[19] Grimsrud A et al. Editorial. Journal of the International AIDS Society 2020, 23(S2):e25526 http://onlinelibrary.wiley.com/doi/10.1002/jia2.25526/full | https://doi.org/10.1002/jia2.25526

Figure 5.6: Knowledge on HIV prevention among young people



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.6 illustrates that levels of knowledge about HIV prevention are still very low and the region is still far from the goal of 90%. Knowledge levels are still lower than 50% for both males and females in all countries except Eswatini and Namibia. 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 of out-of-school youth who face significant barriers to accessing information. The case study from Botswana profiles a local initiative to increase awareness in a way that resonates with the youth.

Botswana: Teen Club Games strengthen HIV awareness

Mabutsane: The Teen Club Inter-district Games in 2019 aimed to strengthen HIV talk among youth in an interactive way. Over one hundred adolescents living with HIV from Mabutsane, Moshupa, and Tsabong discussed adhering to treatment and making healthy lifestyle choices, preventing the spread of HIV and the importance of eliminating GBV.

Using role play, the participants had conversations about behaviour that increases the risk of contracting HIV - including alcohol abuse, multiple sexual partners, sleeping with older partners, and neglecting to use condoms. They also engaged in in-depth conversations about the signs of abusive relationships and strategies of how to leave.

Mixed sex teams participated in volleyball, football, and netball, which encouraged teamwork between adolescents from different districts. The "gender bender" approach resulted in boys joining the netball teams or girls joining the football teams. By holding a beauty pageant where both girls and boys could compete, the facilitators and organisers aimed to challenge gender norms and boost confidence and self-esteem in the participants.

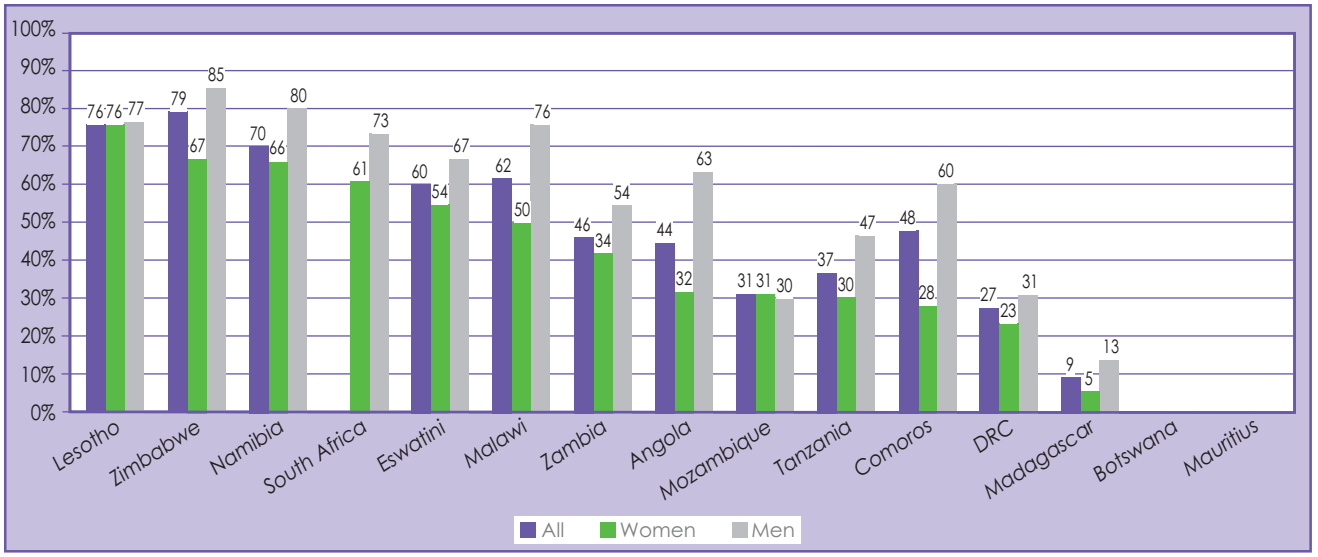
The games were attended, facilitated and managed by four Teen Club facilitators from Moshupa and Tsabong Teen Clubs, 12 from Mabutsane; 4 Peace Corps Volunteers (PCVs) from the respective districts; 20 teen club facilitators from the same districts as well as 40 teens from each of Mabutsane, Moshupa, and Tsabong. PCV's supported facilitators in the development of the programme, competition logistics, and with facilitation techniques.

Source: Botho Tumaeletse; Mabutsane District Health Management Team, SADC Protocol @ Work Summit 2019

Condom use

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

Figure 5.7: Condom use at last high-risk sex in SADC



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.7 shows that access to condoms overall ranges from 79% in Zimbabwe to 9% in Madagascar. Lesotho and Mozambique have very similar rates between women and men while all other countries have higher rates of access for men than women.

Condom use has not expanded rapidly enough over the last decade as a result of decreased priority being placed on condom programmes. Active condom promotion in Namibia and Zimbabwe over two decades has led to some of the highest recorded levels of condom use at least for sex with non-regular partners. Condom use by young women has increased in the last decade in Lesotho, Malawi, Mozambique and Zimbabwe but is declining in Zambia and Tanzania.[20]



Demonstration of female condom usage. Photo: Ntolo Lekau

[20] UNAIDS. 2020. Global AIDS Update 2020: Seizing the moment - Tackling entrenched inequalities to end epidemics". https://aids2020.unaids.org/report/



In **Lesotho** as in many countries, there is still much work to be done for women in need of protective measures against HIV. However, as a result of the perceived undesirability of the female condom to both men and women, supply has decreased, with facilities reporting no stock at all for up to six months. There is a concerted call to boost campaigns for female condoms once again, to normalise the use of the condom. However, various factors need to be taken into account. For instance, the female condom is less convenient than the male condom. Awareness needs to be increased for the female condom to help reduce new HIV infections.[21]

Voluntary Medical Male Circumcision (VMMC)

Voluntary medical male circumcision (VMMC) is currently the only once-off intervention for reducing the risk of HIV infection. The procedure 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 such as condom provision, 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).

Table 5.9: Number of male circumcisions conducted

Country	2015	2016	2017	2018	2019	Total
Tanzania	435,302	548,390	730,435	885,599	799,456	3,399,182
South Africa	485,552	497,186	591,941	572,442	451,636	2,598,757
Zambia	222,481	311,792	483,816	482,183	549,655	2,049,927
Mozambique	198,340	253,079	315,380	311,891	390,589	1,469,279
Zimbabwe	188,732	205,784	301,366	326,012	354,819	1,376,713
Malawi	108,672	129,975	166,350	199,399	114,465	718,861
Namibia	18,549	27,340	30,134	34,942	40,868	151,833
Lesotho	25,966	34,157	25,150	26,448	34,144	145,865
Botswana	15,722	24,042	19,756	24,207	17,123	100,850
Eswatini	12,952	17,374	18,138	14,316	17,360	80,140
TOTAL SADC	**1,712,268**	**2,049,119**	**2,682,466**	**2,877,439**	**2,770,115**	**12,091,407**
Total Priority	**2,623,788**	**2,827,188**	**4,044,740**	**4,135,786**	**4,145,686**	**17,777,188**
SADC as % of all priority	**65%**	**72%**	**66%**	**70%**	**67%**	**68%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.9 shows that health workers conducted 12 million male circumcisions in the ten priority countries of SADC (68% of the total number of circumcisions conducted in the fifteen priority countries). The numbers have not increased dramatically since 2017 leading to the conclusion

[21] https://genderlinks.org.za/news/lesotho-female-condom-low-demand-widens-inequality-gap/
[22] Ensor S et al. Journal of the International AIDS Society 2019, 22(S4):e25299 http://onlinelibrary.wiley.com/doi/10.1002/jia2.25299/full | https://doi.org/10.1002/jia2.25299 "The effectiveness of demand creation interventions for voluntary male medical circumcision for HIV prevention in sub-Saharan Africa: a mixed methods systematic review".

that there is low demand. Achieving the 2020 target of 25 million voluntary male circumcisions by 2020 in the priority countries would involve an enormous expansion of the programme in 2020. This is now impossible as a result of COVID-19.

A number of studies have been conducted on programmes to increase uptake of VMMC. A systematic review[22] examined reports of:

- Financial incentives - direct and lottery.
- Counselling or education for prospective candidates.
- Education and involvement of influencers, and
- Novel information delivery, including SMS to men who have tested HIV negative.

The study found that a range of interventions can increase demand creation and subsequent VMMC uptake. The most acceptable and effective interventions appear to be direct financial incentives, equivalent to two days' wages, food vouchers or conditional cash transfers; and programmes of education or counselling delivered by people who are influential in the community such as religious leaders or have personal experience of VMMC such as coaches in soccer based interventions for youth. Group and individual counselling as well as involving female partners is also effective. All interventions must be appropriate and acceptable in the setting and phase of the programme.

Mathematical modelling suggests that 250, 000 [200,000-330,000] new HIV infections were averted by the end of 2018 (78% among males and 22% among females) in all fifteen priority countries. The future benefits will be larger since VMMC provides lifelong protection. It is estimated that the number of men and boys who have taken up VMMC so far would avert approximately 1.5 million new HIV infections by 2030 and 4.5 million by 2050 if the coverage of other HIV interventions (including antiretroviral therapy) remains constant.[23]

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.

Table 5.10: Number of people accessing PrEP

Country	2017	2018	2019	Total
Botswana		38	1,954	1,992
Lesotho	853	7,279	35,478	43,610
Malawi			459	459
Mauritius		3		3
Mozambique	303	1,934		2,237
Namibia	190			190
Seychelles	2	4	26	32
South Africa	3,189	8,184		11,373
Zambia		3,823		3,823
Zimbabwe	2,714	4,982	8,351	16,047
TOTAL	**7,251**	**26,247**	**46,268**	

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

[23] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

Table 5.10 shows that countries are gradually adopting PrEP as an additional HIV prevention option for key populations and young people in high-prevalence settings who are at high risk of HIV infection.



A study in **South Africa**, the first country to approve PrEP, shows that providing PrEP through routine family planning services is a promising strategy to reach women in settings with a high burden of HIV. South Africa is planning to expand PrEP services to transgender women who are estimated to have an HIV prevalence rate up to 25%. A study of 213 transgender women from Cape Town, East London, and Johannesburg found only 45% of HIV-negative participants knew about PrEP and only 11% are currently taking PrEP. HIV-negative participants experiencing social and interpersonal hardship such as violence, poverty, discrimination or low community connectedness, reported higher levels of PrEP awareness than HIV-negative transgender women who did not experience these. Barriers to PrEP included taking a daily pill, side-effects, and cost. Poor community connectedness was also a barrier. Participants urged greater education and engagement of transgender women in PrEP implementation.[24]



Eswatini has endorsed PrEP for scale-up at 200 health facilities by the end of 2019 and Namibia is developing a standardized PrEP set of tools (including standard operating procedures and a framework for monitoring and evaluation).[25]

Prevention among key populations

Key populations are sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons, prisoners and migrants. The goal is that 90% of key populations access HIV combination prevention services. As new infections continue to decline in young people, the proportion of new infections from key populations is increasing. Key populations face much higher rates of HIV 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 (15%). HIV thus spreads into the general population. The paucity of data about the epidemic in key populations is indicative of the low priority that these segments of the population have received so far in the HIV battle in SADC. However, there is growing attention to them and each year more data is available.



Umguza Rural District Council HIV and STI IEC material, Harare, Zimbabwe.
Photo: Tapiwa Zvaraya

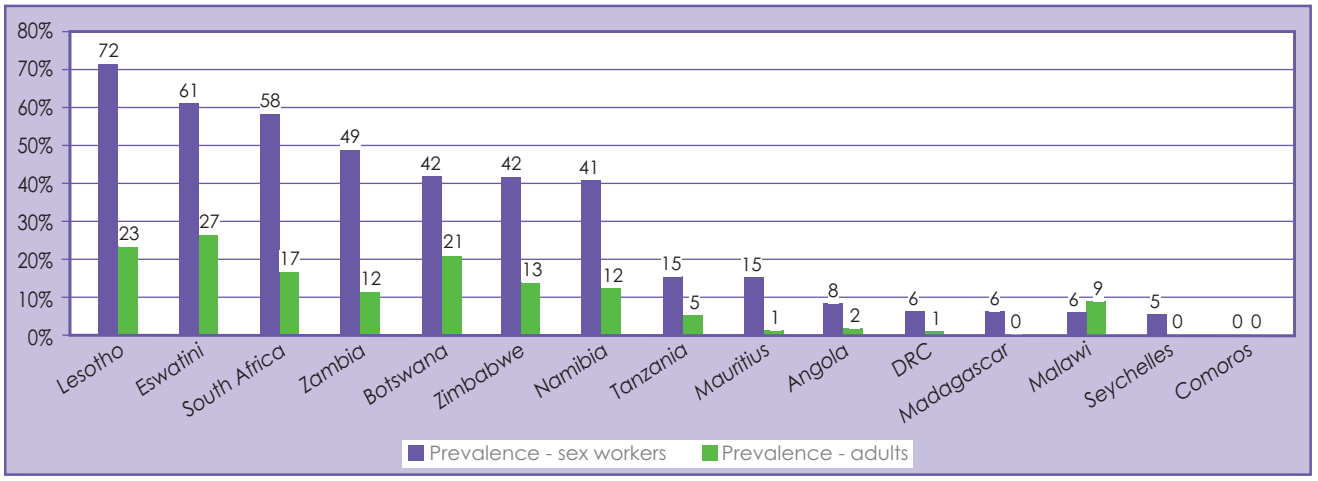


Zimbabwe is intensifying multi-sector efforts to strengthen key population programmes, as outlined in its National Key Populations HIV and AIDS Implementation Plan 2019-2020. Services will include peer education, social networking and digital outreach, with improved health facility services. Actions to address structural barriers include: advocacy for law reforms, sensitization of health-service providers or law enforcement agents, and media campaigns to eliminate stigma and discrimination.[26]

[24] T. Poteat et al. "PrEP awareness and engagement among transgender women in South Africa: a cross-sectional, mixed methods study", The Lancet HIV, 2020. https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30119-3/fulltext accessed 8 July, 2020.
[25] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.
[26] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

Sex Workers

Figure 5.8: HIV Prevalence among sex workers



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Sex Work is criminalised across most of SADC, with the exception of Mozambique. Figure 5.8 shows that HIV prevalence is much higher among sex workers than the whole adult population in all countries except Malawi. In the majority of countries it is between two times (Botswana) to 4.2 times as high (Angola and Zambia). In the DRC the rate of infection among sex workers is 7.1 times higher. Among the islands the rate by which prevalence among sex workers is higher than the general population is three times in Comoros; 12.5 times in Mauritius, 18.3 times in Madagascar and 46 times in Seychelles. However, as noted earlier in the chapter the overall HIV prevalence in these countries is low.

Table 5.11: HIV prevention and management among sex workers

Country	Prevalence %	Condom Use %	HIV Prevention %	Testing %	ARV coverage %
Angola	8	71,7		100	42
Botswana	42,2	75,7			87,6
Comoros	0,3	26		100	
DRC	5,7	69			
Eswatini	60,5	82,9			
Lesotho	71,9	62,3		63,8	
Madagascar	5,5	62,8		40,6	
Malawi	5,5	65	68	72,4	80,8
Mauritius	15	67,2		78,9	
Mozambique	No data available				
Namibia	40,7				
Seychelles	4,6	16		98,1	
South Africa	57,7	86,1			23,6
Tanzania	15,4	72,4	20	98,3	
Zambia	48,8	78,5		56,1	85,9
Zimbabwe	42,2	74,9	34,5	80,5	78,2

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.11 reflects the need for much greater attention to programmes and services for prevention and management of HIV among sex workers throughout SADC. Although some countries appear to have good programmes for testing, with high coverage, this is not translating into condom use or access to ARVs. Disseminating information on HIV among sex workers is important, as reflected in the DRC case study:



DRC: Sex workers have the right to information on HIV



Kinshasa: Female sex workers in the DRC capital face several challenges. Their rights are not respected; they are easily infected with HIV because they are ill informed and they are not protected by law enforcement officials.

Research by *Forum Des Naturalistes* shows that sex workers in Kinshasa charge an average of 3.5 times more for unprotected than protected sex. Sex workers who engage in unprotected sex for extra money are much more likely to live or work in lower socioeconomic areas of Kinshasa. This leads to the conclusion that those who face more socioeconomic challenges are more likely to engage in unprotected sex.

To reduce new HIV infections, awareness programmes encourage young female sex workers to test for HIV. They are provided with testing kits. In the event that they test positive, they are helped to access ARV's. The programme aims to increase legal protection for sex workers rights and their health. The programme is advocating for the regulation of the price of services rendered by sex workers to ensure that they earn a living, and are protected against STI's and HIV infection.

Challenges include difficulties in reaching all communities of sex workers for educational workshops; many women are too far out of the region and travel is difficult. Another threat to the programme is that many sex workers are not willing to miss a day of work as this affects income.

Source: Ngoma Dieu Merci in collaboration with Forum Des Naturalistes. The case study was submitted as part of the SADC Protocol @ Work Summit 2019

As sex worker populations are heterogeneous, health programmes must develop services that reflect the variety and complexity of sex worker needs and behaviours, that are designed in consultation with sex workers. Segmenting sex worker populations according to age, country of origin and place of service delivery, and training healthcare providers accordingly, could help prevent new HIV infections, improve adherence to antiretroviral treatment and increase uptake of SRH services. The Global Fund Key populations programme has supported countries to initiate Pre Exposure Prophylaxis (PreP) programmes with sex workers. Zimbabwe's National Aids Council initiated 1817 sex workers out of a targeted 2200 on PreP during the first quarter of 2020.[27] Stigma is still rife even amongst sex workers.

[27] Gender Links. 2020. Audit of SRHR Laws and Policies in SADC June 2020



Zimbabwe: Stigma bars sex workers from life saving measures[28]

At 17, Andile* a sex worker from Bulawayo has little recourse to medical or legal help due to the nature of her work.

She has turned to sex work at age 13 to enable her siblings to continue with their education. In four years, she has already been exposed to ritual sexual acts, rape, death threats, and unprotected sex for more money. In many cases she has not been given her money; suffered extreme physical abuse and has been held hostage countless times.

She is still unable to access health services. Female police officers often dismiss cases brought by sex workers. This fuels the spread of HIV. Sensitisation drives across Zimbabwe, have focused on training higher-ranking officials. This has not yet trickled down to communities. Stigma keeps young girls such as Andile from accessing critical HIV prevention, reporting their abuse to the police and from being taken seriously by healthcare professionals.

Results of a study conducted by the Centre for Sexual Health and HIV/AIDS Research (CeSHHAR) indicate that the stigmatisation and discrimination of adolescent sex workers at some hospitals and clinics in Zimbabwe is hampering their access to increased HIV/AIDS treatment and care. Presenting the study findings during a Zimbabwe Lawyers for Human Right's health forum for journalists, CeSHHAR programs director, Sibongile Mtetwa, said stigmatisation and discrimination are some of the major barriers to health access faced by sex workers in the country.

Mtetwa revealed that sex workers were also being abused by their clients with the police not doing much to help. Female police officers dismiss adolescent sex workers reports and blame them for spreading HIV/AIDS. This prevents them from approaching health institutions to access treatment and support services.

The 2018 SADC Regional Strategy on HIV prevention and SRHR among Key Populations recognises the abuses of young sex workers and their plight in accessing health care. This has done little to remove the stigma preventing adolescent sex workers from accessing health care services. Efforts by the Ministry of Health to ensure that adolescent sex workers get treatment seems not to be targeting the right people.



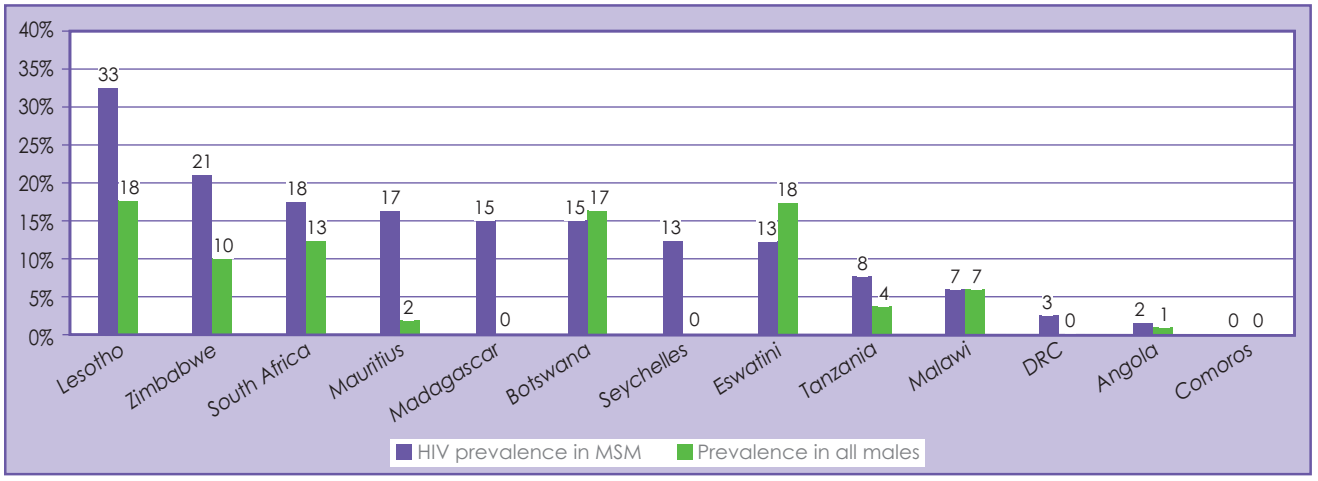
HIV AIDS self-testing booth, Zimbabwe. Photo: Tapiwa Zvaraya

*(*not her real name)*
Source: Hazel Marimbiza, Gender Links News Services

[28] https://genderlinks.org.za/news/zimbabwe-abused-adolescent-sex-workers-ignored/

Men who have Sex with Men (MSM)

Figure 5.9: Men who have sex with men



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.9 reflects much higher HIV prevalence among men who have sex with men (MSM) than in the general population of men in all countries except Botswana and Eswatini. The difference is particularly marked in the island nations of Mauritius, Madagascar and Seychelles.

Table 5.12: Men who have Sex with Men, prevalence and prevention

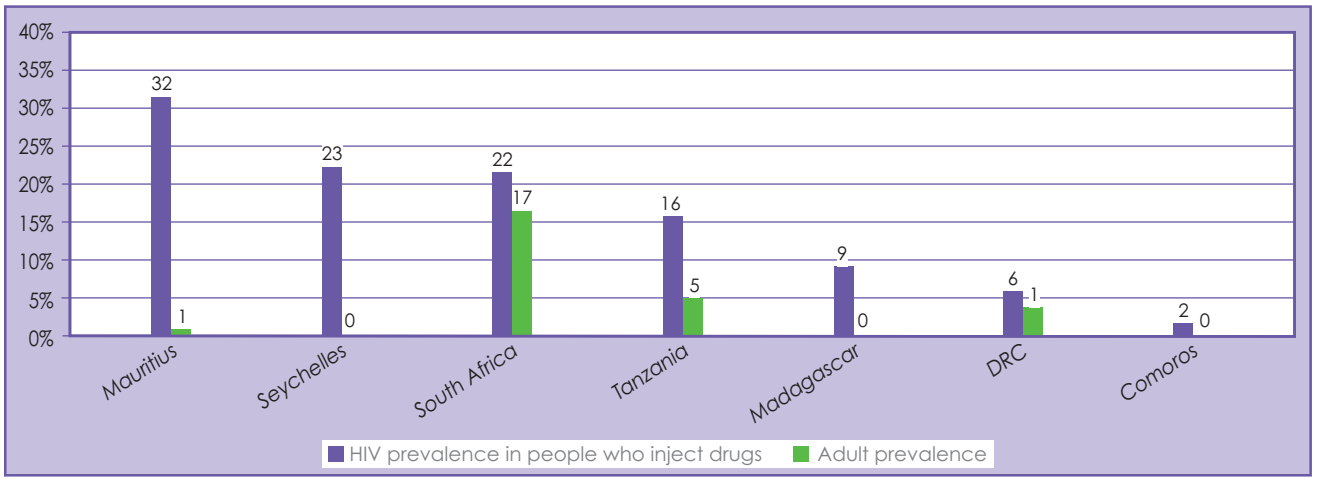
Country	HIV Prevalence in MSM	Testing, Status awareness	Condom Use	ARV coverage
Lesotho	32,9	99,8	59,1	
Zimbabwe	21,1		77,5	
South Africa	18,1	100	56,2	
Mauritius	17,2		77,4	
Madagascar	14,9		57,6	
Botswana	14,8	82,2	46,4	
Seychelles	13,2	19,3	57,2	
Eswatini	12,6		44	85,5
Tanzania	8,4	86,6	53,1	
Malawi	6,8			
DRC	3,3			
Angola	2			
Comoros	0			
Mozambique			13,9	28,1
Namibia		75,7		
Zambia		99,7	69,2	93,7

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.12 shows significant data gaps on men that have sex with men. Without such data it is not possible to design programmes to address HIV spread in this important key population. In general, condom use is very inadequate.

People who inject drugs

Figure 5.10: HIV Prevalence among people who inject drugs



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.10 shows that people who inject drugs are not a priority for many SADC countries. However, where this group is a priority, HIV prevalence is much higher than it is in the general population. The differences are particularly stark in the island nations (Mauritius, Seychelles, Madagascar and Comoros).

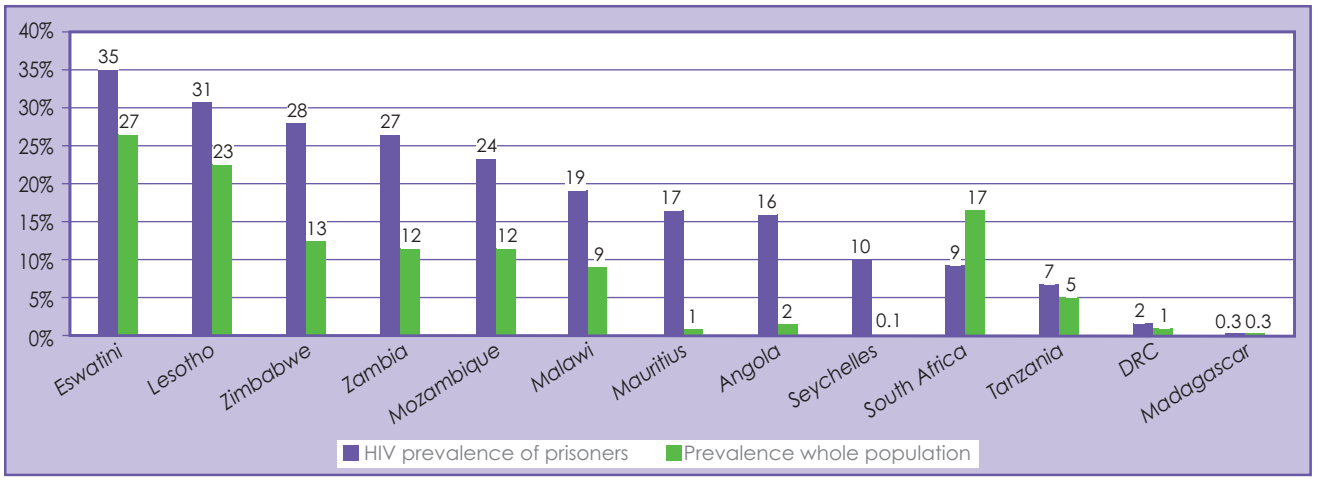
South Africa: Even though people who inject drugs are 22 times more likely to acquire HIV than those that do not, punitive laws, prejudice, stigma and discrimination, and certain donor policies, prevent HIV services from reaching them. To address this, an NGO, TB HIV Care (THC), launched the Step Up project in Cape Town and Durban in 2015. The project offered HIV prevention, testing and linkage to care, harm reduction counselling, and needle-syringe services; and added reporting of human rights violations. With more funding, Step Up now provides TB and STI symptom screening with referrals to health care, opioid substitution therapy (OST), drop-in centres, and psychosocial support and expanded to Port Elizabeth.[29]

The HIV epidemics in Mauritius, Seychelles, Madagascar and Comoros are largely in the people who inject drugs communities

[29] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.

Prisoners

Figure 5.11: HIV prevalence among prisoners



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.11 shows higher HIV prevalence among prisoners than the general population in all countries for which there is data except South Africa. The differences are particularly marked in countries which have lower prevalence in the general population.

Table 5.13: HIV prevalence, prevention and management for prisoners

Country	HIV prevalence of prisoners	ART Coverage	Condoms distributed to prisoners	Clean needles distributed to prisoners	Prisoners receiving opioid substitution therapy
Eswatini	34,9				
Lesotho	31,4	80,1			
Zimbabwe	28				
Zambia	27,4	100			
Mozambique	24				
Malawi	19	100	1,500,000		
Mauritius	17,3	79,1			342
Angola	15,9	100	1,161,600		
Seychelles	9,9		432		165
South Africa	8,9	98,8	2,436,068		
Tanzania	6,7				
DRC	1,6		4,003		
Madagascar	0,3		7,169		
Comoros			2,304		

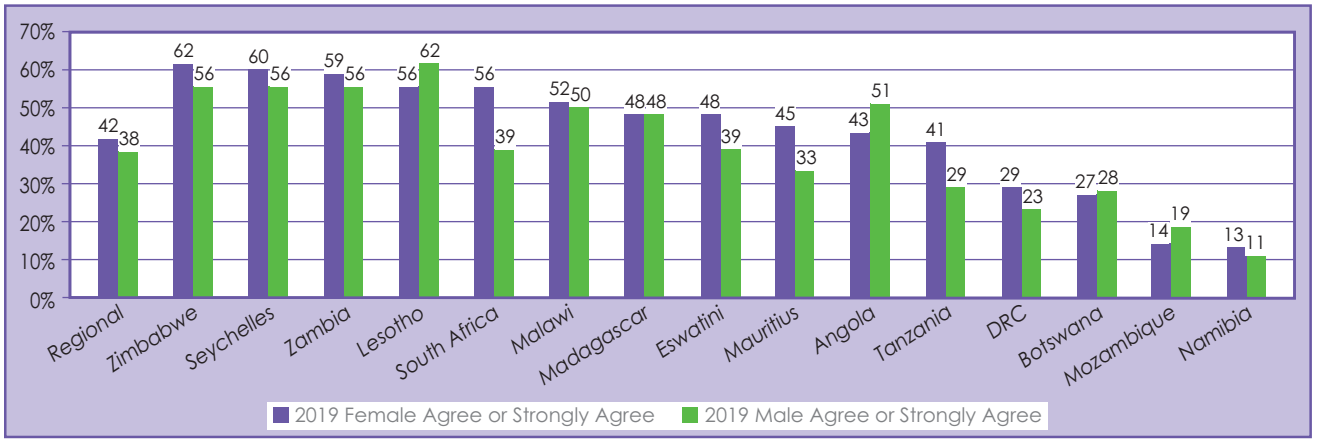
Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.13 reflects low levels of attention to prevention, testing and access to ARVs for prisoners across SADC: an area of great need. A few countries, notably Lesotho and Namibia, are providing integrated HIV and sexual and reproductive health services to people in prisons and other closed settings.

Attitudes

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

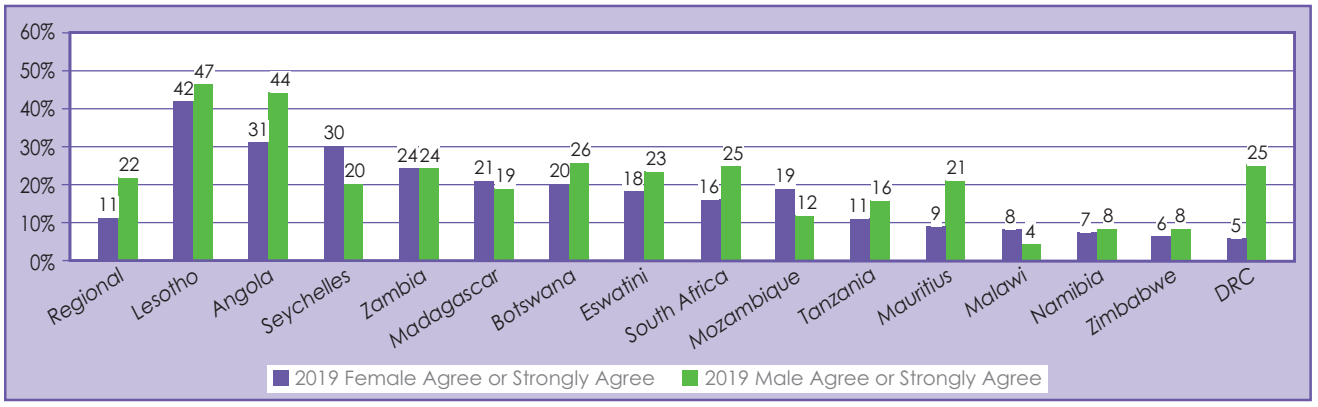
Figure 5.12: A woman can refuse to have sex with her husband



Source: Gender Links Attitude Survey, 2019.

The attitudes on whether a woman can refuse to have sex with her husband range quite widely. Sixty two percent of female respondents in Zimbabwe strongly agreed with the statement compared to 11% men in Namibia. Overall men and women had similar views. Over 50% of both women and men in Zimbabwe, Seychelles, Zambia, Lesotho and Malawi agree with the statement. More females agreed with the statement in South Africa and more men in Angola.

Figure 5.13: Nothing a woman can do if her husband wants to have girlfriends

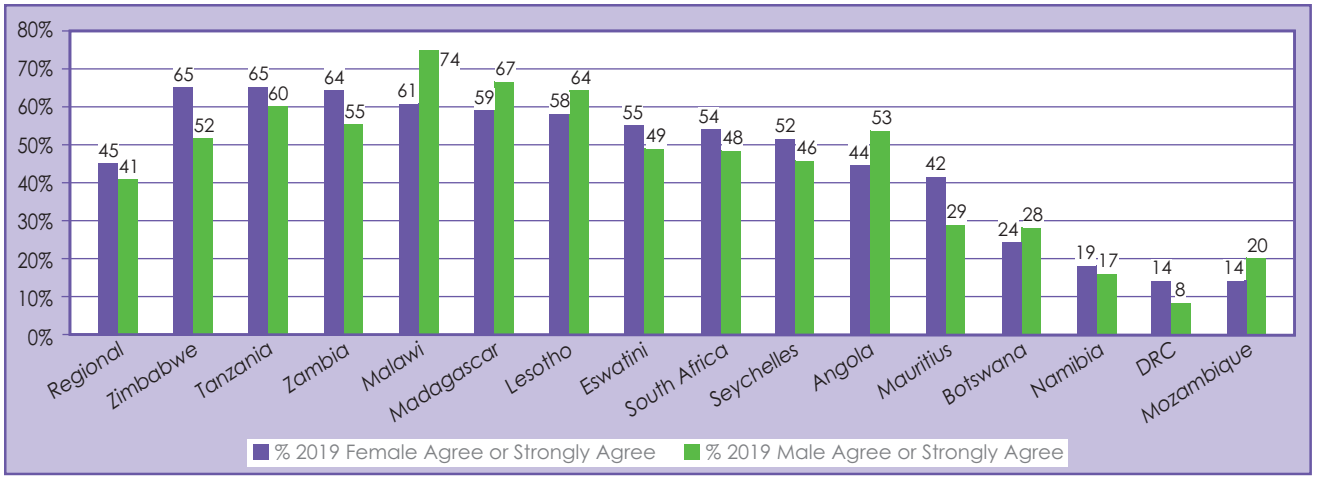


Source: Gender Links Attitude Survey, 2019.

A minority of women and men agreed that "there is nothing that a woman can do if her husband wants to have girlfriends", which means that they believe that a wife can do something. Across the region, only 19% women and 22% men agreed with this statement. The highest rate

of agreement in both females and males is in Lesotho (42% females and 47% males) and lowest for both is Zimbabwe (6% females and 8% males). Women were generally less likely to agree with the statement than men.

Figure 5.14: A woman can insist on a man using a condom



Source: Gender Links Attitude Survey, 2019.

Over 50% of female respondents in Zimbabwe, Tanzania, Zambia, Malawi, Madagascar, Lesotho, Eswatini, South Africa and Seychelles believe that a woman can insist on using a condom. It is disturbing that rates of agreement drop to as low as 14% of female respondents in DRC and Mozambique with a regional average of only 45% for women and 41% for men. In Malawi, Madagascar, Lesotho, Angola, Botswana and Mozambique more males than females agree that women have a right to insist on a man using condom. This reflects some change in attitude, especially at the local level.

Search for an HIV Vaccine

To commemorate World HIV Vaccine Day on 18 May, the National Institute of Allergy and Infectious Diseases (NIAID) highlighted the need for continued effort to find safe, effective and durable vaccines for both HIV and COVID-19. So far the search for an HIV vaccine has faced numerous challenges and developed considerable research capacity which is now being used in the race for a COVID-19 vaccine. Over the past decade, three different vaccine approaches have been implemented and two have moved through clinical evaluation to advanced clinical trials, but we do not have a vaccine yet.

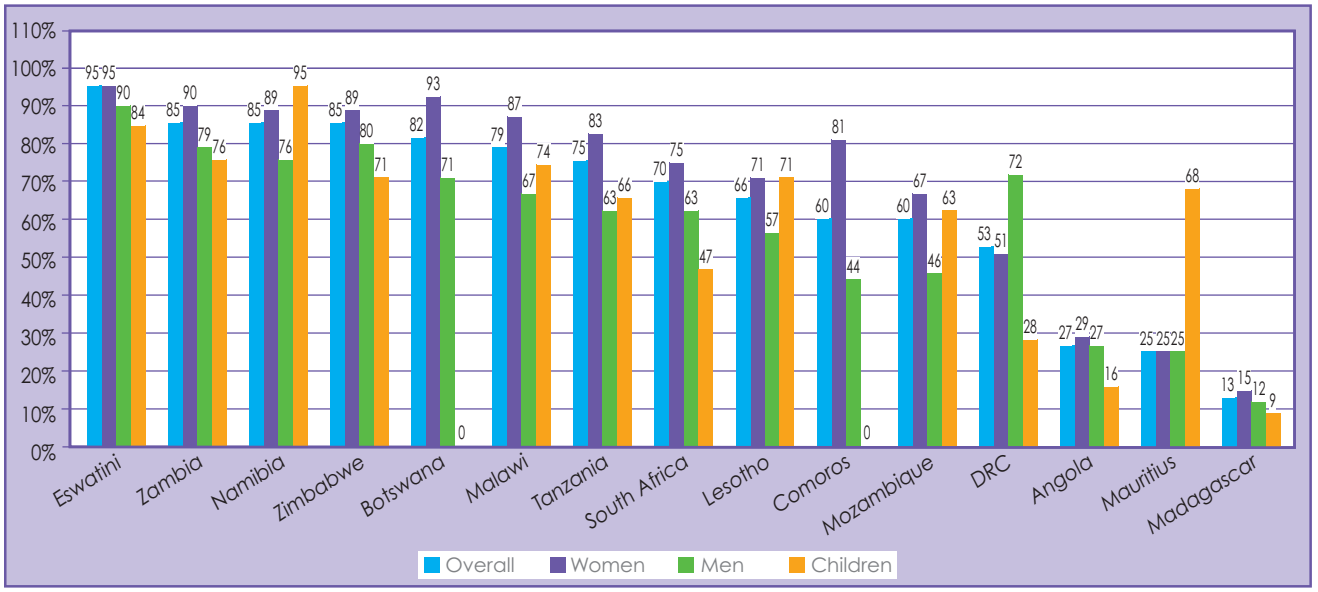
The NIAID concluded: "As we reflect on HIV Vaccine Awareness Day and recent developments in the vaccine field, it is clear that much work remains to be done. Going forward we must continue to engage the community to ensure a shared understanding of our common goals. While we pursue a safe and effective HIV vaccine, we are also seeking ways of improving chemoprophylaxis. We remain optimistic that effective interventions that people will reliably use can be developed and brought to scale."[30]

[30] Dieffenbach CW and Fauci AS Journal of the International AIDS Society 2020, 23:e25506 http://onlinelibrary.wiley.com/doi/10.1002/jia2.25506/full | https://doi.org/10.1002/jia2.25506. The search for an HIV vaccine, the journey continues.

Treatment

Article 27.3
b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and
UNAIDS 90/90/90: Target (2) By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.15: ART Coverage for those living with HIV



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/



HIV AIDS test kits in Mutare, Zimbabwe. Photo: Tapiwa Zvaraya

Figure 5.15 shows the incredible progress that has been made in expanding access to ART across most of SADC. Most of the countries with lower levels of coverage have relatively small epidemics. Clearly, there is need to accelerate action in Mozambique, DRC and Angola. In most countries coverage for women is higher than for men, except in the DRC. Across SADC women are more likely to seek health services for HIV. There is still a marked gap between coverage for adults and that for children except in Namibia, Lesotho, Mozambique and Mauritius which have higher coverage for children than adults. Malawi and Tanzania have higher coverage for children than for men, but not higher than all adults.

Table 5:15: Number of people living with HIV on treatment

Country	Number of People living with HIV on treatment				
	Total	Adults ≥ 15	Women ≥ 15	Men ≥ 15	Children 0 - 14
South Africa	5,231,809	5,074,479	3,505,194	1,569,285	157,330
Mozambique	1,338,100	1,243,020	873,927	369,093	95,080
Tanzania	1,277,012	1,215,802	818,658	397,144	61,210
Zimbabwe	1,149,191	1,089,366	677,167	412,199	59,825
Zambia	1,064,321	1,014,039	639,498	374,541	50,282
Malawi	832,908	784,948	517,944	267,004	47,960
Botswana	313,850	309,692	197,362	112,330	4,158
DRC	277,592	258,610	169,648	88,962	18,982
Lesotho	220,828	212,536	135,458	77,078	8,292
Eswatini	191,782	183,220	120,417	62,803	8,562
Namibia	177,174	167,005	112,001	55,004	10,169
Angola	93,310	88,197	62,808	25,389	5,113
Madagascar	5,166	5,015	2,685	2,330	151
Mauritius	2,837	2,786	852	1,934	51
Comoros	77	74	43	31	3
Seychelles					
SADC Total	**12,175,957**	**11,648,789**	**7,833,662**	**3,815,127**	**527,168**
Global Total	**25,400,000**				**950,000**
SADC as % of global	**48%**				**55%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.15 shows that 12,175,957 (48% of the global total of 25,400,000) people who are on ARVs are in SADC. The 527,168 children on treatment in SADC represent 55% of the global total of 950,000. The number of women on treatment (7,833,662) is a 20% increase from 6,543,160 in 2017. At 3,815,127 the number of men on treatment is considerably lower. This is however a 15% increase compared to 2017.



With 5,231,809 people on ART, the **South Africa** ART programme represents 43% of the SADC total and 19% of the global total - by far the largest ART country programme anywhere in the world. Most of the funding for South Africa's programme is domestic.



By the end of 2019 more than 90% of those needing ART in **Lesotho** were receiving the treatment. COVID-19 threatens to reverse these gains. In May 2020 healthcare professionals went on strike over lack of PPE during a 21 day lockdown. During these uncertain times, the Government of Lesotho encouraged people to use HIV Self-Test kits. Those who tested positive were encouraged to proceed to a healthcare facility. Kits are distributed through all major health facilities in the country in partnership with the Ministry of Health.



HIV/AIDS Campaign, South Africa. Photo: Susan Mogari

Viral suppression

UNAIDS TARGET 3: 90% of all people receiving antiretroviral therapy will have viral suppression.

Table 5.7 on page 15 shows the progress towards viral suppression. Data on suppression is not available from Angola, DRC or Madagascar.

Comoros, Mozambique and Mauritius have low rates of suppression. All other countries are making good progress towards this target.

HIV activists in the USA launched the U = U (undetectable equals un-transmittable) campaign in 2016. The campaign highlights that people that are on ART with suppressed viral load cannot transmit the virus through sexual or other contact. The campaign:

- Encourages people that are not aware of their HIV status to be tested.
- Encourages those that are positive to access treatment to protect themselves and their partners.
- Reduces the shame and fear of sexual transmission.
- Helps to challenge stigma at community, clinical and personal levels.[31]

HIV and TB Co-infection

Despite the fact that Tuberculosis (TB) is both preventable and curable, it is the 10th leading cause of death worldwide, the worldwide top infectious killer and the leading cause of death among people living with HIV. The UN High level meeting on TB in 2016 committed to ending TB by 2030. The milestones for achieving the end of TB include a 75% reduction in TB deaths among people living with HIV between 2010 and 2020. In 2018, 10 million people fell ill with TB worldwide and 1.5 million people lost their lives to the disease, including 251,000 people living with HIV. People living with HIV with latent TB are 20 times more likely to develop active TB.

Table 5.16: TB related deaths in people living with HIV

Country	2005	2018
South Africa	102,000	42,000
Tanzania	49,000	16,000
Mozambique	37,000	22,000
DRC	15,000	10,000
Malawi	14,000	7,000
Zambia	14,000	13,000
Zimbabwe	13,000	3,500
Lesotho	8,800	3,300
Namibia	5,600	1,500
Angola	5,200	3,700
Botswana	2,200	1,200
Eswatini	1,700	510
Madagascar	670	380
Comoros	2	0
Mauritius	1	8
Seychelles	0	0
SADC Total	**268,173**	**124,098**
Global Total	**590,000**	**250,000**
SADC as % of Global	**45%**	**50%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

[31] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.

Table 5.16 compares the number of TB related deaths in people living with HIV in 2005 (a year with one of the highest recorded death rates) and 2018. The overall number of deaths has decreased from 268,173 to 124,098 in 2018. The deaths in 2005 comprised 45% of the global number of TB-related deaths in people living with HIV. This figure rose to 50% in 2018. The rate of decline has been uneven. The decline in Zambia, for instance, has been very slow. Namibia, Zimbabwe and Eswatini have witnessed the highest rates of decline. South Africa has the largest TB epidemic amongst people living with HIV in SADC.

More and more technology is being harnessed to support outreach services. An example of this is a digital health platform called One Impact to increase access to TB services and share insights about their quality. The platform is intended as a bridge between health service users and providers. This enables real-time community monitoring of local TB responses. An example of this, One Impact, brings together four apps designed by and for people and communities affected by TB.

- *Get Knowledgeable:* Provides information about TB.
- *Get Access:* Identifies nearby TB health services (such as directly observed treatment [DOTs] centres, hospitals and laboratories), provides relevant information (including opening hours) and sorts services by distance.
- *Get Connected:* Connects you with peer supporters, people who have experienced TB, peer support groups and TB-related social services.
- *Get Involved:* Allows you to report challenges experienced when accessing TB services, such as stigma, services denied or breaches of confidentiality.[32]

AIDS Related Deaths

Table 5.17: AIDS related deaths

Country	All ages		Young people 15-24		Children		Deaths averted
	2005	2019	2006	2019	2005	2019	2019
Angola	7,800	13,000	<500	<1,000	2,900	3,800	8,600
Botswana	11,000	5,000	<1,000	<1,000			13,000
Comoros	<100	<100	<100	<100			<100
DRC	45,000	15,000	2,000	1,400	11,000	5,000	21,000
Eswatini	8,100	2,300	<500	<500	2,200	<200	8,300
Lesotho	18,000	4,800	<1,000	<500	2,900	<1,000	17,000
Madagascar	<500	1,400	<100	<100	<100	<500	<1,000
Malawi	69,000	13,000	2,600	1,700	16,000	1,900	40,000
Mauritius							
Mozambique	69,000	51,000	2,900	4,600	20,000	8,200	79,000
Namibia	9,400	3,000	<500	<500	2,300	<500	7,900
South Africa	280,000	72,000	22,000	6,900	51,000	4,100	360,000
Tanzania	96,000	27,000	3,000	2,300	19,000	5,900	63,000
Zambia	52,000	17,000	2,000	2,100	12,000	3,600	58,000
Zimbabwe	110,000	20,000	3,900	2,300	18,000	3,000	50,000
SADC Total	**775,300**	**244,500**	**38,400**	**21,300**	**157,300**	**35,500**	**725,800**
Global Total	**1,700,000**	**690,000**	**69,000**	**46,000**	**320,000**	**95,000**	**1,400,000**
SADC as % of global	**46%**	**35%**	**56%**	**46%**	**49%**	**37%**	**52%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

[32] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.

Table 5.17 compares the number of deaths as a result of AIDS for all people, young people and children between either 2005 or 2006 (the year of highest deaths) and 2019. Overall there has been remarkable progress, though Angola has seen increasing numbers of deaths and rates of decline for other countries have been uneven. Noteworthy declines include in total deaths in Zimbabwe; as well as deaths of children in Malawi and South Africa. Deaths in SADC as a percentage of global deaths have declined in all categories. All SADC deaths are now 35% of global total deaths (compared to 46% in 2005). Table 5.17 also shows the estimated number of deaths averted as a result of ART: 725 800 or 52% of the global total in 2019. The largest number of deaths averted is 360,000 in South Africa (49.6% of the SADC total).

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

Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

SADC sponsored UN resolution on Women, Girls and HIV: Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognize, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure.

