Introduction 1



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

KEY POINTS

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



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

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

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

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

COVID-19 and SADC

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

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

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

Source: GitHub[1] August 2021.

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

COVID-19 and Women's Rights



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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