BPFA +20 Africa declaration: Reduce, recognize and redistribute unpaid care work, which falls disproportionately on women and girls, by investing in infrastructure and time-saving technology and emphasising shared responsibilities between women and men, girls and boys;

The critical role of the community, community-based organisations and community care-giving in different forms is widely recognised as being crucial in the fight against HIV and AIDS, and now also against COVID-19. As health centres become more and more difficult to access, "routine" services such as resupply of ART, even HIV testing, will need to move into the community. The new cadres of community caregivers - peer educators, mentor mothers, and others - will be called upon to play increasingly complex roles to ensure that HIV services continue.

However, there is insufficient recognition, appreciation, support, training or remuneration of this critical work force. The Coalition encourages Member States to honour the *2016 Political Declaration on Ending AIDS Commitment* by expanding community-led service delivery to cover at least 30% of all service delivery by 2030. An important area of focus is the involvement of men in care work, as illustrated in the following case study from Namibia:

Namibia: The future starts today



Seth Phillips receives an award during the Namibia SADC Gender Protocol@Work Summit in Windhoek. Photo: Veronika Haimbili

Erongo: Seth Phillips, winner of a 2019 SADC Protocol@Work award, is one of the few male home-based care givers providing support to bed-ridden clients, orphans and vulnerable children.

For the past 15 years Phillips has been a volunteer and agent of change. As a district AIDS coordinator he works in partnership with the Family Care Centre located in Omdel Residential Area. The District Aids Committee is a community- based structure operating under the Office of the Mayor.

Namibia is implementing the National Strategic Framework for HIV and AIDS at the district, national and regional levels. The interventions aim to achieve the following by 2022: new HIV infections reduced by 75%; HIV-related deaths reduced by 75%; Mother to Child Transmission reduced to less than 2%; 100% of newly identified People Living with the HIV enrolled and retained in ART; TB-related mortality reduced; domestic contribution towards the local multi sectoral HIV and AIDS response increased to 80%. The strategy includes providing awareness and services for voluntary medical male circumcision; condom promotion and distribution (targeting all shebeens, bars and businesses in the region).

Involvement of men is key. The Mayor is chairperson of the Erongo Male Forum and advocates for the Men for Change Movement in the region. The forum promotes treatment, care and support (provision of Home- Based Care Activities) as well as HIV Testing Services. Financial disparities and intimate partner violence in relationships often hinder a woman's ability to negotiate condom use and protect herself from HIV. The Henties Bay District AIDS Committee is committed to scaling up efforts to promote gender equality and end violence against women.

Source: Seth Phillips, District AIDS Coordinator with Henties Bay Local Youth Forum, Namibia case study for the SADC Protocol @ Work Summit 2019

More recently, community caregivers are reaching adolescent girls and young women, key populations, men (to encourage VMMC) pregnant women and mothers. The Prevention Coalition notes that "insufficient funding for community-led responses, social and gender inequalities, shrinking civil society space and negative policy environments have tended to stop (community led) successes from reaching full scale and generating the expected impact.

[33] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

More emphasis is needed on including community actors and civil society networks in national dialogues throughout the programme cycle, from the participation of representatives of key affected populations in national programme planning and review bodies, to the establishment and funding of community-led monitoring mechanisms."[33] The case study that follows, from the Limpopo Province of South Africa, illustrates the role played by community-based organisations in providing care services:



South Africa: Making care work count

Mentz, Badimong village: Bulamahlo Home-Based Care next door to the University of Limpopo aims to help all people infected with or affected by HIV. Three years after registration in 2005, the organisation opened a drop-in centre for vulnerable children.

Today, Bulamahlo takes care of 730 orphans, vulnerable children and child-headed families. We make sure these children get good food, uniforms and go to school like all other children. The centre provides sports, arts and culture activities for them. Three satellite centres cater for children that cannot reach the main centre.

Additionally, the organization provides social crime prevention and intervention services, together with prevention, care and support services to people with disabilities. The organisation provides interventions for substance abuse prevention, treatment and rehabilitation. We also help to reduce the incidence of poverty through sustainable livelihood approaches. We provide protection, care and support to older people. While empowering women and people with disabilities we also provide nutrition to ensure healthy lives.

Bulamhlo works with the Child Protection Forum in our community to help keep track of abused



Bulamahlo Home Based Care, Limpopo South Africa.
Photo courtesy of Bula Mahlo Home Based Care Centre

women and children. We work with the South African Social Security Agency to help children who do not have access to social grants and food parcels. We work with social workers to provide counselling and assistance to families who need social interventions. The two closest clinics, Evelyn Lekganyane and A. Mamabolo help us in identifying patients who need help in taking their medication and counselling them. Every year we hold campaigns with two local schools Badimong Primary and Mphetsebe High to teach children about speaking out against abuse, the dangers of teenage pregnancy and HIV. The Capricorn District Municipality provides funds for all our campaigns.

Rosina Ngobeni, Bulamahlo Home Based Care, Limpopo South Africa in the SADC Protocol @ Work Summit 2019

There is insufficient recognition, appreciation, support, training or remuneration for care workers

Care workers are integral to the nationwide COVID-19 response

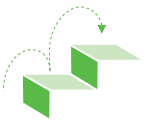
For the last three decades, Southern Africa has been battling the dual threat of HIV and TB. This has resulted in honing sharp community-based skills to prevent, find and treat patients. As COVID-19 hit the nation, government and civil society sought to draw on the decades of learning and skills gained from work with TB and HIV to combat COVID-19. In one such example the Africa Health Research Institute (ARHI) in Durban turned its focus from TB and HIV to redirect its entire staff, including community workers, and mobile clinics to focus on COVID-19.

Care workers, who are part of communities as well as peers, have built trust with the communities over time, so have become essential on the frontlines in screening and identifying possible COVID-19 patients. Under "normal" circumstances, care workers often get infected from their patients. Frontline workers are prone to infection due to lack of protective gear.

It is estimated that 2,500 community health workers throughout South Africa's Kwa Zulu Natal province have lost their lives to TB and related conditions that they acquired or contracted while on the job over the last 10 years. Most of them have been asked to join the COVID-19 tracing programme. Some have vehemently disagreed with the call unless there is sufficient PPE for them, stating that they were afraid to continue working. Care workers emphasise that the need for PPE did not arise with COVID-19. It has existed for years prior as teams have needed masks when handling TB patients but have never received them. The stories are the same across all provinces. There is not enough emphasis placed on care workers' safety.



South Africa's Khayelitsha, Alexandra and Diepsloot high density suburbs introduced COVID testing and contact tracing with over 5,000 fieldworkers deployed for identifying and tracing people who have and may have COVID-19 to mitigate the fast-paced spread through communities. Even with all the planning in place, training for care workers remained minimal and they had to rely on their TB training. Care workers stated that the training they received felt like a crash course. Confusion broke out in many parts regarding the role of care workers, and COVID-19 protocols. Though employed by the Depart-ments of Health or Social Development they do not have access to worker's compensation if they contract any illnesses during the course of their duty, placing them at economic risk, in addition to health risks. Many stakeholders have called for recognition of care work.[34]



Next steps

During the time of COVID-19 UNAIDS recommends action to:

- ***Address the different needs of women and girls***, paying attention to the most marginalized. This includes addressing the specific needs of women and girls living with or affected by HIV, particularly regular access to health care with attention to co morbidities. All policy responses to COVID-19 should incorporate a gender perspective. Issues such as the increased burden on women who spend considerable time collecting water which is so essential to prevent spread of COVID-19 should be recognised.
- ***Recognise and guarantee access to essential health services*** particularly SRHR, ante and postnatal care.
- ***Address the neglected epidemic of gender-based violence against women and girls:*** With-

[34] https://www.spotlightnsp.co.za/2020/04/03/covid-19-discontent-among-chws-on-the-frontlines/

out attention this epidemic has simmered around the world and has soared during lock-downs where relationships have been strained due to poor mental health, security and income and cramped living conditions.

- ***Stop misuse of criminal and punitive laws***, especially those that criminalize sex work, LGBTI and drive these people away from services.
- ***Prioritise adolescent girls' and young women's education, health and well-being:*** Approximately 89% of students in the world have been out of school. Adolescent girls are more likely than boys to drop out completely after school closures and to face early marriage or trafficking.
- ***Value women's work and make unpaid care work everybody's work:*** During the COVID-19 crisis unpaid care work has increased tremendously due to school closures, caring for family members that are not well and caring for the elderly. Even before COVID-19 women did at least two and a half times more unpaid care work than men.s

Other recommendations in this chapter include:

- ***Support continuity of HIV services, despite COVID-19 disruptions.*** SADC has achieved so much in the struggle to end AIDS by 2030 that we cannot afford to go backwards by a decade. All effort from donors, to governments to communities must be invested to ensure that services are continued albeit in new formations.
- ***Invest in HIV prevention*** particularly for young people and also for members of key populations. At this time of challenge, we must forge forward.
- ***Invest in community initiatives*** - this might be the opportunity to "build back better" and acknowledge the critical role of the community in HIV prevention, care and support.
- ***Acknowledge gender disparities*** and find innovative solutions to these.

"When we get past this crisis, we will face a choice... we can go back to the world as it was before or deal decisively with those issues that make us all unnecessarily vulnerable to crises."
António Guterres, United Nations Secretary-General

[35] UNAIDS. 2020. Six Concrete Measures to Support Women and Girls in All Their Diversity in the Context of the COVID-19 Pandemic. Geneva. UNAIDS.

Gender-Based Violence 6



Activists take part in a 16 Days of Activism event dubbed the "Silent March" in Port Louis, Mauritius in November 2019. Photo: Sheistah Bundhoo

KEY POINTS

- COVID-19 lockdowns could have a "catastrophic impact" on women, leading to a 20% surge in domestic violence cases.[1]
- Restrictions linked to the pandemic have worsened existing gender inequalities and left many women and girls without options to escape violent settings as governments across the region shuttered clinics and shelters and limited response mechanisms.
- 57% of women surveyed in Zimbabwe 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.
- Following a spike in violence against women during the pandemic, South Africa announced a R1.6 billion Emergency Response Plan to fight GBV and femicide.
- Some countries still lack critical data on intimate partner violence (IPV) and violence against men.
- Globally, traffickers rob a staggering 24.6 million people of their freedoms and basic human dignity.[2]
- In September 2019, the SADC Parliamentary Forum convened to discuss ways of harmonising and implementing GBV legislation to establish a GBV Model Law for SADC.
- "Hashtag advocacy" has gained tremendous momentum as a social media campaign tool across the region, although researchers warn its successes could be short-lived.
- A global UN Women study in 2019 found that 84% of respondents believe it is essential for society to treat women as equal to men.[3]



1 "Africa: Coronavirus to Have 'Catastrophic' Impact on Women With Domestic Abuse Up 20 Percent - AllAfrica.Com."
2 https://www.state.gov/wp-content/uploads/2019/06/2019-Trafficking-in-Persons-Report.pdf
3 https://www.unwomen.org/en/digital-library/publications/2020/06/gender-equality-attitudes-study-2019

Introduction

Research reveals extremely high rates of violence in Southern African countries, with intimate partner violence (IPV) particularly widespread.[4] As highlighted in numerous studies, acceptance of violence against women and girls (VAWG) remains high in the region.[5] The SADC Regional Strategy and Framework of Action for Addressing Gender Based Violence, 2018-2030 attempts to chart a way forward for the region in addressing this most glaring of human rights abuses. Globally, governments, civil society, and international organisations have collectively called for increased efforts to end VAWG.

In September 2019, the SADC Secretariat collaborated with the SADC Parliamentary Forum (SADC PF) to conduct a consultative workshop on GBV. It aimed to sensitise MPs on the 2018-2030 SADC Regional Strategy and discuss ways to harmonise and implement legislation on GBV, including consultation on establishing a GBV Model Law for SADC.[6]

Member states have made progress in addressing GBV by implementing multisectoral approaches that include legislative and criminal justice responses; measuring incidence and costing of GBV; awareness-raising; women's empowerment programmes; community-based social norm programmes; and health-based interventions.[7] However, some countries still lack critical GBV data.

A year after the GBV and femicide summit in South Africa in 2018, a spate of xenophobic attacks and horrendous murders of women and girls rocked the nation. In September 2019, thousands of women marched in protest throughout the country, using the hashtag #AmINext in their activism. The protests prompted South Africa President Cyril Ramaphosa to renew his pledge to fight GBV. The President, who is also currently the chairperson on the African Union (AU) made one of his strongest statements on GBV during the COVID-19 lockdown, sending home the strong message that GBV is now being taken as a serious political issue.

By the end of the decade, Gender Links (GL) had successfully conducted seven VAWG and/or GBV baseline studies (in Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia, and Zimbabwe), with Botswana conducting a comprehensive follow-up study in 2018. GL continues to collaborate with national statistical offices and regional gender ministries to bolster efforts to collect robust data, track indicators, and encourage the utilisation of data in GBV interventions.

SADC plans to establish a model law on GBV legislation

[4] García-Moreno et al. (2013). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organisation
[5] Lowe Morna, C. Dube S and Makamure, L (2017). SADC Gender Protocol Barometer 2017 Southern Africa. SADC Gender Protocol Alliance, Tran, T. D., Nguyen, H., & Fisher, J. (2016). Attitudes towards intimate partner violence against women among women and men in 39 low-and-middle-income countries. PloS one, 11(11), e0167438
[6] https://www.sadc.int/news-events/news/sadc-secretariat-engages-members-parliament-regional-gbv-legislative-response/
[7] Lowe Morna, C. Dube S and Makamure, L (2017). SADC Gender Protocol Barometer 2017 Southern Africa. SADC Gender Protocol Alliance

Table 6.1: Key data 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)[8]	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 intimate partner physical and/or sexual violence at least once in their lifetime (2013)[9, 10]	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)[11]	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/ sexual violence perpetrated by someone other than an intimate partner at least once in their lifetime (1995-2013)[12]	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[13]	13 countries	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Laws on sexual assault[14]	14 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Human trafficking laws[15]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexual harassment laws[16]	15 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Integrated approaches: national action plans[17]	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[18]	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[19]	14 countries	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Comprehensive treatment, including post-exposure prophylaxis (PEP)[20]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Gender Links, 2020.

8 https://sdg-tracker.org/gender-equality [accessed 14 April 2020;(last updated 2016]
9 https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf
10 https://evaw-global-database.unwomen.org/en/countries/africa/comoros#1 (accessed 16 April 2020)
11 IBID
12 https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf
13 GL Audit of SRHR Policies and Laws in SADC, 2020.
14 IBID
15 Department of State, USA. (2016). Trafficking in persons 2016 report. (0nline) available at https://www.state.gov/documents/organization/258876.pdf (accessed 14 April 2020).
16 GL Audit of SRHR Policies and Laws in SADC, 2020.
17 https://genderlinks.org.za/what-we-do/justice/policy-and-action-plans/ [accessed 30 April 2020].
18 Status of DHS Surveys in SADC countries.
19 IBID
20 SADC Gender Barometer 2019



Activists take part in the 2019 Young Women's Alliance #WalkInHerShoes march in Eswatini. Photo: Thandokuhle Dlamini

Table 6.1 shows that regional progress has not shifted much since previous barometers, partly owing to a lack of data. However, researchers have added new data here for Comoros as well as updates in Zambia thanks to a Demographic and Healthy Survey (DHS) study there. The table shows that:

- 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.
- Only eight countries have data on proportion of women aged 15-49 who have experienced IPV and/or sexual violence at least once in their lifetime. 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 aged 15 years and older subjected to physical and sexual violence by a partner in the previous 12 months.
- All SADC countries but Angola now have legislation on sexual harassment and all 16 have human trafficking laws.
- Several sections in Table 6.1 have irregular data across the SADC countries. These represent critical data indicators that activists have urged decision makers to collect regularly to track the extent of IPV. This is more important than ever as worries mount that COVID-19 lockdowns will exacerbate violence.

Persistent gaps in data, combined with laws and policies dating back as far as 15 years, hamper regional progress in combating GBV.

This chapter assesses progress on the extent, prevention, response, and support of Gender-Based Violence (GBV) across all 16 SADC countries. It tracks performance of member states against normative frameworks, which include the SADC Protocol on Gender and Development, Beijing Platform for Action (BPFA) +20 Africa Declaration, Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Sustainable Development Goals (SDGs), the Maputo Protocol, International Conference on Population and Development (ICPD), and the Commission on the Status of Women (CSW) Resolution 60/2 on Women, the Girl Child, and HIV. This 2020 edition is a continuation of the #VoiceandChoice campaign, building on regional advancements on sexual and reproductive health and rights (SRHR). It also analyses the impact of the COVID-19 pandemic in the region, looking at how it may threaten fragile gains made in recent years toward ending GBV.

Impact of COVID-19 on GBV

The COVID-19 pandemic presented an unprecedented global health emergency in 2020. It had already led to the deaths of more than half a million people worldwide at the time of publication. The virus left many countries in a perilous state, as world leaders struggled to contain both the socio-economic effects and the dire health consequences of the outbreak. In SADC, the crisis continues to present a threat to work that addresses GBV, with early reports noting that lockdowns to contain the virus resulted in increased violence in homes throughout the region.

In almost every country, governments implemented measures to reduce the spread of COVID-

19, including mandatory lockdowns with varying degrees of restrictions. In some countries, like Botswana, governments invoked states of emergency. Unfortunately, mandatory lockdowns may make millions of women and children less safe. The United Nations has warned that the pandemic will have a "catastrophic impact" on women, predicting that lockdowns could lead to a 20% surge in domestic violence as it forces victims to remain trapped at home with their abusers.[21]



Police in Dobsonville, Soweto, arrest a street vendor on 23 April 2020 for working during the lockdown without a permit. Photo: Themba Hadebe

Many women and girls now face an increased risk of exposure to IPV as family members spend more time in close contact and cope with additional stresses, including financial strain and job loss.[22] A 2019 UN Women gender equality attitudes study found that only 53% of women (compared to 66% of men) feel moderately safe or very safe in their home.[23] These unusual circumstances due to the pandemic mean that women have less contact with family and friends who may provide support and protection from violence. Many women and girls also have limited access to phones and helplines, and the pandemic has also disrupted or led to the suspension of public services like police, justice, and social services. This compromises the care and support that survivors need, such as clinical management of rape, as well as mental health and psychosocial support.

Across the region, GBV service providers reported a surge in cases within the first week of lockdowns and over subsequent days. In Zimbabwe, Musasa, an agency that normally provides support to about 500 GBV survivors each month, recorded more than 700 GBV cases in the first week of lockdowns. Meanwhile, the Lesotho Mobile Police Service (LMPS) handled 18 cases of sexual violence in the first two weeks of lockdown, an unusually high number, according to senior inspector 'Malebohang Nepo from the LMPS child and gender protection unit.[24] Between 19 March and 7 April 2020, Botswana recorded 27 cases of rape.[25] The increase in the number of GBV cases represents a dire unintended consequence of the lockdowns, which leaders implemented to protect SADC citizens. UN Women Executive Director Phumzile Mlambo-Ngcuka (also former Deputy President of South Africa) has called VAWG the "shadow" pandemic stalking the COVID-19 lockdowns.

The COVID-19 crisis brought existing gender inequalities into focus, underscoring the need for crisis mitigation strategies that assess the different impacts faced by men, women, boys, and girls. While case fatality rates show that more men die from COVID-19, the unpaid burden of care rests with women and girls, who make up 70% of the world's healthcare workers.[26] In many SADC settings, communities expect women to care for the sick as well as deal with regular household chores, many of which have increased due to the pandemic, including fetching water and queuing for mealie meal or food hampers. In many instances, lockdowns affected women's livelihoods. This includes both documented and undocumented immigrant women in South Africa, who work in markets to sell their wares so they can put food on the table for their families.

As countries move to ease lockdown restrictions and re-open their economies, leaders have announced several economic stimulus packages. It will be important for SADC countries to

[21] https://allafrica.com/stories/202004290002.html?utm_campaign=allafrica%3Aeditor&utm_medium=social&utm_source=twitter&utm_content=promote%3Aaans%3Aacbllp
[22] https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Preparedness_and_Response_-_UNFPA_Interim_Technical_Briefs_Gender_Equality_and_GBV_23_March_2020_.pdf
[23] https://www.unwomen.org/en/digital-library/publications/2020/06/gender-equality-attitudes-study-2019
[24] "Efforts Made to Counter GBV in COVID-19 Crisis."
[25] "GBV during Covid-19."
[26] https://www.weforum.org/agenda/2020/04/women-female-leadership-gender-coronavirus-covid19-response/

prioritise gender-responsive budgeting and approaches to enhance women's economic empowerment at this time as well as in the post COVID-19 recovery period.

In a statement in late April 2020, SADC Executive Secretary Stergomena Lawrence Tax expressed worries about increases in GBV during the pandemic, noting spikes in domestic violence illustrated in police reports.[27] "Clearly, the SADC region has not been spared," said Tax. "The UN Women report shows that some countries around the world, particularly those highly affected by COVID-19, have registered up to 30% increase in reported domestic violence cases and around 33% increase in emergency calls for gender-based violence, with women and girls being the victims of these acts."

Tax reminded SADC leaders of their commitment to address the issue collectively with civil society under the SADC Protocol on Gender and Development, Regional Strategy and Framework of Action for Addressing GBV (2018-2030), and the Regional Strategy on Women, Peace and Security (2018-2022).



SADC Executive Secretary Stergomena Lawrence Tax has expressed worries about increases in GBV during the pandemic. Photo courtesy of Twitter

"While it is very important for governments and stakeholders to focus on measures to contain COVID-19... domestic violence should not be neglected," she said, noting that SADC member states must have flexible tools for reporting, counselling services, and supports for victims. "These tools must be clearly communicated to enable those affected to access and utilise them... in response to this crisis, particularly during lockdown, shelters and places of safety for victims of abuse must be considered an essential service and should be expanded as needed."

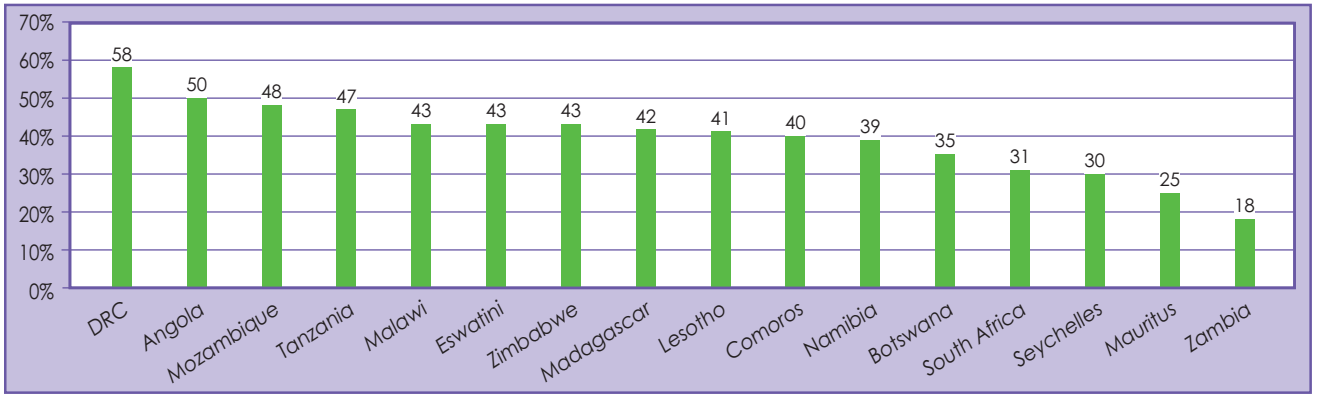
The extent of GBV



GBV has long been recognised as a widespread human rights violation in all countries, yet it remains sensitive, hidden, and stigmatised in many places. For more than a decade, GL has represented a leading voice in the fight against GBV in SADC, spearheading seven dedicated surveys across the region to help address data gaps. Researchers and activists note that collecting data for all SADC countries is even more important now, with the advent of the COVID-19 crisis, which increases the vulnerability of women and girls to abuse.

[27] https://www.sadc.int/news-events/news/statement-sadc-executive-secretary-he-dr-stergomena-lawrence-tax-covid-19-and-gender-based-violence-and-domestic-violence/

Figure 6.1: IPV in SADC



Source: https://sdg-tracker.org/gender-equality

Figure 6.1 shows experience of IPV among respondents in the 12 months prior to the research for women aged 15 to 49. The most recent data comes from a 2016 study in all countries except Zambia, where a DHS study in 2018 supplied more current information. The data shows that experience of IPV ranged from a low of 18% in Zambia to 58% in the DRC. Despite inherent challenges in collecting GBV data, the UN Economic Commission continues to work with governments and civil society to harmonise GBV indicators and enhance the collection and comparability of GBV data across countries. In the meantime, many countries depend on DHS statistics, while others use both GBV baseline studies and the DHS figures.

Table 6.2: Difference between the DHS and GBV Baseline Studies

DHS	GBV Baseline Studies
Scope	
30 questions	More than 150 indicators that seek to measure the prevalence, effects and drivers of violence.
Source	
	Several standard, globally accepted and tested measurement tools, including the UN's Multi-country Study on Women's Health and Domestic Violence, Gender Equitable Men (GEM) scale and the Harvard Trauma Questionnaire (HTQ).
Measures	
Physical, emotional and sexual abuse in intimate relationships	Physical, sexual, psychological and economic intimate partner violence.
Physical abuse by stranger	The VAW/GBV Indicators only looked at physical abuse within intimate relationships, not by strangers. DHS has specific questions on physical abuse by non-partners.
Physical abuse in pregnancy	Physical, sexual, psychological and economic intimate partner violence in pregnancy.
Physical violence perpetration and alcohol	GBV violence perpetration and alcohol, child abuse, attitudes, and demographic factors.
Rape by non-partner	Rape by non-partner.
	Rape and sexual assault by a partner, stranger, acquaintance or family member, experienced by adults and in childhood.
Help-seeking behaviour	Help-seeking behaviour (medical, legal, police, shelter and family) and reporting and conviction patterns.
Witnessing domestic violence of parents	Witnessing domestic violence in the home and community.
	Sexual harassment in schools, workplace and public places.
	The study also has output indicators focusing on the response mechanisms and some prevention strategies, such as campaigns.
	Effects, including reproductive health (HIV, sexually transmitted infections) mental (post-traumatic stress disorder and Center for Epidemiological Studies Depression scales), physical and economic.

Source: GBV Indicators Questionnaire and DHS Domestic Violence Module.

Table 6.2 illustrates the differences and similarities between the DHS studies 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.

Prevalence of GBV and intimate partner violence (IPV)

Of the seven countries where GL conducted GBV Baseline Studies, only Botswana and Seychelles have carried out a follow-up study that included a module on violence against men. The results show that GBV transcends boundaries and the abusers of women are people that they know and live with, in their homes.

Table 6.3: Proportions of women experiencing and men perpetrating GBV and IPV in lifetime

Country	Lifetime GBV (%)				Lifetime IPV (%)			
	Women experiencing	Men perpetrating	Men experiencing	Women perpetrating	Women experiencing	Men perpetrating	Men experiencing	Women perpetrating
Lesotho	86	41	-	-	62	37	-	-
Selected provinces Zambia	77	66	-	-	79	74	-	-
Zimbabwe	68	46	-	-	69	41	-	-
Seychelles	58	43	43	31	54	42	35	40
South Africa (four provinces)	50	39	-	-	49	40	-	-
Botswana	37	30	21	12	37	28	18	18
Mauritius	24	23	-	-	23	22	-	-

Source: GBV/VAW Baseline Studies, Gender Links.

Table 6.3 shows that lifetime experience of GBV among women ranges from a high of 86% in Lesotho to 24% in Mauritius. A higher proportion of women reported experiencing violence than the proportion of men who reported perpetrating violence in all seven countries. However, the extent to which men report such behaviour is high in all countries and is almost equal in Mauritius.

Findings by GL in the two countries (Botswana and Seychelles) that have included a violence against men module show that high numbers of men also reported experiencing both GBV and IPV: 43% of men in Seychelles and 21% in Botswana reported experiencing GBV. Additionally, 35% of men in Seychelles and 18% in Botswana reported experiencing IPV at least once in their lifetime. Many more (40%) women interviewed in Seychelles reported perpetrating IPV compared to 18% of women in Botswana.

Why VAM

Violence against men is generally hidden and not recognised in many countries. In order to effectively tackle it, policy makers require more and better quality information, to guide legislative and policy reforms; to ensure adequate provision of targeted and effective services.

Getting data on VAM poses challenges due to traditional gender roles in society and the stigma of the perceived weakness of any man who admits to falling victim to a woman. In most cases VAM is foreshadowed by actions that may not seem like domestic violence on the surface, but do, in fact, represent a series of abuses against the men.

Trafficking in persons (TIP)



SADC Gender Protocol Article 20.5: State parties shall:

(a) Enact and adopt specific legislative provisions to prevent trafficking in persons and provide holistic services to the victims, with the aim of re-integrating them into society;

(b) Put in place mechanisms by which all relevant law enforcement authorities and institutions should eradicate national, regional and international trafficking in persons' syndicates;

(c)Put in place harmonised data collection mechanisms to improve research and reporting on the types and modes of trafficking to ensure effective programming and monitoring;

(d) Establish bilateral and multilateral agreements to run joint actions against trafficking in persons among origin, transit and destination countries; and

(e) Ensure capacity-building, awareness-raising and sensitisation campaigns on trafficking in persons are put in place for law enforcement officials.

SDGs 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation; and **16.1** Significantly reduce all forms of violence and related death rates everywhere.

A US State Department report in 2019 found that, globally, "traffickers are robbing a staggering 24.9 million people of their freedom and basic human dignity."[28] In SADC, where human trafficking has long been an issue because of porous borders and poverty, activists worry that it may be on the rise due to COVID-19, especially following a June 2020 report on the issue from the United Nations Office on Drugs and Crime (UNODC). It notes that already vulnerable populations have "now become even more exposed to the risk of severe exploitation as they try to identify means to secure their livelihoods."[29]

[28] https://www.hsdl.org/?abstract&did=826408
[29] https://www.unodc.org/documents/Advocacy-Section/HTMSS_Thematic_Brief_on_COVID-19.pdf

Challenging human trafficking

The Palermo Protocol defines human trafficking as the recruitment, transportation, transfer, harbouring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.[30]

> Traffickers rob 24.6 million people globally of their freedoms and basic human dignity

Cultural norms and practices remain important in shaping societies and countries. Yet traffickers often take advantage of certain practices and religious beliefs to coerce victims into servitude and forced commercial sex activities.[31] In line with the SDG 5.2 and the Palermo Protocol, there should be no exceptions when it comes to criminalisation based on cultural variations. Especially during the time of a pandemic, governments must continue to examine and understand how traffickers exploit certain cultural practices to conduct criminal activity and abuse women and girls in the region.

In response to concern regarding increased trafficking due to the pandemic, UNODC released the following recommendations in its June 2020 report, *Impact of the COVID-19 Pandemic on Trafficking in Persons*:

- ***COVID-19 responses must be continuously monitored.*** Where such measures unintentionally negatively impact vulnerable groups, such as trafficking victims, adjustments must be made to minimise harm and to ensure the needs of such groups are adequately addressed.
- ***While prioritising public health, a culture of rule of law needs to prevail.*** Anti-trafficking responses must continue to be based on human rights, while access to health care and social support without discrimination should be guaranteed.
- ***Access to justice must be safeguarded.*** Where feasible, technology should be utilised to facilitate access to judicial processes and enable the collection and provision of evidence, the submission of documents, and the filing or adjudicating of motions or petitions to courts.
- ***Law enforcement:*** officials must remain vigilant in addressing new and evolving crime patterns and adapt their responses to prevent human traffickers from acting with impunity during the pandemic.
- ***Despite the anticipated slowing down of economies because of COVID-19 and the resulting pressures on national budgets***, countries must continue supporting anti-trafficking work and adapt their assistance programmes to the new and extraordinary circumstances created by the pandemic and its aftermath.
- ***Service providers:*** must remain flexible and adapt to an evolving environment to meet the needs of their communities.
- ***There is a need for systematic data collection and analysis*** on the impact of COVID-19 on trafficking in persons. There is no country immune to the pandemic and as COVID-19 does not affect all regions at the same time, experience from one country could be vital to others.[32]

[30] https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx
[31] https://www.state.gov/wp-content/uploads/2019/06/2019-Trafficking-in-Persons-Report.pdf
[32] https://www.unodc.org/documents/Advocacy-Section/HTMSS_Thematic_Brief_on_COVID-19.pdf



Malawi: Trafficking survivors face delays in seeking justice

Activists in Malawi are sounding the alarm about delays in justice for survivors of sex trafficking.Like in many countries, criminals traffic women and girls for the purposes of sexual exploitation in Malawi. They operate in well-connected groups and capitalise on several factors. Key among them: poverty, lack of awareness about sex trafficking, and weak enforcement of laws. COVID-19 has worsened all these factors. Traffickers collaborate with pimps and collude with other criminal networks to evade justice. They use money to connect to powerful people in society, and most evade justice and courts of law in the region.

One brazen incident that involved three young women has exposed a need for political leaders to devote more resources to fight trafficking and improve justice for survivors. In 2018, traffickers recruited three girls from a remote village in Neno District in southern Malawi, promising them work in Blantyre as child minders, only to then take them to work in a brothel. After being forced to work as sex workers for three months, the young women eventually managed to escape.

Thanks to the efforts of a local organisation, People Serving Girls at Risk (PSGR), rescuers located the girls and took them to PSGR for rehabilitation. One of the young women suffered from post-traumatic stress disorder (PTSD) and took medication for a year following the incident to fight depression, nightmares, and stress. As part of the rehabilitation process, PSGR linked the girls to expert psychologists,



Young women take part in a training workshop hosted by People Serving Girls at Risk, a group that fights trafficking and exploitation of young women in Malawi, in March 2016. Photo courtesy of PSGR

and took them to recreational events to play games and engage their minds. Additionally, PSGR facilitated community reintegration. Another organisation, the Justice for Girls Project, helps these and other girls access justice.

Activists told Voice of America that they face many obstacles in seeking justice for survivors. "Lack of enforcement of laws is affecting us in so many ways," PSGR director Caleb Ng'ombo said, noting that the group deals with about 200 trafficking cases each year. "For example, for an institution to take a case to court, requires a lot of resources. And for you just to lose on a technicality is a major setback not only for us as an organisation, but also to the girls who are searching for justice."[33]

Source: SADC Protocol@Work Gender Links Summit, Malawi, 2019

[33] https://www.voanews.com/africa/charity-helps-fight-child-trafficking-malawi-country-grapples-end-vice

Sexual harassment

SADC Gender Protocol Article 22.1: State parties shall enact legislative provisions and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres and provide deterrent sanctions for perpetrators of sexual harassment.

SADC Protocol Article 22.2: State parties shall ensure equal representation of women and men in adjudicating bodies hearing sexual harassment cases.

Sexual harassment legislation: All SADC countries except Angola have legislation on sexual harassment covered in labour laws and penal codes, but many still lack specific laws that outlaw the practice.[34] Researchers have long documented the detrimental effects of sexual harassment, but SADC lawmakers have been slow to address the issue. Sexual harassment is often hidden and even normalised by the victims themselves.[35]



Sextortion increasing due to COVID-19: Sextortion, an emerging form of sexual harassment, urgently needs deterrent laws to abate it. The US Federal Bureau of Investigation (FBI) defines it as a "crime that occurs when someone threatens to distribute your private and sensitive material if you don't provide them images of a sexual nature, sexual favours, or money."[36] Sex, rather than money, is the currency of the bribe.[37] With more people staying home due to the pandemic, the FBI's Internet Crime Complaint Center has said it has seen a spike in reports of online sextortion scams.

Figure 6.2: Understanding sextortion

For sextortion to happen	• **Sexual activity:** Sextortion involves an implicit or explicit request to engage in any kind of unwanted sexual activity, which can range from sexual intercourse to exposing parts of the body. • **Corruption:** The persons who demand the sexual activity must occupy a positio of authority, which they abuse by seeking to extract, or by accepting, a sexual act in exchange for exercising the power entrusted to them.
To differentiate sextortion & other forms of sexual abuse	• **Abuse of authority:** The perpetrator uses the power entrusted to them for personal benefit. • **Quid pro quo or "this-for-that":** The perpetrator demands or accepts a sexual favour in exchange for a benefit that they are empowered to withhold or confer. • **Psychological coercion:** Sextortion relies on coercive pressure rather than physical violence to obtain sexual favours.

Source: adapted from Transparency International 2020: Breaking the silence around sextortion. The links between power, sex and corruption.

[34] Lowe-Morna, C., Makamure, L., Dube, S. (2016) SADC Gender Protocol Barometer (online) available at http://genderlinks.org.za/shop/sadc-gender-protocol-barometer-2016/
[35] Hinde, 2017. #MeToo: All Sexual Harassment Experiences Are Worth Reporting, But Don't Feel Pressured To ShareOpinion piece https://www.huffingtonpost.co.uk/entry/sexual-harassment-experiences-me-too-hashtag-pressure-to-share-stories_uk_59e5dbf1e4b0a2324d1d825e
[36] https://www.fbi.gov/video-repository/newss-what-is-sextortion/view
[37] https://www.transparency.org/whatwedo/publication/breaking_the_silence_around_sextortion

Figure 6.2 summarises the differences between sextortion and other forms of abuse, noting that sextortion relies on coercive pressure instead of physical violence.

Sextortion is part of a culture of bribery in Zimbabwe



A recent study by Transparency International in **Zimbabwe** has shown that more than 57% of women surveyed reported that they had been forced to offer sexual favours in exchange for jobs, medical care, and even when seeking placements at schools for their children. The report shows that sextortion is thus part of a culture of bribery in Zimbabwe. While there is positive momentum to understand it, sextortion remains largely invisible. It is essential that activists and policymakers develop more research projects, laws, and strategies to address it.



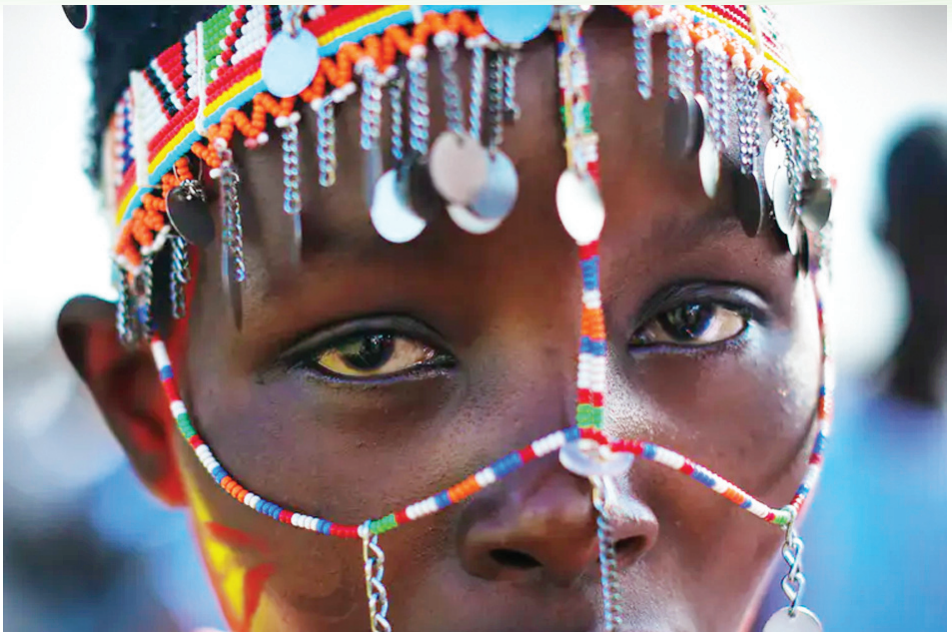
In **Tanzania**, according to the Tanzania Media Women Association (TAMWA), up to 89% of women in the public sector have experienced sextortion while looking for a job, a promotion, or while requesting a service. Meanwhile, nine in every ten women in the public sector has faced sexual harassment. Salome Kaganda, commissioner of Tanzania's independent ethics secretariat, has called for a crackdown on sextortion, "especially against officials who exercise power to sexually exploit someone for a service in his or her authority." In October 2018, a sextortion scandal concerning a lecturer from University of Dodoma made the news after students alleged the professor manipulated them for sexual favours. The story prompted debates around the definition of sextortion in the country. Sextortion affects women and girls of all ages. Indeed, some perpetrators exploit children and teens in primary and secondary schools. In Tanzania, female students complain about lecturers demanding sex from them in exchange for good grades. Catherine Olomi spoke about sextortion at the University of Dar es Salaam, noting, "Many female students get pressure from tutors to have sex for good grades. You have to be very bold to resist temptation; it involves a lot of risks such as failing exams or seating for supplementary examinations."[38] Sextortion victims can experience longlasting psychological effects. Often, they do not report the crime or do not know where to seek help as most existing SADC laws remain inadequate to prosecute sextortion. Governments need to amend or reform laws to specifically address this issue.



Salome Kaganda, commissioner of Tanzania's independent ethics secretariat, wants to see government address sextortion. Photo courtesy of Habarileo

[38] https://genderlinks.org.za/news/tanzania-say-no-to-sextortion/

Tanzania: Sexual abuse of housemaids in Mwanza



A young Masai woman in Tanzania. Photo courtesy of Child Protection Forum

In 2019, a documentary by Tanzania's Saut FM highlighted the story of young women exposed to sexual harassment in domestic housework settings and the need for structures to allow for reporting to police gender desks and known experts to deal with the cases.

The story featured young women in Mwanza who work as maids and child minders. These young women faced molestation, rape, and abuse from their employers.

In one case, a young woman whom they called "Marina," using a pseudonym, said her boss repeatedly raped her and impregnated her, later forcing her to undergo an abortion. Whilst laws and protections exist under the Child Rights and Welfare Act, young women often do not know about their rights or where to report abuse. If they do, they fear further harm from their abusers. They also told the journalists that they want to avoid humiliation, which they worry will occur if others find out about the sexual abuse.

A 2018 report by the Legal and Human Rights Centre (LHRC) noted that from January to June 2018, Tanzanians had reported 6376 incidents of violence against young girls compared to 1648 from the same period in 2017. According to the report, reasons for the increase include lack of proper care and parental guidance, household poverty, witchcraft-beliefs, and lack of awareness about child rights and family disintegration.

Journalists in Tanzania amplified this story using social media, with other NGOs and GBV organisations joining them. During the programme, Saut FM encouraged the audience to send messages to a telephone number and to follow up with a local help desk to report cases of abuse. The police desk of Igogo in Mwanza District followed up on the cases and made referrals to partner organisations. This illustrates the importance of social media as a tool in increasing public awareness and community reach on issues of violence against children and GBV.

Source: Ahimidiwe Olotu, radio presenter on Radio Saut FM Stereo, Tanzania. Prepared as part of the SADC Gender Protocol @ Work 2019

GBV in emergency situations

Large-scale emergencies like the COVID-19 pandemic leave women and children even more vulnerable, as GBV prevention and response coordination mechanisms weaken during these times. Unlike the Cyclone Idai and Kenneth crises, whose effects (though devastating) remained localised to specific regions of the affected countries, the COVID-19 public health emergency has disrupted the entire SADC region. In such situations, the need for (and lack of) stronger coordination and efficient referral pathways becomes even more apparent than in normal times.

It is well documented that weak and corrupt governments use GBV, torture, and rape as a weapon of war against women in times of crisis.[39] Activists worry that such incidences may increase as SADC governments scramble to deflect attention from their lack of preparedness for a crisis like the pandemic, as well as their inconsistent responses to it.

Confronting a GBV scourge in the time of COVID-19

The COVID-19 pandemic found many governments wanting in their preparedness as they faced a huge challenge to contain its spread and the many other related issues, including the lockdown-induced surge in GBV cases. Complications arose when shelters could not admit victims until they had received a test for COVID-19. The crisis underscored the urgent need for better emergency planning at shelters and other facilities for the vulnerable, as well as for more testing. COVID-19 test results take at least 48 hours and in some parts of the region, delays to even receive testing stretched to 14 days. NGOs and other organisations with shelters have struggled to keep up and to house and care for new arrivals during the crisis, including while they waited for test results.

Outside of shelters, women face many additional burdens at this time of crisis, including increased household chores and responsibilities, food insecurity and rising food prices, lack of access to information, and abuse in different forms, among others.



Abductions, torture, sexual abuse, and degrading activities against women activists in **Zimbabwe** have been notoriously common for decades. The most glaring of these illegal actions in recent times is the alleged abduction, torture, and sexual assault in May 2020 of three women members of the country's main opposition party. Cecilia Chimbiri, Netsai Marova, and Zimbabwe's youngest MP, Joanna Mamombe, reported that their abductors physically and sexually harassed them after taking them from a police station. Police had detained the three women following their participation in a demonstration to protest food insecurity during the COVID-19 lockdown in Harare. News reports claim that abductors working for the state took the three women from police custody and violently raped and tortured them over two days.[40] The police have made no arrests in the case at the time of publication. Instead, police arrested the women on charges of allegedly falsifying their abduction. In her open letter to the country's president, Beatrice Mtetwa, the country's top human rights lawyer

[39] "Rape - Rape as a Weapon of War."
[40] Moyo, "Maverick Citizen Op-Ed."

said, "I also wish to point out the gendered nature of these violations where it is clear that these women were targeted for these violations because they are women who have chosen to participate in the country's politics. The attack on them is therefore clearly designed to dissuade young women from engaging in politics outside of the ruling party." The Zimbabwe Human rights Commission[41] and the Zimbabwe Gender Commission[42] also strongly condemned the abductions but the state has denied any involvement, choosing to call it "stage-managed theatre." This belittling of the situation raises concerns about political commitment to gender equality and GBV elimination in Zimbabwe, especially considering the country's international commitments.

Emerging GBV hotspot: Cabo Delgado political crisis



While the focus for much of 2020 has so far been directed at stopping the spread of COVID-19 and mitigating the other social repercussions from it, activists note growing concern about insurgent activities in the Cabo Delgado region of northern **Mozambique**. To date, fighting has killed more than 900 people in the crisis since it began in since October 2017. The conflict has also displaced more than 200 000 people.[43] In a country where more than 54% of women endure physical and sexual violence and exploitation,[44] gender activists worry that the ongoing instability could weaken existing coordination mechanisms for GBV interventions and further heighten the vulnerability of women and girls to GBV.

GBV among women with disabilities

Globally, research shows that women with disabilities face a higher risk of GBV.[45, 46] These findings have led to concern among SADC activists about VAW against women with disabilities in the region. Literature from the SADC region reveals that harmful individual attitudes and values, negative cultural and social norms related to gender and disability, and a lack of access to services and public resources drives violence against this group. Evidence also shows that violence against this group leads to inability to access SRHR and increased risk of acquiring HIV.[47]

According to the United Nations Population Fund (UNFPA), while disability may lead to increased violence, violence in turn may cause a new disability or aggravate an existing disability and increase the severity of one's vulnerability. Limited awareness about SRHR, low educational attainment, lack of resources, and dependence on others all increase women's vulnerability.[48]

However, few global or regional studies have examined the specific vulnerabilities for women with disabilities. An ethnographic study[49] and an academic paper[50] in the region looked at inter-

[41] Zimbabwe Human Rights Commission, "Statement on the Abduction and Torture of Movement for Democratic Change-Alliance (MDC-A) Officials."
[42] "Advisory Statement by ZGC on Violence against Women."
[43] "Mozambique Admits Presence of ISIL-Affiliated Fighters."
[44] "Millions More Cases of Violence, Child Marriage, Female Genital Mutilation, Unintended Pregnancy Expected Due to the COVID-19 Pandemic."
[45] https://www.who.int/disabilities/world_report/2011/report.pdf (accessed 16 June 2020)
[46] https://www.samrc.ac.za/sites/default/files/attachments/2018-11-09/ALIGHTSItuationAnalsys.pdf (accessed 16 June 2020)
[47] ibid
[48] https://reliefweb.int/report/occupied-palestinian-territory/women-and-girls-disabilities-needs-survivors-gender-based
[49] https://www.researchgate.net/publication/227223945_Interweaving_Conceptualizations_of_Gender_and_Disability_in_the_Context_of_Vulnerability_to_HIVAIDS_in_KwaZulu-Natal_South_Africa (accessed 16 June 2020)
[50] Yoshida et al 2014

sectionality, disability, and HIV among women and men in Zambia. They highlighted the intersection of gender, disability, and SRHR/HIV, revealing higher risk of violence for women with disabilities but also linkages to worse SRHR and HIV outcomes for these women due to violence. A 2018 USAID study in Botswana[51] found that the country's policies and programmes to address violence (SRHR, HIV, and GBV) do not link with policies or programmes focusing on disability. This could leave this vulnerable group without protection from abuse. 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.



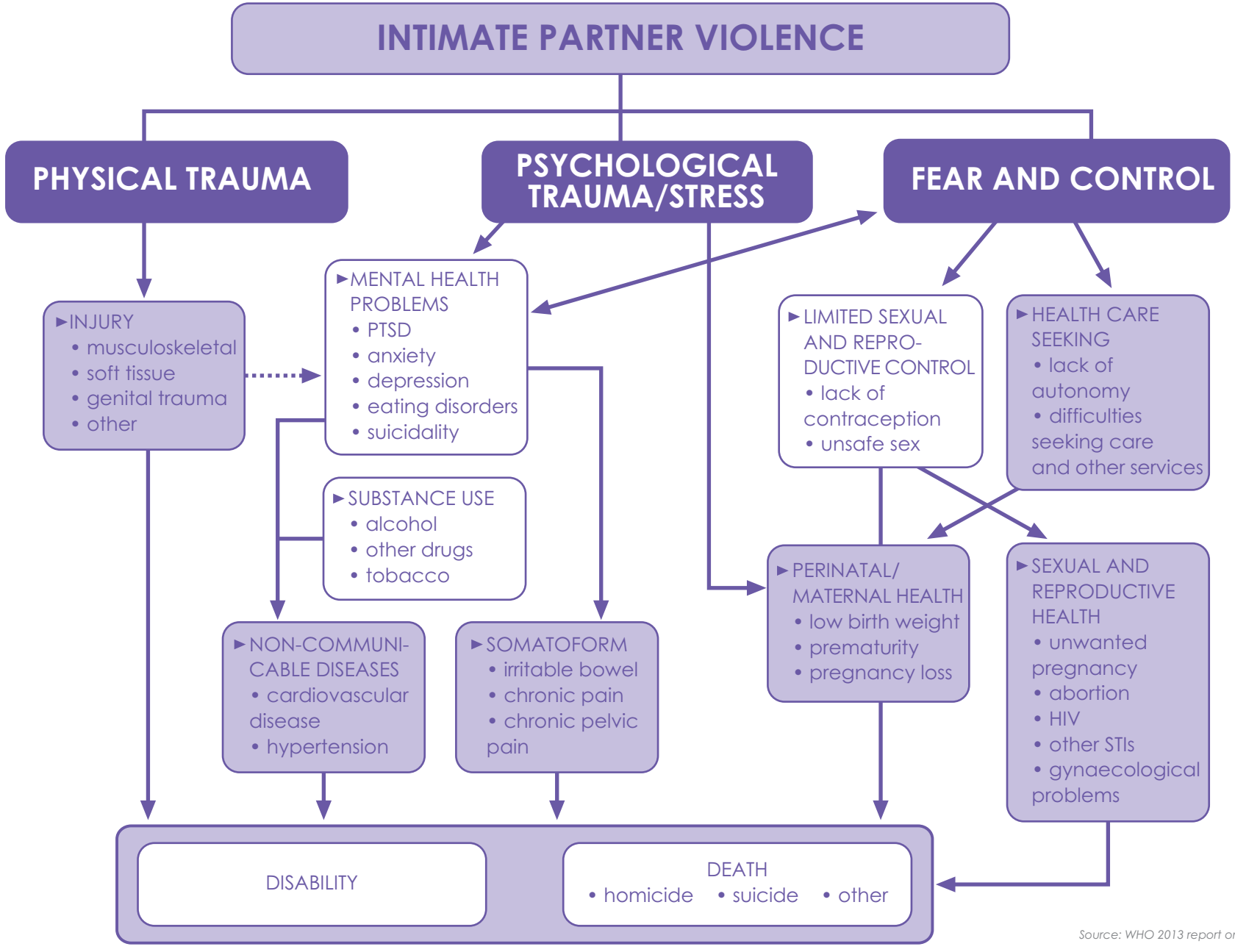
Religious leaders join gender activists in Zibagwe rural district in Zimbabwe to march for an end to GBV during the 2019 16 Days of Activism campaign.
Photo: Grace Nyikavaranda

Effects of GBV

Most population-based surveys have shown the devastating effects of GBV on women and men and society at large. Studies show that GBV leads to adverse health outcomes,[52] including physical injury; mental health challenges such as depression and suicidal tendencies; negative SRH outcomes including HIV and AIDS; economic incapacity; alcohol and substance abuse; and even death.[53] SDG 16.1 urges all countries to significantly reduce all forms of violence and related death rates.

[51] https://www.samrc.ac.za/sites/default/files/attachments/2018-11-09/ALIGHTSItuationAnalsys.pdf
[52] https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf;jsessionid=5E8EDB690C8331FBBEABB76CDEF62BA8?sequence=1 (accessed 24/04/2020)
[53] https://www.unfpa.org/gender-based-violence

Figure 6.3 Pathways and health effects of GBV



Source: WHO 2013 report on IPV.



Figure 6.3 illustrates the health effects of GBV, specifically IPV. These include the multitude of physical and psychological effects, as well as challenges linked to SRHR. For many women, these will end in death or disability.

In Sub-Saharan Africa, research has identified GBV as a major determinant of HIV infection among women. Thus, several interventions focus on the eradication of VAW to fight the spread of the HIV. Where GL has conducted GBV baseline studies and gathered "I" Stories, it has found unimaginable traumatic experiences, often made even worse when intimate partners perpetrate the abuse. Activists worry that such abuse will increase due to the COVID-19 lockdowns, as well as the effects stemming from it. A recent UNFPA analysis revealed that significant levels of lockdown-related disruption over six months could leave 47 million women in low- and middle-income countries unable to use modern contraceptives, leading to a projected seven million more unintended pregnancies and an additional 31 million GBV cases.[54]

Six months of lockdowns could result in an additional 31 million cases of GBV

The economics of violence

GBV presents a substantial barrier to sustainable development and achievement of the SDGs.[55] According to the World Bank, GBV costs an estimated 1.2% - 3.7% of GDP in some countries due to lost productivity, equivalent to the average spending of low- and middle-income countries on primary education.[56] Three prominent studies conducted in Southern Africa show a similar trend.

Table 6.4: Studies to measure the costs of GBV in SADC

Country and study	Findings	Health expenditure as proportion of GDP (%)	Health expenditure as proportion of total government expenditure (%)
Seychelles (Commonwealth Secretariat, 2018)	Seychelles loses more than US $65 million each year to VAWG. This is equivalent to 1.2% of local GDP in direct costs, and 4.6% of GDP in overall economic impact.[57]	3.9	10
South Africa (KPMG, 2014)	South Africa loses an estimated R28.4 to 42.4 billion (US $2-3 billion) per year,[58] equivalent to 0.9%-1.3% of annual GDP.	8.1	13.3
Zimbabwe (SIDA, 2009)	The Zimbabwe government spends close to $2 billion annually on direct and indirect costs of GBV.[59]	9.4	14.5

Source: Commonwealth Secretariat, KPMG, and SIDA reports.

[54] https://www.unfpa.org/news/millions-more-cases-violence-child-marriage-female-genital-mutilation-unintended-pregnancies
[55] https://www.unwomen.org/en/news/stories/2016/9/speech-by-lakshmi-puri-on-economic-costs-of-violence-against-women
[56] https://www.worldbank.org/en/news/factsheet/2018/08/30/fact-sheet-update-on-addressing-gender-based-violence-in-development-projects (accessed 24/04/2020)
[57] http://thecommonwealth.org/media/news/new-commonwealth-study-reveal-true-cost-violence-against-women-and-girls
[58] KPMG, 2014. Too costly to ignore the economic impact of gender based violence in South Africa available at https://assets.kpmg.com/content/dam/kpmg/za/pdf/2017/01/za-Too-costly-to-ignore.pdf
[59] "Gender Violence Costs Zim $2billion Annually."

Table 6.4 show that countries have huge expenditures related GBV. These include resources that governments could dedicate to social development, including achieving gender equality and empowering women and girls. By highlighting health expenditure as a proportion of GDP and total government expenditure, Table 6.3 seeks to illustrate the impact of GBV and make a business case about the importance of addressing it to the overall health of countries and their citizens: economic and physical. This is especially notable because the countries analysed still fall short of meeting key health financing goals, such as the Abuja Declaration target of allocating 15% of the government budget to health.[60]

On the ground in each country, women's lack of economic independence remains a persistent challenge, affecting many other aspects of their lives. Without much-needed economic emancipation, women remain entangled in abusive relationships. To address this imbalance, activists have urged governments to consider gender-sensitive budgeting, especially as the region looks to stimulate economic recovery following the COVID-19 crisis. Now, local governments must focus on attaining more resources and ensuring strategies to serve women's needs now and beyond the crisis period.

A global ten-country study by UN Women found that 87% of respondents believe the overall success of a country rests on creating more opportunities for women in business.[61] As schools prepare to re-open following the pandemic lockdowns, emerging evidence shows the importance of focusing on empowering women and girls through work and education opportunities. Both public and private institutions need to provide financing and support.[62] While SADC countries like Botswana, South Africa and Zimbabwe have announced economic stimulus packages of $400 million, R500 billion, and 18 billion (Zimbabwe dollars) respectively, it remains to be seen how much of these funds they will channel towards enhancing the economic independence of vulnerable women and girls.



Local government in the Murewa community in **Zimbabwe** has been rolling out sensitisation on gender issues and assisting GBV survivors through entrepreneurship trainings and financial assistance. The Sunrise campaign to empower women and end violence spurred this work, including the local council's income generating project (revolving fund) for women. Council's other GBV interventions include construction of a one-stop GBV victim friendly centre at the Murewa District Hospital and offering free land to a partner (Rozaria Memorial Trust) to develop an education and information centre for women in 2018. The centre now provides safe shelter for GBV survivors and a special counselling room for girls.[63]



Following the GBV summit in 2018, and the nationwide campaigns in **South Africa** led by the #Totalshutdown, #MyBodyNotYourCrimeScene, and #24Demands campaigns, civil society organisations presented suggested amendments to parliament linked to specific policies and laws. This included the request to develop a National Strategic Plan. As part of government and civil society's multi-sectoral strategic framework, this initiative aims to work with government to help the country address economic inequalities and achieve freedom from GBV and femicide. The Ministry of Women has set up a COVID-19 Emergency Response Action Plan, which includes the appointment of a steering committee of government and civil society representatives.

SADC countries have begun easing lockdown restrictions to allow economic activities to commence, but the region will feel the effects of the lockdowns for some time, including in relation to the costs of increased GBV during these months. While South Africa has announced specific support measures to women-led businesses, it is clear there will be further need for new investments to mitigate the pandemic's disproportionate impact on women and girls.

[60] https://www.afro.who.int/sites/default/files/2017-06/state-of-health-financing-afro.pdf
[61] https://www.unwomen.org/en/digital-library/publications/2020/06/gender-equality-attitudes-study-2019
[62] "The Sunrise Campaign - Gender Links."
[63] SADC Gender Protocol @ Work Summit, Zimbabwe, 2020.

Response

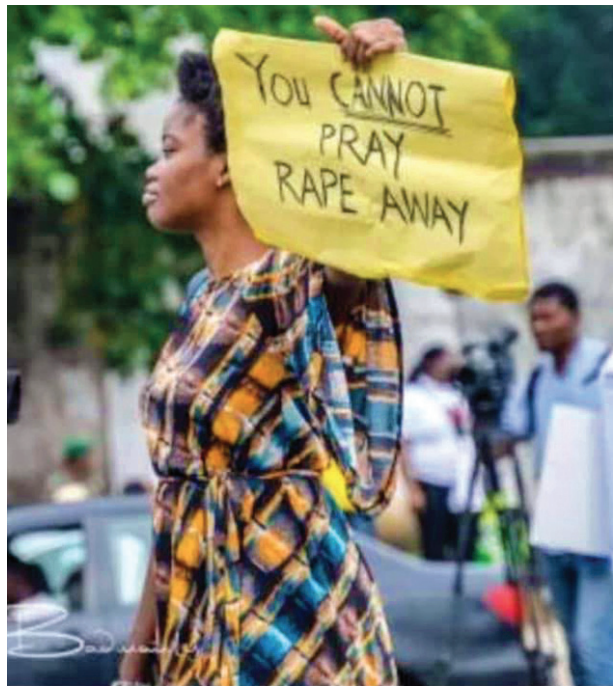
SADC Gender Protocol Article 20.1: States parties shall:
(a) Enact and enforce legislation prohibiting all forms of gender-based violence;
(b) Develop strategies to prevent and eliminate all harmful social and cultural practices, such as child marriage, forced marriage, teenage pregnancies, slavery and female genital mutilation; and
(c) Ensure that perpetrators of GBV, including domestic violence, rape, femicide, sexual harassment, female genital mutilation and all other forms of GBV are tried by a court of competent jurisdiction.
(d) **SADC Gender Protocol Article 20.6:** State parties shall ensure that cases of gender-based violence 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 realization of SRHR in the region (SDGs 5.1 and 5c).
Maputo Protocol 2(a): States parties shall take appropriate and effective measures to: Enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public.

The SADC regional strategy and 2018-2030 Framework of Action for Addressing Gender Based Violence confirm that the region has made progress around legislation dealing with GBV, either through specific laws or penal codes. However, activists have been calling for more reviews to expand the scope of legislation to respond.

The COVID-19 crisis accentuated this need, highlighting gaps throughout the region that have life-threatening consequences for its citizens. For instance, government leaders need to strengthen laws to deal with police brutality and abuse in emergency situations. Reports from across the region have shown that, in addition to domestic violence, a great deal of women and children suffer physical and sexual violence at the hands of law enforcement. A crisis like COVID-19 worsens these abuses, giving licence to perpetuate abuses against the backdrop of curfews and



An activist in Bitou, South Africa, protests against GBV in September 2019.
Photo: Vinthi Neufeld

lockdowns. Sometimes it takes a crisis to change deeply ingrained gender attitudes and norms.



With several plans and policies under review, **South Africa** provides a positive example for the region. Laws under review there include the National Development Plan (NDP) Vision 2030; National Gender Policy Framework; Social Development Guidelines on Services for Victims of Domestic Violence (2010); National Sexual Assault Policy (Department of Health); a civil union bill; a criminal law (sexual offences and related matters) amendment bill; and the domestic violence amendment bill 2020.[64] These welcome adjustments to current legislation will allow the country to respond better to its high rates of GBV.

The Judicial Services Commission (JSC) updated and launched the revised Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in **Zimbabwe** in November 2019.[65] Various groups developed the protocol as a toolkit to give guidance in the referral pathway for those handling sexual abuse. It also stipulates the minimum care package required by survivors of sexual violence. The protocol seeks to safeguard the rights of survivors of sexual and GBV and abuse, guaranteeing that the welfare and justice systems provide them with a holistic package of age- and gender-sensitive, survivor-centred services for their psychosocial well-being and protection. It also focuses on providing a standard set of procedures to ensure a holistic response for all survivors. Further, it aims to strengthen and clarify the roles and responsibilities between service providers and agencies that have legal and thus obligatory responsibilities in the delivery of survivor-centred services, thereby enhancing their accountability and credibility.[66]





Eswatini: New protections for women prove controversial

In a major step toward curbing domestic violence in the country, legislators in Eswatini enacted the Sexual Offences and Domestic Violence Bill in 2018.

The new law aims to, among other things, promote the realisation of the rights of women and girls in Eswatini; include all sexual crimes into one law; and make all forms of sexual abuse or exploitation a crime in order to protect both men and women.

While the Coordinating Assembly of Non-Governmental Organisations (CANGO) said the new SODV act will help tackle VAWG and GBV in the country, others, including some governing politicians, have come out against it.



MP Princess Phumelele has spoken out against the new SODV act.
Photo courtesy of Swazi Observer

MP Princess Phumelele, a member of the country's royal family, has slammed the SODV, saying it could spark domestic violence because men might not accept that their wives can refuse

[64] GL Audit of SRHR Policies and Laws in SADC, 2020
[65] https://musasa.co.zw/gender-based-violence-in-any-form-is-never-acceptable/ (accessed 24/04/2020)
[66] Multi-sectoral Protocol on the Management of Sexual Abuse and Violence in Zimbabwe, 2019

to engage in sexual relations. Others said they worried that the act might only protect women so it could be unconstitutional.

These comments sparked outrage among human rights activists, who have defended the new act. Nkosingiphile Myeni, CANGO's communications officer, said the act is one of the most comprehensive laws made in the country, noting that various groups, including MPs, had engaged in country-wide consultations before the bill became law.

Myeni encouraged people to read the SODV Act so that they can speak about it from a place of knowledge, noting that it sets out to protect all citizens in Eswatini.

Source: Sifisiso Nhlabatsi is a journalist from Eswatini. This story is part of the Gender Links 16 Days News series. https://genderlinks.org.za/news/sodv-act-most-comprehensive-law-in-gbv-fight-cango/

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 gender-based violence.

SADC Gender Protocol Article 23.3: State parties shall provide accessible, affordable, and specialised legal services, including legal aid, to survivors of gender-based violence.

SADC Gender Protocol Article 23.4: State parties shall provide specialised facilities including support mechanisms for survivors of gender-based violence.

Despite all SADC countries having accessible, affordable, and specialised services for survivors of GBV, legal aid stands out as a big gap in most countries. The 2016 Global Study on Legal Aid by UNODC, which included five SADC countries from the SADC region - Angola, DRC, Mauritius, Seychelles, and South Africa[67] - shows that one-third of 153 countries have not yet enacted specific legislation on legal aid and only half offered legal aid to GBV survivors.

GL studies in seven countries show a similar trend but observed that some NGOs provide these services, albeit with funding constraints. For South Africa alone, civil society oversees 60% of social services that support women. These findings leave most women who cannot afford justice to look to men for support. These barriers also force women to use alternative dispute resolution mechanisms and avoid litigation. The costs of travel to access justice, costs of engaging lawyers, as well as the subjective costs that come from religion, stigma, and tradition all delay and consequentially deny justice to GBV survivors.

In the wake of the COVID-19 lockdowns, activists raised critical concerns about the accessibility of specialised GBV units during the pandemic. Movement restrictions left many women unable to access shelters, along with justice and health services, which restrictions also disrupted. Agencies across the region encouraged SADC leaders to consider GBV services as essential services throughout the pandemic period to enable

[67] UNODC Report (2016) available https://www.unodc.org/documents/justice-and-prison-reform/LegalAid/Global_Study_on_Legal_Aid_-_FINAL.pdf (cited in SADC Barometer 2019).

women to access them at any given time without violating lockdown restrictions.

GBV service providers also struggled to secure essential resources, such as rape kits and materials needed for clinical management of rape survivors, as governments closed borders to control the spread of the virus. Another concern for many involved the question of whether governments had provided adequate resources to support GBV service providers and women and girls who seek services such as alternative accommodation away from homes where they have isolated with their abusers. GBV service providers also need personal protective equipment to assist women, as many feared COVID-19 infection could spread at shelters.

The pandemic has illustrated that it is important not to rely on only one form of service provision. GBV service providers should therefore invest in a variety of delivery options, including low-tech responses like SMS-based solutions that cater for women who may not have access to android phones and internet data. Countries like France have set up GBV pop-in centres in grocery stores where women often shop.[68] SADC should replicate successful programmes like this.

Training of service providers

SADC Gender Protocol Article 24: State parties shall introduce, promote and provide:
(a) Gender education and training to service providers involved in gender-based violence, including the police, the judiciary, health and social workers;
(b) Community sensitisation programmes regarding available services and resources for survivors of gender-based violence; and
(c) Training of all service providers to enable them to offer services to people with special needs.
BPFA +20 Africa Declaration (4.1): Enact and strengthen the enforcement of laws addressing and punishing all forms of violence against women and girls through adequate resource allocation and targeted capacity-building of law enforcement agencies, including the judiciary.

Pre-service and on-the-job training remains a crucial element of GBV response and agencies should integrate it into all training for GBV services providers. Research in the region has shown that the attitudes of police officers and health workers toward GBV survivors discourage women and girls from reporting violence.[69] To achieve the SADC Gender Protocol Article 24 and the BPFA +20 Africa Declaration targets, service providers need to be well trained, have a positive and caring attitude, and offer quality service.



Puleng Khosi asks a question during a training session on essential GBV services in Quthing, Lesotho, in October 2019. Photo: Ntolo Lekau

[68] Erskine, "Not Just Hotlines and Mobile Phones:"
[69] GL GBV Baseline studies in seven SADC countries

Zimbabwe Women Lawyers Association (ZWLA) reports that women complain about the service from justice institutions and providers who have not received proper training. One example involved a pregnant woman whose husband stabbed her. She explained how the police came to take a statement while she was in hospital. "My first problem with police is they came to take a statement while I was on oxygen [on a respirator machine]," she said. "Then the court said I was absconding at least three or more times. They also were not considering my condition, my operation [from surgery] had not even healed, my wounds were fresh. The magistrate was also saying this woman is not serious as she is absconding."

Violence against men studies have found that men shy away from reporting as they also face ridicule from police and other service providers.[70] Emerging evidence shows that the establishment of victim support units within police stations helps mitigate this and has resulted in increased training of police officers throughout the region.[71]

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 gender-based violence.

While prevention is often put at the end of the chain in GBV management, efforts to address social norms, structures of gender inequality, and the general acceptance of VAWG should be at the centre of all such strategies. Activists see primary prevention efforts as particularly crucial since response services by themselves, albeit crucially important, are unlikely to yield a significant reduction in the perpetration of violence.[72] Primary prevention initiatives play vita role to response and care services for survivors.[73]

Recognising this role, researchers, civil society, and international organisations have increasingly promoted primary prevention efforts and engaged in research on their effectiveness. Because GBV response remains the focus in large parts of the world - including many SADC member states, which see fierce competition for funding - these various actors also advocate for increased investments in primary prevention.[74]

The attitudes of police officers and health workers toward GBV survivors discourage women and girls from reporting violence

[70] https://info.undp.org/docs/pdc/Documents/NAM/UNAM%20Research%20GBV%20Report%202015.pdf
[71] "SADC Gender Protocol Barometer 2017 - Gender Links."
[72] García-Moreno et al., "Addressing Violence against Women."
[73] Jewkes and Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa."
[74] Jewkes and Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa."

GBV campaigns

To date, all SADC countries have implemented prevention strategies to raise awareness and advocate for GBV prevention. These include engaging in coordinated campaigns such as the annual 16 Days of Activism and One Billion Rising, themed "Raise the Vibration Rise for Revolution 2020." Regionally, the NGO sector, governments, academia, and international development partners continue to emphasise the need for evidence-based, theoretically grounded, and technology-based interventions.



In August 2018, the World Bank committed $100 million to help prevent GBV in the **DRC**.[75] Its Gender-Based Violence Prevention and Response Project will reach 795 000 direct beneficiaries over the course of four years. The project will provide help to survivors of GBV and aim to shift social norms by promoting gender equality and behavioural change through strong partnerships with civil society organisations.

Elsewhere in the region, SADC first ladies have taken up the issue, highlighting their commitment to fighting GBV and using their influence and platform to underscore political commitment in their countries.



In **Madagascar**, the nomination of First lady Mialy Rajoelina as the UNFPA ambassador on the fight against GBV and child marriage provided a renewed incentive for government to engage in the issue.[76] Many activists welcomed the appointment, which came at the same time as the 50th anniversary of the UNPFA's presence in Madagascar. A first lady fighting for the cause provides an opportunity to influence government and other decision-makers. Indeed, many saw the appointment as the catalyst that sparked government's interest in GBV. It also led to the passage of a new bill that caused a public outcry for a different reason: critics said the law would pave the way for same sex marriage. However, the government clarified its intent, noting through a spokesperson that, "This law was designed to protect women and children who are the main targets of violence in the home, in the family or at the level of society, because they are too often still considered vulnerable and easy to abuse... No article of the said law favours the marriage of two persons of the same sex."[77]



In her role as the country's health ambassador, **Zimbabwe**'s First Lady Auxillia Mnangagwa took time while speaking at a pandemic awareness programme to also mention the rising cases of GBV during the COVID-19 lockdown. She raised concerns about Zimbabweans who had been spending time in each other's homes fighting during the crisis. "Now if the elderly fight, what sort of example are we setting? *Vana vanozodzidzei?* [what do the children learn?]... Because of the lockdown, young couples are spending more time together and I am told some are using this to fight."[78] She then encouraged the elderly to counsel young couples and encouraged all citizens to report violence to the police and courts so that victims do not suffer in silence.

All SADC countries have implemented prevention strategies to raise awareness and advocate for GBV prevention

[75] "DRC - Gender Based Violence Prevention and Response Project."
[76] Utilisateur, "50ème Anniversaire Du Fonds Des Nations Unies Pour La Population41 Années de Son Implication à Madagascar."
[77] "Polémique Stérile Sur La Loi Sur La Lutte Contre Le VBG - Le Gouvernement Siffle La Fin."
[78] Rupapa, "Zimbabwe."



Malawi: New funds will spotlight GBV



Former Malawi Gender Minister Mary Navicha. Photo courtesy of YouTube

The European Union selected Malawi and seven other African countries in 2019 to receive part of a global grant of €500 million to implement the Spotlight Initiative, which focuses on eliminating VAWG, including SGBV and harmful practices.

For Malawi's minister of gender, it means the country's battle against GBV will go beyond the annual 16 Days of Activism.

Former Gender Minister Mary Navicha said Malawians must join hands and condemn violence against women all the time and bring perpetrators into the open to face the law and deter others from committing similar offences.

"Let us put GBV into the spotlight and end all forms of violence against women and girls," said Navicha, noting the initiative will help women and girls to speak out on issues of GBV.

According to a press release from the government, "In addition to enabling a holistic approach to end violence against women and girls, the initiative will promote Agenda 2030's guiding principle of 'leaving no one behind' and build on the momentum of the Sustainable Development Goals (SDGs) efforts, especially Goal 5 on gender equality and women's empowerment."

Navicha said government will work with civil society, including through its NAP, to eliminate GBV and trafficking. "All we are trying to do is to make sure that no woman or girl is left behind or should continue to suffer in silence. We are taking a new direction that empowers women to talk about their rights and take issues of violence head on," she said.

The Spotlight Initiative has partnered with faith-based institutions on GBV advocacy campaigns. Their work together engaged more than 1000 women faith-based leaders and influencers through a partnership with the Seventh Day Adventist Church's "End It Now" campaign. Through these efforts, the religious and community leaders committed to address norms that promote harmful attitudes and behaviours around VAWG in churches and other spaces where they have influence.[79]

Source: SADC Protocol@Work Summit, Malawi, 2019

[79] https://endvawnow.org/uploads/browser/files/spotlight_initiative_early_results_report_-_november_2019.pdf

Religious groups campaign against GBV

Spiritual leaders across SADC have stepped up their campaigns against GBV through an inter-faith initiative that brings together leaders from African (traditional religion), Christian, Islamic, and Bahai faiths. Some religious groups actively participate in the 16 Days of Activism annual campaigns. Group members have sought to deepen awareness of GBV and religion. Further, the group engages in the interfaith "Thursdays in Black" campaign against GBV, which has been gaining momentum. The World Council of Churches campaign looks to mobilise the faith community to recognise the urgency of addressing GBV. It challenges people of faith to prioritise response to GBV within their communities.[80]

THURSDAYS IN BLACK: RESISTANCE AND RESILIENCE

The campaign is simple but profound. Wear Black on Thursdays. Wear a pin to declare you are part of the global movement resisting attitudes and practices that permit rape and violence. Show your respect for women who are resilient in the face of injustice and violence. Encourage others to join you. Often black has been used with negative racial connotations. In this campaign Black is used as a colour of resistance and resilience.

Role of the media

SADC Gender Protocol Article 29.7: State parties shall take appropriate measures to encourage the media to play a constructive role in the eradication of gender-based violence by adopting guidelines which ensure gender sensitive coverage.

The Protocol urges the media to ensure gender equality in and through the media and to challenge gender stereotypes. The Protocol also discourages media from promoting pornography and violence against all persons, especially women and children.[81]

The media continues to play a key role in raising public awareness and contributing to the discourse on GBV prevention, response, and support activities.[82] Social media has emerged as a crucial tool for sharing news and information, both accurate and false. In today's world - awash with fake news and leaders who refer to genuine news as fake news - the media remains more critical than ever in counteracting myths and negative attitudes that may perpetuate violence. The COVID-19 pandemic underscored this need, as citizens across SADC relied on local news and social media for updates about health issues and government response measures.

[80] https://genderlinks.org.za/wp-content/uploads/2020/04/Interfaith-Brief-on-Gender-Based-Violence.pdf
[81] SADC Protocol on Gender and Development Article 29 (1-7).
[82] Chiramba, K. Musariri, L and Rasesigo G, (2018). Botswana Relationship Study. MNIGA.



Botswana: Survivors' message resonates around the world

Over a few months in 2018 and 2019, seven young women embarked on a project in Botswana that led to both digital and personal transformations.

The project, led by Women Against Rape (WAR), an organisation based in Maun, in northwest Botswana, identified young women who had experienced violence and travelled far enough along in their healing journeys that they could revisit and re-tell their stories without experiencing further trauma.

The seven girl champions produced digital stories about the abuse they had experienced, which WAR then shared via Facebook and Twitter.

Through the exercise, the girls gained confidence and felt heard and validated by other GBV survivors and the public.

Meanwhile, community members, professionals, and family members read the digital stories and saw the impact and power of listening to survivors simply to hear their stories rather than to fulfil a separate agenda.

More than 565 community members viewed the powerful digital stories and videos, which reached more than one million others on social media, hopefully increasing awareness and reducing instances of violence as well as the fear of reporting.



Gofileone Gontle Samakabadi, a Botswana gender activist, worked with Women Against Rape to raise awareness about GBV in Maun, Botswana, in September 2017. Photo: Bangwe Chalebgwa

Through this strategy, WAR aimed to give survivors a voice and a safe platform to share their stories, empowering the survivors to be open and honest about their experiences, while keeping their identities confidential. By creating these digital stories for social media, people heard the messages of the survivors all around the world.

Source: Gofileone Gontle Samakabadi from WoMen Against Rape Botswana as part of the SADC Protocol@Work Summit 2019

Social media

Its ability to disseminate content far and wide has made social media an effective campaign tool in raising awareness around GBV laws and GBV in general. Twitter and Facebook campaigns represent the leading social media platforms, and activists in the region increasingly use both to share country-specific and global campaigns such as, #24Demands, #AmINext, #MeToo, #TotalShutDown, #NotInMyName, and #NotOurLeaders, to name but a few. The momentum towards a change in thinking, from response to prevention, has intensified as more

voices speak out at various levels and on various platforms. A 2018 study in Botswana shows a notable increase in awareness of both GBV laws and campaigns from 2012 to 2018 thanks to social media.[83]

Social media proved useful during COVID-19 lockdowns to promote materials on a broad array of GBV topics and inform men and women about service availability across the region. This enhanced knowledge on several issues, including awareness about increases in sexual violence, rape, and mental health. Social media also provides an effective tool for crowdfunding against GBV. To fundraise for female students against GBV over the past year, students at the University of Cape Town used the hashtag #IWillNotBeNext on BackaBuddy, a crowdfunding platform that helps create campaigns to raise funds for positive impact on individuals, communities, and the environment.[84]

Social media also plays a significant role in perpetuating gender stereotypes and many men still use it to share derogatory comments and content that perpetuate ideas of women as sex objects. This makes social media a valuable tool for activists to also transform negative perceptions.[85] As the world continues to move in the digital direction, organisations must devise innovative ways of tapping into the many advantages of digital technology to protect women and girls at risk of GBV.

SADC: Growing role for "hashtag advocacy"

A recent study of social media datasets found a marked increase in online advocacy against GBV due to "hashtag advocacy," but researchers note that this change may be short-lived and connected to targeted campaigns. The research, carried out by MEASURE (Monitoring and Evaluation to ASsess and Use REsults) Evaluation, an agency that provides technical leadership to advance the field of global health monitoring and evaluation, assessed sexual relationships between younger women and older men and attitudes on GBV against women and girls.

The study looked at ten countries in Sub-Saharan African, including eight in SADC (Eswatini, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe). All have programmes funded under the umbrella of USAID's Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) programme, which focuses on adolescent girls and young women.



A recent study found that "viral" events, like the 16 days of Activism campaign, influence online discussion. Photo courtesy of MEASURE Evaluation

DREAMS aims to curtail HIV transmission among young women in countries with the highest HIV burden. Results show that social media data can be useful. The study obtained a picture of the conversations around popular hashtags and discovered how hashtags change quickly. Because the data is 100% user-generated, it removed most researcher bias.

The study observed how news articles and "viral" events, like the 16 days of Activism campaign, influence online discussion. Data collection in 2017 overlapped with this cam-

[83] Chiramba, K, Musariri, L. and Rasesigo, G. (2018). Botswana Relationship Study, MNIGA.
[84] "UCT Students Crowdfund to Retaliate against Gender-Based Violence."
[85] https://www.unwomen.org/en/digital-library/publications/2020/06/gender-equality-attitudes-study-2019 (accessed 17 June 2020)

paign and showed a decrease in social media posts defending GBV and a spike in comments decrying violence.

However, shortly after the campaign, sentiments expressed about GBV returned to the original, less impassioned attitude.

Evidence shows that "hashtag advocacy" can be fleeting in its success at changing opinion and that follow-on work will be needed to fan the flames of change that may begin during social media campaigns.

Adapted from: https://www.measureevaluation.org/resources/newsroom/news/can-analysis-of-tweets-inform-interventions-to-prevent-gender-based-violence

Restorative justice



SADC Gender Protocol Article 20.4: State parties shall put in place mechanisms for the social and psychological rehabilitation of perpetrators of gender-based violence. **SADC Gender Protocol Article 23.5:** State parties shall provide effective rehabilitation and re-integration programmes for perpetrators of gender-based violence.

Emerging evidence suggests that achieving SADC Gender Protocol Article 20.4 and 23.5 means working more meaningfully with the perpetrators of violence. In this instance, men represent the main perpetrators due to several factors, including negative constructions of masculinity in the region. Countries can only manage to prevent violence if they invest in programmes to change attitudes, identities, and relations that encourage violence. One way of achieving this is by altering the perceptions of those involved. The SADC GBV strategy framework 2018-2030, notes that regional GBV prevention and response has seen limited male involvement and few programmes to support rehabilitation and integration of GBV perpetrators into the community.[86]

While anecdotal evidence suggests the existence of psychological rehabilitation for perpetrators of GBV in the region, governments must continue to both scale up this important work and document it for effective monitoring and learning of best practices. Analysis of national action plans shows that Malawi has planned to increase perpetrator accountability and rehabilitation. A stronger network of relevant agencies and actors needs to support this work, including working with men at all levels in communities.

Countries can only manage to prevent violence if they invest in programmes to change attitudes, identities, and relations that encourage violence

[86] https://www.unodc.org/documents/southernafrica/Stories/2019/SADC_Regional_Strategy_and_Framework_for_Action_on_GBV_-_FINAL_September_2018_-_ENGLISH_VERSION.pdf

Engaging men and boys in the fight against GBV



Men take part in the 16 Days of Activism campaign in Siteki, Eswatini, in November 2019. Photo: Thandokuhle Dlamini

As activists continue to understand the magnitude of GBV in the region, especially during the COVID-19 lockdowns, the need to work with men becomes even more apparent. Through its GBV strategy framework 2018-2030, SADC leaders identified men and boys as key change agents in the fight against GBV. Work has already begun with local civil society organisations and regional networks that link to global alliances such as the Men Engage network, which promotes gender equality through transforming masculinities.[87] Given the power that traditional and religious leaders have in local communities across the region, it is especially important to work with them on setting positive examples in the fight against VAWG.[88]

Based in Gaborone but with a wider reach in all corners of the country, Men and Boys for Gender Equality (MBGE) engages men and boys to address GBV and promote gender equality in **Botswana**. The organisation partners with GL to advance gender justice. MBGE uses a robust public education programme through various media, including radio and television shows, adverts, social media, and community presentations in *kgotlas* (public meetings) and workshops. It offers the following programmes: "One man can," which focuses on training men on issues around GBV; "Men care," which trains expectant fathers about their responsibilities during the pregnancy period, birthing, and in child rearing; and "Love to Live," an alcohol rehabilitation intervention project funded by the Ministry of Health and wellness that targets youth in an attempt to decrease substance abuse and rehabilitate former addicts in their societies and families. MBGE has recently been at the forefront of demands for justice during the COVID-19 lockdown following accusations against a Botswana MP who allegedly raped a minor.[89]

Changing narratives on GBV

GBV is gradually entering mainstream political discourse in SADC. Many leaders now publicly acknowledge the scourge of GBV, including the huge financial strain it presents. However, the bold actions required to address widespread GBV in the region require a concerted commitment and long-term investment - something that has often been lacking. The COVID-19 pandemic highlighted this lack of vision and regional incoherence, as leaders signed off on restrictions that endangered women, shuttered essential GBV services, and possibly set the region back

[87] "MenEngage."
[88] Machisa & Chiramba (2013)
[89] https://genderlinks.org.za/casestudies/botswana-men-and-boys-for-equality/

after years of progress to reduce GBV. Social media has also provided new opportunities for activism, forcing politicians to respond.

South Africa, still in the grips of the #TotalShutdown campaign reported in last year's #VoiceandChoice Barometer is an example of how feminist action has forced the matter onto the political agenda. A new cycle of horrendous acts of VAWG made headlines in 2019. This included the rape and murder of several women, Uyinene Mrwetyana, Leighandre Jegels, Janika Mallo, and Ayakha Jiyane, as well as the murder of Jiyane's three little siblings. Following a series of street and online protests employing the hashtag #AmInext, the government made seven pledges to end violence against women: 1) Establishing dedicated sexual offences courts (South Africa has had 92 courts established since 2013 and it will now add 11 more); 2) A fully accessible register of sexual offenders; 3) Stricter jail sentences and focus on rehabilitation programmes; 4) Strengthened response to GBV; 5) Strategic partnerships to end GBV by 2030; 6) Fighting xenophobia; and 7) Improved justice for victims and survivors. GBV again came into focus during the COVID-19 lock down - this time prompting an impassioned plea from the President, who devoted half of a nation-wide speech on easing lockdown restrictions to the twin pandemic of GBV.

South Africa: President commits funds to fight GBV pandemic



In a speech announcing the easing of COVID-19 restrictions in June, South African President Cyril Ramaphosa pledged R1.6 billion to fight GBV in the country. Photo courtesy of Times Live

As South African President Cyril Ramaphosa eased the restrictions put in place to prevent the spread of COVID-19, he reminded citizens in a nationwide televised address on 17 June that the nation continues to deal with another deadly pandemic: "the killing of women and children by men in the country."

Ramaphosa signalled the government's commitment to end GBV in South Africa, which has some of the highest rates of violence against women and children in the world. "As a man, as a husband and as a father, I am appalled at what is no less than a war being waged against the women and children of our country," he said.

In a move that gender activists celebrated as game-changing - even if long overdue - the government committed R1.6 billion to its Emergency Response Plan to combat GBV and femicide in South Africa.

Ramaphosa named some of the victims of GBV, including the elderly, and bemoaned the killings of 21 women and children during the COVID-19 lockdowns. He also commended the South African Police Service for their work in arresting almost all of the alleged perpetrators.

Along with the new funding, the president announced that the government now has a National Strategic Plan to guide the country's effort to fight GBV in place. This includes increasing support to the GBV hotline and shelters and providing new supports for victims of sexual violence.

Other measures announced include:

- The Department of Social Development will now use 10 government-owned buildings as shelters, addressing one of the biggest challenges facing survivors who want to leave abusive relationships;
- Government has upgraded 13 regional courts into sexual offences courts to support the work of law-enforcement;
- Government agencies will distribute 7000 evidence collection kits to every police station in the country and South Africa now has more than 1000 survivor friendly rooms at police stations;
- Many police, prosecutors, magistrates, and policymakers have undergone sensitivity and awareness training, and more than 3000 government employees who work with children and mentally disabled persons have been checked against the National Register of Sex Offenders; and
- The government has prepared legislative amendments around, among other things, minimum sentencing in cases of GBV, bail conditions for suspects, and greater protection for victims of IPV.

In a nod to gender activists who have coined the hashtag #FemaleLivesMatter, Ramaphosa noted an urgent need to speak out against GBV, noting that, by looking away, by discouraging victims from laying charges, by shaming women for their lifestyle choices or their style of dress, we become complicit in these crimes.

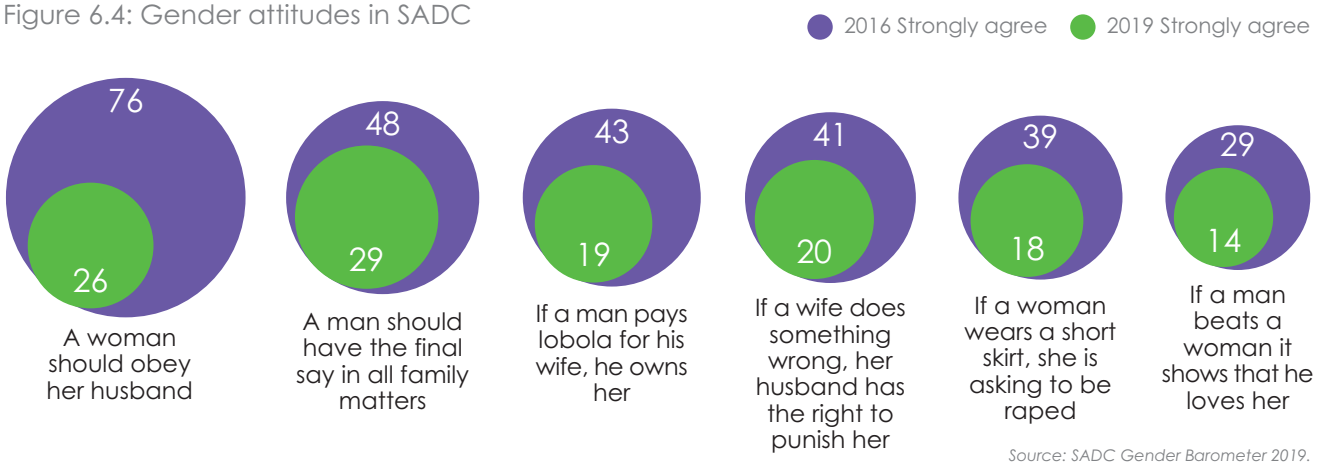
Source: various news reports, including News24 and CNN. https://www.news24.com/news24/SouthAfrica/News/full-text-these-are-the-new-changes-to-level-3-lockdown-as-ramaphosa-eases-restrictions-20200617?isapp=true

Attitudes

Social norms that promote gender inequality can increase violence and compromise women's sexual and reproductive health. Transforming inequitable gender norms (i.e., societal messages that dictate appropriate or expected behaviour for males and females) remains an important strategy to eliminate GBV, counter the spread of HIV, and generally improve reproductive health.[90]

Over the years, GL has asked survey participants for their attitudes on several provocative statements and questions. The responses obtained between 2016 and 2019 show deep patriarchal and sexist attitudes remain in some areas, but overall demonstrate a significant shifting of views that could highlight a broad positive societal shift in attitudes.

Figure 6.4: Gender attitudes in SADC



Source: SADC Gender Barometer 2019.

Figure 6.4 illustrates (without significant changes from the 2019 edition), a clear shift in attitudes in a short time. Between 2016 and 2019, the percentage point of those who strongly agree with the problematic statements ticked downward - in some cases quite substantially. For example, the number of respondents who said a woman should obey her husband dropped from 76% in 2016 to 26% in 2019. However, activists recognise that a lot of work remains to transform attitudes in the elderly cohorts. For example, during a COVID-19 awareness programme led by Zimbabwe's first lady, some elderly women revealed that they would never report their husband to the police, even when he severely beat them.[91]

In 2019, UN Women released a *Gender Attitudes Study* that showed that, beyond biases in attitudes today, most people see gender equality as essential. More than 90% of respondents believe more respect for women's rights in all areas is important to their country's future success. Similarly, more than 90% of respondents believe in equal pay for equal work, and 87% believe more opportunities for women in business are important for the overall success of their country.[92]

Integrated approaches

SADC Gender Protocol Article 25: State parties shall adopt integrated approaches including institutional cross-sector structures, with the aim of eliminating gender-based violence.

All SADC countries have created 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 the countries in which GL conducted GBV baseline studies, it continues to work with national and local governments to develop action plans to end GBV.

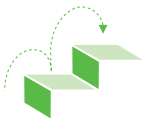
In **Lesotho**, a 2018 report on the prevention of violence against women and girls by Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) notes that lawmakers drafted a gender and development policy in 2003, reviewed it in 2016, and finally adopted it in July 2018. Based on efforts by the Ministry of Gender and Youth, Sports and Recreation (MGYSR), Lesotho adopted the 2011-2016 National Action Plan to End Violence Against Women in 2011,[93] but it now needs a new action plan to operationalise the new gender policy. Furthermore, lawmakers have been working on a Domestic Violence Bill. While all three instruments would be central for coordinating and guiding efforts to combat VAWG in Lesotho, their revision or approval remains pending, and legislators have yet to pass the Domestic Violence Bill.[94]

[90] https://www.measureevaluation.org/prh/rh_indicators/mens-health/me/percent-of-men-who-hold-gender-equitable-beliefs
[91] https://allafrica.com/stories/202005220677.html
[92] UNWOMEN https://www.unwomen.org/en/digital-library/publications/2020/06/gender-equality-attitudes-study-2019
[93] https://aidsfree.usaid.gov/sites/default/files/aidstar-one_prc-lesotho_lr_web.pdf (accessed 29/04/2020)
[94] Gender Links (2018). Lesotho: Domestic Violence Bill, hope to ending GBV. https://genderlinks.org.za/news/lesotho-domestic-violence-bill-2018-beacon-hope-ending-gbv/

As noted earlier, GBV survivors often experience prolonged mental health and poor reproductive health problems. They are also at higher risk of acquiring HIV and becoming intensive long-term users of health services.[95] However, countries continue to lack capacity in providing adequate and well-coordinated essential services.



Research by GL established that women prefer informal or traditional support to formal support. This is true for **Comoros**, where, under the Comorian legal system (which rests on Islamic law and an inherited French legal code[96]), women often do not report violence to the courts but to the extended family and village elders, who address most cases.[97]



Next steps

- **GBV in emergencies:** Governments and other actors should continue to document and assess the impact of emergencies such as COVID-19 on GBV. This will provide lessons to inform concrete action plans and long-term strategies to prevent, respond, and support GBV actions and service provision.
- **Prevention:** Member states must pay special attention to the rising cases of domestic violence and GBV during the COVID-19 pandemic by, among others, ensuring they protect women and girls from all forms of abuse. Further, governments must incorporate gender perspectives in all responses to COVID-19 and the recovery phases to ensure that actions during and after the crisis build more equal, inclusive, and sustainable economies and societies.[98]
- **Media coverage:** There is a need to continue to assess the impact of hashtag advocacy and social media and understand how this can be integrated with traditional media approaches to increase the reach and impact of advocacy campaigns.
- **Legal:** Member states should urgently review legislation dealing with movement restrictions, essential services, and law enforcement conduct during public health pandemics.
- **Support:** It is essential to continue to scale up rehabilitation of GBV perpetrators and their reintegration in communities to reduce repeat offenses. Governments and donors should provide new resources to civil society organisations to enable them to continue their advocacy and service provision to end VAW.
- **Integrated approaches:** Collaboration and collective working together between governments and civil society must continue to ensure smooth coordination of GBV responses, especially during emergencies like COVID-19.
- **Inter-sectoral funding:** The costs of GBV remain far higher than the funding available to eliminate it. Member states should adopt the funding approach they used for HIV. This should include increases in private sector funding.
- **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.

SADC countries should ensure that actions during and after the COVID-19 crisis aim to build more equal, inclusive, and sustainable economies and societies

[95] Lowe-Morna, C., Makamure, L., Dube, S. (2016) SADC Gender Protocol Barometer (online) available at http://genderlinks.org.za/shop/sadc-gender-protocol-barometer-2016/
[96] https://en.wikipedia.org/wiki/Law_of_Comoros accessed 01/05/2020
[97] "Comoros - United States Department of State."
[98] "Southern African Development Community: Bulletin 2: SADC Regional Response to COVID-19 An Analysis of the Regional Situation and Impact."

Harmful Practices 7



Youth from Kapoche Secondary school in Luangwa, Zambia, take part in a demonstration against child marriage in October 2019. Photo: Albert Ngosa

KEY POINTS

- The Tanzania Court of Appeal upheld a 2016 High Court judgment outlawing child marriage and declaring it unconstitutional. The Government had appealed the 2016 ruling, arguing that the court should uphold Islamic and customary laws, which allowed for marriage before age 18.
- Civil society in Mauritius continue to lobby government to repeal Section 145 of the Civil Code, which allows children from the age of 16 years to marry if they have parental consent. Meanwhile, the government has tabled a Children's Bill, which seeks to repeal the Child Protection Act and replace it with a new legislative framework to protect children.
- In South Africa, a 2019 Constitutional Court ruling gave spouses in both monogamous and polygamous customary marriages equal rights of ownership and control over matrimonial property.
- In Eswatini, the progressive Sexual and Domestic Violence Act continued to face resistance, mostly because it criminalises marital rape.
- DRC is on track to pass its Disability Rights Bill in 2020. The Act will protect children with disabilities from accusations of witchcraft.
- Zimbabwe gazetted a Marriage Bill to harmonise its different marriage regimes and laws and ensure that it governs all marriages under one law.
- Emerging harmful practices in the region, such as skin lightening/bleaching and vaginal tightening have negative impacts on women's health yet remain readily available.

Introduction

Harmful cultural and traditional practices continue to threaten lives and the overall health and wellbeing of girls and women in Southern Africa. Various stakeholders in the Southern African Development Community (SADC), including media and gender activists, continue to report cases of child marriage, marital rape, witchcraft accusations, widow inheritance, and female genital mutilation (FGM).

These practices have a negative impact on women and girls' sexual and reproductive health and rights (SRHR). Additionally, child marriage, marital rape, widow inheritance, virginity testing, and FGM also contribute to increased transmission of sexually transmitted infections (STIs), including HIV, amongst women and girls. Meanwhile, the problematic practice of virginity testing leaves young women more vulnerable to rape and HIV transmission due to the false belief, held among some in the region, that engaging in sexual intercourse with a virgin can cure HIV and AIDS.

Practices such as wearing the traditional mourning dress stigmatise women and can cause emotional distress. It is also a discriminatory practice because most regional customs do not require men to don traditional mourning clothes or, if they do, their mourning apparel is not as easily recognisable as what women wear in these circumstances. Other cultural and religious rules forbid women from undertaking certain activities, such as cooking, whilst they are menstruating. This leads to stigmatisation of a natural bodily function. It also affects the dignity and privacy of girls and women, given that most would prefer to keep menstruation to themselves.

It is commendable that many governments in the region have recently led efforts to end some of these practices through legislation, enforcement, and educating members of the public about the dangers associated with them. The courts have also played a significant role in declaring harmful cultural practices discriminatory and unconstitutional, thereby paving the way for law reforms that protect women, girls, and children. In 2019, higher courts in the region highlighted their vital role in this regard in rulings on customary marriage in South Africa and on child marriage in Tanzania.



NEWS IN DEPTH

Ending child marriages in Zambia

Gender Focus

In her piece in the *Times of Zambia*, Emelda Mwitwa notes that the country has some of the highest rates of child marriage in SADC.

Photo courtesy of Times of Zambia

However, several crises affecting the region in recent years may imperil recent achievements to address harmful cultural practices. This includes major droughts during the 2018-2019 and 2019-2020 agricultural seasons that, according to World Vision and the International Federation of Red Cross, caused a spike in child marriages, especially in Angola, Lesotho, Namibia, Zambia, and Zimbabwe.[1] In January 2020, the World Food Programme reported that 45 million people in Southern Africa needed food aid because of droughts, flooding, and other factors.[2] These dire circumstances force many families to consider early marriage for young girls as a way to get money for food through the custom of bride price payment from the groom to the parents of the bride. Marrying off young daughters also reduces the number of people to feed and look

[1] Reuters. (2020). Cheap as bread, girls sell sex to survive drought crisis in Angola. Retrieved from https://www.dispatchlive.co.za/news/africa/2020-01-31-cheap-as-bread-girls-sell-sex-to-survive-drought-crisis-in-angola

[2] Al Jazeera. (2020, January 16). Record 45 million need urgent food aid in southern Africa: UN. Retrieved from https://www.aljazeera.com/news/2020/01/record-45-million-urgent-food-aid-southern-africa-200116161326843.html

after. Additionally, the droughts led to increasing instances of rape and sexual assault and forced many girls and women into transactional sex in order to buy food.[3]

The Global COVID-19 pandemic has similarly exposed women, girls, and children to violence and harmful cultural practices. Property grabbing from widows and widow inheritance may also increase in a disaster.

The SADC Protocol on Gender and Development (SADC Gender Protocol) 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 that "States Parties and policies must ensure that policies and programmes take account of the unequal status of women, the particular vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS."[4]



South Africa: COVID-19 school closures raise alarm on child marriages

On 19 May 2020, Angie Motshekga, South Africa's basic education minister, announced that the country's schools would re-open on 15 June after being closed for more than two months due to COVID-19. Motshekga cited the scourge of child marriages as one reason why children must get back to school. The announcement sparked a heated debate in the country, as many parents questioned whether governments and schools had prepared adequately to ensure children's safety from COVID-19 infection.



South Africa's Basic Education Minister Angie Motshekga fears an increase in child marriage if schools remain closed due to COVID-19.
Photo courtesy of Twitter

The government then advised parents that they could not guarantee children would remain free of infection, despite its best efforts, but it also emphasised that the longer children stayed away from school, the higher the probability that some would never return. Many experts worry that teenagers or children from poorer households will not to return to school, as well as teenage girls who get married during this time.

As the COVID-19 lockdown continued, more affluent schools moved more quickly to provide online learning options for children, but school administrators in poorer communities in both rural and urban areas could not provide such facilities in many cases. This has pushed many children away from the structure and routine of education and school systems, potentially exposing them to harmful practices, including child marriage.

Despite some reservations about the reopening of schools in South Africa, including key institutions like the South African Human Rights Commission, the decision by government has to be viewed in the context of the other dangers children face outside the school system. As long as harmful practices persist, the school system will continue to play an important role in protecting children from them.

Source: Adapted from News24 website and South African Women in Dialogue conversations.

[3] Shrimpton, W. (2020, January 15). Children in southern Africa are being forced into prostitution due to drought. Retrieved from https://www.newshub.co.nz/home/world/2020/01/children-in-southern-africa-are-being-forced-into-prostitution-due-to-drought.html
[4] Article 27 (2), SADC Protocol on Gender and Development

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	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	Yes
Gender Responsive Assessment of constitutions and laws (all articles refer to the SADC Protocol on Gender and Development)																
Gender Responsive Assessment (GRA) of constitutions and laws %	50	43		39	30	50	49	73	54	32	68	73	62	67	58	74
Constitutional rights (Article 4) %	52	52		60	24	44	56	84	60	56	72	60	68	48	52	72
Laws and practice (Article 6) %	40	40		N/A	30	52	64	66	62	N/A	56	72	46	62	56	56
Access to justice (Article 7) %	48	30		42	6	42	24	56	48	34	68	78	64	56	62	76
Persons with disability (Article 9) %	80	40		40	60	40	80	60	N/A	80	80	60	100	100	80	100
Widows and widowers (Article 10) %	70	50		60	0	60	60	80	80	40	80	100	90	100	100	100
Marriage and family rights (Article 8) %	47	50		70	57	40	63	93	37	50	87	73	63	77	60	83
Early Child Marriages																
Minimum legal age of consent to marriage for women	15	21	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	Legisla-tion under appeal	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	Legisla-tion under appeal	16	None
Percentage young women married by age 18	30	n/d	32	37	5	17	41	42	n/d	48	7	n/d	6	31	31	32
Percentage young women married by age 15	8	n/d	10	10	1	1	12	9	n/d	14	2	n/d	1	5	6	4

Source: Gender Links and Girls Not Brides.

Over the years, many SADC governments have made provisions in both constitutions and acts of parliament to provide protections for women and girls as illustrated in Table 7.1. It summarises key indicators on harmful practices, 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.
- The highest rated GRA areas include disability and widower/widow rights. The lowest is access to justice.
- 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.
- Eswatini has the lowest percentage of women married by age 18 (5%) and Mozambique has the highest (48%).

This chapter will look at the impact of harmful cultural practices on the rights of women, girls, and children in Southern Africa. It identifies the enablers of such practices; efforts made by governments, civil society, and communities to end them. The chapter is framed in the context of the COVID-19 pandemic, its likely impact, and mitigation strategies.

States can end harmful cultural practices through legislation reviews and public education

Harmful cultural practices and COVID-19

In response to the COVID-19 outbreak, many SADC governments issued various regulations to contain the pandemic. They formulated these in terms of states of emergency (as provided for in constitutions), states of disaster (as provided in national disaster management laws), and as public health emergencies (as contained in public health legislation). In all instances, the most far-reaching provisions related to lockdowns (social and physical distancing measures), which entailed limits on fundamental rights and freedoms, in particular the rights to freedom of movement and association.

This confined many people to their homes, which resulted in an inability to protect many women and girls from GBV and harmful practices. Indeed, stakeholders worry that some may "take advantage of emergency situations such as the COVID-19 pandemic to perpetuate such harmful practices."[5] As a result of the lockdown, many of these, such as FGM, can now happen in the confinement of the home during a time when communities have little or no outside over-sight from neighbours, schools, and law enforcement. When in session, schools can provide a protective social net for children experiencing abuse in the home. Children can report abuse and harmful cultural practices to teachers and other school authorities who can then refer these on to law enforcement agencies.

Most teachers have the requisite training to identify trauma in children, or they can quickly identify absent children, including those who fall victim to child marriage. The World Economic

[5] COVID-19 pandemic putting girls at high risk of FGM in Kenya. (2020, February 4). Retrieved from https://www.endfgm.eu/news-en-events/news/covid-19-pandemic-putting-girls-at-high-risk-of-fgm-in-kenya

Forum has reported that the COVID-19 pandemic could expose up to four million girls worldwide to child marriages.[6] The closure of schools therefore means the absence of such protection mechanisms for children. Effectively, it will take longer for the relevant stakeholders to identify abuse. Further, appropriate and meaningful assistance for children suffering, or recovering, from harmful cultural practices may be minimal or unavailable.

In many parts of the region, COVID-19 has overwhelmed law enforcement authorities because of additional duties related to an emergency situation like a pandemic. This includes ensuring that people observe regulations such as social distancing; controlling non-essential travel, both within and across borders; and monitoring business and industry for operational compliance in line with regulations. This has led to lapses and gaps in other areas of policing, including in protecting women and girls from harmful cultural practices. Courts have also been operating minimally and attending only to "urgent" cases. Without clear definitions of what courts should consider "urgent," cases relating to harmful cultural practices may fall through the cracks.

In some communities, there may be limited scientific understanding of the causes and origins of COVID-19, leading to witchcraft accusations against women and girls, and particularly elderly women.

> The COVID-19 pandemic could expose up to four million girls worldwide to child marriages

Countries such as South Africa have acknowledged that the lockdowns associated with COVID-19 have negative impacts on women and children, leading to increases in GBV. Because of this, the Government of South Africa declared the Commission for Gender Equality and other women's rights organisations to be essential service providers during its lockdown to ensure they could help those experiencing GBV. Data from 3 April 2020 backed up worries about increased violence, as the police reported that their phone lines had been "flooded" with 87 000 calls linked to GBV in the first seven days of the country's lockdown.[7]

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.

There have been no new constitutional enactments in the region during the year under review. However, after its 2019 elections, Botswana saw an increased debate about the need for constitutional reform. This may present an opportunity to address its constitutional provisions that perpetuate gender-based discrimination and, consequently, harmful cultural practices. Similarly,

[6] Batha, E., & Thomson Reuters Foundation. (2020). Coronavirus could put 4 million girls at risk of child marriage. Retrieved from https://www.weforum.org/agenda/2020/05/coronavirus-early-child-marriage-covid19-pandemic
[7] Covid-19 lockdown: Police receive 87 000 gender-based violence calls. (2020, April 3). Retrieved from https://www.power987.co.za/news/covid-19-lockdown-police-receive-87-000-gender-based-violence-calls

discussions for constitutional reform have been ongoing in Lesotho as part of the SADC-mediated political negotiations in the country. Lawmakers and activists can use the constitution-making process to ensure stronger protections for women and girls, including the removal of provisions that promote discrimination and harmful cultural practices.



Comoros promulgated a new constitution in 2018 (mentioned here because this is the first time the Barometer has incorporated Comoros since it joined SADC in 2017). The Constitution prohibits gender-based discrimination. However, most women do not yet enjoy these enshrined rights. For example, reports indicate village leaders and families continue to settle rape cases using traditional approaches, and they do not bring such cases to, or report them within, the formal criminal justice system.[8]



On 31 December 2019, **Zimbabwe** gazetted a constitutional amendment (Constitutional Amendment Bill Number 2) that sparked controversy, especially because it seeks to reverse many positive provisions in the current Constitution (2013). As a result, the negative provisions in the proposed bill have overshadowed the positive ones. Its 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.

Female MPs have been particularly vocal in calling for legislation to outlaw child marriage. They have also been at the forefront of explaining the civil partnership clause in section 40 of the 2019 Marriage Bill. Religious Zimbabweans and some women's rights NGOs viewed it negatively and saw it as promoting "small houses."[9] However, female MPs such as Priscilla Misihairabwi-Mushonga have been out front in explaining the clause to both fellow parliamentarians and members of the public, including its benefits to Zimbabwean women, many of whom are in such partnerships. A major benefit of civil partnership would be that at the dissolution of a partnership, the law would treat the property of the civil partners the same way it treats the property of legally married couples. Currently, the law does not recognise such a partnership.



Even though **South Africa** prohibits child marriage, legislative provisions and inconsistencies about it remain. Whilst the legal age of marriage is 18, exceptions still exist. For example, a minor can get married with the consent of his or her parents. In August 2019, the South African Law Reform Commission (SALRC) began an investigation into a single marriage statute. It noted discrepancies regarding the legal age of marriage in the three marriage statutes, namely: the Marriage Act, the Recognition of Customary Marriages, and the Civil Union Act. The Commission has solicited public views about whether South Africa should "comply with international and regional instruments to set a uniform minimum age for marriage of 18 without any exceptions for third party consent by parents, courts, or any other official to prevent children being married or to enter into unmarried intimate relationships."

Several SADC countries still need to reform their laws to criminalise marital rape. Most of the countries that outlaw marital rape in legislation rely on customary law to support it, noting that once a family pays bride price, a woman must always consent to sexual intercourse with her husband. SADC countries still using this customary law approach in 2020 include Botswana, the Democratic Republic of the Congo (DRC), and Madagascar. Tanzania clearly excludes marital rape as a criminal offence and, in Malawi, the courts have ruled that the law only considers it an offence if a couple has separated.

Coupled with legislative enactments is the need for governments to raise awareness about available laws, as well as the role of society, families and communities in protecting women and girls against harmful cultural practices.

[8] Comoros - United States Department of State. (2020, March 11). Retrieved from https://www.state.gov/reports/2019-country-reports-on-human-rights-practices/comoros
[9] A term used in Zimbabwe to refer to women in extramarital relationships with married men.
[10] South African Law Reform Commission (2019), Issue Paper 35: Project 144: Investigation into a Single Marriage Statute: Questions, South African Law Reform Commission, South African Law Reform Commission (2019), Issue Paper 35: Project 144: Investigation into a Single Marriage Statute: Questions, South African Law Reform Commission (2019).

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

Table 7.2 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.

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.

Village leaders and families continue to settle rape cases using traditional approaches in Comoros

Harmful practices discourse analysis in Namibia

Media monitoring researchers in Namibia tracked political discourse on harmful cultural practices and their impact on enjoyment of SRHR during the period under review. In particular, researchers looked at the objectification of young girls during the festival of *Olufuko*, which its supporters argue represents a "means of observing and preserving culture."

To many others, the festival is controversial, like Eswatini's reed dance, which has been a point of contention in the region for years. *Olufuko* is an Ovambo word meaning "wedding" or "to be wed." As part of the festival, girls as young as 14 (some literature claim girls can be as young as 12) participate in the traditional initiation ceremony. Its proponents claim it prepares girls for marriage, childbearing, and caring for a family. Participants view these girls as "brides-in-waiting."

The festival lasts for seven days and, during this time, the young female participants regularly dance for local men, who then adorn those girls whom they wish to have as a bride with jewellery, such as bracelets. Both single and married men reportedly participate in the festival. The gifts these men supply serve as expressions of intent to secure the young girl of their choice, highlighting a problematic objectification of young children. Researchers found that girls who refuse to take part have been threatened and told their parents would suffer harm. Key human rights organisations, such as NamRights and various churches, have rejected and condemned the practice.



FESTIVAL BRANDED A 'STRIP SHOW' FOR RICH MEN

NamRights to sue over Olufuko

CATHERINE SASMAN

The human rights organisation says the cultural festival is more like a strip show where young girls are put on display for men with money.

NamRights is preparing a lawsuit to stop the Olufuko festival and other cultural practices that it considers harmful sexual initiations.

It intends to lodge the legal challenge before the end of the year, and argues Olufuko is unconstitutional because it seeks to convert young children into adult, child-bearing women.

It says the festival deprives and robs children of their normal and natural childhood-to-adulthood mental and physical development, and that it is simply illegal, both in terms of international customary, humanitarian and human rights laws.

NamRights says the Olufuko festival is also contrary to Namibia's contemporary, civil, cultural, political and social customs and practices, and parades poor, bare-breasted girls in public without their consent to attract economic investments for affluent families.

The organisation says further that the festival is criminal enterprise, which constitutes indecent exposure, and holds nothing positive in terms of culture and tradition.

CONTINUED ON PAGE 2

PENDING BATTLE: NamRights is preparing a lawsuit to stop the annual Olufuko festival. PHOTO: NAMPA

NamRights, a Namibian human rights organisation, has condemned the practice of *Olufoko* and took a case in 2018 to the country's highest court.

Photo courtesy of Namibia Sun

Former President Sam Nujoma approved the resuscitation of the practice of *Olufuko* in 2012. Namibians had not widely practiced it for many years. In 2019, Namibia's Supreme Court dismissed a challenge brought forward by NamRights on the basis that the human rights agency did not have locus standi, or the proper standing to bring the challenge to court.

This underscores the need for provisions in Namibia's Constitution and other laws to ensure that civil society organisations and agencies, and other individuals can have the right to bring such cases linked to the public interest before the courts without limitations. Many expect an appeal in future linked to this case.

Unfortunately, the patronage of the festival by the former president means the practice has gained wider support within government and the ruling South West Africa People's Organisation (SWAPO) party. For example, Sophia Shaningwa, minister of urban development, officially opened the an Olufuko festival at Outapi in the Omusati Region in August 2016. Instead of using her platform to call attention to the harmful effects of the practice on young girls, Shaningwa said she supported the practice, claiming that it prepares girls for marriage by teaching them various skills such as pounding maize and preparing traditional beverages for the men - what she views as elements of the country's cultural values.

Civil society organisations and the Namibian media must continue to call out the practice and the political figures who support it, as it is clearly detrimental to girls' development and wellbeing. Litigation should also continue to push the courts to see their role in protecting the rights of girl children. Positive court decisions that recognise the rights of women and girls will oblige lawmakers to repeal the laws that promote these harmful practices.[11]

[11] Source: GenderLinks, Namibia Political Discourse Analysis: GMPS Qualitative Analysis: Sexual and Reproductive Health and Rights (SRHR) 2020

Discriminatory legislation

Article 6: State parties shall review, amend, or repeal all discriminatory laws and specifically abolish the minority status of women.

In July 2019, the South African Cabinet submitted the Recognition of Customary Marriages Amendment Bill to Parliament for debate. It sought to amend Section 7 (1) of the 1998 Recognition of Customary Marriages Act by further regulating the proprietary consequences of customary marriages before the commencement of that Act. This followed a 2017 Constitutional Court judgment, which ordered Parliament to amend the Act by 30 November 2019 to remove provisions that unfairly discriminated against women who had entered polygamous customary marriages before 1998.[12] Parliament failed to amend the Act by the set date and consequently the interim order of the Constitutional Court became final on 30 November 2019.

A new law in South Africa gives spouses joint and equal ownership and management of property

The earlier Act gave husbands the rights of ownership and control over marital property while wives had no such powers. The new law means that spouses in both monogamous and polygamous customary marriages have joint and equal ownership and management of, and control over, property.[13]

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;

[12] Ramuhovhi and Others v President of the Republic of South Africa and Others [2017] ZACC 41
[13] Memorandum on the Objects of the Recognition of Customary Marriages Amendment Bill, 2019 (2019).

- 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."[14]

Access to justice for women, however, remains a challenge in the region for several reasons. These include the physical inaccessibility of the courts, in particular superior courts, which are centrally located in major cities and therefore inaccessible for women in rural areas. South Africa, with 14 provincial divisions of its High Court, has the most high courts in the region, but even these operate only in major urban areas.



Women discuss issues of inheritance in Siloe, Lesotho, during the 16 Days of Activism campaign in 2019. Photo: Ntolo Lekau

Customary courts, which exist closer to the people, remain the most accessible for many women. However, women also face challenges in utilising these courts, including discriminatory customary laws and practices, which, for example, prohibit them from accessing courts without a male chaperone. The customary court structures and models in the region therefore need to be modernised to ensure full and equal accessibility for women.[15]

Legal representation is also expensive, making it difficult for many women to hire lawyers. Yet most SADC countries do not have viable state legal aid systems to ensure equal access to quality legal representation. Legal aid provision must be a priority service for many governments in the region if they want to improve women's access to justice.

In the context of COVID-19, due to the limited operations of the courts, many women faced challenges in accessing justice, in particular those who experienced domestic violence. Most jurisdictions did not initially classify legal services as essential during the lockdowns, making it difficult for women to access lawyers or NGOs that provide these services.

[14] Maregere, T. (2018). Justice in Transition and the Complexities of Access. African Centre for the Constructive Resolution of Disputes.
[15] Despite many South Africans recognising the need for traditional courts as a way of improving access to justice, the 2017 Traditional Courts Bill has faced resistance because of its failure to protect the fundamental rights of rural people, including rural women.

Marriage and family rights

Article 8: Marriage and family rights

1. State parties enact and adopt appropriate legislative, adminis-trative and other measures to ensure that women and men enjoy equal rights in marriage and are regarded as equal partners in marriage.
2. Legislation on marriage shall therefore ensure that:
(a) No person under the age of 18 shall marry;
(b) Every marriage takes place with free and full consent of both parties;
(c) Every marriage including civil, religious, traditional or customary, is registered in accordance with national laws; and
(d) During the subsistence of their marriage the parties shall have reciprocal rights and duties towards their children with the best interest of the children always being paramount.
3. State parties shall enact and adopt appropriate legislative and other measures to ensure that where spouses separate, divorce or have their marriage annulled:
(a) They shall have reciprocal rights and duties towards their children with the best interest of the children always being paramount; and
(b) They shall, subject to the choice of any marriage regime or marriage contract, have equitable share of property acquired during their relationship.
4. States parties shall put in place legislative and other measures to ensure that parents honour their duty of care towards their children, and maintenance orders are enforced.
5. States parties shall put in place legislative provisions which ensure that married women and men have the right to choose whether to retain their nationality or acquire their spouse's nationality.

Polygamy

The practice of polygamy continues to present challenges for many women in the region and it persists despite international acknowledgment that polygamy has a negative impact on women's rights and wellbeing. This includes HIV and AIDS exposure, as polygamous marriages expose women to concurrent sexual partner alliances.[16]

The economic empowerment of women remains paramount as it ensures that challenging economic circumstances do not force women into polygamous marriages. It also helps in ensuring that women in untenable polygamous marriages can leave them without worrying about their economic wellbeing and that of their children.

[16] Reniers, G., & Watkins, S. (2010). Polygyny and the spread of HIV in sub-Saharan Africa: a case of benign concurrency. Aids, 24(2), 299-307. doi: 10.1097/qad.0b013e328333af03



Mozambican woman gets new lease on life after leaving polygamous marriage



Women of Gaza Mandlakazi market trained by GL. Photo: GL Mozambique

Research shows that there is a considerable mental health burden amongst women in polygamous marriages. These mental health problems often include somatisation, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Nora António Luís, a mother of four from Gaza-Mandlakazi in Mozambique, has experienced some of these first-hand. She gave birth to her children while in a polygamous marriage before she finally separated from her husband in 2011.

In a Gender Links "I" Story, Luís recounted that, during her marriage, she suffered from psychological violence because her husband had two other wives. Luís lived in the same home with the other wives until she gathered the courage to take her children and leave the marriage.

After she left, her husband persuaded her to come back, but she preferred to stay away from the marriage, and she remains happy with her decision. Her three older children have finished high school and her youngest, 16, still attends school.

Luís operates a vegetable stall at an informal market. After leaving her husband in 2013, she attended a gender-based entrepreneurship and violence training workshop, which she says provided many benefits. After the training, Luís learned how to prepare a budget, and save her earnings. Eventually she left the informal market to become a wholesaler in the central market in her town.

According to Luís, she feels "like a victorious woman" because her decision to leave the polygamous marriage improved her mental wellbeing and gave her the courage and determination to learn new things and excel in her business. Polygamous marriages often prevent women from partaking in such opportunities, ensuring they have lower economic status and forcing them to share their few available resources amongst the large families.

Since the training and improvement in her business, Luís has managed to make significant profits. She installed electricity in her house, where she lives with her children, bought a freezer and a TV, and paid the school fees for her four children. She also bought a piece of land, on which she intends to build a new house. She says she feels "self-sufficient and free to do what she wants." She is happy she has gained back her dignity and shaken off the burden of polygamy.

Source: Gender Links "I" Stories: https://genderlinks.org.za/istories/after-we-broke-up-my-husband-asked-me-to-return-and-i-refused/

Advocacy to stop harmful practices

Members of civil society organisations taking part in a harmful practices campaign in Zimbabwe say they have noticed a direct link between COVID-19-induced poverty and harmful cultural practices in the country. Zimbabwean women who depend on the informal sector for their livelihoods have been experiencing significant financial challenges due to the prolonged lockdown, which legislators first imposed on 27 March 2020.

Women's rights advocates say the ripple effects from this include increases in child marriage in a country with a high prevalence of them even before the pandemic.[17] Because of the limited operation and movement of civil society teams, much of this has occurred away from public glare. Thus, CSOs have created a new campaign to push for an end to child marriages.

As part of this campaign, Zimbabwe's women's rights movement has engaged President Emmerson Mnangagwa and presented a list of "key asks," including calling for the finalisation of the Marriages Bill, which would domesticate Zimbabwe's international commitments to gender equality and set the legal age of marriage at 18 years. Past advocacy of this sort contributed to the initial drafting of the Marriage Bill, which has provisions on eradication of child marriages and enshrines commitments to eliminate child, early, and forced marriage by 2030 in line with target 5.3 of the Sustainable Development Goals (SDGs).

Lawmakers have since gazetted the bill and given it a second reading in Parliament. It is set to continue to the committee stage of Parliament. Women's rights groups must remain vigilant to ensure that lawmakers do not dilute the law before they pass it.[18]

> CSOs have created a new campaign to push for an end to child marriages

Child marriages

SDGs 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
CEDAW, Article 16(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;
Article 16(2) The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.
ICPD 6.11 Countries should create a socio-economic environment conducive to the elimination of all child marriages and other unions as a matter of urgency, and should discourage early marriage.
Maputo Protocol Article 6a) no marriage shall take place without the free and full consent of both parties; Article 6b) the minimum age of marriage for women shall be 18 years.

[17] 32% of girls in Zimbabwe are married before the age of 18 and 4% are married before their 15th birthday.
[18] Source: Gender Links, Zimbabwe Report for the Analysis of SRHR Campaigns.

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.[19] The same Model Law defines a child as any person under the age of 18 years in line with other international human rights instruments.[20]

Child marriages directly affect children's sexual and reproductive health and rights, including exposing children to HIV and AIDS infection and impeding their ability to access safe abortion. In South Africa and other countries in the region, practices such as *ukuthwala*[21], which encourage child marriage, have been justified as customary by some quarters as part of tradition and custom.[21] At a time when the region is struggling to end child marriages, decision-makers should condemn any additional justifications for such harmful practices.

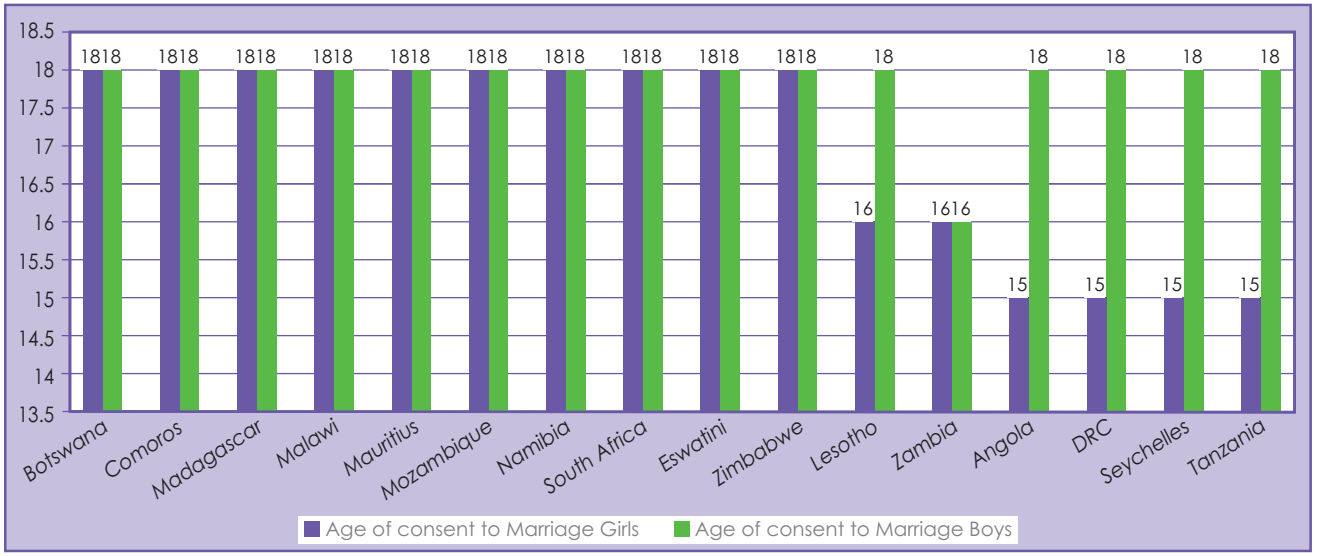


In May 2020, three men from Binga in Matabeleland North, Zimbabwe, invoked the harmful *ukuthwala* practice, also known as *musengabere* in Zimbabwe, and kidnapped a 17-year-old girl. One of the men then raped the young girl and attempted to claim her as his wife, including by introducing her to his family. Thankfully, police arrested the three men and charged them with rape.[23]

It is important that people in positions of power also discourage marriages between children as they deprive children of their rights to education, often condemning them and their own children to a life of poverty. In May 2020, the Government of South Africa announced a plan to overhaul the country's marriage law regime, stating that "the current legislation does not regulate some religious marriages such as the Hindu, Muslim and other customary marriages that are practised in some African or royal families."[24] This is a welcome development given that it is often in the context of religious, customary, and royal traditions that arranged or forced marriages continue in the region, including forcing marriages between children. Often this occurs in the context of maintaining royal alliances and blood, or ensuring that children marry within the same religious sect.

[19] SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, s 2.
[20] Article 1 of the Convention on the Rights of the Child defines a child as every human being below the age of 18 years
[21] Marriage by kidnapping/abducting a girl and then forcing her into marriage.
[22] Social Institutions and Gender Index, 2019
[23] SHOCK as Binga Trio invoke Ancient 'Musengabere' Custom, Arrested for Rape.' (2020, May 12). Zwnews.
[24] South Africa is changing its marriage laws' . (2020, May 12). Businesstech

Figure 7.1: Age of consent to marriage for girls and boys by country



Source: Gender Links.

Figure 7.1 shows that most SADC countries have set the age of consent to marriage at 18, which aligns to the provisions in the SADC Gender Protocol. Six countries - Angola, DRC, Lesotho, Seychelles, Tanzania, and Zambia - have lower ages of consent for either girls, boys, or both.



In 2019, the **Tanzanian** Court of Appeal upheld a 2016 High Court judgment outlawing child marriage and declaring it unconstitutional.[25] The government had appealed the earlier decision that outlawed marriage before the age of 18 under Islamic and customary laws. In dismissing the government's appeal, the Court of Appeal ordered the Government of Tanzania to uphold the judgment of the High Court and amend the offending sections of the country's Law of Marriage Act.[26]

The SADC Gender Protocol obliges state parties to introduce and support gender sensitisation and public awareness programmes aimed at changing behaviours and eradicating GBV.[27]

The intersection between tradition, religion, and politics continues to be a stumbling block in eliminating child marriage



Zambia has accelerated campaigns to end child marriages, as highlighted in a case study which saw senior government officials taking the lead on this issue.

[25] The Attorney General v Rebeca Z. Gyumi, Civil Appeal Number 204 of 2017 (October 2019)
[26] Tanzania: Celebrating ending child marriages judgement. (n.d.). Retrieved from https://genderlinks.org.za/news/tanzania-celebrating-judgement-on-ending-child-marriages
[27] SADC Protocol on Gender and Development, Article 21 (2)



Zambia: Leaders do their part to end child marriage



A Zambian community comes together to protest child marriage in October 2019. Photo: Albert Ngosa

The Zambian government has been at the forefront of fighting child marriage in the country. However, despite its efforts, Zambia still experiences high levels of child marriage. According to Girls Not Brides "31% of Zambian girls are married before their 18th birthday and 6% are married before the age of 15."[28] Take Bridget Tendwa, of Kawambwa District in Luapula Province, for example. After getting married at the age of 16, her marriage later failed, which proved to be a blessing in disguise for Tendwa.

Like many girls in her situation, Tendwa decided to go back to school and she is currently studying to become a teacher. In 2016, the Ministry of Education found that, of the 11 000 girls who fell pregnant or were married, half went back to school. Unfortunately, many others face a lifetime of poverty and abuse. Early marriage for them means that they cannot proceed with their education and will likely not have adequate resources to look after their families and children, perpetuating a cycle of poverty.

Activists have commended the President and First Lady for playing a leading role in ending child marriage. This includes spearheading a campaign to ensure that Zambian girls get the same educational opportunities as boys. President Edgar Lungu is also a champion of the campaign to end child marriage in Africa, working closely with the African Union to end the scourge.

Meanwhile, First Lady Esther Lungu works for the same aim through the foundation that bears her name. She has teamed up with traditional leaders, such as Chief Mazimawe of the Ngoni people in Eastern Province, and other stakeholders to help fight the scourge. Such open efforts by national leaders to end child marriage are critical in sending a clear message to citizens about the dangers of the practice and the consequences to adults who marry or aid in the marriage of children.

Source: Gender Links News Service 'Married off at 16' available at: https://genderlinks.org.za/news/zambiamarried-off-at-16/ (accessed 27 April 2020)

[28] Girls Not Brides. (2018, December 16). Zambia - Child Marriage Around the World. Girls Not Brides. Retrieved from https://www.girlsnotbrides.org/child-marriage/zambia/

Strengthening laws and policies on child marriage in SADC



Zimbabwe gazetted its Marriage Bill on 19 July 2019. The Bill seeks to harmonise the country's different marriage regimes and laws and ensure that one law governs all marriages. Significant issues covered by the Bill include the recognition of customary law unions, including registration of the unions, recognition of civil partnerships for purposes of sharing property at dissolution, and the prohibition of child marriages. Currently, Zimbabwe has different marriage regimes, i.e. civil marriages, registered customary marriages, and unregistered customary law unions.[29] The regimes come with differentiated, hierarchical, and often discriminatory rights during a marriage, at divorce, and in terms of inheritance, with civil marriage having the best bundle of rights, and the unregistered customary law union, the lowest. The Bill seeks to domesticate the SADC Model Law on Child Marriages by ending all forms of child marriage. It also looks to align with the provisions of the 2013 Constitution by addressing gender-based discrimination, aligning customary law with the constitution and ending child marriages.



Zimbabwean citizens hold up a UNICEF poster advocating against GBV and gender discrimination. Many religious groups continue to push the Zimbabwean government to perpetuate gender inequalites.

Photo courtesy of UNICEF Zimbabwe

The intersection between tradition, religion, and politics continues to be a stumbling block in eliminating child marriage and other harmful cultural practices in Zimbabwe and elsewhere in the region.[30] 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.

Politics in Zimbabwe, especially by the ruling party, has thrived thanks to its alignment with a coalition of traditional leaders and religious sects that influence the vote of the citizens they lead. As a result, these same groups often negatively influence policy- and law-making at government level on harmful cultural and religious practices. For example, religious groups such as the Johane Masowe and Johane Marange apostolic sects have managed to create strong ties with the government.[31] The apostolic sects in Zimbabwe represents one of the largest religious groups, with an estimated membership of 34% of the country's population (ZimStats, 2011), ensuring they will remain a powerful constituency.[32] Gender advocates should consider ways to work with these groups as part of a strategy to tackle harmful practices.



To date, **Mauritius** has not signed the SADC Protocol on Gender and Development. However, in September 2019, its Cabinet approved the introduction of the Children's Bill in Parliament for debate and enactment. The enactment of the Children's Bill aims to address the issue of child marriages in the country.

[29] Customary law unions are currently not recognised as marriages except for specific limited purposes, and in particular the recognition of the rights of children born out of such unions.
[30] Chamisa, M., (2019). Religious Affiliation - Child Marriages Nexus in Zimbabwe: A Case of Marange. Dynamic Research Journals: Journal for Economics and Finance, 4(2), 38-44
[31] Chamisa, M., (2019). Religious Affiliation - Child Marriages Nexus in Zimbabwe: A Case of Marange. Dynamic Research Journals: Journal for Economics and Finance, 4(2), 38-44
[32] Chamisa, M., (2019). Religious Affiliation - Child Marriages Nexus in Zimbabwe: A Case of Marange. Dynamic Research Journals: Journal for Economics and Finance, 4(2), 38-44



Mauritius: Activists seize the momentum on child marriages

Change may be coming for children in Mauritius. According to its government, the new Children's Bill looks to "repeal the Child Protection Act and replace it with a more appropriate, comprehensive and modern legislative framework."

The aim is "to better protect children and to give better effect to the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child."[33]

Following the introduction of the Bill, civil society organisations in Mauritius formed a consortium called Kolektif Drwa Imin (KDI) that includes Gender Links, Pils, Young Queer Alliance, Collectif Arc en Ciel, and Kollectif Drwa Zanfan Morisien. Their aim is to lobby government for a more comprehensive act that addresses all the country's critical children's rights issues.

The group wants the government, using its new bill, to repeal Section 145 of the Civil Code, which allows children as young as 16 to be married with parental consent. The other issues they want addressed include:

- Increase minimum age of criminal responsibility (MACR) from 12 to 16, with the upper limit at 18 years;
- Include Lesbian, Gay, Bisexual, Trans, and Intersex (LGBTI) citizens in the non-discrimination principle; and



The Kolektif Drwa Imi, a group that advocates for children's rights in Mauritius, taking part in a children's activity day in November 2016.

Photo courtesy of DefiMedia

- Include the right to health for children and young people.

As part of their lobbying and advocacy, the group sent a letter to the prime minister's office, the attorney general, minister of gender and all parliamentarians underlining the positive provisions in the Children's Bill which stakeholders presented to Parliament on 17 September 2019. The letter also included recommendations on the issues stated above, which the groups requested be included the Bill. The coalition of groups also held a press conference to highlight these issues.

The Bill is awaiting its third reading in Parliament and the group of organisations is hopeful that government will incorporate their issues into it. Once lawmakers pass the Bill civil society groups in Mauritius intend to reignite their lobby efforts to convince government to ratify the revised SADC Protocol on Gender and Development.

Source: GL Mauritius country manager, Anushka Virahsawmy

[33] Pep, L. E. (2019, September 30). The Children's Bill. Retrieved from http://www.mauritiustimes.com/mt/the-childrens-bill

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).[34]

Many programmes and governments continue to exclude people with disabilities from enjoying their SRHR or accessing information on these topics that is relevant for them. This presents an issue for stakeholders in the region to address, because "persons with disabilities have the same sexual and reproductive health (SRH) needs as other people."[35]

Because of this, they should not face barriers to information and services, including information and services on family planning, maternal health, and HIV and AIDS.

The COVID-19 pandemic brought this issue into focus, given that many people with disabilities required special care during the pandemic and in lockdown. Thus, targeting them with such information in the context of COVID-19 has been even more critical although, as noted earlier, the pandemic has increasingly made information and services on SRHR generally inaccessible to all.[36]



The DRC is on track to pass its Disability Rights Bill into law in 2020. Activists expect the law to improve the lives of millions of people living with disabilities in the country.[37] The bill will address the discrimination and harmful cultural practices directed specifically at women and children with disabilities. Children with disabilities in the DRC have often been accused of witchcraft. The new law is a critical piece of legislation aimed at addressing this issue and providing these children with protection.[38]



Women attending the launch of the Barometer in January 2020 in Palapye, Botswana, where activists also highlighted the challenges faced by women with disabilities. Photo: Keletso Serowe

[34] United Nations Convention on the Rights of Persons with Disabilities.
[35] Promoting sexual and reproductive health for persons with disabilities. (2020, January 16). Retrieved from https://www.who.int/reproductivehealth/publications/general/9789241598682/en
[36] Access to SRHR services impacted by COVID-19 pandemic. (2020). Retrieved from https://genderlinks.org.za/news/absence-of-srhr-services-may-trigger-health-crisis-for-women
[37] Disability Rights Bill Offers Hope in Congo. (2020, May 30). Retrieved from https://www.hrw.org/news/2020/03/11/disability-rights-bill-offers-hope-congo
[38] Hope for disabled Congolese kids accused of witchcraft | | The Southern Times. (n.d.). Retrieved from https://southerntimesafrica.com/site/news/hope-for-disabled-congolese-kids-accused-of-witchcraft

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.



The **Comoros** is a culturally and traditionally matrilineal society and therefore property and inheritance rights favour its women. The result is that most inheritable property is in the hands of women.[39] Whilst this may look positive for women, gender activists view any practices that discriminate against either men or women based on gender as detrimental in the long term. Legislators should address these matrilineal property and inheritance practices in the Comoros constitution to remove gender-based discrimination.

Most inheritable property in Comoros is in the hands of its women

Marital rape



Activists celebrated the passing of the Sexual and Domestic Violence Act in 2018 in **Eswatini** as a landmark development in the country. However, the law has seen significant resistance from men and traditionalists, with most disagreeing with its criminalisation of marital rape. These men share the same beliefs as Bongani 'S'gcokosiyancinca' Dlamini, who has said that when a man asks for a woman's hand in marriage the traditional way, the woman must be submissive, forfeit her rights and only refuse sexual intercourse if she is ill.[40] Some MPs petitioned Parliament to review the Act, although they later withdrew their request.[41]

Such attitudes deter women from reporting cases of marital rape even when the law is on their side. In addition, women fear being ostracised by friends, family, and religious communities, which is why few women report instances of marital rape in the region. In Zimbabwe, women's

[39] Comoros - United States Department of State. (2020, March 11). Retrieved from https://www.state.gov/reports/2019-country-reports-on-human-rights-practices/comoros
[40] Hlatshwayo, S. (n.d.). Over 400 SODV Cases Reported in 8 Months' . Times of Swaziland. Retrieved from http://www.times.co.sz/news/123699-over-400-sodv-cases-reported-in-8-months.html
[41] Mdluli, M. (2019). SODV Act Petition Withdrawn' . The Observer. Retrieved from http://new.observer.org.sz/details.php?id=10603

rights activists have reported that "the majority of women suffer in silence [because] the way our society is structured... makes it harder to discuss these issues openly."[42]



Men and women discuss harmful traditional practices in Eswatini in 2019.
Photo: Thandokuhle Dlamini

Women's rights activists worry that the COVID-19 pandemic has exacerbated this issue as SADC women suffer in confinement under lockdown. Marital rape cases have likely increased during this period, with no immediate help or recourse for women.

Despite the above-noted challenges, the reporting of the first marital rape case in Eswatini in January 2020 marks a significant step toward stemming the scourge of marital rape. Police arrested a 34-year-old man, Nhlanhla Dlamini, for marital rape: the first instance of this in the country following the passing of its Sexual Offences and Domestic Violence Act.[43]

Female genital mutilation

SDGs 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

Tanzania has the highest number of FGM cases in Southern Africa. The harmful practice remains common in several communities in the country. Activists worry that some Tanzanian communities increasingly seem to be performing FGM on babies. One in ten women in Tanzania (aged 15-49) has experienced FGM. Of these, 35% were mutilated before the age of one. However, the practice has been declining thanks to advocacy and awareness-raising from government, civil society, and development partners. Some of their interventions include working with peer educators to educate girls and communities about the many dangers associated with FGM. Because the practice provides a needed source of income for those who perform it, eliminating FGM has taken longer in a country where many live in impoverished conditions. Providing alternative sources of income remains an important way to ensure these communities eliminate the practice once and for all. Organisations such as Plan International and Child Dignity Forum in Tanzania have been leading these efforts.[44]

Few legal and policy interventions exist to protect women and girls from FGM in other countries of the region. Emerging evidence in Zimbabwe suggests that the practise may be more widespread in other countries of the region than is generally believed.

[42] Mbanje , P. (2009). Spousal rape remains under-reported. Newsday. Retrieved from https://www.newsday.co.zw/2019/12/spousal-rape-remains-under-reported
[43] First arrest puts marital rape in spotlight in Eswatini. (2020). Daily Monitor. Retrieved from https://www.monitor.co.ug/News/World/First-arrest-puts-marital-rape-spotlight-Eswatini/688340-5421376-ps86xbz/index.html
[44] RIORDAN, L. (2020, February 4). Countering child marriage and FGM in Tanzania - International Cooperation Development European Commission. Retrieved from https://ec.europa.eu/international-partnerships/stories/countering-child-marriage-and-fgm-tanzania_en



Zimbabwe: Tackling the hidden scourge of FGM

Due to widespread belief that FGM does not occur in Zimbabwe, few women's rights organisations offer support to women and girls who experience FGM or, for that matter, spend their time demanding action from policymakers to address the problem. Beyond the broad legal and constitutional protection on gender equality, protection of women's rights, and the outlawing of harmful customary practices, including Section 80 (3) of the Constitution of Zimbabwe and its Domestic Violence Act, no explicit protections exist.



Gogo Sariya Muyinde (left) and Lebeka Munkuli of the BaTonga tribe in Binga, Zimbabwe in October 2015. FGM remains common in the community.
Photo courtesy of Chronicle Zimbabwe

Recently, organisations such as Amakhosikazi Media have helped bring the issue to the fore and reignite debate about the practice in the country. The organisation has highlighted specific cases of girls who have experienced FGM in the country so these women can get much needed assistance. This included Thapelo Muleya, a 16-year-old from Binga who confirmed that the practice is prevalent in that area. She was subjected to FGM at age 15.

The death of a woman in 2016 after excessive bleeding following a botched FGM procedure showed that many routinely practice FGM in Binga. Police took the woman who performed the procedure to court and Zimbabwean media quoted the surprised local chief, who acknowledged the long-standing practice in his community:

"We are not sure how things went wrong considering the effectiveness of the method which has been part of us for generations. Maybe they cut off a wrong part I cannot say but I'm told it's before the courts now, which is very unfortunate. The practice of removing fibroids mostly done by grandmothers has helped married women who have trouble conceiving become pregnant."

This incorrect and misleading view on the part of the local leadership underscores the need for Zimbabwe's policymakers to both acknowledge the existence of the practice and disseminate information about its dangers in order to protect women and girls. In addition, government must create specific legislative and policy measures to protect women from FGM.

Source: Amakhosikazi Media, http://www.amakhosikazimedia.org/index.php/news/109-female-genital-mutilation-still-a-big-problem-in-zimbabwe-s-rural-communities

Government must create specific legislative and policy measures to protect women from FGM

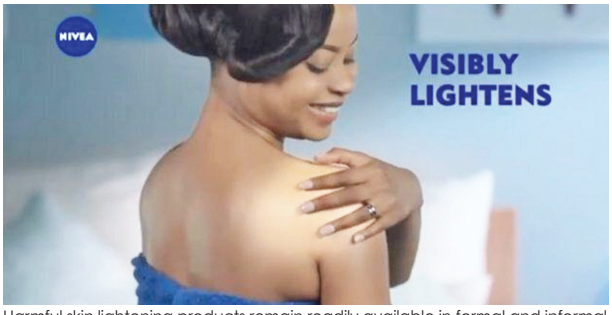
Other harmful practices



The **Zimbabwe** Domestic Violence Act recognises the practice of fathers-in-law engaging in sexual intercourse with their newly married daughters-in-law as a form of domestic violence and a harmful cultural practice. Research shows that this practice is part of the Kalanga culture, a group largely found in Matabeleland South Province in Zimbabwe. Kalanga also live in north-eastern Botswana, in Gaza Province in Mozambique, and in the Limpopo Province in South Africa. Following awareness-raising campaigns carried out by government and NGO staff, who recognised the practice's role in spreading STIs and HIV, it is believed that most Kalanga people no longer engage in this practice.[45] However, there is a need for governments in the region to continue monitoring communities and continue raising awareness about the harms associated with it.

Emerging harmful practices

Even as stakeholders and activists grapple with harmful practices that have affected the health and wellbeing of SADC women and girls for years, they must also address emerging ones such as skin lightening and bleaching, and vaginal tightening. Experts note that these practices increase the risk of getting cancer. Scientists have also linked skin lightening to organ failure.



Harmful skin lightening products remain readily available in formal and informal markets across SADC. Photo courtesy of Google

The World Health Organisation acknowledges that skin bleaching can cause liver and kidney damage, psychosis, brain damage in foetuses and cancer, noting that "beauty standards promoted by media, advertising and marketing reinforce the bias that lighter skin tone is more desirable than darker skin tone."[46]

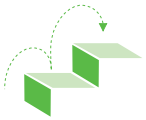
Yet despite this knowledge, harmful skin lightening products including creams, injections, and pills remain readily available in formal and informal markets. Traders sell them online and even ship them across borders and continents. SADC governments must therefore work to ensure restrictions in the sale and marketing of such products and provide information and education to women and girls about the dangers associated with them.

Vaginal tightening is also a growing harmful practice with women using creams, gels, laser procedures, traditional herbs, and even home remedies to achieve it. However, in many instances, these products and procedures are harmful.[47] Some of the dangers include vaginal scarring and burns and infection.[48] Women need more information about the dangers of such practices.

Harmful practices that negatively affect men and boys in Southern Africa also exist. This includes male initiation, an important event in many cultures as it supposedly marks the transition of a boy into a man, and often involves circumcision. Whilst many governments in the region

[45] The CSW SADC Resolution on HIV/AIDS acknowledged the role of harmful cultural practices in spreading HIV and AIDS amongst women and girls.
[46] World Health organisation. (2019). Mercury in Skin Lightening Products. Geneva.
[47] Coyle Institute. (2020, April 27). Vaginal Tightening Gel: Miracle or Vaginal Health Hazard? Retrieved from https://coyleinstitute.com/does-vaginal-tightening-gel-work
[48] Vaginal Rejuvenation Surgery: Vaginoplasty Risks and Results. (n.d.). Retrieved from https://www.isaps.org/procedures/body/vaginal-rejuvenation

allow the practice, many boys die during initiation season due to complications during or after circumcision.[49] There is a need for more thorough government monitoring of these practices, as well as involvement of medical personnel, to reduce the attendant harms.



Next steps

- The 2019 Barometer called on courts to play a more pronounced role in challenging harmful practices that undermine constitutional provisions. In the same year, courts in South Africa and Tanzania played prominent roles in outlawing harmful cultural practices and declaring them unconstitutional. Governments should follow their lead and step up to play a stronger role in implementing these types of court rulings as well as enacting laws that recognise court rulings and protect their citizens from these harms.
- The Parliament of South Africa must still amend Section 7 of the Recognition of Customary Marriages Act to ensure that it aligns with the recent Constitutional Court ruling. This helps ensure laws sit in one place. Instead of cross-referencing the law to the Constitutional Court ruling, citizens and other actors can then easily refer to the amended Act when seeking enforcement.
- Civil society organisations and the Namibian media must continue to call out the practice of *Olufuko* and the political figures who support it, as it is clearly detrimental to girls' development and wellbeing.
- Most leaders continued to speak out against child marriage in line with the SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. However, lawmakers across SADC must get better at enforcing laws that protect children, taking a page from the Zambian President and First Lady.
- Governments and activists must invest more in education for men and boys, as well as traditional leaders, about the rights of children, girls and women, as well as the eradication of harmful cultural practices.
- Legislators should review customary court structures and models to ensure that women can access them and that they accommodate women, given their proximity to most women in the region, as opposed to formal courts in urban centres.
- Advocacy, education, and economic empowerment programmes should target older women, who often enforce harmful practices, such as FGM in Tanzania.
- Implement clear and unequivocal mandates for institutions that advance women's rights to address harmful practices, especially in the context of COVID-19 and the additional and new threats that women and girls face because of it. The declaration of the Commission for Gender Equality and other women and girls' rights organisations by the Government of South Africa as essential service providers during the COVID-19 lockdown provides one example of how governments should respond in such a crisis.
- SADC Governments must restrict the sale and marketing of skin lightening products given their negative impact on the health of women and girls. They should also provide information and education about the dangers of these products.

[49] Fihlani, P. (2019, December 20). South Africa initiation schools suspended after circumcision deaths. Retrieved from https://www.bbc.com/news/world-africa-50838014

Sexual diversity 8



Eswatini's first pride march in 2019 advocating for LGBTI rights. Photo courtesy of Mathias Wasik

KEY POINTS

- 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 strategies towards the attainment of universal health care.

Introduction



Photo courtesy of Global Citizen

Homophobia, transphobia, and other forms of stigma, violence, and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI) people contribute significantly to their exclusion from society, limit their access to health and social services, as well as hinder social and economic development.

LGBTI people face elevated levels of violence, discrimination, and stigma

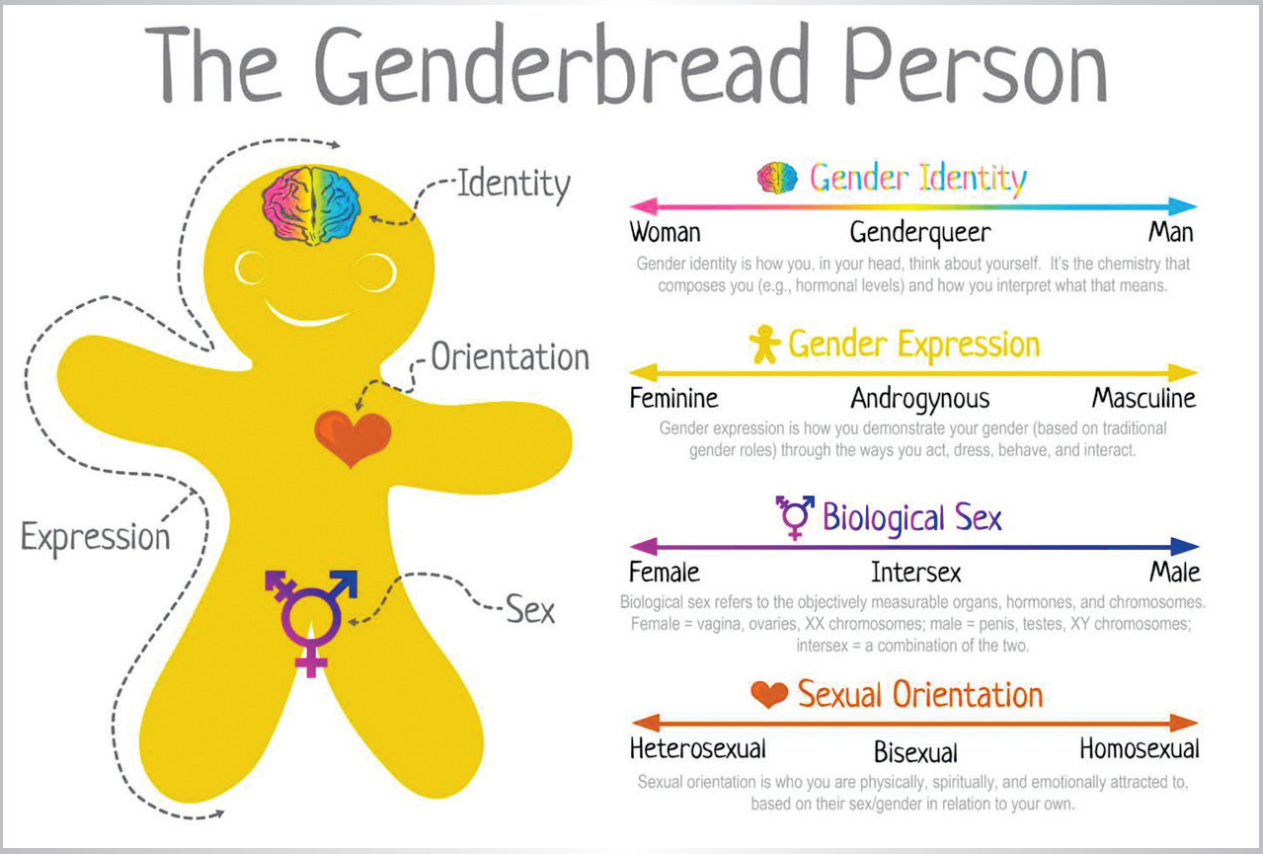
[1] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf

Although LGBTI people have made many important gains, in large part thanks to their own activism and support from civil society organisations and their allies, no country in the world has successfully eliminated all forms of discrimination against, and exclusion of, LGBTI people. Around the world and across Southern Africa, homophobic and transphobic attitudes, often combined with punitive laws and/or lack of effective legal protections against discrimination, continue to expose many LGBTI people to serious violations of their human rights.[1]

LGBTI people face elevated levels of violence, discrimination, and stigma because of their sexual orientation, gender identity and expression, and sex characteristics. In addition to removing discriminatory laws and policies, governments must provide protections in existing and new laws and policies. This section covers protection against discrimination, criminalisation of violence, and discrimination against LGBTI people, including conversion therapy.

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 - 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 whom we are attracted to. 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).

It is also important for legislators in member states to recognise that their populations include people of diverse sexual orientations, gender identities and expressions. LGBTI refers to all people across the sexual orientation, gender identity and expression and sex characteristics (SOGIESC) spectrum and all have a right to be treated with dignity, be safe, live freely, and be equal.

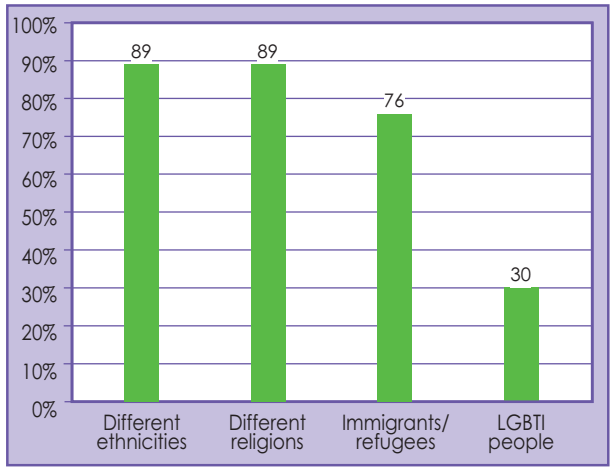
The inaugural Barometer Sexual Diversity chapter in 2019 advocated that governments' and other decision-makers in all countries should prioritise the creation of a safe, enabling environment for LGBTI communities to fully enjoy their rights and freedoms, as represented in below.



Such an environment requires:

- Repealing all discriminatory laws and policies against the LGBTI community;
- Ensuring laws and policies exist to protect LGBTI communities from all forms of violence and discrimination; and
- Implementing policies, laws and practices that promote and recognise the rights of LGBTI communities.

Figure 8.2: Would like having people from this group as neighbours?



Source: Afro Barometer 2018, accessed 1 July 2020.

Figure 8.2 shows responses to Afrobarometer, a pan-African series of national public attitude surveys on democracy, governance, and society, to a question about possible neighbours. The study analysed 45 823 responses from 34 countries, including 12 in SADC (Botswana, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe). It shows that participants mostly accept different ethnicities and religions, and to a lesser extent immigrants and refugees. However, they appear least tolerant to LGBTI people. Only 30% would want to have LGBTI neighbours. These findings underscore the need for strengthened interventions to create a safer and more enabling environment for LGBTI people in the region. It underscores the need for concerted campaigns to challenge discrimination and stigma.



Table 8.1: Sexual diversity baseline indicators in 2019[2]

INDICATORS	Angola	Botswana	Comoros[2]	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	Yes	No	(Never criminalised)	(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

2 https://ilga.org/state-sponsored-homophobia-report
3 https://en.wikipedia.org/wiki/LGBT_rights_in_the_Comoros

Table 8.1 shows that:

- Five out of the 16 SADC countries (or about one third) have decriminalised same sex consensual acts: Angola, DRC, Mozambique, Seychelles, and South Africa. Lesotho has not ever criminalised homosexuality, so its laws require further clarity, and Madagascar decriminalises homosexuality for those older than 21 but criminalises it for anyone younger than 21.
- Four countries (Mauritius, Namibia, Tanzania, and Zimbabwe) criminalise homosexuality for men only.
- Only South Africa has constitutional provisions to protect LGBTI people.
- Five countries (Angola, Botswana, Mauritius, Mozambique, and South Africa) have employment protection for LGBTI people.
- Only Angola criminalises hate crimes and incitement to violence against LGBTI communities.
- 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).[4]
- Some countries, like Mauritius, have contradictory legislation, criminalising homosexual sex acts yet protecting LGBTI 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[5] and their name (Mauritius, Namibia, South Africa, and Zambia); while four others nominally allow these changes (Angola, Botswana, Malawi and Mozambique).
- LGBTI organisations can legally register in nine countries (Angola, Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa, and Zimbabwe) and operate freely in the five countries in which homosexuality has been decriminalised, as well as Botswana, Mauritius, and Namibia.

Only 5 of 16 countries in SADC have decriminalised homosexuality, which activists see as an important first step towards full recognition of LGBTI rights

This chapter includes new case studies and information on LGBTI concerns in the Southern African Development Community (SADC). Sections on global, continental, and national legislative frameworks align with last year, as these remain unchanged. This is a concern because only five of 16 countries in SADC have decriminalised homosexuality, which activists see as an important first step towards full recognition of LGBTI rights. Governments must accelerate this moving forward.

Researchers prepared this sexual diversity chapter against the backdrop of the COVID-19 pandemic. Like other communities, COVID-19 has affected LGBTI people in fundamental ways mentioned throughout the chapter. The current crisis highlights the need for governments and civil society to engage with COVID-19, development priorities, and the unique impact of both on key populations, including the LGBTI community.

[4] https://en.wikipedia.org/wiki/Conversion_therapy, accessed 15 July 2019.
[5] 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 LGBTI



The COVID-19 crisis has resulted in far-reaching socio-economic implications for many marginalised communities. The pandemic - like other disasters such as Cyclone Idai - sharply highlights existing inequalities and exclusion. "Vulnerable communities become more vulnerable during times of crisis and for LGBTI people, this is amplified even more so exponentially," says Daina Ruduša, senior communications manager at OutRight Action International, an LGBTI advocacy organisation, told Global Citizen.[6]

In SADC as elsewhere, the pandemic has added to the multiple and intersecting forms of marginalisation this community already experiences. Emergency measures enacted by states to control the spread of the virus have affected public service delivery and sexual and reproductive health services (SRH).[7]

OutRight Action International undertook a literature review and conducted 59 in-depth interviews with LGBTI people in 38 countries, including South Africa and Zimbabwe. The study, which researchers conducted between March and April 2020, looked at how the COVID-19 pandemic and the public health measures to curb its transmission affected LGBTI people and their movements.

The report, *Vulnerability amplified: The impact of the COVID-19 pandemic on LGBQTI people* identified the following key challenges:[8]

- ***Devastation of livelihoods:*** rising food and shelter insecurity resulting from job loss, and economic fall out because of over-representation of LGBTI people in the informal sector and broad employment discrimination.
- ***Disruptions in accessing health care***, including crucial HIV medication and gender affirming treatments, and reluctance to seek healthcare due to discrimination, stigma and refusal of services experienced by LGBTI people, even outside a pandemic.
- ***Elevated risk of domestic and family violence:*** a crisis heightens the most prevalent form of violence faced by LGBTI people on a day-to-day basis, in circumstances of lockdowns, curfews, and lack of access to support services and community resources.
- ***Social isolation and increased anxiety*** occur when people get cut off from chosen families and the LGBTI community.
- ***Scapegoating, societal discrimination, and stigma*** - there is an unfortunate history of LGBTI people being blamed for social problems in emergency situations, leading to further stigmatisation, marginalisation, violence, and danger.
- ***Abuse of state power***, repression, exclusion, and criminalisation have all increased in countries prone to authoritarianism and regressive gender ideologies, with some states using the emergency situation to clamp down specifically on LGBTI people.
- Concerns about organisational survival, due to fears about closures of LGBTI community organisations and spaces, which provide a lifeline to countless people. Organisations now face an uncertain future with funding cuts, lockdowns, and having to shift activities online. Activists have called for direct support for these groups.

6 https://www.globalcitizen.org/en/content/how-covid-19-is-affecting-lgbtq/
7 http://theotherfoundation.org/covid-19-crisis/
8 https://outrightinternational.org/content/vulnerability-amplified-impact-covid-19-pandemic-lgbtiq-people

COVID-19 has negatively affected refugees since the onset of the pandemic in March 2020, as evidenced by Robert Mudzuri's story (not his real name).

COVID-19 affects the livelihood of gay sex workers[9]

Six years ago, Robert Mudzuri fled Zimbabwe when his family found out he is gay. "We are either going to call the police to arrest you or kill you ourselves," they threatened. Fleeing in the middle of the night to the country's capital, Harare, he then caught a bus to South Africa. "I did not have a passport, but you just give those officials R50 and they leave you to pass. When I got to Johannesburg, I stayed at the bus station, Park Station for almost three weeks. Life was very hectic for me. I almost committed suicide that time."

Mudzuri eventually made his way to Cape Town, where he took up sex work as a way to survive. Although it puts food on the table, the decision led to him becoming HIV-positive. "Clients sometimes force you. They will rape you," Mudzuri told All Africa in April 2020.

With the outbreak of COVID-19 and the implementation of a national lockdown, the 28-year-old no longer earns any income. "Going to bed without eating is really something else. If you are not having any food, you know you cannot take your medication. It is not just me. It is all of us," he adds, speaking of his circle of friends, a group of sex workers from other parts of Africa who, like him, have fled persecution in their countries of birth.

"It is actually a disaster for us. All of us, we are HIV-positive now. So we are going to suffer. We are going to starve. So you just end up thinking. Why is this happening to me? If I go home, it will be better. But home is where they wanted to kill me, you know? So that's why thinking of committing suicide does come into my head every now and then."

Source: All Africa.com



This story also highlights the need for free and fair environments in which LGBTI communities can fully realise their human rights and be safe and secure. The time is now to put in place legislation and policies that will decriminalise LGBTI activities and provide social protections for LGBTI people.

[9] https://allafrica.com/stories/202004290781.html

SADC: Can a new society emerge from the crisis?



Amid the COVID-19 pandemic, some LGBTI people have struggled to adhere to regulations in the face of increasing stigmatisation, discrimination, and violence as many live in lockdown with prejudiced families and communities.

Sade, an LGBTI activist and dancer in South Africa, had no option but to leave her family during the pandemic because she received constant physical and verbal abuse from them. Relying on friends and forced to choose between safety and legality, she broke lockdown regulations to move out of her family home.

At the same time, activists in the #AllBlackLivesMatter movement in the United States also broke regulations there - fuelled by the murders of Black trans women Riah Milton and Dominique Fells - to demand an end to ongoing violence against LGBTI people. Their message calls for expanding the perception of what constitutes gender-based violence (GBV) to dismantle the culture of violence.

In SADC, with stereotypes of homosexuality as "un-African," regardless of its legality in South Africa, some families and communities act antagonistically. Many LGBTI people face severe long-term trauma from verbal, physical, and emotional abuse.

Counselling psychologist Thomas Geffen explains, "from a psychological perspective, verbal, emotional and psychological abuse is as harmful as physical abuse. It can be just as damaging and frightening."

Activists from the #EndGBV and #TotalShutDown movement of 2018 emphasised the importance of unpacking rape culture and its subtle forms of violence, such as inappropriate jokes. To steer away from a violent society, individuals need to contemplate the ways they have contributed to, or allied with, antagonistic behaviour towards the LGBTI community.

Source: Nazlee Arbee is a multimedia artist and journalist based in Cape Town, South Africa. This story is part of the GL News Service

A frightening dimension of the current COVID-19 crisis includes widespread uncertainty about the funding and sustainability of LGBTI organisations. Donor priorities have shifted to COVID-19 emergency responses that widely prioritise large implementers over community-led groups.

As governments continue to discriminate against LGBTI people, denying them essential services, these persecuted groups will turn to community-based and -led organisations, making them more important than ever.

Gender Links (GL) is managing the Canadian Government Women's Voice and Leadership (WVL) project in South Africa. This initiative arises from Canada's Feminist International Assistance Policy (FIAP) which has six main elements: promoting gender equality and the empowerment of women and girls; human dignity; growth that works for everyone; environment and climate action; including governance; peace and security. The WVL Fund augmented by United Kingdom's Department for International Development (UKAID), is supporting 18 organisations with small grants to manage the impact of COVID-19. Three of the grantees are LGBTI organisations.

WVL stands with the LGBTI community in lockdown



When COVID-19 hit South Africa in March 2020, many LGBTI persons had to go into lockdown with hostile families. Some lost their jobs and income.

Fear, depression and anxiety escalated drastically. **Queerwell** is hosting online weekly expert led discussions covering different topics on mental health and wellbeing of LGBTI persons in South Africa.

Transhope Caregivers is using its WVL-SA Grant to carry out home visits educating community members in the KwaZulu-Natal province, South Africa on COVID-19 prevention. Transhope Caregivers provide support to LGBTI individuals who are bedridden living with HIV and AIDS and tucerculosis. They also train family members on how to provide care to the infected individuals in ways that are safe, and educate them on nutrition and dietary requirement for persons on ARV treatment. To destigmatise COVID-19 and negative attitudes towards LGBTI persons, Transhope airs radio shows that discuss these matters in local languages. The organisation created online and telephonic peer support groups that currently support 60 LGBTI individuals.

Gala Queer Archives (GQA) aims to provide education and awareness around risks associated with COVID-19 and mental health, prevention of the virus, mental health management and access to mental health services, care and support to the vulnerable LGBTI people within South Africa. During this time of uncertainty and precariousness GQA provides monthly food parcels, flu and hygiene packs (containing flu medication and soap).



Food parcels for LGBTI beneficiaries.
Photo courtesy of Gala

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 LGBTI rights. As such, the SDGs do not include any specific references to LGBTI people or issues. But to ensure that the global development agenda does not leave LGBTI communities behind, the UNDP developed the LGBTI Inclusion Index to inform evidence-based development strategies to advance their inclusion. Following extensive multi-sectoral and civil society consultations, the five priority dimensions for measurement in the LGBTI Inclusion Index are political and civic participation, economic well-being, personal security and violence, health, and education.[10]

To bring greater clarity and coherence to states' human rights obligations, the International Commission of Jurists and the International Service for Human Rights, on behalf of a coalition of human rights organisations, developed a set of international legal principles on the application of international law to human rights violations based on sexual orientation and gender identity.[11] Although stakeholders first adopted the "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:*** Principles one through three establish the universality of human rights and their application to all without discrimination. All people have a right to recognition as a person before the law, regardless of their sexual orientation or gender identity. Forced medical procedures, like sterilisation or sex reassignment surgery, cannot be required for legal recognition.
- ***Rights to human and personal security:*** Principles four through 11 address fundamental rights to life, freedom from violence and torture, privacy, access to justice and freedom from arbitrary detention and human trafficking.
- ***Economic, social, and cultural rights:*** Principles 12 through 18 elaborate on non-discrimination in the enjoyment of economic, social, and cultural rights. This covers the rights to employment, housing accommodations, social security, and education, as well as sexual and reproductive health rights that include the right to informed consent and sex reassignment therapy.
- ***Rights to expression, opinion, and association:*** Principles 19 through 21 set forth the freedom to express oneself, one's identity, and one's sexuality based on sexual orientation or gender identity, without state interference. Along with this right to free expression, everyone also has the right to freely participate in peaceful assemblies and associate.
- ***Freedom of movement and asylum:*** Principles 22 and 23 highlight the rights of persons to seek asylum from persecution based on sexual orientation or gender identity.
- ***Rights of participation in cultural and family life:*** Principles 24 to 26 address the rights of people to have family life and to participate in public affairs and the cultural life of their communities without discrimination based on sexual orientation or gender identity.
- ***Rights of human rights defenders:*** Principle 27 establishes the right to defend and promote human rights without discrimination based on sexual orientation and gender identity, as well

[10] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf
[11] http://yogyakartaprinciples.org/introduction/

as the obligation of states to ensure the protection of human rights defenders working in these areas.

- ***Rights of redress and accountability:*** Principles 28 and 29 elaborate on holding rights violators accountable and ensuring appropriate redress for those who face rights violations.
- ***Additional recommendations:*** The principles establish 16 additional recommendations to national human rights institutions, professional bodies, funders, NGOs, the High Commissioner for Human Rights, United Nations agencies, treaty bodies, special procedures, and others.[12]

The UN has rolled out several instruments that enshrine these rights, and SADC countries have signed onto many of them.

Table 8.2: Overview of key UN instruments and SADC commitments[13]

Country	International Convention on Civil and Political Rights (ICCPR)	International Covenant on Economic, Social, and Cultural rights (ICESRC)	Convention on Torture (CAT)	Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)	Convention on the Rights of the Child (CRC)	UN Centre for Regional Development (SDGs) (CRD)	International Convention on the Elimination of all forms of Racial Discrimination (ICERD)
Angola	SP	SP	S	SP	SP	SP	S
Botswana	N	N	N	SP	SP	S	S
DRC	SP	SP	SP	SP	SP	SP	SP
Eswatini	SP	SP	SP	SP	SP	SP	SP
Lesotho	SP	SP	SP	SP	SP	SP	SP
Madagascar	SP	SP	SP	SP	SP	SP	SP
Malawi	SP	SP	SP	SP	SP	SP	SP
Mauritius	SP	SP	SP	SP	SP	SP	SP
Mozambique	SP	N	SP	SP	SP	SP	SP
Namibia	SP	SP	SP	SP	SP	SP	SP
Seychelles	SP	SP	SP	SP	SP	SP	SP
South Africa	SP	SP	SP	SP	SP	SP	SP
Tanzania	SP	SP	N	SP	SP	SP	SP
Zambia	SP	SP	SP	SP	SP	SP	SP
Zimbabwe	SP	SP	N	SP	SP	SP	SP

Table 8.2 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:

- None means a state has not committed to the instrument, indicated with an "N."
- Signatory means a state has signed an agreement but has not ratified it at national level, indicated with an "S."
- State party means a state has ratified the instrument at national level, which means it must be domesticated, indicated with an "SP."

Ten SADC countries have committed to implementing all seven instruments in country: DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Namibia, Seychelles, South Africa, and Zambia. It is a concern that Tanzania and Zimbabwe have not signed the Convention on Torture.

Angola has not ratified the CAT and ICERD, while Botswana lags in several areas as it has not committed to the ICCPR, ICESRC and CAT and it has only signed up to, but not domesticated, the CRD and ICERD.

[12] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf
[13] https://ilga.org/downloads/Treaty_Bodies_SOGIESC_references_2016_ILGA.pdf

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 LGBTI communities. Resolution 275 calls on member states to:

- Ensure that human rights defenders work in an enabling environment free of stigma, reprisals, or criminal prosecution because of their human rights protection activities, including the rights of sexual minorities; and
- End all acts of violence and abuse, whether committed by state or non-state actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence, including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.[15]

The first clause in resolution 275 commits member states to allowing LGBTI 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.

Clause two commits member states to creating a legal environment that criminalises violence against LGBTI 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 LGBTI people from violence and discrimination. Other countries should urgently bring in similar legislation.

The 2019/2020 *South African Institute of Race Relations study LGBTQ rights in Sub-Saharan Africa: Perspectives of the region from the region* provides anecdotal accounts of the status of LGBTI people and organisations based on interviews with activists. Analysis of progress on legal and social protections in selected SADC countries shows varying degrees of progress despite their commitments to global and continental frameworks.

No SADC instruments currently exist specifically to address LGBTI rights

[14] http://cfnhri.org/uploads/files/resolution_275_eng.pdf
[15] http://www.achpr.org/sessions/55th/resolutions/275/

Regional instruments

No SADC instruments currently exist specifically to address LGBTI rights. This is indicative of the resistance amongst legislators in most SADC states to address the needs of these communities. South Africa 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 LGBTI people - one that includes global and continental provisions within a SADC context.

Three SADC instruments speak to improving SRHR in member states:

- Strategy for Sexual and Reproductive Health and Rights in the SADC region, 2019-2030;
- SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights among key populations; and
- Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region.

The **SADC SRHR strategy** includes LGBTI people in its list of beneficiaries (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 LGBTI, migrants, refugees, mobile populations, people living with disabilities, and victims of sexual exploitation).[16] The SRHR strategy makes no other specific reference to the needs of LGBTI people.

The **SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights** does not include LGBTI people among key populations at all. However, it does identify Men who have Sex with Men (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 health care settings, the workplace, families, and within communities.[17]

The Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region takes a similar approach by referencing LGBTI persons as a key population. It calls on states to:

- Review and revise or develop new policies that support access to integrated SRH and HIV services for key populations, especially adolescents, youth, migrant populations, LGBTI persons, and people with disabilities; and
- 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.[18]

Constitutional provisions

Only South Africa has specific provisions in its constitution recognising the rights of LGBTI people. Chapter two (the Bill of Rights of the South African constitution) states under subsection 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

[16] https://genderlinks.org.za/wp-content/uploads/2018/11/1-Final-signed-SADC-SRHR-Strategy-2019-2030.pdf
[17] https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf
[18] http://www.integrainitiative.org/wp/wp-content/uploads/2015/12/tmp-11285-SADC-Min-Stds-Eng-final-1158402048.pdf

origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth... No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection... National legislation must be enacted to prevent or prohibit unfair discrimination... Discrimination on one or more of the grounds listed in subsection 3 is unfair unless it is established that the discrimination is fair."

It is important to include protections for gender and sexual orientation in country constitutions. This guarantees long term protection for LGBTI people. Fourteen SADC countries include equality and non-discrimination clauses in their constitutions, but do not include sexual orientation. The Constitution provides fundamental foundational principles that apply to all citizens. Governments should not use a constitution to exclude any individuals or groups.



The **Namibia** Legal Assistance Centre (LAC) published a report *Namibian Law on LGBTI issues* in 2015 that explored the Namibia legal framework regarding LGBTI issues. It noted that:

- Article 10(2) of the Namibian Constitution [...] constitutes a "closed list" of impermissible grounds of discrimination, which does not include sexual orientation or gender identity. (It also excludes some other obvious categories such as age or disability.) However, this does not mean that sexual minorities are not protected. First, the equality provision in Article 10(1) is absolute. Everyone is equal before Namibian law, including LGBTI persons. Secondly, the word "sex" in Article 10(2) can be interpreted to include sexual orientation - as it has been in other countries and under international law. Thirdly, in countries like Botswana, constitutions with a "closed list" of protected grounds have at times been interpreted as constituting examples rather than being exhaustive.[19]
- Article 14 [of the Constitution] does not expressly guarantee anyone's right to family. Instead, it appears to protect (i) the right of adults to marry; and (ii) the family as a unit. It should be noted that there is no indication in the references to marriage that marriage must be a union between a man and a woman. The Namibian Constitution merely provides that men and women may marry, and that the "spouses" must enter into the union of their own free will. In considering the meaning of "family" in the Namibian Constitution, the Frank case [...] interpreted the wording of Article 14(1) in the Namibian Constitution to mean that "marriage is between men and women - not men and men and women and women"; it stated that homosexual relationships, "whether between men and men and women and women, clearly fall outside the scope and intent of Article 14."[20]

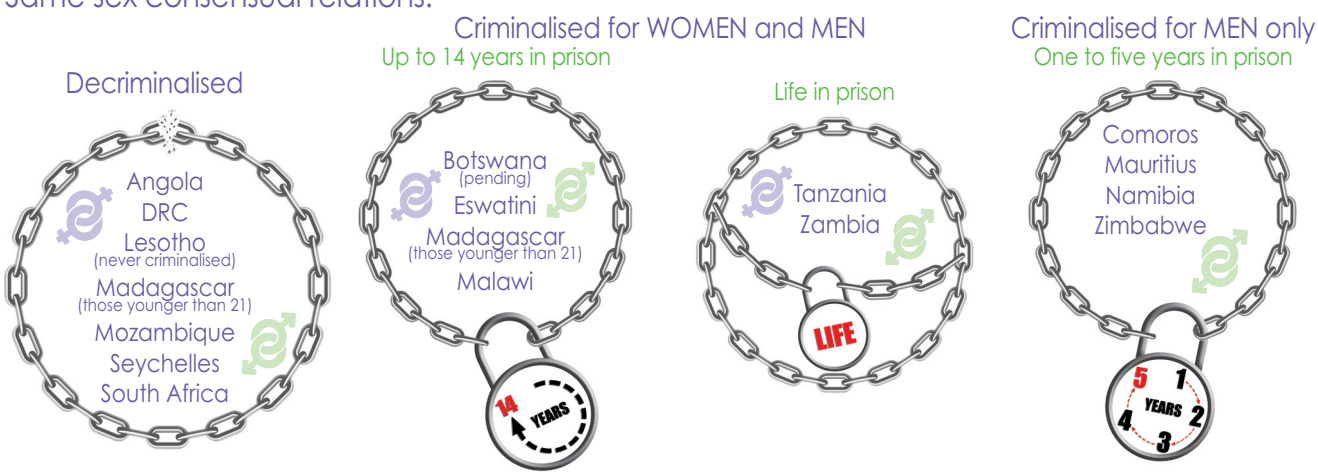
As is clear in the Namibia example, the lack of specific references to LGBTI rights in constitutions leave room for interpretation and could affirm or refute certain inalienable rights. The ruling on marriage being only between women and men represents one such example. Thus, activists must lobby for broad protections and recognition of LGBTI rights in constitutions. Legislative reform should start with constitutions and cascade to all other laws and policies.

Status of same-sex consensual relations in SADC

People engaged in same-sex consensual relations face stigma and discrimination across SADC. Even in countries where legislators have decriminalised same-sex consensual relations, most governments stop at decriminalisation without putting requisite rights in place. Political will and strong religious opposition remain a major challenge.

[19] LAC, Namibian Law on LGBT Issues (p35), 2015
[20] LAC, Namibian Law on LGBT Issues (p.38), 2015

Figure 8.3: Legal status of same-sex relationships in SADC



Source: Southern Africa Gender Protocol Alliance mapping of SRHR policies and laws, 2018.

Figure 8.3 shows that five countries (Angola, DRC, Mozambique, Seychelles, and South Africa) have decriminalised homosexuality. In Lesotho, homosexuality was never criminalised. In Madagascar, homosexuality is decriminalised for those over 21 years of age. Meanwhile, nine countries have laws in place criminalising same-sex consensual relations. In Madagascar, homosexuality remains a crime for people younger than 21. Only Angola, Mozambique, and South Africa provide broad protections for the LGBTI community.



Angola passed legislation in January 2019 making it a criminal act to discriminate based on sexual orientation, with punishment of up to two years' imprisonment.[21] This law accompanied decrimi-nalisation of same-sex consensual relations in the country.



Mozambique decriminalised same-sex consensual relations in 2015. At that time, lawmakers in the country had an opportunity to broaden the provisions on discrimination. Article 243 of the 2015 Mozambique Penal Code covers discrimination against different people and sites.

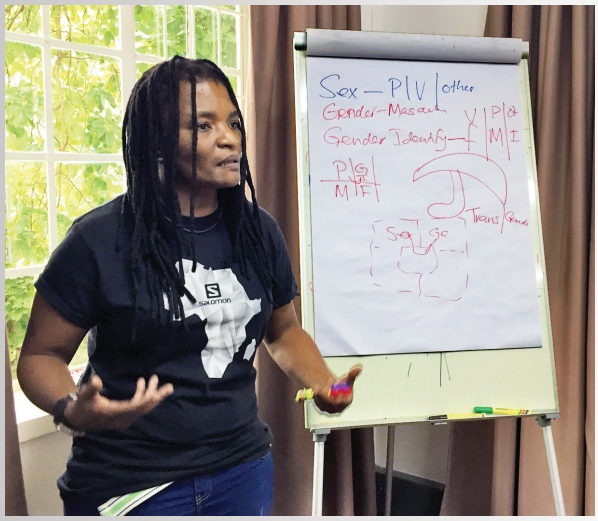
Ten countries have gender distinctions around the criminalisation of consensual same-sex relations. Six of the ten - Botswana, Eswatini, Madagascar, Malawi, Tanzania, and Zambia - criminalise same-sex consensual relations for both women and men. But Comoros, Mauritius, Namibia, and Zimbabwe only criminalise same sex consensual relations between men.

These conditions create legal uncertainty and ambiguity. The latter three countries do not restrict lesbians, and the reason for this anomaly remains unclear. It could be gender blindness; an implicit acknowledgement that legislators believe gay relationships between men to somehow be more serious and/or threatening. The different ways that laws treat gay men and women points to a serious violation of the principles of equality and fairness. Decriminalising all same-sex consensual relations will remove any legal questions linked to this. In Tanzania and Zambia, men and women both receive life sentences for engaging in same-sex consensual relations.

Religious conservatism drives prejudice and discrimination against LGBTI people. Activists urgently need to develop lobbying, advocacy, and communication strategies to guard against increasing prejudice and to ensure that LGBTI communities have access to basic services, safely, and security. LGBTI communities, civil society organisations, government, and other stakeholders must work in consultation to identify and implement effective strategies.

[21] https://www.iol.co.za/news/africa/angola-lifts-ban-on-homosexuality-18965269

Working to change the LGBTI landscape



LGBTI activist, Linda Bauman, presenting at an Alliance meeting in August 2019. Photo: Gender Links

The Southern African Gender Protocol Alliance (the Alliance) has been working to strengthen Sexual and Reproductive Health and Rights (SRHR) at national and local level. The Alliance National SRHR clusters mapped 121 organisations working on SRHR; nine LGTBI organisations. The nine organisations constitute an LGBTI subgroup in the SRHR cluster.

There are three categories of SADC countries: seven in which homosexuality is legal; those where there is growing tolerance and those that remain closed on LGBTI issues. GL and the SADC Protocol Alliance targeted the middle category to prize open the door further and strengthen the LGBTI voice, presence and advocacy in the network.

Through the support of an Amplify Change Networking grant GL as secretariat of the Alliance is working with LGBTI organisations in five countries (Botswana, Eswatini, Malawi, Mauritius and Namibia) to strengthen their institutional capacity. The organisations identified monitoring and evaluation as an important foundational area to be strengthened in order to track advocacy strategies to decriminalise homosexuality: a key entry point to creating an enabling environment for LGBTI communities. To this end:

- GL conducted an institutional capacity building needs assessment in June 2019.
- The results were analysed and all organisations identified monitoring and evaluation as the most important capacity need in their organisations.
- GL ran a monitoring and evaluation training workshop in August 2019.
- Organisations developed theory of change and results frame works including indicators to measure goals, outcomes and outputs.
- This led to the creation of a results chain which then linked to organisations work plans and the relevant monitoring and evaluation tools.
- Organisations have been implementing their result frame works over the last year.
- On site workshop planned for April to June 2020, pivoted to virtual interventions due to COVID-19.
- An assessment of the implementation of the monitoring and evaluation systems will be conducted by September 2020. The table summarises progress to date:

Country	Organisation	Progress towards decriminalisation
Botswana	Lesbians, Gays & Bisexuals of Botswana (LEGABIBO)	• Homosexuality was decriminalised in June 2019. • The Botswana Attorney General appealed the decision. • LEGABIBO has been pushing for the Appeal to be heard. • The Appeal hearing was scheduled for July 2020 but has been remanded due to COVID-19. • There is no scheduled date as at July 2020.
Eswatini	Eswatini Sexual and Gender Minorities (ESGM)	• Melusi Simelane and Others are challenging Eswatini's Registrar of Companies to register the organisation Eswatini Sexual and Gender Minorities (ESGM). • This will represent an important first step towards the decriminalisation of homosexuality and the recognition of LGBTI rights.

Country	Organisation	Progress towards decriminalisation
Malawi	Centre for the Development of People (CEDEP)	• CEDEP continues to call for the repeal of Malawi's anti-homosexuality laws. • Same-sex sexual relations are illegal in Malawi under Sections 137, 153, 154 and 156 of the Penal Code and are punishable by up to 5 years imprisonment for women and up to 14 years for men. • The organisation has not been able to move on the legal front due to the country's May 2019 election being declared illegal and a new democratic election was only concluded in June 2020.
Mauritius	Young Queer Alliance (YQA)	• Najeeb Ahmad Fokeerbux from the YQA, one of four men, brought a legal case challenging the constitutionality of Section 250, a law that punishes gay sex. • The Supreme Court heard the case for the first time in December 2019. • After a number of hearings, on the 12 of June 2020, the Supreme Court granted leave to lodge the case for constitutional redress. • The organisation will be focusing on the Constitutional challenge over the next six to 12 months.
Namibia	Namibian NGO Forum Trust (NANGOF)	• OUTRIGHT Namibia, a member of NANGOF, is engaging with the government to decriminalise homosexuality. • Due to the tolerant environment and lack of active state opposition to homosexuality this is proving challenging. • As this process is unfolding OUTRIGHT Namibia has been documenting and responding to human rights violations within the LGBTI community around the country. • As a result of the complaints submitted, the organisation identified the need for engagement and training of safety and health officials. • LGBTI community faces secondary victimisation when contacting or seeking help from the police or health professionals. • OUTRIGHT is engaging the police, health authorities, and traditional and religious leaders to seek solutions on how to increase the accessibility of public services offered, and to sensitise these officials on the unmet needs of LGBTI persons in Namibia.

All five organisations are in the process of writing up case studies, gathering first-hand accounts of experiences LGBTI persons, and administering an LGBTI attitude quiz that is aligned to the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) global attitudes survey.



Alliance LGBTI strategy meeting, 2019. Photo: Colleen Lowe Morna

The Attitudes survey will include questions that measure public perceptions on:

- Knowing and being in close proximity of different sexual orientations.
- Different gender identities and expression.
- How individuals would deal with different SOGIEs in their family.
- Religion and SOGIE.
- How and where SOGIE occurs and where it originates.
- Recognition of SOGIE as human rights and the need for legal protections.

The three-pronged monitoring and evaluation strategy that assesses the environment, individual experiences as well and public perceptions will be concluded at the end of September and the report launched during the 2020 Sixteen Days of no Violence Against Women campaign running from the 25 November to the 10 December.



Botswana: Interview with an LGBTI activist[22]

Civicus, which represents a global alliance of civil society organisations (CSOs), spoke to Dumiso Gatsha, a young LGBTI rights activist, about the recent High Court decision to decriminalise gay sex. Gatsha founded Success Capital Organisation, a youth-led CSO that supports civic action and promotes the rights of LGBTI people.

How significant was the June 2019 court decision that decriminalised homosexuality in Botswana?
This ruling is very significant on two fronts. The first is that this decision eliminates the risk of persecution altogether. Although the prohibition was not necessarily implemented by law enforcement agencies, it could have been, as it added elements of uncertainty and arbitrary treatment. The second is that it essentially provides an avenue for building protections and safeguards in health, employment, business, governance, service delivery and, more importantly, eliminating systemic stigma and discrimination.

Was civil society in Botswana instrumental in bringing about this decision?
LGBTI civil society has been very active since the 1990s. Litigation for decriminalisation was led by civil society, on behalf of a young gay man. Procedurally, only an individual can bring such a challenge to the courts, not an organisation. The most progressive of recent court cases (in terms of gender marker changes) were led by people. Civil society partnerships helped ensure financial and technical assistance.

However, it is very difficult to bring the rest of the community along. Decriminalisation does not mean protection or that it will be any easier for people to navigate difficult conversations about sexual orientation and gender identity with family members or educators, or in the workplace.

Has the court decision prompted any backlash against LGBTI rights?
I think society is divided, and attitudes may take longer than laws to change. The ruling political party initially said that it would abide by the court decision. The president released a statement commemorating 16 Days against gender-based violence and spoke about discrimination experienced by people in same-sex relationships. This was the first time a sitting head of state publicly recognised and acknowledged the gay community affirmatively.

A new opposition party saw an opportunity to use the decriminalisation ruling to seek votes. They blamed the president for decriminalising same-sex intercourse. The decriminalisation case became a political issue rather than a rights issue. Since the court ruling, religious institutions, mostly evangelical groups, became more vocal in their intolerance of LGBTI people. Some churches stated that the court ruling was an avenue for same-sex marriage and adoption of children by LGBTI people.

What is next for LGBTI civil society in Botswana?
If the High Court ruling survives the appeals and any other further legal challenges, a gap will remain. There have been some fragments of civic action aimed at educating people on LGBTI issues. There is an urgent need to work on changing the hearts and minds of people. More importantly, there is a lot of work needed in moving LGBTI people from surviving to thriving. A lot of advocacy strategies and narratives are pre-determined and attached to funding. There is a lot of gatekeeping in terms of the narratives that are considered relevant and valid, and therefore granted access to funding and to policymakers. The main narrative currently appears to be around public health. We need to move towards a community-led narrative. In sum, I would say it is very important to diversify both the forms of advocacy that are undertaken and the ways that they are being supported.

Source: CIVICUS, 2020

[22] https://www.civicus.org/index.php/media-resources/news/interviews/4005-botswana-anti-right-groups-are-emerging-in-reaction-to-progressive-gains



On 11 June 2019, the **Botswana** High Court decriminalised same-sex sexual conduct among consenting adults. The Attorney General of Botswana lodged an intention to appeal the decision immediately after the ruling. There has been no further legal action since. Legislators have not yet promulgated the High Court decision into law due to the impending appeal, leaving it in limbo.



Comoros, a Muslim country and the only country in SADC governed by Sharia law, criminalises homosexuality and gay sex, regardless of age. The Penal Code provides a punishment of up to five years' imprisonment, and a fine of 50 000 to 1 000 000 Comoran francs (USD $166 to 3333). The age of consent is 13. Most LGBTI people do not publicly discuss their sexual orientation due to societal pressure. Comoros does not have any LGBTI organisations.[23] In January 2013, then-President Ikililou Dhoinine promulgated a law declaring Sunni Islam as the country's official religion.[24] The four leading Sunni schools of thought and most Islamic scholars believe homosexual acts are a major sin.[25]



In **Malawi**, conservative laws represent a major symbol of oppression, targeting anyone who looks, acts, or dresses differently from the norm. While authorities do not enforce such laws, they create an atmosphere of fear and prejudice. However, Malawi was one of few countries in Africa to prevent US pastor Steven Anderson (who gained infamy for advocating for the extermination of gay people) from establishing a church.[26] Yet, at the same time, the Malawian government refused to take action against homophobic politician Ken Msonda (spokesperson of the former ruling People's Party), who described homosexuals as being worse than dogs and said gays and lesbians are the sons and daughters of the devil. He wrote, "Arresting them won't address this problem because sooner or later they are being released on bail. The best way to deal with this problem is to kill them!"



In **Mozambique**, LGBTI programmes usually do not go beyond targeting MSM as a key population. Focusing on the health aspect of this community has helped to direct more attention to people most vulnerable to HIV and AIDS, such as MSM. MSM work and HIV and AIDS-related initiatives by the public health sector provide space, visibility, and funding for MSM and LGBTI activism in Mozambique. However, focusing only on MSM and HIV and AIDS when it comes to LGBTI rights also creates a specific - and very stigmatised - narrative. Other areas of focus should include education and awareness campaigns.



In **Zambia**, the government uses LGBTI issue as a way of deflecting attention from more pressing problems that result from governance failure, such as corruption, poor service delivery, and high taxes. LGBTI activists and civil society organisations lobbied successfully to include gay and transgender rights in HIV and AIDS strategies. Public health strategies also now include LGBTI people. LGBTI organisations have created safe spaces where LGBTI people can talk openly about issues concerning their community.

The Sustainable Development Goals do not include any specific references to LGBTI people

[23] https://www.globalgayz.com/gay-comoros-africa/2035/
[24] https://www.gov.uk/foreign-travel-advice/comoros/local-laws-and-customs#:~:text=Homosexuality%20is%20illegal%20in%20Comoros,LGBT%20community%20before%20you%20travel.
[25] https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=2322&context=ilj
[26] Collison, 2016



Zimbabwe: Homophobia on the rise[27]

While some SADC countries have amended laws over the past two decades to increase protections for LGBTI citizens, Zimbabwe has changed its laws to expand discrimination.

A 2006 revision to Zimbabwe's criminal code broadened the penalty for sodomy to include acts that "would be regarded by a reasonable person as an indecent act." To many in the country, this includes two men holding hands or embracing - acts that could now result in extended time in prison.

Laws like this make life more difficult for gay people in the country as well as the heterosexual people they often marry to blend in and protect themselves. Many LGBTI people give in to pressure from parents and their extended family and agree to heterosexual marriages, thus living a lie, an emotionally draining situation that leads to extreme psychological distress.

For others who do not take this route, discrimination, exclusion, and violent attacks can cause permanent fear and loneliness. Many suffer from poor mental health. Some local civil-society organisations provide help, but policy must change.

Many LGBTI people in Zimbabwe suffer from low self-esteem; they are isolated and often depressed. "I have no place in society," a young lesbian in Harare told Gays and Lesbians of Zimbabwe (GALZ), a group that advocates for LGBTI rights in the country. "Where do I run to?"

Current legislation makes specific sexual acts illegal but falls short of criminalising LGBTI status. According to widespread belief, however, homosexuality is a crime in the country. An uninformed media perpetuates this belief. Homophobic statements by government leaders also contribute to a misinformed, highly discriminatory socio-political environment.



Gays and Lesbians of Zimbabwe (GALZ) activists in Harare in 2019.
Photo courtesy of GALZ

Gay people experience violence and marginalisation because of this. Aggression ranges from verbal abuse and bullying to social discrimination, physical violence, and psychological torture.

According to a 2018 GALZ survey, 50% of gay men in Zimbabwe said they had been physically assaulted, and 64% said their family had disowned them. Meanwhile, 27% of lesbians reported disownment. Often, parents accuse their gay children of exposing them to "blame and shame."

Some families in rural areas assume that demons have possessed a gay son or lesbian daughter. Traditional leaders evict gay people from their villages. A young man from western Zimbabwe, who preferred to remain anonymous, said that people in his village believed that "even with a handshake, I would transfer homosexuality." Elders decided that he was unfit to stay in the community.

Another frequent problem relates to healthcare workers, who mistreat people from the LGBTI community. Hospital staff "are afraid to touch me," recounts a gay man about his experience accessing health care in Zimbabwe. "Some will even start preaching the Bible." Consequently, LGBTI people avoid seeking support, even for essential health services.

Source: GALZ, 2019, and Development and Cooperation

[27] https://www.dandc.eu/en/article/homophobia-zimbabwe-hurts-mental-health-lgbti-people

Employment

Five SADC countries protect LGBTI peoples' rights to equal access to employment: Angola, Botswana, Mauritius, Mozambique, and South Africa.

The Vulnerability amplified: The impact of the COVID-19 pandemic on LGBTIQ people report delves a little deeper into how COVID-19 has impacted employment in the LGBTI community. It found rising food and shelter insecurity in the community due to job loss, and economic consequences because of its over-representation in the informal sector.

In South Africa Queer Women in Business + Allies is one of the organisations supported by the Global Affairs Canada Women Voice and Leadership Fund. The organisation aims to launch and develop African queer women owned businesses through access to business coaching, skills development, funding and long-term mentorship for business sustainability. Research by the organisation shows that 60% of queer women entreprenuers be-lieve that the lack of business know-ledge, resources and funding stunts their business growth and is a significant barrier to entry into business. The Network will include queer women owned start-ups in urban and non-urban areas.

In many countries, LGBTI people predominantly work in the informal sector, relying on daily wages and surviving without job protections, making them especially vulnerable to economic slowdowns and restrictions on movement like those that occurred during the COVID-19 pandemic.

Southern Africa: LGBTI persons among the most at risk from COVID-19[28]

Interviews conducted by Human Rights Watch revealed that, during the COVID-19 pandemic, many LGBTI people had to choose between risking infection to earn enough money to pay for food and shelter or adhering to lockdown requirements and risking going without basic necessities.

With imposed lockdowns, mandatory curfews, and physical distancing requirements, millions of businesses have closed, at least temporarily, and countless people have been laid off. Those who survive in cash-based, informal economies and live day-to-day to make enough to subsist represent those who COVID-19 hit the hardest.

These include LGBTIQ people living on the margins, many of whom may have been excluded from education and employment due to stigma and discrimination, with little access to formal employment and the corresponding job security.

According to the World Food Programme, 130 million additional people across up to 36 countries may be "pushed to the brink of starvation" due to the COVID-19 pandemic, effectively doubling the total number of people suffering from severe hunger globally.[29]

The reality is that COVID-19 forced many among the world's poorest into even more difficult situations. As state and local governments moved to enforce curfews and physical distancing orders, those relying on day-to-day incomes faced an increased risk of arrest and violence, as well as exposure to the virus.

Staying at home provides no guarantee of safety, especially for those in overcrowded housing, densely populated neighbourhoods and settlements, and communities with limited or no access to clean water.[30] Because of discrimination and marginalisation, many LGBTI people across the SADC region live in these conditions.

Source: ILGA and Human Rights Watch, 2020. Accessed 22 July 2020

[28] https://www.hrw.org/news/2020/05/20/south-africa-end-bias-covid-19-food-aid#
[29] United National World Food Programme."WFP Chief warns of huger pandemic as COVID-19 spreads (Statement to the UN Security Council)" April 21, 2020. https://www.wfp. org/news/wfp-chief-warns-hunger-pandemic-covid-19-spreads-statement-un-security-council
[30] CARE International, 2020.

Violence and discrimination

LGBTI people face elevated levels of discrimination and violence across the region. In some instances, such as in Tanzania, homophobic politicians encourage it. In other countries, a lack of progressive legislation creates unsafe environments for these communities. Where enabling environments exist (such as in South Africa) there is need for ongoing advocacy to ensure that public values and attitudes align with the legal and constitutional environment.

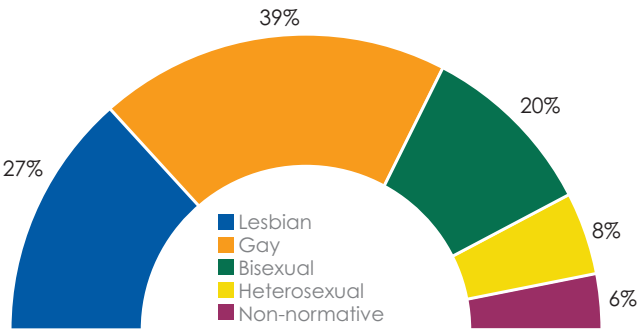
At its worst, violence and discrimination manifests in hate crimes and mob violence. Bullying and public humiliation represent other common forms. The 2019 research report *Are we doing alright? Realities of violence, mental health, and access to healthcare related to sexual orientation and gender identity and expression*, a community-led study in nine countries, provides insights into the experiences of violence and discrimination in six Southern African and three East African countries. The University of Cape Town's Gender, Health and Justice Research Unit conducted the study with support from the Netherlands Ministry of Foreign Affairs, in partnership with LGBTI organisations.

Table 8.3: Breakdown of the sample by country

Country	Number of respondents
Botswana	583
Eswatini	103
Lesotho	171
Malawi	197
South Africa	831
Zimbabwe	343
Total	**2228**

Table 8.3 shows the number of respondents in the six SADC countries: Botswana, Eswatini, Lesotho, Malawi, South Africa, and Zimbabwe. Researchers spoke to 2228 respondents in these countries, with the largest proportion from South Africa (831) followed by Botswana (583). The results presented here link to the findings for these six countries.

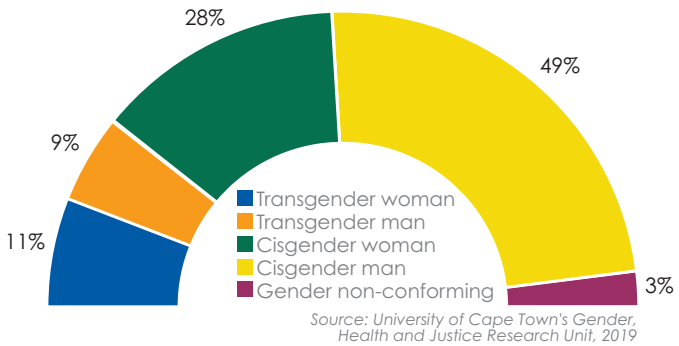
Figure 8.4: Sexual orientationof the sample



Source: University of Cape Town's Gender, Health and Justice Research Unit, 2019.

Figure 8.4 shows the proportion of the sample for lesbian, gay, bisexual, heterosexual, and non-normative respondents. At 39% gay men represented the largest proportion of the sample, followed by lesbians and heterosexuals at 27% and 20% respectively.

Figure 8.5: Sample by gender identity

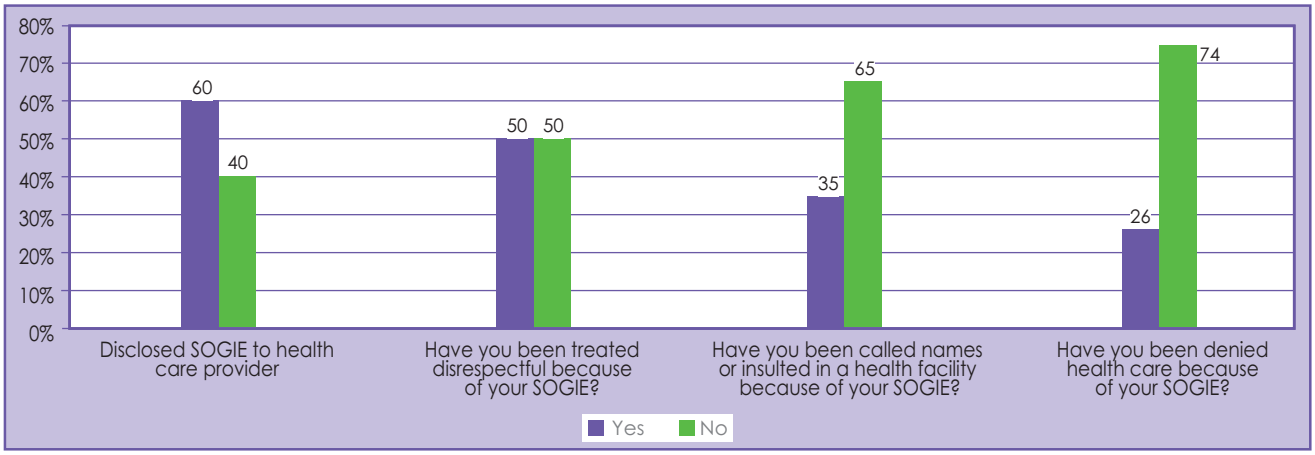


Source: University of Cape Town's Gender, Health and Justice Research Unit, 2019

Figure 8.5 illustrates that cisgender[31] men made up the largest number of respondents, followed by cisgender women at 28%. Of the total sample, 11% included transgender women and 9% transgender men.

[31] A person whose sense of personal identity and gender corresponds with their birth sex.

Figure 8.6: Discrimination in healthcare

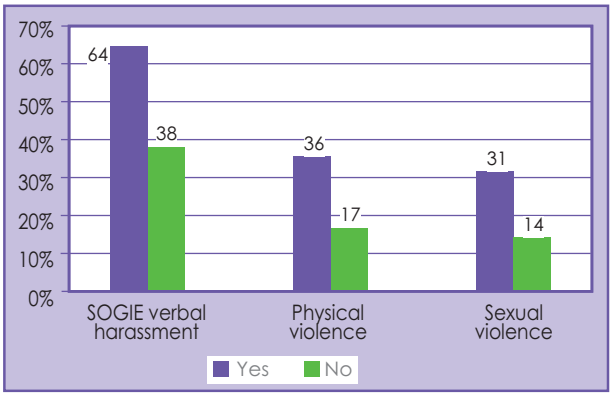


Source: University of Cape Town's Gender, Health and Justice Research Unit, 2019.

Figure 8.6 shows that a high proportion of respondents (40%) did not disclose their sexual orientation or gender identity (SOGIE) to healthcare providers. A third of respondents said health care providers had called them names or insulted them because of their SOGIE, while a quarter had their healthcare denied. Equitable access to health care is a basic human right. The findings in the study point to gatekeeping in the healthcare system that prevents LGBTI people from utilising health facilities. Better health worker training will help address this type of discrimination. Health facilities must be held accountable when they withhold healthcare from, or provide sub-standard care to, LGBTI persons.

Figure 8.7 illustrates an alarming amount of violence against LGBTI people in the region. Of the total sample, 64% reported that they had experienced verbal harassment in their lifetime with 38% experienced it in the last year. About a third of all respondents experienced physical and sexual violence in their lifetime. Similar proportions of LGBTI people experienced physical (17%) and sexual violence (14%) in the last year.

Figure 8.7: Violence against LGBTI persons



Source: University of Cape Town's Gender, Health and Justice Research Unit, 2019.

Hate crimes and incitement to hatred and violence

A hate crime typically involves violence motivated by prejudice based on race, religion, sexual orientation, or other grounds.[32] In criminal law, incitement is the encouragement of another person to commit a crime.[33] Angola is the only country that has specific hate crime legislation.

The Human Dignity Trust, on behalf of the Equality & Justice Alliance, conducted research on *Hate Crimes against the LGBTI Community in the Commonwealth: A Situational Analysis*. The study provides important insights into hates crimes in particular Southern African countries.

[32] Dictionary.com
[33] IBID

The study reveals physical and sexual homophobia and transphobia across African Commonwealth countries. Men frequently rape lesbian and bisexual women in a purported attempt to "turn" them straight.[34] Families force lesbian women into heterosexual marriages to preserve their "honour" and that of their family. This may involve forced impregnation through rape, physical violence, and degrading treatment.



In **South Africa**, a report by the Centre for Risk Analysis at the Institute of Race Relations[35] found that 49% of black members of LGBTI communities are likely to know someone who murdered for being LGBTI, compared to 26% of white community members.

The study also found that black people were the most likely to be victims of physical violence, while white people tended to experience verbal abuse. However, the report notes increasing tolerance for the LGBTI community. Half (51%) of South Africans surveyed agreed that LGBTI people should be afforded the same human rights as the rest of the population. More than half (61%) disagreed that sexual orientation should be criminalised.

The torture and subsequent attack on the transgender woman in Namibia and the burgeoning hate crimes against LGBTI persons across the region underscore the need for countries to develop holistic and inclusive hate crimes legislation.



Namibia: Civil society group condemns abuse of trans woman[36]

The Namibian Civil Society, a local human rights agency, recently condemned the gross dehumanisation, unlawful detention, and torture of a trans woman on a farm near Gobabis in April 2020. The perpetrators filmed the attack and circulated it on social media.

Following the release of the video, the survivor faced community scrutiny, threats, and further discrimination, exacerbating her trauma. "Criminal charges have been opened against the assailants and despite the lack of safe houses and shelters, especially catering for transwomen, the survivor of this violent act has been relocated to a place of safety and psychosocial support has been provided," the Society noted in a statement.

The group also commended the Ministry of Justice and Gender, the Namibian police and law enforcement agents for apprehending the perpetrator and accomplices. It highlighted Chapter 3 of the Namibian Constitution, the "Fundamental Rights and Freedoms of all citizens," which includes LGBTI Namibians.

"As a country we have been progressive in policy and law, however, the widespread hate speech, transphobic attacks, legitimisation and sensationalism of the tortuous act, by the community and online responses, removes the human dignity of the survivor and violates so many of the rights that we all expect for the advancement and betterment of our country," the group said.

"We call on the Namibian government to stand by its zero tolerance stance against human rights violations, including those faced by the LGBTI community, and for the nation to restrain from homophobic and transphobic hate speech, harassment and discrimination towards members of the LGBTI community." The statement also called on the media to "ethically and objectively report on the case by avoiding sensational headlines and misrepresentation of the gender identity/gender expression of members of the transgender community."

Source: The Namibian Economist, 2020

[34] ActionAid, 2009
[35] "We're queer and we're here!" report, South African Institute of Race Relations, 2017
[36] https://economist.com.na/52720/extra/civil-society-condemns-abuse-of-transgender/

Conversion therapy

So-called "conversion therapy," sometimes known as "reparative therapy," is a range of dangerous and discredited practices that falsely claim to change a person's sexual orientation or gender identity or expression. Most mainstream medical and mental health organisations have rejected such practices for decades, but due to continuing discrimination and societal bias against LGBTI people, some practitioners continue to conduct conversion therapy. Minors can be especially vulnerable, and conversion therapy often leads to depression, anxiety, drug use, homelessness, and suicide.[37]

Mauritius and South Africa both ban conversion therapy. The Office of the United Nations High Commissioner for Human Rights has called on all nations to ban conversion therapy, stating that it represents a form of torture and a violation of human rights.

Global: "Conversion therapy" a form of torture, says UN expert

Conversion therapy is cruel, degrading, and inhuman, according to a UN Independent Expert on sexual orientation and gender identity. Speaking at the Human Rights Council, where he presented his latest report, Victor ," Madrigal-Borloz called on all states to "work together to institute a global ban on practices of conversion therapy."

He added that, "depending on the severity or physical or mental pain and suffering inflicted to the victim, [conversion therapy] may amount to torture."

"Conversion therapy" describes interventions that purport to achieve a change in a person's sexual orientation or gender identity, and thus claim to aim at changing people from gay, lesbian or bisexual to heterosexual, and from trans or gender diverse to cisgender - meaning whose gender identity corresponds to the sex they were assigned at birth.

"Practices of conversion therapy are rooted in the belief that persons of diverse sexual orientation and gender identity are somehow inferior, either morally, spiritually or physically because of their orientation or identity, and



that they must modify that orientation or identity to remedy that inferiority," Madrigal-Borloz said. "Practices of conversion therapy are not only ineffective, but they can also be extremely harmful.

"They often lead to pain and suffering that will last far beyond their occurrence, leaving indelible scars on a person's body and mind... The combined effects of feeling powerless and extreme humiliation generate profound feelings of shame, guilt, self-disgust and worthlessness, which can result in a damaged self-concept and enduring personality changes."

Source: United Nations Human Rights Council, 2020

Recognition of LGBTI rights

Recognition of LGBTI human rights is an integral part of a process to ensure that this community enjoys the same rights and freedoms as all other citizens. These include, amongst others, the right to marriage, adopt children, and have free expression.

Same sex marriages and civil unions

Only South Africa provides for same sex marriages and civil unions in its legal frameworks. All other SADC countries define marriage as a union between a woman and a man.

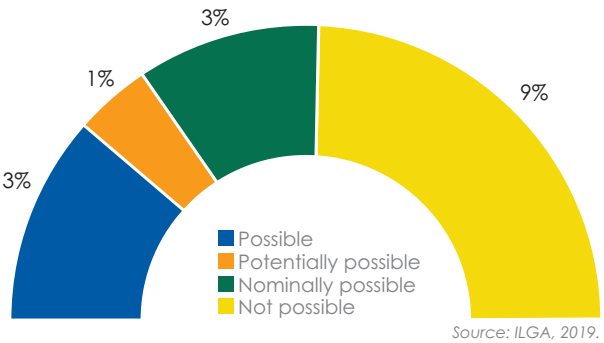
Joint/second parent adoption of children

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 LGBTI people from adopting children violates their rights.

Changing sex designation, name, or gender marker

The ability to change a gender marker or name is a critical right for trans and diverse people. Experts refer to this as "legal gender recognition." In countries where people cannot change gender markers, the ability to change names represents a stopgap measure. Research conducted by the International Lesbian, Gay, Bisexual, Trans, and Intersex Association (ILGA) suggests that, even where it is possible to change names and gender markers, the process remains inordinately difficult.

Figure 8.8: Changing gender markers in SADC



Source: ILGA, 2019.

[37] https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy

Figure 8.8 shows that only three SADC countries allow for changing gender markers unconditionally: Namibia, South Africa, and Zambia. Changing a gender marker is potentially possible in Botswana and nominally possible in Angola, Malawi, and Mozambique. Citizens cannot change their gender markers in the Comoros, DRC, Eswatini, Lesotho, Madagascar, Mauritius, Seychelles, Tanzania, and Zimbabwe.

At a practical level, the inability to change gender markers affects trans people in several ways:[38]

- Certain institutions, both private and public, may require a legal gender identity on official documents, this includes health care services;
- If a person is presenting in a gender opposite to their gender marker it makes it difficult to engage in everyday activities, everything from opening a bank account to applying for a job or driver's licence, to boarding a plane;
- Most countries around the world still use a binary gender system of male and female. This also applies to visa applications, which people often need to complete in person;
- Correctional services, also known as imprisonment/prison/incarceration or gaol. Gender markers will determine where prison officials house an individual during imprisonment.

For these reasons and more, it is critical for all SADC countries to enact and implement laws and policies to facilitate the process of changing gender markers.

Table 8.4: Conditions under which citizens can change gender markers[39]

Country	Relevant law	Conditions	Issue
Angola	Código do Registo Civil 2015, Section 87	Although s. 78 of the Code does not allow alterations of details entered in the registration of records of the Civil Registrar, s.87 permits changes, including change of name where there is a change of facts which alter the legal identity or status of the person.	Unclear, no specific reference to trans and diverse gender identities.
Botswana	National Registration Act 26 of 1986, s.16	Section 16. Material change. (1) Where the registrar is of the opinion that any change in the particulars relating to a registered person materially affects his registration, he shall record the change and notify the Registrar of National Registration of the circumstances and recommend that the person concerned should be issued with a new identity card. […] (3) The particulars relating to the new identity card and its holder shall be recorded in the national register and the register of the area in which that person is registered.	At the discretion of the registrar not an unconditional right.
Malawi	National Registration Act 13 of 2010 (not trans specific).	Section 20(1) provides that where a change in particulars of a registered person materially affect his registration, the district registrar shall record the change and notify the Director of the circumstances and recommend that the person be issued with a new identity card. Section 21(1) provides that every registered person may, when he is satisfied that his appearance has changed so as to make it likely that his identity may be questioned, apply to the district registrar for the issue of a new card with a more recent photograph.	Unclear, no specific reference to trans and diverse gender identities.
Mozambique	Código do Registo Civil 2004	Section 85(1) gives the Civil Registrar general authority to make changes when there is a change of facts which alter the legal identity or status of the person registered.	Unclear, no specific reference to trans and diverse gender identities.

[38] https://www.betrue2me.org/resources/be-true-2-me-guideline-legal-gender-marker-and-forename-change/
[39] https://ilga.org/downloads/ILGA_Trans_Legal_Mapping_Report_2017_ENG.pdf

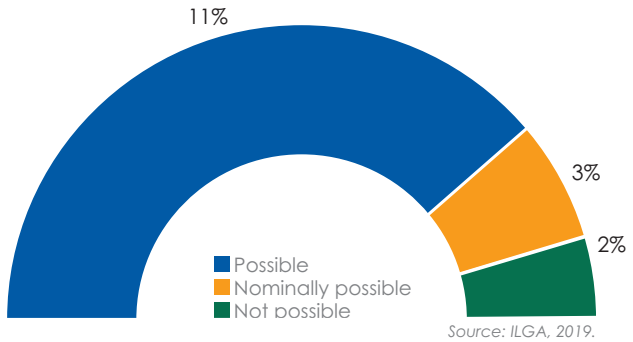
Country	Relevant law	Conditions	Issue
Namibia	Births, Marriages and Deaths Registration Act 81 of 1963; Identification Act 2 of 1996	The Secretary may on the recommendation of the Secretary of Health, alter in the birth register of any person who has undergone a change of sex, the description of the 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. Comprehensive legislation, barrier in the public health system.
South Africa	Alteration of Sex Status and Sex Descriptor Act, No.49 of 2003	(2) Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register. There are no directives from the National Department of Home Affairs (DHA) on how to interpret the Act, and in practice this causes arbitrary obstacles such as requiring proof of gender reassignment surgery, long waiting periods for applications to be processed (averaging 1-7 years), what forms to use and what documents and applicant must bring.	Comprehensive legislation, barrier in the Home Affairs.
Zambia	National Registration Act 19 of 1964	Section 9(2): In any case where a national registration card issued to a registered person ceases in any material particular to accurately represent his identity, such person shall, without undue delay, produce his national registration card and give such particulars as shall be necessary for the issue of a new national registration card to a registrar who… shall issue to such person a new national registration card	
Not possible currently, law or policy needed in DRC, Eswatini, Lesotho, Madagascar, Mauritius, Seychelles, Tanzania, Zimbabwe			

Source: ILGA, 2017.

Table 8.4 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 trans people attempt to attain their rights under these laws.

Name change

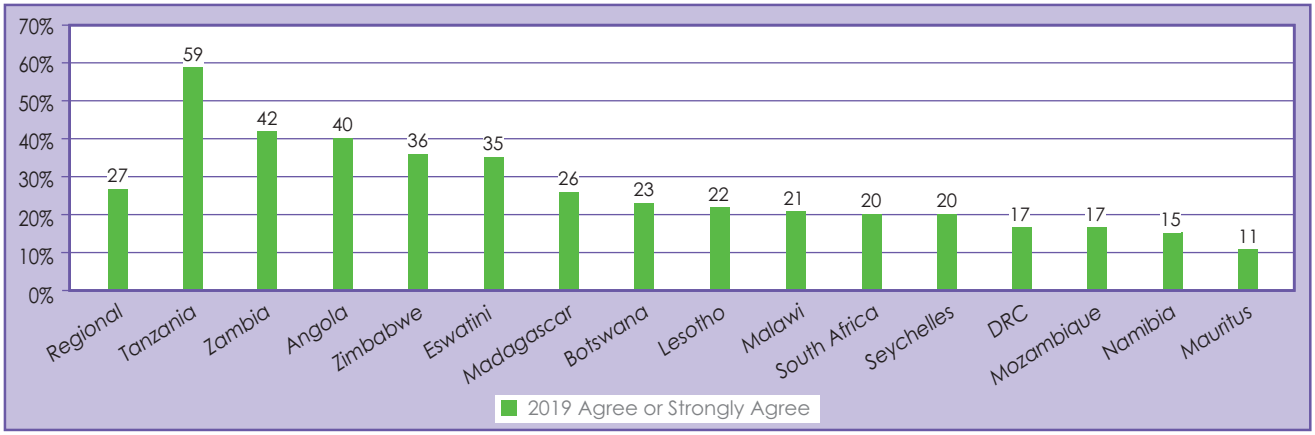
Figure 8.9: Ability to change a name



Source: ILGA, 2019.

Figure 8.9 illustrates that changing names in SADC countries appears to be easier than changing gender markers. People can legally change their names in 11 SADC countries: Botswana, DRC, Eswatini, Lesotho, Madagascar, Mauritius, Namibia, Seychelles, South Africa, Zambia, and Zimbabwe. It is nominally possible to change names in Angola, Mozambique, and Malawi. It is not possible to legally change a name in Comoros or Tanzania. While not ideal, trans and gender diverse people may use this option until countries allow changes in gender markers.

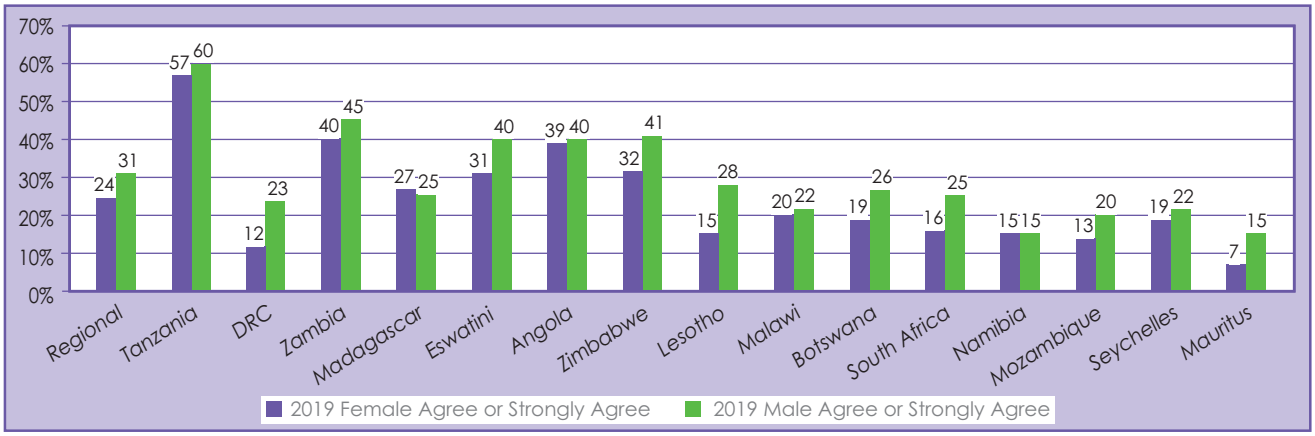
Figure 8.10: Attitudes in SADC in 2019: It bothers me when a girl acts like a boy



Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey, 2019.

Figure 8.10 shows that, in response to the statement "It bothers me when a girl acts like a boy," between 40% and 59% of respondents to the Southern Africa Gender Attitudes Survey in Angola, Tanzania and Zambia agreed or strongly agreed. The scores in other SADC countries range from a low of 11% in Mauritius to 36% in Zimbabwe. The research did not include Comoros. These scores point to relatively high levels of intolerance of gender diversity.

Figure 8.11: It bothers me when a girl acts like a boy, male vs female



Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey, 2019.

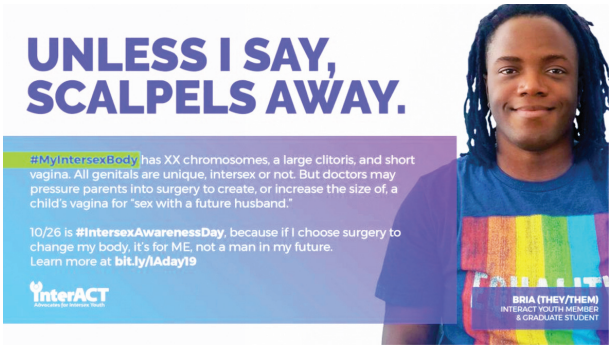
Changing names in SADC countries appears to be easier than changing gender markers

Figure 8.11 shows that women and men in many countries hold similar views about this statement. But in the DRC, Lesotho, Mauritius, Mozambique, South Africa, Swaziland, and Zimbabwe, fewer women agreed or strongly agreed with the statement.

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 seem to fit the typical definitions of female or male. For example, a person might be born appearing to be female on the outside but having mostly male-typical anatomy on the inside.

Alternatively, a person may be born with genitals that seem to be in-between the usual male and female types. For example, a girl may be born with a noticeably large clitoris, or lacking a vaginal opening, or a boy may be born with a notably small penis, or with a scrotum that is divided so that it has formed more like labia. A person may 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.[40]



In 2013, the third International Intersex Forum issued the Malta Declaration,[41] which sets out key demands to end discrimination against intersex people and ensure the right of bodily integrity, physical autonomy, and self-determination. The demands include:

- End mutilating and "normalising" practices such as genital surgeries, psychological and other medical treatments through legislative and other means. Intersex people must be empowered to make their own decisions affecting their own bodily integrity, physical autonomy, and self-determination;
- End pre-implantation genetic diagnosis, prenatal screening and treatment, and selective abortion of intersex foetuses;
- End infanticide and killings of intersex people;
- End non-consensual sterilisation of intersex people;
- Depathologise variations in sex characteristics in medical guidelines, protocols, and classifications, such as the World Health Organisation's International Classification of Diseases;
- Register intersex children as females or males, with the awareness that, like all people, they may grow up to identify with a different sex or gender;
- Ensure that sex or gender classifications can be amended through a simple administrative procedure at the request of the individuals concerned. All adults and capable minors should be able to choose between female (F), male (M), non-binary, or multiple options. In the future, as with race or religion, sex or gender should not be a category on birth certificates or identification documents for anybody;
- Raise awareness around intersex issues and the rights of intersex people in society at large;
- Create and facilitate supportive, safe, and celebratory environments for intersex people, their families, and surroundings;
- Ensure that all professionals and healthcare providers that have a specific role to play in intersex people's wellbeing receive adequate training to provide quality services;
- Ensure that intersex people have the right to full information and access to their own medical records and history;
- Provide adequate acknowledgement of the suffering and injustice caused to intersex people in the past, and provide adequate redress, reparation, access to justice, and the right to truth;

[40] https://isna.org/faq/what_is_intersex/
[41] https://oiieurope.org/malta-declaration/

- Build intersex anti-discrimination legislation in addition to other grounds, and to ensure protection against intersectional discrimination;
- Ensure the provision of all human rights and citizenship rights to intersex people, including the right to marry and form a family;
- Ensure that intersex people can participate in competitive sport, at all levels, in accordance with their legal sex. Intersex athletes who have been humiliated or stripped of their titles should receive reparation and reinstatement;
- Recognition that medicalisation and stigmatisation of intersex people result in significant trauma and mental health concerns; and
- Psychosocial, and peer support for intersex people throughout their life (as self-required), as well as to parents and/or care providers.



South Africa: Semenya still fighting for a role in women's sport[42]

Caster Semenya, who is currently banned from participating in 800m and 1500m athletics, has welcomed a UN report calling for revoking of sporting regulations that pressure athletes into medical procedures. Semenya thanked the UN High Commissioner "for highlighting the discrimination and harm faced by women and girls in sport." Semenya, widely believed to be intersex, has been fighting the Court of Arbitration for Sport to participate in world athletics.

Semenya has backed a UN report, launched on 30 June 2020, calling for countries to outlaw sporting regulations that pressurise athletes like her to undergo "unnecessary" medical interventions. "It is time for white men to stop telling women and girls how they should look and to stop messing with our bodies," said the double 800m Olympic champion and poster girl for those with differences of sexual development (DSD).

Semenya said sports governing bodies should "review, revise and revoke eligibility rules and regulations that have negative effects on athletes' rights, including those addressing athletes with intersex [DSD] variations."

The UN High Commissioner for Human Rights, Michelle Bachelet, conducted an inquiry into the "intersection of race and gender discrimination in sport" following a resolution presented to the council by South Africa in March last year as Semenya fought to overturn World Athletics' eligibility regulations for DSD athletes. Semenya, who the rules prevent from competing against other women in the 800m or 1500m unless she takes testosterone suppressants or undergoes a gonadectomy, lost her landmark case at the Court of Arbitration for Sport and has been awaiting the outcome of an appeal to the Swiss Federal Tribunal.

A spokeswoman for World Athletics said of Bachelet's report: "We have common ground in that we both believe it is important to preserve fair competition in female sport, so women are free to compete in national and international sport.

"To do this, it is necessary to ensure the female category in sport is a protected category, which requires rules and regulations to protect it. Otherwise, we risk losing the next generation of female athletes, since they will see no path to success in female sport.

Source: The Telegraph, 2020

[42] https://www.telegraph.co.uk/athletics/2020/06/30/caster-semenya-welcomes-un-report-calling-revoking-sporting/

LGBTI organisations able to register and operate freely

The ability to organise and operate freely is a vital right for LGBTI organisations advocating for change. As well as organising events and promoting LGBTI rights, these groups often provide a safe space and shelter for LGBTI youth to talk about their sexuality or gender identity. In countries where registration of an LGBTI organisation is impossible, LGBTI activists often register using generic umbrella names, such as women's groups or human rights groups. Inability to formally register and operate freely also impedes fundraising. LGBTI groups can only register in eight or half of all SADC countries (Comoros, DRC, Eswatini, Madagascar, Malawi, Tanzania, Zambia and Zimbabwe).[43]



Eswatini's High Court heard arguments in the case of Simelane and Others versus the Minister of Commerce and Industry and Others on 24 July 2020. The applicants sought a review of the Registrar of Companies' decision to refuse Eswatini Sexual and Gender Minorities (ESGM) legal registration. ESGM and its members argue that the Registrar's refusal violated ESGM members' right to dignity, to associate and express themselves freely, to be treated equally and not to be discriminated against. ESGM aims to advance the protection of human rights of LGBTI people in Eswatini. ESGM assists those who experience stigma, discrimination and violence as a result of their sexual orientation, gender identity and expression.[44]

LGBTI Sexual and Reproductive Health Rights

LGBTI communities face prominent levels of exclusion from SRHR services. For example, health centres throughout the region will turn trans people away because they do not resemble their photograph in an identity document.

The lack of, or disparities in, healthcare available to LGBTI persons represents a denial of their civil and human rights and illustrates societal stigma and discrimination. While much anecdotal evidence for this exclusion exists, there is limited data on LGBTI communities' access to SRH services. Additionally, SADC countries do not have specific health programming for lesbians and women who have sex with women (WSW).

Moreover, existing provisions on transgender people and MSM in the national strategic plans and frameworks of many countries in the region unfortunately remained unimplemented. A lack of clear guidelines on healthcare provision to LGBTI persons means healthcare workers face a major roadblock in their quest to ensure universal access to health services for all citizens.[45]

The ability to organise and operate freely is a vital right for LGBTI organisations advocating for change

[43] Canaries in the Coal mine, 2017, accessed 1 July 2020, http://theotherfoundation.org/canaries-in-the-coal-mines/
[44] https://www.southernafricalitigationcentre.org/2020/06/25/media-advisory-eswatini-high-court-postpones-case-on-the-refusal-to-register-an-lgbt-advocacy-group/
[45] http://catalogue.safaids.net/sites/default/files/publications/LGBTI%20Southern%20Africa%202014.pdf



Tanzania: Government cracks down on LGBTI community[46]

The government of Tanzania's health policies continue to deny adequate services to LGBTI people and others who are particularly vulnerable to HIV, jeopardising public health.



An HIV positive man in Tanzania in 2016 said he had been afraid to pick his medicine up for two weeks despite the risks to his health.
Photo courtesy of Kevin Sieff /Getty Images

Activists have called on Tanzania to reverse these policies, end arbitrary arrests of LGBTI people, and ban forced anal examinations that some use as spurious evidence of homosexual conduct.

The 2020 Human Rights Watch report *If We Don't Get Services We Will Die: Tanzania's Anti-LGBTI Crackdown and the Right to Health* documents how, since 2016, the government of Tanzania has cracked down on LGBTI people and the community-based organisations that serve them.

The Health Ministry in mainland Tanzania has prohibited commu-nity-based organisations from conducting outreach on HIV pre-vention to MSM and other key populations vulnerable to HIV. It closed drop-in centres that provided HIV testing and other tar-geted and inclusive services, and banned the distribution of lubricant, essential for effective condom use for HIV prevention among key populations and much of the wider public.

"The Tanzanian authorities have orchestrated a systematic attack on the rights of LGBTI people, including their right to health," said Neela Ghoshal, senior LGBTI rights researcher at Human Rights Watch. "Manufactured threats around the so-called 'promotion of homosexuality' have displaced best practices and evidence-based approaches in guiding HIV policy in Tanzania."

In April 2019, the government's Non-Governmental Organisation Co-ordination Board withdrew registration from Community Health Education and Advocacy Services (CHESA), a key organisation serving LGBTI people, on grounds of "promoting unethical acts." Hamad Masauni, former deputy home affairs minister, publicly called for arrests of gay men while visiting Zanzibar in September 2019.

"The Tanzanian authorities should ensure that not one more Tanzanian is arrested for being gay or trans - or for attending an HIV education session," Ghoshal said. "Concrete steps forward should also include banning forced anal examinations and reforming health policies so that they are based on evidence, not prejudice."

One of the people interviewed in the report, Kim (not their real name), a gender non-conforming person from a small town, spoke about being subjected to a forced anal examination at a government health facility. "These doctors did an anal test. It was by force. The police officers were there with guns, so many of them... We went to the maternal ward where the women go and give birth. They took this metal instrument and they stick it - they penetrate it in our [anus], and it was very, very painful. And then they say 'Cough, try to cough' while the steel is inside our [anus], and when I coughed, they were pressing the metal into me. It was very brutal and painful. They were pressing the testicles and the penis. Everything about that testing was very brutal," Kim said.

[46] https://www.hrw.org/news/2020/02/03/tanzania-obstructions-lgbt-health-rights

Universal Health the Care (UHC) is goal 3.8 in the SDGs. The vulnerability of key populations like the LGBTI community highlighted 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.



Zimbabwe: LGBTI people face healthcare discrimination during COVID-19

Nomvula Nkiwane, a gay man from Bulawayo, says he has been praying that he does not test positive for COVID-19. "I used to go to private health practitioners before the COVID-19 outbreak, but now I am being forced to seek medical attention from public health institutions where I face discrimination."

Zimbabwe's laws do not recognise LGBTI rights. As a result, LGBTI people in the country have been forced to operate underground for fear of victimisation. "We had our own challenges of discrimination and stigmatisation before the outbreak of the coronavirus," Nkiwane told Gender Links. "Now with this lockdown and social distancing measures; it has been tough for us. Just recently I struggled to get to Population Services International (PSI), where I collect my anti-retroviral therapy medication."

In 2016 Gays and Lesbian Association of Zimbabwe (GALZ) entered into partnership with three private health facilities as part of facilitating increased access to decent care for its LGBTI constituency. As a result, the organisations offered a broad range of sexual and health services to key populations, mainly in Harare and Bulawayo.

While the LGBTI community has managed to engage government on some SHSR issues, more needs to be done so the community has full access to public health institutions.



Zimbabwean gay rights activist and GALZ director Chester Samba.
Photo courtesy of Washington Blade

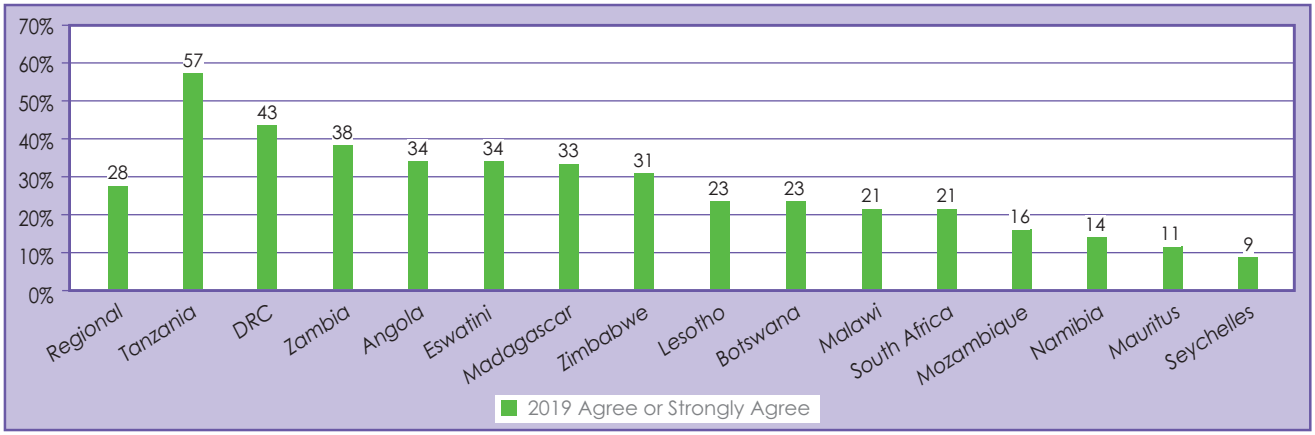
GALZ director Chester Samba said their members have faced a plethora of challenges be-cause of the COVID-19 out-break. "We have reported cases of mental health issues," he said. "Depression and anxiety have increased among LGBTI people. The closure of drop-in-centres where LGBTI community was getting psychosocial therapy and other recreational services has left community more vulnerable."

Source: Jeffrey Muvundusi is a journalist working for Daily News in Zimbabwe. This article follows GL media training on Reporting SRHR in Zimbabwe. This article is part of the GL News Service, Gender and COVID-19 news series

Changing attitudes

Every year GL administers the Gender Attitudes Survey to citizens across 15 SADC countries. The survey measures attitudes and the prevailing levels of gender awareness in countries based on a series of 25 questions. For the 2020 SRHR Barometer, GL used the 2019 results due to restrictions in data collection resulting from the COVID-19 pandemic. In 2019, GL and its Alliance partners collected 11 068 responses from 5985 women and 5083 men.

Figure 8.12: "Homosexuality is a psychological disease," 2019



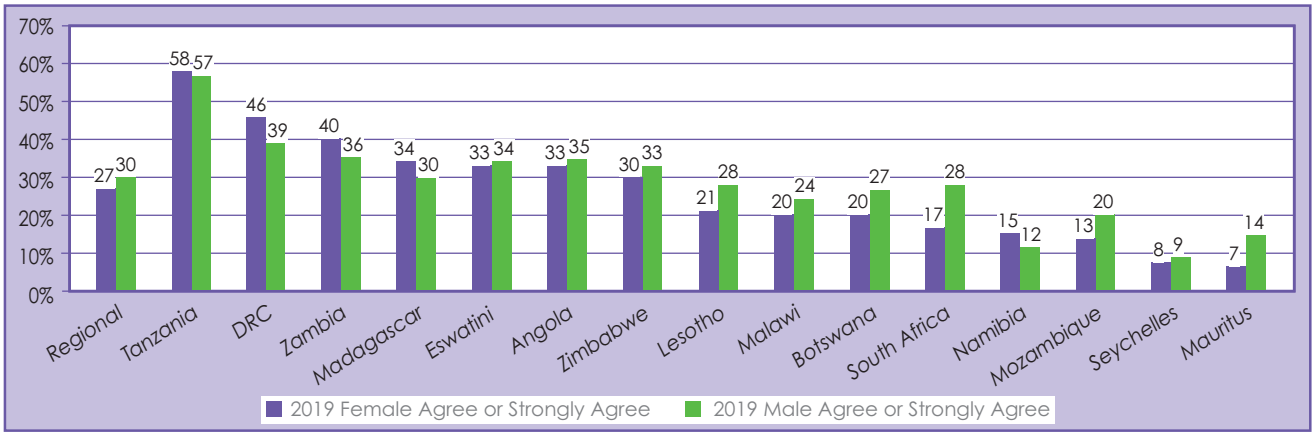
Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey.

Figure 8.12 shows that 28% of respondents across the region agreed or strongly agreed in response to the statement "Homosexuality is a psychological disease." It may not be surprising, given the anti-LGBTI sentiment in Tanzania, stoked by lawmakers there, that the highest proportion of respondents in that country agreed or strongly agreed with the statement (57%).

A concerning number of respondents, between 33% and 43% agreed or strongly agreed with the statement in three countries in which governments have decriminalised same-sex consensual relations: Angola, DRC, and Madagascar. This underscores the need to prioritise ongoing advocacy and awareness-raising campaigns.

Same-sex consensual relations remain a crime in Namibia and Mauritius, but both display more progressive public perceptions and attitudes. Between 76% and 89% of respondents do not agree that homosexuality is a psychological disease. Given this finding, which points to high levels of acceptance, it is an opportune time to push for decriminalisation of same-sex consensual relations in these countries.

Figure 8.13: "Homosexuality is a psychological disease, by sex



Source: Agenda 2030 SADC Gender and Sustainable Development Attitudes Survey.

Figure 8.13 illustrates that the most significant differences between women's and men's responses to the question appeared in Botswana, Mauritius, Mozambique, and South Africa, with men agreeing with the statement more than women, between seven and nine percentage points more. Overall, women's attitudes appear less conservative.

Strategic litigation remains an important way to challenge discriminatory laws and policies in countries that criminalise homosexuality. However, stakeholders should accompany these initiatives with social protection strategies for LGBTI communities.

The mixed messages in Botswana and increasing government aggression in Tanzania show the fragility of gains made so far. There is a need for more monitoring and activism to hold states accountable for discriminatory laws and practices, so they ensure that LGBTI citizens receive the same protections as all other citizens.



Angola has seen increased dialogue between LGBTI groups and certain ministries, especially the justice ministry. The LGBTI community now has a seat at the table. However, families and schools still reject many LGBTI people. Women in the LGBTI community remain largely "invisible" and often excluded from the political, economic, and social aspects of the movement. Transgender people have received increased exposure in recent years thanks to a few popular Angolan artists who talk openly about their sexuality and gender identity.



In **Botswana**, Lesbians, Gays & Bisexuals of Botswana (LEGABIBO), an agency that works with the community, runs campaigns to address the negative attitudes of health workers towards the LGBTQI community. Many in the community continue to face discrimination from health providers and religious leaders. Botswana has seen violence against LGBTQI people during COVID-19, which may affect future work in this area as activists wait for the cases to make their way through the country's court system. Further research needs to be carried out on attitudes around decriminalisation of same-sex relationships as the government addresses this topic.



Eswatini has seen a visible shift of perceptions about homosexuality amongst young people. Many young people came out to support Eswatini's first Pride March in 2018. LGBTI issues and people has become more visible in Eswatini society. News outlets used to regularly promote anti-gay propaganda, but this has changed. Homophobic comments in the media are now rare, a sign the country has made progress.

Next steps

The lack of recognition of LGBTI rights represents a fundamental violation of human rights and requires urgent action in all SADC countries. Researchers have divided recommendations into two sections: overarching and those related to COVID-19.

Overarching recommendations

- Enact comprehensive anti-discrimination legislation and adopt public policy that specifically addresses violence and discrimination based on real or imputed sexual orientation and/or gender identity.
- Adopt measures to prevent, investigate and punish arbitrary arrests and extortion based on sexual orientation and/or gender identity and expression.
- Conduct training with the police and law enforcement on human rights and the need to respect the rights of LGBTI people.
- Adopt comprehensive measures to prevent, investigate and punish GBV, including sexual violence.
- Adopt measures to combat hate speech.
- Conduct public awareness campaigns geared towards youth, in schools and health care facilities, and towards society in general, to promote respect for the human rights of people with diverse sexual orientations, gender identities and expressions, including the right to be free from discrimination.
- Strengthen civil society capacity to hold governments and other decision-making bodies accountable for creating a safe, enabling environment for LGBTI communities to full enjoy their rights and freedoms.

COVID-19 recommendations[47]

- Ensure that all emergency measures adopted in the face of the pandemic as well as emergency support and compensation and socio-economic support measures leave no one behind, but take the particular vulnerability of the most marginalised in society into account, including specific vulnerabilities in the LGBTI community.
- In support efforts, pay attention to those working in informal and insecure settings, including ensuring access to social protection and heath care, as well as basic needs.
- Speak out and condemn any incorrect information and hate speech that blames the LGBTI community or other minorities for the pandemic.
- Specific initiatives to tackle increased domestic violence must also account for the increased risks to LGBTI people, and especially young people.
- Focus on non-discrimination in the policing of emergency measures.
- Any quarantine legislation and controls must allow people to choose where they quarantine. This will allow people to quarantine in a safe space that is free from violence.

[47] ILGA Europe, 2020

Climate Justice 9



Ubuntu Project in South Africa on urban farming to improve food security during COVID-19.
Photo courtesy of Ubuntu

KEY POINTS

- Increases in carbon dioxide (CO2) levels and other greenhouse gases in the atmosphere in 2019 helped make it the second warmest year on record, according to a new report compiled by a network led by the World Meteorological Organisation.
- The past year witnessed increasing temperatures throughout the region, accelerating sea level rise, droughts, cyclones, and other disasters and pushing 12 million people in nine countries into a state of food insecurity.
- Climate change will make future disasters and epidemics, such as COVID-19 inevitable, pushing millions of women and girls even further into poverty.
- Globally, increasing natural disasters and weather-related emergencies have contributed to large increases in sexual trafficking and forced child marriage.
- The COVID-19 crisis represents an unprecedented wake-up call in the region, reminding leaders that they must prepare for more frequent emergencies linked to climate change.
- The COVID-19 pandemic exacerbated food insecurity and other social challenges, leaving women and girls in impoverished communities, marginalised people, refugees and other displaced people especially vulnerable.
- The environmental crisis in SADC has extended from directly affecting agriculture and food security to impacting healthcare across the region. In 2019, climate shocks worsened measles outbreaks and Namibia saw a spike in hepatitis E transmissions in informal settlements due to poor access to water and adequate sanitation.
- The COVID-19 virus will contribute to food insecurity, conflict, and gender-based violence (GBV) for months and possibly years to come. However, it also presents an opportunity for governments in the region to re-align their priorities and pursue the development of renewable energy and "greener" economies.

Introduction



Water distribution in Atsimondrano, Madagascar, in 2014.
Photo: Zotonantenaina Razanadratefa

Annual global temperatures will likely be at least 1°C warmer than pre-industrial levels in each of the coming five years, jeopardising globally-agreed climate change targets.[1] The Southern Africa Development Community (SADC), like much of the rest of the world, needs to act fast to mitigate the worst effects of this warming. Already feeling the effects in 2019, the region experienced increased food insecurity due to droughts and flooding, with many families struggling to get a harvest from their arable land. Ongoing energy crises in the region add to this challenge, as citizens continue to struggle to access clean energy sources for their daily household needs.

Over the next decade, a warming climate will have major implications for Southern Africa, which faces a decrease in precipitation of as much as 20% and increases in the number of consecutive dry days. The greatest temperature increases will occur in Botswana, Namibia, northern Zimbabwe, and southern Zambia, with increases in the occurrence and intensity of temperature extremes across the region.[2] The western part of the region will become drier, with increasing drought frequency and heat waves. As warming continues, less rain will fall over the Limpopo basin and areas of the Zambezi basin in Zambia, as well as parts of western South Africa.

Increases in global temperature, sea level rise, ocean acidification, and other climate change impacts affect coastal areas and low-lying regions, including the small island states like Seychelles and Comoros. Climate change puts the survival of many societies, and of the biological support systems of the planet, at risk.[3]

Extreme climate-related hazards have already become more common across the region. During Cyclone Idai, which ravaged Malawi, Mozambique, and Zimbabwe in early 2019, leaving more than 1300 people dead, women found themselves in difficult situations, including an estimated 7000 women who faced life-threatening complications giving birth during the crisis.

The Intergovernmental Panel on Climate Change (IPCC) maintains that it remains possible to limit global temperature rise to 1.5° C - if, and only if, there "are rapid and far-reaching transitions in land, energy, industry, buildings, transport, and cities." It warns that, for Sub-Saharan Africa, which has experienced more frequent and more intense climate extremes over the past decades, the ramifications of the world's warming by more than 1.5° C would be profound. Temperature increases in the region will be higher than the



Women wade through flood waters in Namibia in 2019. Photo: Veronika Haimbili

[1] World Meteorological Organisation (WMO) data, 2020
[2] https://www.un.org/africarenewal/magazine/december-2018-march-2019/global-warming-severe-consequences-africa
[3] https://sustainabledevelopment.un.org/topics/climatechange

global mean temperature increase, and regions in Africa near the equator will experience more hot nights and longer and more frequent heat waves.

Key events over the past year in this area of work include the rise of citizen action and civil disobedience on climate change and gender issues. Youth have become more vocal in their activism for climate justice and sustainable development. Sweden environmental activist Greta Thunberg galvanised the movement when she challenged world leaders who prioritise economic gain over environmental action. Thunberg's famous "how dare you" speech at the United Nations urged leaders to think about future generations in their actions of today.[4]

The United Nations 25th Conference of the Parties (COP25) to the United Nations Framework Convention on Climate Change (UNFCCC) in December 2019 in Spain provided another important milestone on the path to fully operationalise the landmark Paris Climate Change Agreement.[5] Countries submitted new and updated climate action plans at the conference. At a continental level, climate change representatives met in February 2019 to discuss Africa's engagement at COP25, along with the African Climate Commissions.

Table 9.1: Key climate justice indicators

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
National Action Plans submitted to UNFCCC[6]	No	No	No	No	No	No	No	No	No	Yes, but out-dated[7]	No	No	No	No	No	No
Number of National climate change policies/guidelines[8]	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)
% women in climate decision-making[9]	22	30	None	None	14	None	None	None	17	30	21	17	40	11	10	25
% women sources on gender and climate change[10]	N/A	9	N/A	21	22	38	23	14	20	30	10	55	41	23	30	39
Prevalence of severe food insecurity in the population (%)[11]		41.3						51.7	6.2		39	3.2	29.2	36.9		
Access to electricity (%)[12]	43.3	64.9	81.9	19	76.5	47	25.9	18	97.5	31.1	53.9	100	91.2	35.6	39.8	41
Country has signed and ratified the global climate change treaty (Paris Agreement)[13]	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 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

Source: Gender Links, 2020.

[4] Greta Thunberg Speech during the UN 2019 General Assembly, accessed on 9 July 2020 from https://www.cntraveller.in/story/full-text-greta-thunberg-speech-how-dare-you-un-climate-action-summit/
[5] UN Climate Change Conference 2019, accessed on 10 July 2020 from https://unfccc.int/about-the-un-climate-change-conference-december-2019
[6] UNFCCC data https://www4.unfccc.int/sites/NAPC/Pages/NationalPolicies.aspx
[7] https://www4.unfccc.int/sites/NAPC/Country%20Documents/Parties/UNDAF-Action-Plan-Final-ENG-signed.pdf
[8] UNFCC Country Profiles , https://www4.unfccc.int/sites/NAPC/Pages/NationalPolicies.aspx
[9] National Government websites, Gender Links computations
[10] Gender Links, State of Women in SADC, 2019
[11] World Bank Data, Food Security Portal https://data.worldbank.org/indicator/SN.ITK.SVFI.ZS?locations=AO-BW-KM-CD-SZ-MG-MW-MU-MZ-NA-SC-ZA-TZ-ZW-ZM
[12] 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
[13] UNFCC Agreement signatories, accessed from https://en.wikipedia.org/wiki/List_of_parties_to_the_Paris_Agreement#Signatories on 11 July 2020

Table 9.1 presents several climate justice indicators for the SADC region. It shows that:

- All countries have signed and ratified the Paris Climate Change Agreement, except Angola, which signed it but has yet to ratify it.
- Only one SADC country, Mozambique, has sent a climate action plan to the UNFCCC, although several have national climate change policies and guidelines.
- Five countries have no women in decision-making positions related to climate: Comoros, DRC, Lesotho, Madagascar, and Malawi.
- Women's voices remain underreported on media topics related to climate and the environment. Women comprised only 9% of sources in climate stories in Botswana, with Seychelles, at 55%, sharing the most women's perspectives in the region.
- Severe food insecurity has increased in parts of the region, especially in Malawi and Botswana, where 51.7% and 41.3%, respectively, do not have enough to eat.

The COVID-19 pandemic is a wake-up call, further destabilising the region and imperilling tenuous development gains. Experts have described it as a warning that should force world leaders to address growing pressures linked to excessive carbon emissions, deforestation, massive food and meat production and consumption, industrialisation, and human encroachment in isolated ecosystems.

The COVID-19 pandemic also offers opportunities for environmental action. For instance, it sets a new baseline for what the region can achieve digitally: remote work, education, shopping, and more. As governments, private institutions, and even social media companies succeed in partnering, the pandemic helps build capacity to tackle climate change.[14] It also presents an opportunity to build women and girls' capacity with digital platforms as frontline workers in food security.

This chapter analyses climate justice in Southern Africa through a gender lens. It employs legal and policy frameworks to explore links between climate change, COVID-19, and the fight for gender equality. It examines the perilous risks, as well as opportunities arising from the twin pandemics of climate change and COVID-19. Examples cited include local level initiatives showing the power of people-driven action. The chapter ends with examples of movement building, including the youth-led movements that are taking the world, and Southern Africa, by storm.

COVID-19 presents an opportunity for women and girls to access digital platforms as frontline workers in food security

Climate change - the Southern African reality

According to the Intergovernmental Panel on Climate Change (IPCC), temperatures in Southern Africa will increase at twice the global average. Six Southern African Development Community (SADC) countries are among the nine African countries that dramatic weather events will hit hardest in the coming years: the Democratic Republic of the Congo (DRC),

[14] Jason Pareja, Oneyoungworld, The effect of COVID-19 on climate change, May 2020

Malawi, Mozambique, Tanzania, Zambia and Zimbabwe.[15] Late rains, the aftermath of two major cyclones, drought, and flooding have already put millions of lives at risk over the past year.



In **Angola**, unchecked warming could lead to the loss of 20% of the country's fisheries. Angola lacks the capacity, especially in vulnerable fishing towns like Tombwa, to adjust or adapt to the drastic changes, which have left many fishing communities increasingly vulnerable. Sea temperatures off the Angolan coast have risen 1.5 degrees - and possibly more - over the past century. The industry is home to some of the country's poorest citizens, including many migrants, who already live on the edge.[16]



In **Botswana**, recent droughts led to total crop failure in some parts of the country. For many in Botswana's agricultural sector, which boasts the most women farmers in the region,[17] changing seasonal weather patterns now arrive with frightening regularity each year.[18] "The effects of climate change are hitting home because crop production has decreased," said Thabang Botshoma, deputy permanent secretary in the agriculture ministry. "Climate change is currently doing more harm within the agricultural sector and this calls for action."



Comoros faces a range of threats from climate change, including increased variability in rainfall levels, leading to drought, flooding, and threats to water supplies for agriculture, drinking, and sanitation. Erratic rainfall supplies a paradoxical combination of droughts and floods, hindering agriculture in a country in which farm work employs up to 80% of the population. Crops on which farmers used to depend for their livelihoods, such as taro, now no longer succeed in the country.[19]



In the **DRC**, climate change has increased vulnerabilities in the already fragile state, particularly in the northeast, which has been experiencing increasing temperatures and erratic rainfall patterns. Widespread poverty, high population density, socioeconomic inequalities, and ongoing conflict already create stress in the country; the effects of climate change now add to this dangerous mix. Crop losses and failures from changing weather patterns will continue to reduce food security, increase livestock mortality, deplete fisheries, and damage infrastructure.[20]



GL country manager for Lesotho, Lucia Mabetha, on a field visit in Lesotho in June 2020. Photo: Ntolo Lekau



In **Lesotho**, reduced rainfall and frequent drought diminish crop production and result in lack of water availability and reduced water quality.[21] Drought and hot temperatures also create the conditions for more diseases and pests. The resultant crop failures have been creating food shortages and malnutrition. More frequent droughts and flooding also increase soil erosion, desertification, and land degradation.



Over the years, **Madagascar** has allowed extensive deforestation and overharvesting, which compounds some of the impacts of climate change in the country such as droughts and floods. Madagas-

[15] https://www.wfp.org/news/climate-shocks-intensify-un-food-agencies-urge-more-support-southern-africas-hungry-people
[16] Washington Post, 2019, Climate change in Angola accessed from https://www.washingtonpost.com/graphics/2019/world/climate-environment/angola-climate-change/ on 5 July 2020
[17] https://genderlinks.org.za/programme-web-menu/botswana-women-farmers-lead-the-way-2011-09-30/#:~:text=In%20most%20countries%20there%20is,land%20owners%20in%20the%20region.
[18] https://southerntimesafrica.com/site/news/botswana-hit-hard-by-climate-change-effects
[19] https://english.alaraby.co.uk/english/indepth/2019/2/5/comoros-spearheading-the-international-communitys-fight-against-climate-change
[20] https://reliefweb.int/report/democratic-republic-congo/climate-change-profile-democratic-republic-congo-east
[21] https://www.lesmet.org.ls/home/open/Impacts-and-Adaptation

car is especially vulnerable to climate change, which presents its leaders with a dilemma as 90% of its citizens work in agriculture, which contributes 26% of its GDP. Bush fires, deforestation and deep ploughing have already significantly degraded the soil.

At least 1.6 million people in central and south **Mozambique** need assistance due to drought and severe weather. Mozambique is one of the world's most vulnerable countries to natural disasters and climate change. Severe food shortages have been taking a heavy toll, especially on children younger than five years, with some 67 500 children facing acute malnutrition. Crops have been failing; communities do not have enough food to eat; and families cannot produce enough to sell. All these result in an elevated risk of negative coping mechanisms, which often include reduction of number of meals and portion sizes. Mozambique is still reeling from the devastating effects of two major cyclones - Idai in the central-eastern parts and Kenneth in the northern parts of the country - which hit the country in 2019.



Extreme weather events already affect **South Africa**, with the Eastern, Western and Northern Cape recently experiencing the longest periods of drought in recorded history. Meanwhile, KwaZulu-Natal and the Wild Coast have seen severe storms and flooding with unprecedented frequency, and coastal cities face rising sea levels and increasingly common storm surges. An official government report has noted that more extreme weather events and a rise of 6°C in average temperatures across the country could be possible by the end of the century. It notes that climate change has already ravaged South Africa, predicting that the worst has yet to come.[22] Community led initiatives to mitigate the worse effects represent a crucial lifeline for many.



Tanzania faces more frequent and intense droughts, storms, heat waves, rising sea levels, melting glaciers, and warming oceans. The effects of these will directly harm livestock and destroy people's livelihoods. The agricultural sector in Tanzania currently engages 80% of the country's labour force - about 13 million people and 49% of the country's GDP. Tanza-nia has already experienced decreasing annual rains, causing dire consequences for farmers and pastoralists, including loss of livestock.[23]



Climate change also represents a major threat to **Seychelles**' economy and way of life due to changes in rainfall patterns, sea level rise, increased coastal erosion, and flooding. Ocean warming and coral bleaching also have a significant impact on its marine ecosystems and fisheries. Its estuarine and coastal ecosystems are among the most threatened natural ecosystems in Seychelles, which means that, as a tourism destination, adopting ecosystem-based approaches will be vital to sustain this pillar of its economy.[24]

The recent spate of droughts and cyclones have tested the limits of SADC's emergency re-sponse and raised questions about preparedness and the effectiveness of regional early warning systems. The environmental crisis in SADC has extended from directly affecting agriculture and food security to impacting healthcare across the region. In 2019, climate shocks worsened measles outbreaks in Angola (3127 cases; 64 deaths), Comoros (132 cases; no deaths), and Madagascar (202 692 cases; 966 deaths), and Namibia saw a spike in hepatitis E transmissions (6527 cases; 55 deaths) in informal settlements due to poor access to water and adequate sanitation.

Malnutrition remains high in the region with 13 countries reporting prevalence of stunting at more than 20%, of which seven have a prevalence of stunting higher than 30%. The severity of the most recent droughts has resulted in a regional crisis that warrants immediate action to avoid more fatalities and emergencies. Following the 2018/19 El Niño episode, experts predicted that the number of food insecure people in SADC would rise to 41.2 million.[25]

[22] https://www.thesouthafrican.com/news/climate-change-effects-south-africa-report/
[23] https://klimaretter.hamburg/wp-content/uploads/2018/01/CLIMATE-CHANGE-IN-TANZANIA_information.pdf
[24] https://www.climatechangenews.com/2020/06/29/ecosystem-based-adaptation-project-reduces-flood-risk-seychelles/
[25] https://politicaleconomy.org.za/2020/04/climate-change-and-adaptation-in-sadc/



Table 9.2: Representation of women and men in key decision-making positions related to the environment

	Angola		Botswana		Comoros		DRC		Lesotho		Madagascar		Malawi		Mauritius		Mozambique		Namibia		Seychelles		South Africa		Eswatini		Tanzania		Zambia		Zimbabwe		Total Female	Total Male	Overall total	% Female
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F				
Year	2019		2019		2019		2019		2019		2019		2019		2019		2019		2019		2019		2019		2019		2019		2019		2019					
Minister of Environmental Affairs (Wildlife)	1	0	0	1	1	0	1	0	1	0	1	0	1	0	1	0	0	1	1	0	1	0	0	1	1	0	1	0	0	1	0	1	5	11	16	25
Deputy Minister of Environmental Affairs	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	1	0	1	4	5	33
Permanent Secretary (DG)	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0	0	0	5	5	25
Minister of Tourism	0	1	0	1	1	0	1	0	1	0	1	0	1	0	1	0	0	1	1	0	1	0	0	1	1	0	1	0	1	0	0	1	5	11	16	13
Deputy Minister of Tourism	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	3	75
Permanent Secretary (DG)	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	1	0	0	6	6	0
Minister of Fisheries	0	1	0	0	1	0	1	0	0	0	1	0	0	0	1	0	1	0	1	0	1	0	0	1	0	0	1	0	1	0	0	0	2	9	11	27
Deputy Minister of Fisheries	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	2	3	5	25
Permanent Secretary (DG)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	4	4	0
Minister of Water Affairs	1	0	1	0	0	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	0	1	0	1	0	1	1	0	1	0	1	0	3	12	15	23
Deputy Minister of Water Affairs	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	1	0	1	0	0	0	2	4	6	29
Permanent Secretary (DG)	0	0	1	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	5	6	22
Minister of Agriculture	1	0	0	1	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	15	16	6
Deputy Minister of Agriculture	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	1	0	0	1	1	0	1	0	2	7	9	33
Permanent Secretary (DG)	1	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	10	10	0
Total	7	2	7	3	6	0	5	0	7	0	6	0	5	0	5	1	7	3	11	3	5	1	9	6	6	1	8	1	9	1	6	2	24	109	133	20
Total Composite	9		10		6		5		7		6		5		6		10		14		6		15		7		9		10		8					
Percentage	22%		30%		0%		0%		0%		0%		0%		17%		30%		21%		17%		40%		14%		11%		10%		25%					

Source: Gender Links, complied from government websites.

Gender and climate justice are closely intertwined. Women are those most affected by natural disasters. Yet they are missing from the decision-making tables on climate change. Table 9.2 illustrates women's representation in climate change decision-making in SADC. The table provides sex disaggregated data for women ministers, deputy ministers and permanent secretaries/director generals in the ministries of Tourism; Fisheries; Water Affairs and Agriculture. This shows that on average women constitute one fifth (20%) of those making decisions in key environment ministries, down from 28% in 2017. South Africa (40%) leads the way. Other countries hover between zero and 30% representation of women in these key positions.

Table 9.3: 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 9.3 summarises several gender dimensions of climate change. It shows how climate change has become a cause of conflict and how it perpetuates poverty, GBV, and an increased burden of care work amongst women. Climate impacts and environmental degradation drive increases in VAWG, while gender-based exploitation hampers efforts to address violence, according to a massive study released in February 2020 by the International Union for the Conservation of Nature.

"Gender-based violence is one of the most pervasive but least talked-about barriers that face us in conservation and climate work," said lead author Cate Owren, adding that her report found unmistakable evidence that climate change leads to increased rates of GBV. "We need to take the blinders off and pay this concerted attention."[26] The number of people in need of emergency reproductive health services or protection from GBV escalates during a crisis. Concurrently, climate-induced natural disasters limit access to SRH services, safe water and sanitation, food security, and education. Disasters like Idai and COVID-19 also interrupt access to contraception and other important sexual and reproductive health (SRH) services.[27]

The pandemic further emphasises the urgency for the region to understand and address the relationship between the effects of climate change and the persistence of violence against women and girls (VAWG). Women and girls face increasing vulnerabilities to gender-based violence (GBV) if governments do not find ways to mitigate recurrent climate-related threats such as drought, flooding, and disease outbreaks. In southern parts of Madagascar, for example, food insecurity following recurrent droughts forced some parents to pull young girls out of school to collect food, including cactus fruit, to sustain their families. As a food source, these fruits provide insufficient nutrients.[28]



Community members in Mahe, Seychelles, work to rehabilitate vital wetlands, which help decrease vulnerability to flooding.
Photo courtesy of Climate Home News

In March and April 2019, Southern Africa was hit by two devastating cyclones that left a trail of destruction in their path, and close to 2.2 million people in need urgent assistance in Mozambique alone. On 14 to 15 March **Tropical Cyclone Idai**[29] made landfall near Beira City, Sofala Province, in central Mozambique. The cyclone brought torrential rains and winds to Sofala, Zambezia, Manica and Inhambane provinces. Cyclone Idai continued across land as a Tropical Storm and hit eastern Zimbabwe with heavy rains and strong winds. The storm caused high winds and heavy precipitation in Chimanimani and Chipinge districts causing riverine and flash flooding and subsequent deaths, destruction of livelihoods and properties. Idai left more than 600 people dead and an estimated 1.85 million people in need in Mozambique alone.

On 24 April, **Tropical Cyclone Kenneth**[30] passed north of the Comoros Islands, hitting the northern island of Ngazidja. On the evening of 25 April, the cyclone made landfall in Mozambique between the districts of Macomia and Mocimboa da Praia in Cabo Delgado province. With wind gusts of up to 220km/h, Tropical Cyclone Kenneth became the strongest cyclone to ever hit the African continent. Cyclone Kenneth left 374,000 people in need.

[26] https://theenergymix.com/2020/02/14/massive-study-links-gender-based-violence-to-climate-change-environmental-degradation/
[27] http://venturesafrica.com/over-2billion-in-recovery-costs-following-the-impact-of-cyclone-idai/
[28] https://www.un.org/africarenewal/news/un-agencies-warn-deteriorating-food-security-southern-madagascar
[29] https://www.unocha.org/southern-and-eastern-africa-rosea/cyclones-idai-and-kenneth
[30] Ibid



Zimbabwe: Women disproportionately affected by Cyclone Idai

The United Nations Development Programme (UNDP) estimates that Cyclone Idai affected 250 000 people in eastern Zimbabwe in 2019, including a disproportionate number of women. Idai affected 35 000 households consisting of more than 120 000 women and 60 000 children. Overall, Idai killed more than 1000 people in Zimbabwe, Malawi, and Mozambique.[31] The World Bank estimated that the affected areas will require more than two billion dollars for economic recovery. This includes repairing sanitations systems damaged by the cyclone, which put families at risk of water- and food-borne diseases.

Women and girls faced increased sexual violence, unsafe labour, and an inability to reach medical centres during the disaster. More broadly, the disaster interrupted access to contraception and other vital reproductive and sexual health services. Idai also led to mental health challenges for many women and severe loss of incomes and livelihoods. The cyclone has pushed the government to think about creating more sustainable and resilient communities to ensure that such disasters do not cause such devastation in future.

While the donor community provided emergency relief aid, women continue to face the long-term effects of the cyclone. Chimanimani Council, one of several Gender Links Centres of Excellence, created a gender action plan that includes gender responsive disaster management. However, the council may not have the financial capacity to implement the plan without help from the government and business community. This presents a good opportunity for Zimbabwe's leaders to consider women, in particular survivors of gender violence, in its economic recovery planning for cyclone affected areas.

Source: Adapted from Health News Zimbabwe, United Nations Development Programme in Zimbabwe, Government of Zimbabwe, Global Fund for Women, Gender Links Chimanimani Action Plan, 2019.









Cyclone Idai wreaks havoc in Chimanimani.

Photos: Colleen Lowe Morna

[31] Global Fund for Women, 2019 Cyclone Idai: Standing in Solidarity with the Feminists Driving Recovery Efforts

Climate Justice and COVID-19

The COVID-19 pandemic came as no surprise to many in the movement for climate justice. It represents a stark reminder of the impact of environmental degradation and deforestation, which exposes humans to closer interaction with wild animals and the viruses they carry. Many see our response to this pandemic as a dress rehearsal for future climate-related emergencies. The impact of the virus and future crises will be most severe on communities already weakened by undernutrition, poverty, and environmental degeneration. COVID-19 has already increased food insecurity and caused a spike in GBV and harmful cultural practices - all of which disproportionately affect women and girls.

Disaster management pushed its way onto the agenda across the SADC region, as leaders sought to have measured and appropriate COVID-19 responses, even as several responded to multiple crises, including disasters linked to climate change. As in other emergencies, women and girls bear the brunt of the fallout from COVID-19, including additional household care, violence and abuse, and loss of income.

Women who step in to provide care during a pandemic face the highest risk of infection, even though they cannot isolate because of their care responsibilities. Internally displaced people in refugee camps, homeless people, people in detention and other institutions also suffer, as these places often lack access to proper running water and sanitation. Further, these groups go without adequate SRH services and are at heightened risk of GBV. Women frontline workers in essential services such as healthcare and agriculture need protective clothing to prevent the COVID-19 virus from spreading. However, many went without these protections as SADC countries scrambled to respond to the pandemic, as South African President Cyril Ramaphosa acknowledged in March 2020 when he appointed Zimbabwean business leader Strive Masiyiwa to assist with efforts to source personal protection equipment (PPE) for the region.[32]



A woman washes her hands at a cash-distribution site in Nsanje District, Malawi, as part of measures to help prevent the spread of COVID-19 in April 2020.
Photo courtesy of World Food Programme, Badre Bahaj

Women and girls already take on most care work in the current system, contributing to the burden of unpaid care work in homes and communities throughout the region as well as holding most care roles in hospitals. The COVID-19 pandemic has highlighted the importance of care work in a crisis, as support workers care for the sick, their families, and those who already needed care before the pandemic. The lack of public services and social institutions and structures to plug the holes in this crisis will have a profound impact on women in the region, including those already overburdened with this work.

In SADC, many countries and organisations launched special efforts to keep agriculture work safely running as an essential business and markets well supplied with affordable and nutritious food despite movement restrictions and income losses.[33] Food prices increased due to the pandemic and lockdown restrictions prevented many small-scale farmers - largely women - from

[32] https://www.dw.com/en/covid-19-lack-of-regional-coordination-could-lead-to-more-deaths-in-africa/a-53456087
[33] World Bank, July 2020, Food security and COVID-19 accessed from https://www.worldbank.org/en/topic/agriculture/brief/food-security-and-covid-19 on 11 July 2020

accessing income or food for their households. Indeed, despite government efforts, the COVID-19 pandemic has contributed to an increase in food insecurity for most households in the region.

Food producers also face large losses on perishable and nutritious food as buyers have become limited and consumption patterns shift. Though food shortages usually *do not* drive food insecurity, disruptions to the supply of agricultural inputs such as fertilisers, seeds, or labour could diminish crops. When small-scale farmers face hunger they may resort to buying food instead of buying implements for the next planting season.

Other effects of COVID-19 on food security include:[34]

- Increased malnutrition among women from fragile and conflict-affected states, where logistics and distribution challenges already exist and where social distancing will lead to food shortages and abuse during COVID-19.
- Countries affected by multiple emergencies from more frequent extreme weather events (floods, droughts) may ignore the gender dimensions of food insecurity during COVID-19 as they battle to prioritise responses to multiple crises.
- Women in already chronically food insecure communities will have an additional burden to source food for themselves and their families during COVID-19. This includes women displaced by conflict and disasters related to the climate crisis.
- Women from countries with significant currency depreciation, (which drives up the cost of food imports) will face limited financial capacity to buy food.

> Food prices increased due to the pandemic and lockdown restrictions prevented many small-scale farmers - largely women - from accessing income or food for their households



In **Angola**, the World Bank-financed Commercial Agriculture Development Project helps farming cooperatives and small- and mid-sized agricultural enterprises expand and improve their operations to meet the needs of local communities during the pandemic. This will benefit women who work in agriculture as they struggle to maintain an income during COVID-19.



In the **DRC**, the average price of a basic food basket has increased by 15% since COVID-19 hit the region. Many people displaced due to political unrest have resorted to negative coping mechanisms such as skipping meals or reducing meal portions. Without urgent action, aid agencies warned that levels of acute malnutrition, stunting, and anaemia will rise. These groups have urged governments to include refugees and displaced populations in social safety nets and COVID-19 response plans. Women and children suffer the most in these circumstances.[35] The World Food Programme has been working with the government and communities to improve the frequency and quality of food price and stock data, in particular around main urban consumption centres affected by COVID-19. It also helped the DRC plan for appropriate social protection, food and nutrition interventions and emergency response to food price hikes.[36]

[34] World Food Programme, Impact of COVID-19 on food security, June 2020
[35] United Nations News, July 2020, Refugees in Africa 'even more vulnerable than ever' amid COVID crisis, accessed from https://news.un.org/en/story/2020/07/1068021 on 11 July 2020
[36] World Bank, July 2020, Food Security and COVID-19 accessed from https://www.worldbank.org/en/topic/agriculture/brief/food-security-and-covid-19 on 11 July 2020

South Africa: Feeding communities during COVID-19



Beneficiaries of the Ubuntu Project collect their seedlings for planting during COVID-19 in Gauteng, South Africa, in April 2020. Photo: Dorah Marema

The team behind the Ubuntu Project know that food security means so much more than food on the table: it means human dignity. With this guiding principle, the programme, an initiative of the Green Business College, a social enterprise that trains green social entrepreneurs, has provided food to the neediest families during the COVID-19 pandemic while ensuring their communities remain part of the process of producing it.

The project team also knows that food insecurity poses all sorts of social and economic risks. During the COVID-19 pandemic, increased violence within the household represents one major consequence of food shortages. Another relates to small-scale farmers, including many women, who watched their fresh produce go to waste because they could not get it to their usual markets during COVID-19.

To help address these issues, the Ubuntu Project collaborated with 23 permaculture farmers (mostly women) to provide food packages to the most vulnerable in their communities for a small fee, encouraging them to also grow their own food. These families receive a box of fresh produce, along with dried beans, eggs, soap, two packets of seeds, 50 seedlings, and compost. The project thus promotes urban farming as a means of ensuring food security.

The cost of a starter food package for a family of five is R350. With honey, add R80. The cost of just a fresh produce package is R220. The scheme has amplified the role that women smallholder farmers can play in a community in pioneering and building local healthy food systems. Across the country during the COVID-19 lockdown, South Africa saw a rise in the number of smallholder farmers supplying fresh produce, seedlings, seeds, and compost to their communities.

In another example, a group of 16 smallholder farmers in Gauteng province worked with the project to assist more than 2000 families and generate revenue for the farmers. The farmers also partnered with the households in those communities to teach them how to grow their own food, make seedlings, and compost. The farmers later bought back the seedlings and excess compost from the households.

The project plans to establish community solidarity markets and customers can also now order online and have the boxes delivered to their doorsteps across Johannesburg.

Source: Ubuntu project coordinator, Dorah Marema

COVID-19 has delivered some environmental benefits: cleaner air, lower carbon emissions, a favourable environment for wildlife to blossom and thrive

In the short term, COVID-19 has affected the environment both negatively and positively. The pandemic has disrupted livelihoods and increased food insecurity. Lockdowns and other restrictions mean farmers cannot plant crops or access inputs such as seeds, which will further imperil yields. Women, who carry most of the burden of overseeing food production and preparation, will be hardest hit. Many lost employment during the pandemic, pointing to the vital need for governments to explore new ways of empowering women to access income at times of crisis. In a new study published in the *Nature Communications* journal, researchers used a statistical model to predict how climate change, with its temperature increases and impact on socio-economic development, could increase the spread of epidemics like Ebola and COVID-19.[37]

COVID-19 has delivered some environmental benefits: cleaner air, lower carbon emissions, and a more favourable environment for wildlife to blossom and thrive. Now the big question is whether women can capitalise on this moment. The case of fisher women in Comoros demonstrates the challenges and the opportunities:



Comoros: Pandemic further strains a struggling fisheries sector

For women in Comoros who rely on the fisheries sector, the days are longer, and the work is harder as warming sea temperatures deplete fish stocks. But the restrictions on fishing imposed by the COVID-19 pandemic could help to replenish the stocks and provide a space for women to have a say.

The fisheries sector accounts for 10% of the country's gross domestic product (GDP), which means reduced fish numbers due to climate change affect the health and livelihoods of many women. Fewer fish means the fishing community must go further and further out into the open sea to catch them.



Nasbata Ahamada in Comoros in 2016. Ahamada works at a fish drying facility.
Photo courtesy of Erick Rabemananoro, World Bank

Small-scale fishing provides a vital safety net for many in Comoros - a historically reliable source of employment for the poorest.

[37] https://www.telegraph.co.uk/global-health/science-and-disease/climate-change-could-push-ebola-untouched-regions-report-warns/

While the island's Directorate General for Fisheries Resources (DGRH) manages the industry, the international donor community, including the World Bank, assists small scale fisheries and vulnerable people in the industry. Comoros, Mozambique, and Tanzania form part of the South West Indian Ocean Fisheries Governance and Shared Growth Project, a World Bank-led initiative that aims to create a sustainable seafood industry through improved management of the sector.

In Mtsamoudou, where 10 000 residents depend primarily on agriculture and fishing for their livelihoods, COVID-19 has been an additional strain. The pandemic restrictions added to existing challenges in the sector that, on top of depleted fish stocks, include acute energy shortages, infrastructure challenges, inadequate and in some cases obsolete fishing equipment, limited financial support from the national budget, and a lack of coordination in the country's fishing industry.

To build resilience in the sector, Comoros needs to introduce women to modern and sustainable means of fishing. However, this may not be possible until the country can address its regular electricity shortages. Activists in the country say women need to have a voice in the management of their fisheries to minimise overfishing and boost the economic benefits of the industry for their communities. The COVID-19 pandemic presents an opportunity for both women and men to collaborate with the government to introduce more sustainable systems and processes in the vital industry.

Source: Adapted from the World Bank and the South West Indian Ocean Fisheries Governance and Shared Growth (SWIOFish 1) programme, January 2020

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

For more than 25 years, the international community has sought to address climate change at the multilateral level - but so far it has seen only limited success. The international climate change regime provides for a set of norms and institutions that exist to address rising greenhouse gas emissions, which remains arguably the world's most controversial environmental issue.

The 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. Adopted in 1997, the Kyoto Protocol quantified mitigation targets for industrialised countries with targets to reduce greenhouse gases by 5% from 1990 levels. Discussions about justice played a significant role in shaping the UNFCCC, its Kyoto Protocol, and the global treaty signed in Paris in December 2015. The UNFCCC has provided a forum for discussions about key justice issues alongside international climate policy. However, the topic once again proved to be a controversial one at the 2015 Paris meeting, COP21.



Women work together to prepare the soil for farming in Limpopo, South Africa, in January 2019. Photo courtesy of Sethosa Ruth

Long-standing divisions still exist at the international level, most prominently between developed and developing countries. The former group includes countries responsible for the largest share of carbon emissions, while the latter group has so far disproportionally faced the larger impact of a changing climate in the form of droughts, flooding, rising sea waters, and other challenges. Other dimensions to justice within the area of climate change governance and policy focus on gender, Indigenous communities, and land use rights, but these debates usually still play out within the frame of North-South relations.[38]

After the 2009 UN Copenhagen climate change conference, which marked the end of a two-year process to increase international cooperation on the issue, the international climate regime witnessed a gradual paradigm shift: away from the top-down, prescriptive logic of the Kyoto Protocol towards a more flexible bottom-up approach.[39] At the same time, the long-standing "firewall" between countries in the global north and south began to crumble. Negotiations eventually resulted in the adoption of a new climate treaty at COP21 in Paris. The Paris Agreement introduced a new hybrid approach to global climate governance, combining bottom-up national target-setting with a rigorous top-down oversight system.

The Paris Agreement

The Paris Agreement, adopted in December 2015 at COP21, was a new milestone in the fight to address climate change. It represents the first time that states signed an international legally binding treaty to reduce carbon emissions that establishes obligations for all signatories to submit mitigation contributions every five years, and to report on implementation. A stock taking process will regularly assess these contributions with respect to the joint goal to keep temperature increases well below 2°C.

Climate activists celebrated its adoption as a historic achievement. It enshrines a new logic of global cooperation, representing a decisive shift away from the top-down regulatory approach that had previously underpinned the international climate change regime. Experts have referred to the Paris Agreement as a "model for effective global governance in the 21st century," because it does not attempt to "resurrect Kyoto-style 'mega-multilateralism," acknowledging that bottom-up national action, combined with sub-

[38] https://warwick.ac.uk/fac/cross_fac/iatl/study/ugmodules/climatechange/seminars/climate_justice_okereke_and_coventry.pdf
[39] http://docplayer.net/179314097-The-long-road-to-paris.html

national and private experimentation, provide the most realistic approach to keeping global warming to 1.5-2°C.[40] However, the agreement's success hinges on whether or not ambition will be scaled up significantly over time. For now, it remains a global promise, even though evidence suggests that current mitigation pledges will be insufficient to limit global warming to 2°C.[41]

The Paris Agreement, adopted in December 2015 by the COP21, represented a new milestone in the fight to address climate change

The fact that climate change transcends international boundaries has made it a global political issue, ensuring that measures for combating it require collective action from the entire international community. However, getting all countries to agree on how to combat climate change represents a major challenge. Disagreements and discussions revolve around topics such as distributive justice, reciprocity, and economic rationality.

On 1 June 2017, the United States announced its intention to withdraw from the Paris Agreement and stop implementation of its nationally determined contribution (NDC), with its president, Donald Trump, stating that the agreement "is simply the latest example of Washington entering into an agreement that disadvantages the United States to the exclusive benefit of other countries." Since this significant development, other US players, including governments of US states like California, have continued to participate in climate discussions; indeed, California hosted the Global Climate Action Summit in September 2018.

On 1 January 2020, a new international climate regime took effect under the 2015 Paris Agreement, according to detailed rules agreed at the COP24 climate summit in December 2018. But one piece of that regime remains unresolved, having proved so contentious that countries have been unable to agree on the rules governing its use: Article 6 of the Paris Agreement, covering a single side of A4 and containing just nine densely worded paragraphs (6.1 through 6.9).

This short text contains three separate mechanisms for "voluntary cooperation" towards climate goals: two based on markets and a third based on "non-market approaches." The text outlines requirements for those taking part but leaves the details - the Article 6 "rulebook" - undecided.

In simple terms, the first mechanism would allow a country that meets its Paris climate pledge to sell any overachievement to a nation that has fallen short on its own goals. This overachievement could be emissions cuts but might also cover other targets. For example, some countries have set goals for renewable energy capacity or forest expansion.



Farmers set up drip irrigation systems to support agriculture during dry periods in Eswatini in 2020. Photo courtesy of Zethu Shongwe

[40] https://www.weforum.org/agenda/2015/12/why-the-paris-agreement-is-a-model-for-21st-century-global-governance/
[41] https://www.ucl.ac.uk/global-governance/sites/global-governance/files/the_long_road_to_paris_the_history_of_the_global_climate_change_regime.pdf

The second mechanism would create a new international carbon market, governed by a UN body, for the trading of emissions reductions created anywhere in the world by the public or private sector. A renewable power plant could, for example, generate carbon credits, or an emissions-saving factory could upgrade its facility.[42]

Madrid hosted the 25th COP from 2 to 13 December 2019, intending it as a launchpad for the full implementation of the Paris Agreement post-2020. COP25 asked countries to, *inter alia*:

- Submit climate action plans and timeframes;
- Resolve the financing of climate action worldwide;
- Resolve how to support countries affected by the impacts of climate change;
- Conclude the negotiations related to Art. 6 of the Paris Agreement; and
- Establish financing of loss and damage from climate change.

> Leaders must begin to pay more than lip-service to action plans to curb carbon emissions

Countries did not agree on several issues and failed to reach consensus on several contentious issues including, among others, negotiations related to Article 6 of the Paris Agreement; financing of global climate action; and transparency reporting requirements and (common) timeframes for climate commitments. Countries agreed to try to resolve these issues at COP26 in Glasgow, Scotland, in November 2020. However, the UN later postponed this conference due to the COVID-19 pandemic.

Overall, COP25 made very little progress on critical issues such as Article 6 and other ambitious plans. Many attendees expressed their frustration with the conference outcomes. UN Secretary General António Guterres noted that "the international community lost an important opportunity to show increased ambition on mitigation, adaptation, and finance to tackle the climate crisis." Several climate campaigner groups and Indigenous rights activists staged a protest to demand that nations do more to avert catastrophic climate change outcomes.

Devoted political will and urgent collective action of state and non-state actors (at all levels) will be necessary in future discussions to address climate change. Leaders must begin to pay more than lip-service to action plans to curb carbon emissions. They should take the period before COP26 as an opportunity to renew commitments and appropriately plan for climate action. COP26 will initiate the implementation of the Paris Agreement.

Seychelles and Zimbabwe introduced partnership plans during the 2019 climate meeting in Spain. Their plans included best practices on climate leadership efforts, shared stories and best practices, and highlighted gaps in support to achieve their climate objectives and the SDGs.[43]



Zimbabwe's partnership plan outcomes include local climate change mainstreaming; capacity strengthening for climate finance; reducing water vulnerability; engaging micro, small, and medium-sized enterprises; increasing the adoption of low-carbon and clean technologies; scaling up climate-smart agriculture; and strengthening early warning systems. The plan has 27 partners, with financial contributions of US$23 million.

[42] https://www.carbonbrief.org/in-depth-q-and-a-how-article-6-carbon-markets-could-make-or-break-the-paris-agreement
[43] SDG Knowledge Hub, January 2020, accessed from https://sdg.iisd.org/news/six-countries-launch-ndc-partnership-plans-at-unfccc-cop-25/ accessed on 10 July 2020



Zimbabwe: Tree planting "the acacia way"

Using one of the most iconic trees in Africa, Zimbabweans have been "greening" their communities in what some refer to as "the acacia way." In the city of Kadoma, a growing population means the city has lost some of its green space over the years. To counter this trend, officials at the department of housing recently embarked on a tree planting program under their "green cities" scheme.

The programme to plant native trees like the acacia in parks and open spaces also mitigates the effects of climate change by adding new plant life that will convert carbon dioxide into oxygen. Indigenous tree planting also promotes natural bird life.

As a Centre of Excellence, the Kadoma City Council also uses tree planting to improve the livelihoods of marginalised people. It awarded management of the activity to six community groups of widows and men's clusters.

The Council now presents its work at major events and conferences, workshops, national tree planting days, and school programmes, challenging attendees to plant indigenous trees, "the acacia way." The council works in conjunction with the Forestry Commission, Environment Africa, and Kadoma Community Capacity Centre to encourage developmental initiatives in natural resources conservation and management for the primary benefit of women and children. Council named its programme "Going the Acacia Way." The project provides both indigenous and exotic nursery trees to those willing to plant them.

Through the project, wards in the city have initiated ward-based parks, where residents plant and maintain their green belts. Local companies such as Kadoma Hotel and Conference Centre and Nyaradzo Funeral Services have financed some of these activities. The Nyaradzo Group provided 300 Trees to Kadoma City Council and 2000 trees to Kadoma Women for Development.

By Gaudencia Goredema Zimbabwe as part of a submission for the SADC Protocol@Work Gender Links Summit 2020.



"Greening" the "the acacia way" by adding new plant life that will convert carbon dioxide into oxygen. Indigenous tree planting also promotes natural bird life. Photo courtesy of Freepix

UNFCCC COVID-19 response

During the COVID-19 pandemic, Secretary-General Guterres highlighted that the crisis represents an unprecedented wake-up call for governments. He noted that they should heed the warning as they transition their economies to meet the needs of the future.

COVID-19 spurred the UN to devise a blueprint for a healthier planet and society that leaves no one behind, this includes acting across the UN system to ensure a more resilient future.[44]

Due to the global crisis, the UN postponed the COP26 conference set to take place in Glasgow in November. However, African countries spoke out, urging developed countries to close the climate finance gap in 2020 and asking the UNFCCC to hold COP27 in 2021 in Africa, as originally planned.[45]

COVID-19 spurred the UN to devise a blueprint for a healthier planet

Gender dimensions of the UNFCCC



Comorian women and children carry logs, branches, and twigs from forests on Anjouan Island, where the UN has helped communities restore forests in important watersheds to stop soil erosion and failing harvests.
Photo courtesy of Hannah McNeish

From the very start of the UN climate negotiations, feminists, gender experts, and civil society groups have fought for climate action to have women's rights and gender equality at its core. A gender-responsive answer to climate change strengthens the overall effectiveness of climate action and ensures it does not further exacerbate inequalities. The Lima Work Programme on Gender (LWPG) in 2014 (adopted at COP20 and prolonged at COP22) marked one milestone on this path, as did the gender action plan (GAP) in 2017 (adopted at COP23). Their aims included the advancement and implementation of mandates for gender equality that already exist under the UNFCCC, institutionalisation of gender into all UNFCCC areas, and support for implementation of gender-responsive climate action.[46]

Parties to the UNFCCC have recognised the importance of involving women and men equally in UNFCCC processes and in the development and implementation of gender-responsive national climate policies. In 2019, at COP25, parties agreed to review and enhance the LWPG and GAP for an additional five years or more. During the two weeks of negotiations, controversies and setbacks on basic issues dogged gender negotiations. Nevertheless, the advocacy strate-

[44] United Nations, Corona Virus Communications, March 2020, https://www.un.org/en/un-coronavirus-communications-team/un-urges-countries-%E2%80%98build-back-better%E2%80%99 accessed on 9 July 2020
[45] SDG Knowledge Hub, Africa Group responds to postponement of COP26 accessed from https://sdg.iisd.org/news/african-group-responds-to-postponement-of-cop-26/ on 10 July 2020
[46] https://www.rosalux.de/en/publication/id/41624/no-gender-justice-on-a-dead-planet

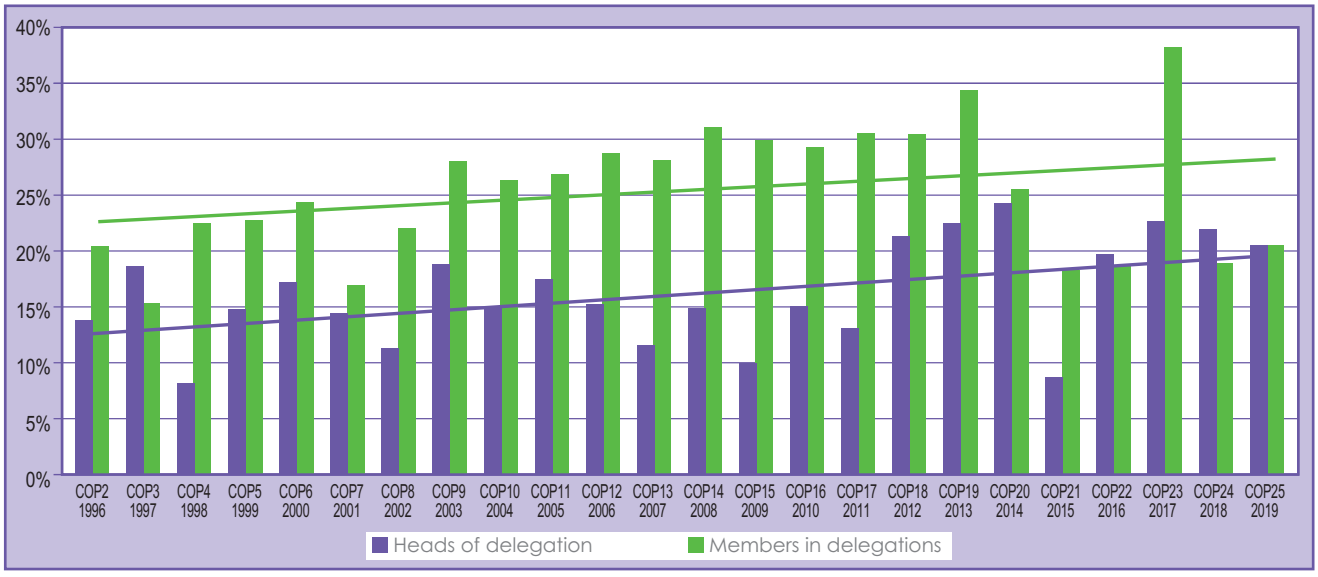
gies of the Women and Gender Constituency (WGC) and allied groups mobilised and put pressure on the parties. Finally, this led to an agreement by the end of the conference. It represented one of the few outcomes of the event that civil society groups celebrated.

The GAP maintained the five priority areas contained in its earlier version: 1) Capacity-building, knowledge management, and communication; 2) Gender balance, participation, and women's leadership; 3) Coherence; 4) Gender-responsive implementation and means of implementation; and 5) Monitoring and reporting. It has a set of objectives and activities that includes a new specification on the level (international, regional, national, and local) for implementation of each area. It aims to advance the knowledge of gender-responsive climate action and translate it into climate action taken on by the UNFCCC Secretariat, governments, international organisations, and other stakeholders.

Compared to the previous GAP, it has broader objectives with more comprehensive activities, which often go beyond capacity building and information exchange. Importantly, it integrates gender-just climate solutions, e.g. gender-responsive technologies, and an acknowledgement of Indigenous knowledge in conserving and protecting nature and climate. It also integrates an intersectional approach to understand the multiple impacts that people suffer in the climate crisis according to their gender, race, country of origin, and age. However, the new enhanced gender decision remains loose in terms of financing mechanisms for implementing the GAP activities, as well as in the very outline of the activities, which do not have specific targets or outcomes set for the five-year term. The current indifference of governments to review their NDCs and accelerate action to implement the Paris Agreement also endangers effective gender-responsive climate action altogether.

While women and girls around the world have received recognition for their dedicated advocacy for climate action, climate decision-making processes still do not equally include their voices. The annual *UN Gender Composition Report* looks at two fundamental areas: gender make up of decision-making and technical bodies under UN Climate Change (also known as constituted bodies) and national delegations to climate conferences. It shows that an initial positive trend in 2018 towards more gender-balanced constituted bodies reversed in 2019. The report posits that changes in gender balance remain inconsistent and vary from year to year and across constituted bodies.

Figure 9.1: Women's participation in climate negotiations



Source: https://www.gendercc.net/genderunfccc.html

Figure 9.1 shows women's participation in COP climate negotiations over several years. Most years, women represented less than 30% of delegations, with COP23 representing the first time that more than 35% of delegations included women. COP25 had an almost equal number of women for both heads of delegations and members of delegations.

Based on 2019 data in the *Gender Composition Report*, only five out of 15 constituted bodies had female representation, down from eight of 13 in 2018. Average female representation on constituted bodies sits at 33%. The Clean Development Mechanism (CDM) executive board had the lowest number, with only 10% female representation. National delegations also show a lack of progress in achieving equal representation. Women comprised only 38% of the 11 306 national delegates to the 2018 UN Climate Change conference in Katowice, Poland, an improvement of one percentage point from the previous year. The numbers decline further for heads of delegation, with women holding 27% of these spots.[47]

At this rate of change, these UN conferences will not achieve gender parity for delegates until 2046, and not until 2068 for COP heads of delegation. Even though the presence of women within the climate change negotiations does not necessarily ensure that discussions will robustly address gender issues, it is important for women to have equal representation in these discussions.

The 2020 *Women 2030 Global Shadow Report* noted that urgent gender just climate and forest conservation action can only happen "with women's meaningful participation in decision-making, building on international agreements and gender work plans." The report called for increased supports for locally-owned, women-led climate resilient solutions, such as agroecological food production. It also noted that COVID-19 has further restricted women's representation at, and access to, international climate processes. Researchers want the UN and other bodies to implement policies to ensure equal participation during the pandemic.[48]

Women and Gender constituency of the UNFCCC

The Women and Gender Constituency (WGC) is one of nine UNFCCC stakeholder groups. Established in 2009, the WGC now consists of more than 30 women's and environmental civil society organisations that work to embed women's voices and rights in all processes and results of the UNFCCC framework.

The WGC provides several ways for these groups to influence the annual conferences and shape the UNFCCC as well as a platform to exchange information between members and with the UNFCCC Secretariat. The constituency also ensures that meetings, workshops, and conferences include women's civil society.

It draws on global commitments to gender equality and women's rights, especially as they relate to climate change and the achievement of the Sustainable Development Goals (SDGs) and related commitments. The constituency also challenges exploitative and patriarchal economic models that created the climate crisis.

The WGC bases its principles on democratic and participatory governance, respectful and supportive participation, wide and inclusive membership of accredited civil society observers, and regional balance. Other principles include transparent procedures and clear, timely and flexible communication; processes that allow for effective participation of members from all regions and backgrounds; building on history (collectively and individually); mentoring (of younger generations and other newcomers); a goal-oriented approach; and providing a plat-

[47] https://unfccc.int/news/women-still-underrepresented-in-decision-making-on-climate-issues-under-the-un
[48] https://www.women2030.org/global-report/

form for women's leadership with broad and participatory access.[49]



Women small holder farmers in South Africa in 2017.
Photo courtesy of Sandiswa Manana

The main objectives of the WGC include:

- Ensuring the representation of women's voices, experiences, needs and capacities in the UNFCCC process and providing gender perspectives in all related discussions;
- Developing and advocating for common positions based on climate justice principles and working together towards achieving shared goals;
- Contributing women and gender-sensitive perspectives and a wider critical analysis of current developments within and around the official negotiations to help foster communication between women and gender organisations and groups;
- Facilitating and engaging in the daily women and gender caucuses during the negotiations;
- Liaising with other caucuses and constituencies, especially to identify and build upon common ground; and
- Collaborating on funding opportunities in a transparent manner and according to agreed guidelines to support the collective work and diverse representation of the Constituency in the UNFCCC process and allow for enhanced capacity building and knowledge sharing.

The Sustainable Development Goals

In the 2030 Agenda for Sustainable Development, member states express their commitment to protect the planet from degradation and take urgent action on climate change. The Agenda identifies climate change as "one of the greatest challenges of our time" and notes that "its adverse impacts undermine the ability of all countries to achieve sustainable development."

Women's equality and empowerment has a standalone SDG, number five, but attainment of this goal is integral to all the SDGs, including those related to climate change and the environment.

SDG 13 aims to "take urgent action to combat climate change and its impact," while acknowledging the UNFCCC as the primary international, intergovernmental forum for negotiating the global response to climate change. More specifically, the associated targets of SDG 13 focus on the integration of climate change measures into national policies, the improvement of education, awareness-raising and institutional capacity on climate change mitigation, adaptation, impact reduction, and early warnings. SDG 13's alphabetical targets also call for the implementation of commitments undertaken at the UNFCCC and for the promotion of mechanisms able to increase capacity for effective climate change related planning and management in least developed countries and small island developing states.

The COVID-19 pandemic poses a huge challenge to the attainment of all SDGs, as communities around the world will experience setbacks toward progress. The pandemic has already imperilled progress on several fronts, as illustrated across the SADC region by increases

[49] UNFCCC, Women and Gender Constituency objectives

in food insecurity and malnutrition after years of reducing hunger; massive unemployment and economic insecurity that may take years to overcome; and land loss due to drought, flooding, desertification, and erosion. The virus also presents opportunities, including around innovation and digital solutions to address the SDGs and development challenges.

Global: Peoples' Summit calls for safety and equality

In September 2019, during the UN General Assembly, Amnesty International co-organised a climate change and human rights summit that highlighted the principles of safety, equality, peace, and justice.[50]

Summit attendees committed to a world where people thrive as part of nature and where human rights - including the rights of Indigenous peoples - and the environment come before corporate profit.



People's Summit participants march for climate change action in New York at the UN General Assembly in 2019. Photo courtesy of Google Images

Gender organisations in attendance included Gender Links and Earthlife.

The summit declaration highlights the following gender equality commitments, which remain especially relevant in the COVID-19 era.

- Recognised that businesses have wilfully disregarded their responsibility to respect human rights, further contributing to infringements of the human rights of women, children, Indigenous peoples, local communities, and other disproportionately affected groups, and to the destruction of ecosystems across the planet.
- We pay particular attention to those who face multiple and intersecting forms of discrimination and who are most at risk of attacks and restrictions based on gender, race, and other forms of discrimination, such as women human rights defenders, Indigenous rights defenders, and other excluded and marginalised defenders and communities. We will defend all those who peacefully demonstrate and engage in acts of civil disobedience to demand climate action from undue repression and persecution.
- Committed to increase efforts to place human rights at the core of climate activism. This will be done through following the lead of Indigenous peoples, youth, women, people living in poverty, persons with disabilities, fishing communities, peasants, pastoralists, local communities, workers, and other disproportionately-affected groups, who are leading the call for climate justice and against activities that destroy the planet.

The summit also raised concerns about escalating climate justice related killings and GBV, threats, harassment, and criminalisation of environmental human rights defenders that often go unpunished.

Source: Adapted from People's Summit on Human Rights and Climate change declaration, September 2019

[50] Amnesty International, Climate, Rights and Human Survival Summit Declaration, September 2019

African frameworks

Climate change threatens to push millions of Africans into poverty by 2030 and unravel hard-won development gains. Many African countries have made significant development achievements in the last few decades with annual growth averaging 4.5%, but increasing weather, water, and climate risks threaten these gains.

Africa, a continent covering 54 countries, contributes only 4% of the total global emissions. According to the IPCC, Africa will suffer some of the most adverse climate impacts. African countries have already come to the table with ambitious NDC climate plans under the Paris Agreement.[51]

African Union commitments

Even before the SDGs, the African Union (AU) climate strategy included implementation of climate change programmes to achieve sustainable development and alleviate poverty, with emphasis on the most vulnerable groups, especially women and children.[52] The AU has been exploring the idea of electing a special envoy for climate change and security to strengthen its response to climate risks. The idea of the envoy stems from an AU peace and security council meeting in May 2018. It represents a unique opportunity to pre-empt migration and forced displacement and "climate-proof" the AU's peace and security architecture.[53] Climate change related displacements affect women and children more than any other groups.

Transformative policies and climate-smart development approaches are crucial to adapt to the increasingly complex and uncertain impacts of climate change. At COP25, African countries called on developed countries to take robust action and implementation to close the ambition gap of both cutting emissions and climate finance, which they had promised to do by 2020 in the Kyoto Protocol.

Africans already experience more disasters. For instance, in 2019 Cyclone Idai affected more than three million people in the SADC region, destroying almost half of Mozambique's annual crop production and critical infrastructure. By 2050, climate change could force more than 86 million people to move across countries in Sub-Saharan Africa. Rising conflict, political instability, and the climate crisis have become inextricably linked.

> One in every three people already face water scarcity in Africa

Conflict happens for many reasons, but water insecurity, and its subsequent impact on land resources, is often a factor. In 2017, water played a major role in conflict in at least 45 countries, particularly in North Africa and the Middle East. As climate change increases the risk of drought, in Africa - where one in every three people already face water scarcity - the stakes will also increase.

The AU prioritises adaptation and resilience building, given that the continent emits the least greenhouse gases yet bears the most negative impacts of climate change. Unfortunately, adaptation does not receive the global attention that it deserves. African leaders must continue to raise this issue at international events.

[51] https://www.cnbcafrica.com/insights/energy-environment/2020/02/05/op-ed-now-is-the-time-to-put-climate-change-on-the-african-unions-agenda-ngozi-okonjo-iweala/
[52] African Union Climate Change Strategy, 2014, accessed from https://www.un.org/en/africa/osaa/pdf/au/cap_draft_auclimatestrategy_2015.pdf on 8 July 2020
[53] Florian Krampe and Vane Moraa Aminga; February 2019, The need for an African Union Special Envoy for Climate Change and Security

SADC frameworks for climate change

While the entire world is struggling with the challenges presented by the changing global climate, Southern Africa is uniquely susceptible to the impacts of climate change. In coming decades, experts expect the SADC region to experience higher land and ocean surface temperatures than in the past, which will affect rainfall, winds and the timing and intensity of weather events. As noted earlier in this chapter, climate change poses several risks to SADC goals for regional economic development. Increased frequency of floods, cyclones and droughts may damage infrastructure, destroy agricultural crops, disrupt livelihoods, and cause loss of life.

SADC leaders have committed to several international conventions and programmes on climate change. All SADC Member States have signed on to the following conventions:

- The United Nations Framework Convention on Climate Change, which advocates for reduced emissions toward lowering global temperatures and offers guidance on coping with the impacts of climate change;
- The Ramsar Convention on Wetlands, which specifically targets the preservation of internationally important wetlands and contains a resolution covering climate change impacts, adaptation and mitigation; and
- The Convention on Biological Diversity, which has resulted in numerous decisions and technical papers describing the links between biodiversity and mitigation of climate change effects.

Furthermore, a Memorandum of Understanding between SADC and the World Food Programme highlights adaptation to climate change as one of six principal areas for cooperation. Similarly, stakeholders associated with the African Ministerial Conference on the Environment (AMCEN) and the regional climate change programme have developed a framework of sub-regional climate change programmes.

The SADC Gender and Development Protocol

The post-2015 SADC Protocol on Gender and Development states in Article 31 in Part Ten, Gender and Climate Change that: Develop policies, strategies, and programmes to address gender issues in climate change should be in accordance with the SADC Protocol on Environment and Sustainable Development. It also obliges states to conduct research to assess the differential gendered impacts of climate change and put in place effective mitigation and adaptation measures.



Women learning to use renewable energy and energy effiencent technology in Joubert Park and Alexandra township, South Africa.
Photo courtesy of GenderCCSA

The SADC Protocol on Environmental Management for Sustainable Development

The SADC Protocol on Environmental Management for Sustainable Development's main objective is to promote sustainable utilisation and trans-boundary management of the environment. It covers environmental issues such as climate change, waste and pollution, management of chemicals, bio-diversity and natural heritage, sustainable land management, marine and inland resources, as well as cross-cutting issues on gender, science, technology, trade and investment.[54]

The Protocol aims to enhance the protection of the environment; promote equitable and sustainable use of natural resources and the environment; promote shared management of trans-boundary environment and natural resources and promote effective management and response to impacts of climate change and variability. It also facilitates the harmonisation of policies, strategies and legal frameworks to enhance regional coordination of environmental management, as well as regional integration and it provides a legal framework for trans-boundary environment and natural resources.

Article 12 commits that state parties shall take measures to address issues of climate change including trans-boundary considerations, through adopting the necessary *legislative and administrative* measures to enhance *adaptation* to the impacts of climate change, bearing in mind the diverse and *gender differentiated levels of vulnerabilities*; taking nationally appropriate voluntary climate change mitigation measures; addressing the negative impact of climate change on, among others food security, water resources, health, economic activities: particularly agriculture, tourism, energy and industrial development, fisheries and infrastructure, human security, poverty eradication efforts and gender equality initiatives.

National strategies

SADC Protocol on Environment and Sustainable Development Article 31, 1a: State parties shall develop policies, strategies, and programmes to address the gender issues in climate change.

Protocol on Environmental Management for Sustainable Development Article 20.2: State parties shall undertake gender analysis and gender mainstreaming of all environmental management, climate change and sustainable development policies, programmes, projects and budgets.

Botswana has created a multi-stakeholder National Climate Change Committee (NCCC) to ensure broad representation, qualifications, and experience in climate change matters. It includes youth, women, and vulnerable groups with relevant skills. The NCCC will provide technical guidance to the government of Botswana on implemen-

[54] https://pmg.org.za/committee-meeting/25617/

tation of UNFCCC resolutions, decisions, and recommendations. It will also guide implementation requirements for the IPCC reports and dissemination of findings. The committee will also have a role in guiding strategies for national responses, in particular recommendations of vulnerability assessments, hydro-meteorological hazards such as floods, veldt fires, and drought, and technology needs assessments. In collaboration with the Climate Change Coordination Unit, NCCC will also guide the implementation of public awareness strategies and outreach programmes and incorporate climate change in the national education curriculum at all levels.



Women working on a cabbage farm in Botswana in 2016.
Photo courtesy of William Moseley



The government in **Comoros** has been helping create a Green Climate Fund (GCF) to build capacity to understand and respond to threats from climate change. The government hopes to access funding from GCF and other sources to fund a project called Ensuring Climate-Resilient Water Supplies in the Comoro Islands, which will directly help nearly half a million people manage water supplies and strengthen water infrastructure.[55]



Malawi developed a national climate change policy in 2016. The government also launched its National Adaptation Plan (NAP) in 2019. Malawi has been recovering from the cumulative impact of flooding from the 2019 cyclones and the COVID-19 pandemic, which saw the country declare a state of emergency. The pandemic caused a major disruption that will hinder progress towards the achievement of milestones set in the NAP. The cyclones destroyed between 25000 and 35000 hectares of maturing crops in southern parts of the country, thus decreasing production estimates.[56] Women and girls face an additional burden: their unpaid care responsibilities increased because of the storms and the pandemic. They must walk longer distances to water points and sanitation facilities, increasing the risk of GBV.



Namibia has both a national policy on climate change and its National Climate Change Strategy and Action Plan 2013-2020 to support the government's climate and development agenda.[57] Climate change will affect the already arid country's agricultural systems, especially in the north, where many people rely on animal husbandry. Namibia has endured recurrent drought conditions since 2013, affecting drier regions and claiming human lives. Although it has seen some improvements in rainfall activities since 2016, erratic and irregular rainfall remains common in most parts of the country, threatening agricultural productivity.



The Government of **Seychelles** developed a climate change policy in 2020.[58] In it, the government contends that, while Seychelles ranks as a low emitter, its susceptibility to climate change has increased over the years. The small island republic relies on tourism for its economic growth. Climate change threatens this, as it manifests primarily in the form of rising and warming sea levels in the Seychelles. This also represents a major problem for vulnerable populations in low-lying areas. Warming seas destroy coral reefs and reduce marine life important for food and tourism. The country developed the Blue Economy Strategic Policy and Roadmap of 2018-2030 to help it maximise sustainably in the ways it benefits from the sea.

[55] https://english.alaraby.co.uk/english/indepth/2019/2/5/comoros-spearheading-the-international-communitys-fight-against-climate-change
[56] FEWS NET led joint assessment
[57] https://ndcpartnership.org/sites/all/themes/ndcp_v2/docs/country-engagement/countries/NCDP_Outlook_Namibia_v1b.pdf
[58] http://www.meecc.gov.sc/wp-content/uploads/2019/10/seychelles-national-climate-change-policy-may-2020.pdf

South Africa has made strides in developing climate change policy. The country adopted its Integrated Resource Plan (IRP) in October 2019, representing a major shift in energy policy. The government also enacted a carbon tax bill and it is readying to enact a climate change bill to provide a coordinated and integrated response to climate change and its impacts in accordance with the principles of cooperative governance. In 2019, the government also published the Draft National Climate Change Adaptation Strategy for public comment in Government Gazette 42446. Emerging evidence suggests a rise in extreme weather events in South Africa, with increased heat wave conditions, longer dry spells, and increased intensity in rainfall. Climate zones across the country have already been shifting, degrading ecosystems and landscapes, and increasing the frequency of veldt fires.[59]

Zambia has felt the pinch from climate change over the past two years as parts of the country faced famine following one of the worst droughts in the past decade.[60] This is despite Zambian legislators launching a national policy to mitigate the threats posed by climate change. It provides guidance on how the Zambian economy can grow in a sustainable manner and complement the implementation of the seventh National Development Plan. It also promotes coordination of all adaptation and mitigation measures towards combating climate change, with the vision for "a prosperous and climate resilient economy by 2030."

Excellent climate change mitigation and planning in **Zimbabwe** did not spare the country from the devastation of Cyclone Idai in 2019. Eastern Zimbabwe experienced torrential rainfall and high winds, resulting in crop and livestock losses and destruction of food stocks. The worst affected districts, Chimanimani and Chipinge in Manicaland, represent the country's breadbasket, where "agricultural activity forms the main source of income and contributes to Zimbabwe's main agricultural exports, including tea and tobacco."[61] In total, researchers estimate that the storms affected 270 000 people in nine districts. Making matters worse, COVID-19 hit Zimbabwe hard, just as many in these regions had begun to recover from Cyclone Idai.



Cyclone Adai affected Chimanimani, which was one of the hardest districts hit in Zimbabwe.
Photo courtesy of Colleen Lowe Morna

[59] https://www.gov.za/speeches/minister-environmental-affairs-publishes-draft-national-climate-change-adaptation-strategy
[60] https://www.caritas.org/2020/02/zambia-droughts/
[61] http://www.fao.org/3/y4632e/y4632e0y.htm

Mitigation and adaptation measures

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.

Across SADC member states, policymakers have invested in numerous pilot studies aimed at establishing the most appropriate approaches to building the resilience of the region's agriculture sector, especially for smallholder farmers who produce the bulk of the region's food. After many trials, the region has plenty of information about proven interventions whose implementation holds the key to building climate resilience. However, lack of financial, institutional, and human capacities still constrains implementation of these measures. To address this, leaders need to mobilise investment, which will be central to supporting the necessary transformation and the scaling of climate resilient agriculture.

The increasing body of evidence on climate change impacts, as well as increasing demand from a growing population, requires a cross-sectoral approach such as the Water Energy Food (WEF) nexus, to promote sustainable development. The WEF nexus provides a framework for managing synergies and trade-offs between water, energy, and food in the context of emerging constraints on sustainable development. As a socio-ecological approach, it provides an opportunity to sustainably address complex problems such as climate change adaptation, while still promoting regional economic development.

Women's unique role in climate mitigation

Social, economic, and political realities provide the context in which adaptation and mitigation take place. Complex power relations and socio-economic characteristics result in different people experiencing different climate impacts. Capacity building linked to climate and women's rights and gender equality should focus on gender differences and ensuring that climate change does not erode gains made toward gender equality. Women, men, and child-headed households have different capacities to mitigate and adapt to climate change.

Studies show that women face greater difficulties in adapting to climate change than their male counterparts. This is especially true for women who depend on agriculture as a source of livelihood, as illustrated throughout this chapter. While women face unique and sometimes disproportionate burdens because of climate change, they are not merely victims. To the contrary, women are also agents with important perspectives and homegrown knowledge, which can

[62] http://mzansiagritalk.com/archives/4233

inform and influence solutions to address climate change. In many communities around the world, climate change has already forced women to adapt if they want to survive and care for their dependents.

One study conducted in two communities of Gaza Province in southern Mozambique - Mapai-Ngale in Chicualacuala District and Magondzwene in Chibuto District - revealed that climate change has a differential impact on women and men due to power relations and their differentiated roles in these communities. The former community sits upstream on the Limpopo River and is vulnerable to droughts, while the latter is downstream on the same river and vulnerable to flooding. Researchers selected the communities based on agreed common criteria for the region: rural, poor, vulnerable, and already facing climate change effects.[63]

The study found that women have access to, but not control over, natural resources and other property rights. Women do most of the reproductive and part of the productive work, while men control the productive work. Successive droughts in these communities has increased men's migration to South Africa and other places in search of work. Consequently, women's role in productive work has increased. For example, women's participation in alcoholic drink brewing in Mapai-Ngale and fisheries-related work in Magondzwene has increased. This imposes pressure on women, forcing them to spend extra time doing productive work instead of their reproductive jobs and time spent with their children. On the positive side, men's migration has enhanced women's participation in decision-making. Women currently employ several coping and adaptation strategies, including the use of alternative food sources.

The 2020 *Women 2030 Global Shadow Report* found that "women farmers often have different preferences than men. They tend to adopt more environmentally sustainable practices and have a stronger focus on agroecology, climate resilience and nutrition." It found that men often even rate women's influence in climate mitigation and agricultural sustainability even higher than women themselves do, although some still protest women's leadership in the sector.[64]

There is general consensus amongst policymakers and academics on four ways to strengthen women and men's capacities for better adaptation to climate change. These include implementation of existing policies and programmes, allocation of resources, capacity building, and reinforcement of women's participation in local institutions. Due to the key role women play, facilitators should always consider them as the priority group in any activity. Since agriculture represents the main women's activity in many SADC communities, experts recommend capacity building of women in agriculture and agro-processing techniques.[65]



A health worker in Mozambique responds to the COVID-19 crisis in April 2020.
Photo courtesy of Club of Mozambique

Lack of adequate funding has prevented some climate research from taking a gendered focus. This may eventually pose a risk. It is important to understand the unique risks that women face and find ways to share them, for example through trade, technology transfer, and information sharing among SADC countries.

[63] https://www.fanrpan.org/archive/documents/d00922/
[64] https://www.women2030.org/global-report/
[65] Source: https://www.fanrpan.org/archive/documents/d00922/



Madagascar: Building resilience to climate change



Women farmers gather for a meeting to discuss climate change mitigation techniques in Madagascar in April 2019. Photo courtesy of Edwin Fitobea

Women farmers have been taking action to protect their communities from the worst effects of climate change in southern Madagascar, employing new gardening skills to bolster local food security.

In the Amboasary Sud region, increases in droughts and malnutrition regularly affect the public and local farmers.

To address these challenges, women's groups created market gardening projects to involve more women in agriculture as well as empower them financially.

Apart from climate change mitigation, specific objectives of this project include raising awareness within society about the equal rights of men and women to access agricultural work and eliminating the stereotype that forces women into care work. Both men and women have a responsibility to feed their families.

The project also works with students to plant leafy vegetables in irrigated family plots. Families can consume the vegetables and sell them in local markets. Convincing locals of the value in planting non-traditional crops that have resistance to drought (including cassava and corn) has been a challenge in some cases. Agricultural experts provided technical support to educate the community and set up water systems.

Now, families in the community, including many that had previously resorted to selling livestock to feed themselves, have more sustainable food sources as well as income from their gardens.

Experts have also shown locals how to adapt their gardens to cold, heat, frost, abnormal wind, hail, nematodes, insecticides, worms, and increased rainfall. This holistic approach to adaptation builds resilience among local communities for years to come.

By Edwin Fitobea as part of a submission for the SADC Protocol @ Work Gender Links Summit 2019

Access to clean energy sources

More than half of the population of the SADC region live in rural areas and lack access to clean energy and water. The interrelationship between water and energy supply, water resources, and climate change thus factor into decision-making in most countries. According to a recent World Bank report published as a background paper to support dialogue, the silo approach to issues of energy in the region contributes to the failure to achieve set goals that would move the region toward clean energy for all.[66]

[66] Water Power Magazine (2017), Addressing the energy-water nexus in Southern Africa, available at http://www.waterpowermagazine.com/opinion/opinionaddressing-the-energy-water-nexus-in-southern-africa-5818909/

The global energy transition offers an unprecedented opportunity to transform the energy sector in all aspects. The transition towards a renewable, distributed, decarbonised energy system will create an array of social and economic benefits, including growing employment.

With public policy support, women can garner a growing share of expanding employment in this young and dynamic sector. Perceptions of gender roles remain the most important barrier to entry into the sector. Cultural and social norms drive these and influence many of the fundamental decision in the region.

So far, access to clean energy sources has focused on electrification. However, households within the SADC region have increasingly acquired solar energy. Yet unaffordable prices for solar equipment prevent many women from accessing this energy source. Most SADC countries have not achieved universal electricity and clean water supply. This adds to the burdens that women face in their multiple roles.[67]



Botswana will soon add renewable energy and natural gas generation sources to its portfolio through independent power producer (IPP) projects. Previous IPP projects have not succeeded due to regulatory framework challenges; however, Botswana now permits production for export by an IPP under its 2007 amendment to the Electricity Supply Act. Botswana has tremendous potential for solar energy utilisation. In September 2016, the government renamed its energy organ the Ministry of Mineral Resources, Green Technology and Energy Security to signal a new commitment to introducing renewable energy. The government has developed a new medium-scale solar project outside Gaborone, but it still primarily uses solar applications for water heating and small-scale electricity generation.



The DRC has one of the lowest rates of electrification in Africa. This puts the country in an advantageous position to move towards renewable energy. The DRC has large mineral resources and a potential to install up to 100 000 megawatts of hydropower capacity. Off-grid solar systems, which provide solar-powered products, have been a key part of reaching the rural poor across East Africa. Thus far, off-grid solar providers have shied away from the DRC, but new research shows that the country presents a compelling market.[68] There is vast potential to serve urban consumers and businesses with higher levels of demand. Innovative renewable energy suppliers can pilot new concepts at a competitive price and achieve sustainable returns. Lessons from research in the Kivu regions could serve as a model for a diverse energy system reaching across the DRC. It could include: grid connection for large industry; mini-grids powered by solar and hydro for medium-size "anchor" businesses and neighbouring households; large solar home systems for small businesses and large households; and "pico-solar" for low-income households. The DRC already employs a myriad of energy solutions in a patchwork across cities. So, the behavioural change required to shift to this model would be far less drastic than in locations with a functioning grid. Thus, the DRC could demonstrate "leapfrogging" at scale, and provide an example for other post-conflict countries to emulate.[69]



The World Bank and the International Development Association (IDA) have provided the Government of **Lesotho** with up to US$52.9 million in funding for the implementation of the Scaling Up Renewable Energy Programme. It will improve access to energy for people living in rural areas and in the outskirts of urban areas, small and medium enterprises, and off-the-grid economic centres. IDA and the World Bank will also provide technical assistance to build the capacity of both public and private sectors to ensure sustainable provision of electricity in Lesotho. The Lesotho Electricity Corporation will upgrade hydro-based mini-grids, provide new metering for new and existing households as well as extend its grid to commercial and industrial consumers. The project will strengthen the legal and regulatory frame-

[67] Annual Development Effectiveness review (2015) Level 1 Development in Africa, available at https://www.afdb.org/fileadmin/uploads/afdb/Documents/Development_Effectiveness_Review_2015/ADER_2015__En__-_Level_1.pdf
[68] https://nextbillion.net/drc-energy-urban-development/
[69] https://nextbillion.net/drc-energy-urban-development/

work for the deployment of mini-grids and help finance the construction of mini-grid infrastructure to provide electricity services to new users in up to 40 communities.[70]



Mauritius currently depends on expensive energy imports. It has set a target to achieve 35% renewable energy by 2030. It is also conducting research on ocean energy. The country has announced key projects to accelerate its shift to clean and renewable sources of energy. Mauritius also plans to increase the share of local renewable energy in the energy mix to 40% by 2030. The new projects include: setting up of a two megawatt floating solar photovoltaics (PV) plant at the Tamarind Falls reservoir; increasing the capacity of the solar PV farm at Henrietta from two megawatts to ten megawatts; installing 1000 solar panels on houses of low-income families; and commissioning a battery energy storage system of 14 megawatts. The COVID-19 pandemic presents an opportunity for Mauritius to accelerate the shift away from imported energy. In the aftermath of the pandemic, reliable electricity will be crucial to support businesses and boost the economy.



Police check IDs as people enter a shopping mall during the COVID-19 pandemic in Mahebourg, Mauritius, in May 2020.
Photo courtesy of Doreck Clair/AFP via Getty Images

Attitudes in **Comoros** towards electricity policy have also shifted. The authorities want to replace decades of reactionary decision-making with a proactive approach, so they have been looking at renewable energy, particularly solar PV with battery storage. A number of private sector-led projects have cropped up and the European Union is funding a 300 kilo-watt pilot scheme in Mohéli. Such projects, alongside plans for a ten megawatt geothermal plant at Karthala, could transform the Comoros energy sector, which currently relies on partially-operational diesel plants. However, some worry that both private sector interest and international donor support could dry up should the political situation deteriorate, or in the wake of COVID-19.[71]





Malawi has an opportunity to achieve 100% access to electricity by 2030 according to a sustainable energy study recently launched in the country. With a population of 17.6 million people, the African nation lags behind much of the world on energy access with just 11% of its population able to access grid electricity. For those connected to grid power, supply remains largely unreliable. Accelerating energy access has clear benefits to poverty eradication efforts, climate change mitigation, health, water, and economic transformation.[72] The country has a high potential for solar and new hydro technologies to enter into the power market. Malawi's energy sector has undergone important sector reform efforts recently, including the unbundling of the national utility, the Electric Supply Company of Malawi (ESCOM). The Government of Malawi is conducting a restructuring exercise of the power market with the intention to IPPs to enter the market.



Coal still dominates **South Africa**'s indigenous energy resource base. Internationally, coal remains the most widely used primary fuel, accounting for about 36% of the total fuel consumption of the world's electricity production. Coal provides 77% of South Africa's primary energy needs, whilst renewable energy sources generate just 8.8%. In 2011, South Africa launched its Renewable Energy Independent Power Producer Procurement Programme (REIPPPP), which its leaders

[70] https://www.smart-energy.com/industry-sectors/policy-regulation/52-9-million-in-funding-to-improve-access-to-energy-for-basotho-people-lesotho/
[71] https://www.africa-energy.com/case-study/comoros-political-instability-threatens-energy-sector-recovery
[72] http://unohrlls.org/news/malawi-has-an-opportunity-to-achieve-100-sustainable-energy-access-by-2030/

see as a big success. REIPPPP signed 27 power purchase agreements in June 2018 and plans to add 19 400 megawatts of new renewable generation by 2030 according to the draft updated Integrated Resource Plan (IRP) released in August 2018.



South Africa: Village gardens grow food to reduce carbon footprint

A group in Limpopo has discovered that one of the best ways to reduce greenhouse gases may also be one of the simplest: local agriculture and food production. The Reakgona Disability Centre at GaMabiloane village in Polokwane works with disabled adults in its community to grow vegetables.

The centre began the project in 2012 and it now includes 28 women and 20 men who take part in soil preparation and fertilisation, weed control, pest control, and other gardening care.

After harvesting, the group also sell their produce at the local market. Partners involved in the project include the Limpopo Department of Social Development and the Department of Agriculture, which supplies advice, seeds for farming, and a space to farm.

Ward councillors and ward committee members also help at the centre, which runs on a membership basis and uses monthly R100 contributions instead of donor funding to pay the bills. The membership fees also help provide seeds and garden tools.

The success of the project means the community members no longer need to travel into town to buy imported produce, which reduces the village's carbon footprint and helps support local jobs and a sense of community solidarity.

Source: Ruth Sethosa as part of a submission for the SADC Protocol@Work Gender Links Summit 2019

Adaptation in the water sector

Although all sectors must deal with the impact of climate change, it affects water resources more than most. Already unreliable in much of the SADC region, experts predict that access to water will become more challenging due to climate change. Water scarcity challenges have already intensified in recent years thanks to disrupted rainfall patterns, increased evaporation loss, and increased demand. Consequently, the SADC Secretariat has been working to develop a Climate Change Adaptation (CCA) Strategy for the Water Sector. It aims to minimise the impacts of climate change through adaptive water resources development and management.

The CCA strategy recognises that water issues impact a range of sectors, including energy,

[73] https://southerntimesafrica.com/site/news/global-climate-challenges-a-sadc-cry-for-water-energy-and-food-security

health, and agriculture. Likewise, adaptation measures require diverse levels of governance and management oversight. Therefore, water use in the region needs an Integrated Water Resources Management (IWRM) approach, which offers a goal-oriented system of controlling use of water as a means of slowing the effects of climate change. Southern Africa is one of five global regions in the world most exposed to serious risk of flooding in coastal and deltaic areas. At the regional level, SADC has been developing a programme to respond to this.



Namibia: Local government reckons with changing weather

As residents of the driest country south of the Sahara, Namibia's leaders know they face unique risks from climate change compared to their counterparts in other parts of the SADC region.



Oshikuku experienced destructive flooding from heavy rainfall during the annual rainy season in April 2018. The community faces increased droughts and flooding due to the changing climate. Photo courtesy of The Namibian

Predicted increases in temperature and evaporation as well as increased variability of rainfall will exacerbate the existing agricultural and social challenges linked to climate change in the community. This includes intense flooding during the annual rainy season.

To mitigate changing weather patterns, the Oshikuku Town Council has established groups to fight against climate change, including a women and youth group. It includes a disaster risk management committee that distributes food to communities affected by prolonged droughts.

Councillors worry about changing weather patterns because they affect food production, wind, and rainfall. Death and disease will increase if the council cannot effectively meet the basic needs of its citizens.

Along with the women and youth group, Council established different committees to educate community members on ways to mitigate the worst effects of prolonged drought and protect enough of their crops and gardens to ensure food security.

Council has also mainstreamed climate change into its policy and legal frameworks and developed specific climate change interventions; education programmes; and capacity building to prepare community members for climate change.

The local government also allocated some of its budget to sponsor a chicken project for community food production. Gender Links worked with the council to conduct entrepreneurship training to equip community members with knowledge and capabilities to set up new green business ventures.

Source: Submitted as an entry for the Namibia summit by Oshikuku council, July 2019

Capacity

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.

Women and men have different capabilities in terms of mitigating and adapting to climate change at the individual and group levels. Education, gender roles, division of labour and income shape the options available to women and men to convert to low-carbon lifestyles and related technologies. Capacity building initiatives on gender and climate change have been attempting to help close the gender gap in climate change mitigation in the region.

Uncovering the dynamics of power relations helps stakeholders understand why some groups contribute differently to greenhouse gas emissions and why climate change affects some differently than others. It also allows for an analysis of the ways in which climate change mitigation and adaptation may lead to different roles and responsibilities in the future. All stakeholders must consider these to identify solutions that draw on the skills, knowledge, resources and experiences of both sexes.

Stakeholder engagement

Protocol on Environmental Management for Sustainable Development 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.

A number of global campaigns now collaborate to raise the issue of gender and climate change with the objective to fight for gender justice alongside activism for action to address climate change. Most of these campaigns highlight the disproportionate impact of climate change on women, including the poorest and most marginalised women throughout the developing world who represent the group that has contributed least to global warming.

Gender and climate justice

The Women's Global Call for Climate Justice global campaign brings together a group of regionally diverse women's rights and feminist organisations to address the urgent need for just action on climate change. Since its launch, the campaign has become a platform for hundreds of women's rights organisations and thousands of activists and allies to demand climate justice.

Women Building Power (WoMin) represents working-class women impacted by extractives industries in more than 12 African countries. The campaign's work supports women's organisations towards a future in which African women enjoy climate, energy, food, gender, and development justice. Activists in the group have rooted their current campaigns in grassroots struggles led by women in four countries - the DRC, Nigeria, South Africa, and Uganda. This women-led, women's rights campaign against exploitative fossil fuel and extractive industries supports movement-building in these specific localities and at national and global levels. It unifies women's struggles across localities and countries through a common set of political demands.[74]

Earthlife Africa climate change campaign mobilises women and youth on climate change issues. It provides support to these often-marginalised groups to engage the government, the UNFCCC, and other international agencies in implementing climate change mitigation and adaptation policies. It helps create environmental awareness amongst citizens on the detrimental impacts of nuclear and coal, whilst promoting the uptake of cleaner and low-cost renewable energy technologies. It has partners in South Africa and the other BRICS (Brazil, Russia, India, China, and South Africa) countries. Earthlife is a member of the Friends of the Earth International.[75]

Voice and Choice campaign: Gender Links leads the #VoiceandChoice campaign at both local and national levels to highlight the need to include women in climate change decision-making, financing, adaptation, and policy-making. Gender Links' Centres of Excellence lead the fight against climate change through their gender-responsive action plans.



Members of Earthlife demonstrate against fossil fuel energy in Johannesburg in 2018. Photo courtesy of Google Images

Youth and climate justice

Youth involvement in climate justice policy-making is crucial. Policies need to be gender-sensitive and pro-youth, with focus on women and children, especially those in rural areas. As the future is theirs, young people need to be involved in local climate adaptation funds and national action plans. These action plans should also include all citizens in research and development; planning and policymaking; knowledge and capacity development; and enhancing women's participation in climate change adaptation.[76]

[74] https://womin.org.za/who-we-are/what-is-womin.html
[75] Earthlife campaigns page, accessed from https://earthlife.org.za/campaign-climate-change/ on 11 July 2020.
[76] UNFCC, Guidelines and Submissions for gender and youth involvement in National Action Plans on Climate Change, 2019 accessed from https://www4.unfccc.int/sites/SubmissionsStaging/Documents/201904231521---PHL%20Submission%20-%20Gender%20and%20Climate%20Change.pdf on 10 July 2020

Key areas for youth involvement in gender-responsive climate change policymaking and planning include:

- Disaster response, including responding to events like the COVID-19 pandemic;
- Gender-sensitive impact studies;
- Conducting gender needs assessments;
- Systematic application of gender mainstreaming methods in adaptation and mitigation interventions;
- Use of gender-responsive monitoring and evaluation methods that will collect data from youth;
- Fostering gender equality in green job creation and promotion;
- Designing gender-responsive climate actions to enhance access to climate finance;
- Gender-responsive climate budgeting;
- Identification of community-based organisations to form communities of practice and knowledge exchanges that strengthen young women leadership in the grassroots; and
- Knowledge management.



South Africa youth climate activist Ayakha Melithafa
Photo courtesy of Google Images

Youth such as 17-year-old South African climate activist Ayakha Melithafa have demonstrated they have the capacity and drive to challenge outdated policies and approaches to climate justice. In January 2020, Melithafa told the 50th annual World Economic Forum in Davos, Switzerland, that climate change connects to other chronic global problems like poverty, inequality, xenophobia, and GBV. The Grade 12 student at the Centre of Science and Technology in Khayelitsha shared a stage at the event alongside other youth activists, including Sweden's Greta Thunberg. In Davos, she used her platform to inspire social and climate activism in her community, speaking out against the country's polluters. She also called on the South African government to cut its carbon emissions and plan a just transition to a greener economy and future.

Melithafa works as a recruitment officer and spokesperson for the African Climate Alliance, a youth-led climate advocacy group. A graduate of Project 90 by 2030's YouLead Initiative, which selects youth environmental leaders, she also received a bronze President's Award for Youth Empowerment medal in 2019. In September 2019, Melithafa joined a group of 16 children and youth, including Thunberg, to file a groundbreaking legal complaint to the UN Committee on the Rights of the Child.

The group aimed their petition at the biggest climate polluters among the signatories to the UN Convention on the Rights of the Child. It documents how , in early 2018, Cape Town residents prepared for "Day Zero," when government planned to switch off the city's water supply to nearly four million residents. Melithafa says the climate changes she experiences in Cape Town make her feel "sad and angry" and she worries about a "miserable future." In September 2019 the climate activist told the Saturday Star: "The world is starting to listen to us, and more old people have stopped seeing what we are doing as a rebellious act."

Sadly, youth leading the movement at Davos also faced the unfortunate reality that their generation will also continue to confront racism alongside their fight for environmental protections. In an episode that reflected media bias and made headlines around the world, Ugandan climate change activist Vanessa Nakate called out the Associated Press after she noticed she had been cropped out of a photograph, where she appeared alongside Thunberg, and youth activists Isabelle Axelsson, Luisa Neubauer and Loukina Tille.

"Africans have truly been erased from the map of climate action," Nakate said during an interview with CNN, noting that it points to the wider issue of erasing African voices from discussions about climate change. "Very many African activists have been doing a lot of work, putting in a lot of effort, trying to get their message heard and listened to... It was the first time in my life that I understood the definition of the word 'racism.'"[77]

[77] https://www.cnn.com/2020/01/30/africa/uganda-activist-vanessa-nakate-cropped-intl/index.html

Nakate received an outpouring of support on social media and the incident forced AP to apologise. Coupled with global protests against anti-Black racism in early 2020, the incident shines a spotlight on the numerous concurrent battles that many African youth activists must fight as they carve space in a Western-dominated dialogue to raise their voices and speak out about climate change, inequality, and racism.



Vanessa Nakate, left, appeared at a joint press conference in Davos in 2020 with other well-known youth climate activists. When the AP published a picture of the event, she had been cut from the image.
. Screen grab comparing the edited AP image with the original photo

Next steps

- The region needs to capitalise on the positive environmental impacts of the COVID-19 pandemic and use it to inform strategies to combat climate change.
- Reflection on the COVID-19 responses, or lack of, must inform how the SADC region shapes climate change adaption for generations to come. Country policymakers should focus on building a future that uses a gender lens and addresses the concerns of the most vulnerable members of society.
- Many SADC countries demonstrated that they could flatten the COVID-19 curve and in some cases almost eliminate the virus; they should apply the same urgency and ingenuity to fight climate change, which will have even more devastating impacts.
- Climate change could soon become the worst crisis of our times. Countries in the SADC region should appreciate the collective vulnerability and responsibility and act accordingly. Its consequences will shape the region for many centuries to come.
- Economic stimulus packages, recovery plans and company bailouts put forward by countries in the SADC region to fight the economic consequences of the COVID-19 pandemic should include incentives for building a greener and healthier future. Green recovery packages should address both the impacts of the COVID-19 pandemic and the ongoing climate crisis.
- Both climate change and the COVID-19 pandemic rely on scientists and experts, and thus leaders must unite behind the science and not play politics.
- All the key stakeholders in the SADC region (governments, businesses, civil society, and citizens) should take advantage of this historic moment to change the course of the future by investing in technologies that prevent and address the systemic risks and vulnerabilities caused by climate change. Now is the time to drastically reduce carbon emissions and improve resilience to future pandemics and climate-related emergencies.
- Leaders must nominate more women to represent the region at international climate change events as well as on regional and national bodies that address climate change.
- SADC countries should invest in raising awareness about climate change and spreading accurate facts and science to counter misinformation that puts lives at risk.

ANNEX A
TECHNICAL NOTE: METHODOLOGY FOR SCORING THE SADC SRHR SCORE CARD

In November 2018, SADC member states approved the SADC Regional Strategy and Scorecard for Sexual and Reproductive Health and Rights (SRHR) 2019-2030. The SRHR Scorecard is an important monitoring and evaluating tool that set targets as articulated in the Sustainable development Goals (SDGs), descriptions, outcomes and frequency.

The Score card consists of 20 key indicators that covers sexual and reproductive health; comprehensive sexuality education; HIV and AIDS; gender-based violence; child marriage and safe abortion.

The indicators will be divided into two groups. One those that have global or regional target and those that do not. The indicators will be measured using a 'Traffic light' approach:

- GREEN = Member State has achieved the target;
- YELLOW = Progress made but more efforts required to achieve the targets;
- RED = Urgent action required if targets are to be met.

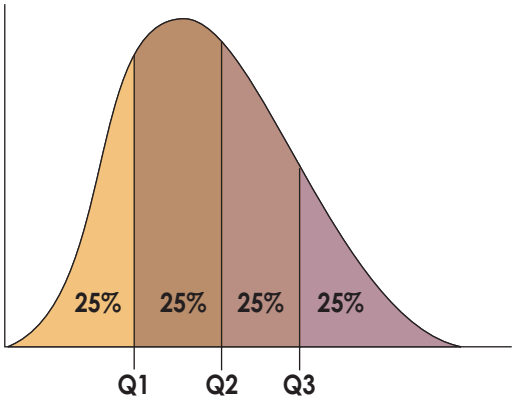
Where global target exists, data from the 16 SADC member states will be used as the initial regional baseline and progress measured year on year. The dataset is sorted in ascending or descending order depending on the nature of the indicator.

Where targets do not exist, the data is divided into three parts. The dataset will be divided into three sections using the interquartile range:

- 1st quartile will consist of the GREEN color - best performers.
- Values in between the 1st and 3rd quartile will fall under the YELLOW color.
- Those below the 3rd quartile will fall under the RED color - worst performers.

The diagram provides the method for calculating the four quartiles.

Determination of Cut-off points



- Sort scores low to high or vice versa.
- Calculate Q1 by dividing the sum of country scores by 4.
- Calculate Q2 by multiplying Q1 by 2.
- Calculate Q3 by multiplying Q1 by 3.
- Calculate Q4 by multiplying Q1 by 4.
- Add the firs score to the second and second to the third and so on.
- Compare the recalculated scores to the Q1 to Q4 scores to determine the colour allocation.

Indicator	Means of verification	Sources of data
1. Maternal mortality, institutional (to be complemented with population-based estimates or survey data, where available).	Comparison against global target 70 per 100 000	The World Health Organisation (WHO)
2. Neonatal mortality, institutional (to be complemented with population-based estimates or survey data, where available).	Comparison against global target 12 per 100	The World Health Organisation (WHO)
3. Percentage of obstetric and gynecological admissions due to abortion, b) Facility records for the treatment of abortion complications.	Health facilities admission data	Quantifying data is difficult, health facilities record admissions as obstetric or gynaecological complications
4. Adolescent birth rate, 10-19 years of age.	Country health data	The World Health Organisation (WHO)
5. Proportion of population accessing integrated SRH services (total population).	Country health data	Definition of integrated SRHR services unclear; data is not recorded in health facilities
6. Existence of laws and policies that allow adolescents to access SRH services without third party authorization.	Laws exist or not	National laws and policies
7. Percentage of primary and secondary schools that provided life skills-based HIV and sexuality education in the previous academic year.	Country education data	This data is currently not measured annually
8. Unmet need for family planning (contraception).	Country health data	The World Health Organisation (WHO)
9. Percentage reduction in new HIV infections, females 15 - 24.	National HIV and AIDS data	UNAIDS
10. Mother to child transmission of HIV	National HIV and AIDS data	UNAIDS
11. Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age.	National HIV and AIDS data	UNAIDS
12. Sexually transmitted infections (STIs) incidence rate, using the overall rate of syphilis, given the impact of syphilis on sexual and reproductive health outcomes.	Country health data	Country level data on STIs is not consistently gathered or available in central repository
13. Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (age).	Country health data	The HPV is not widely available in health facilities
14. Minimum legal age of consent to marriage, 18 years for all irrespective.	Age of marriage legal provisions	National laws and policies
15. Legal status of abortion	Abortion available on demand or not	National laws and policies
16. Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months.	Country GBV prevalence data	Demographic Health Surveys (DHS); not done annually or at regular intervals
17. Non-partner sexual violence prevalence	Country GBV prevalence data	Demographic Health Surveys (DHS); not done annually or at regular intervals
18. Percentage of annual budgets allocated to health sector	Abuja Declaration recommends 15%	National budgets
19. Health worker density and distribution for SRMNAH	Statistics from health facilities	Departments of Health, health workers provide a broad of services and it is not disaggregated by area of work
20. Proportion of services within the essential package of SRHR services covered by public health system	SRHR services offered at health facilities	Departments of Health, health workers provide a broad of services and it is not disaggregated by area of work

Key issues on scoring

- ***Data gaps and anomalies:*** On certain indicators data is not being collected in a manner that will enable its measurement. In some instances, data does not exist. Some indicators require annual measurement but the data is gathered over a different time period.
- ***When global or regional targets exist:*** If targets are met it is green however how yellow and red be determined. What are the cut off scores that determine where the result should be located? There should guidance on for the different indicators.
- ***Measuring policy or legislation:*** A policy or legislation exists or does not. Does that imply that the result is a green or a red? Or, for example, abortion legislation, does it refer to abortion on demand?
- ***Measuring numerical indicators that are not standard:*** For example, the age of marriage. While countries stipulate that 18 is the age of marriage they provide for exceptions. Guidance is needed on how to interpret the data.
- ***Calculating scores where no target exists:*** The scores are calculated using a quartile system. This means that scores are calculating using a four-part measurement system. The calculations are made using the countries performance scores and working out where countries are by comparing country to country without establishing what the optimum target is. Working out what a good or bad performance is, is relative to other countries. In this regard, a fixed target might be a better option.
- ***Colour coding ranges where no target exist:*** Green in this instance are the best performers and red the worst. The challenge is in the yellow classification. Yellow includes quartiles two and three. This creates vastly varying set of scores that are grouped together. The lower end of quartile three is often closer to the red zone. Splitting the two quartiles will provide a more accurate representation of the score.

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The SADC Protocol on Gender and Development

Encompasses

commitments made in all regional, global and continental instruments for achieving gender equality.

Enhances

these instruments through a Monitoring, Evaluation and Reporting Framework.

Advances

gender equality by ensuring accountability by all SADC Member States, as well as providing a form for the sharing of best practices, peer support and review.



Southern Africa Gender Protocol Alliance

Scoring another goal for gender equality, the 2019 SADC Gender Protocol Barometer breaks with past tradition in focusing solely on Sexual and Reproductive Health and Rights. Measuring 100 indicators across seven themes, the Barometer is the first civil society shadow report on SADC's new SRHR Strategy Score Card, ranking countries based on their performance, while offering detailed analysis and insights into what is changing and still needs to change. The no-hold-barred #VoiceandChoice Barometer features the first stand-along chapters on Adolescent Sexual and Reproductive Health and Rights, Safe Abortion, and Sexual Diversity. It provides the data that underpins 40 national campaigns led the focal networks of the Southern African Gender Protocol Alliance, and 174 local campaigns led by the Centres of Excellence for Gender in Local Government. A must read for all those committed to *Action and Results for Agenda 2030* in the SADC region.

Yes we can and yes we must!



Community peer educators from Let us Grow in Orange Farm champion the Sunrise Campaign - End Violence, Empower Women.
Photo: Thatho Phakela

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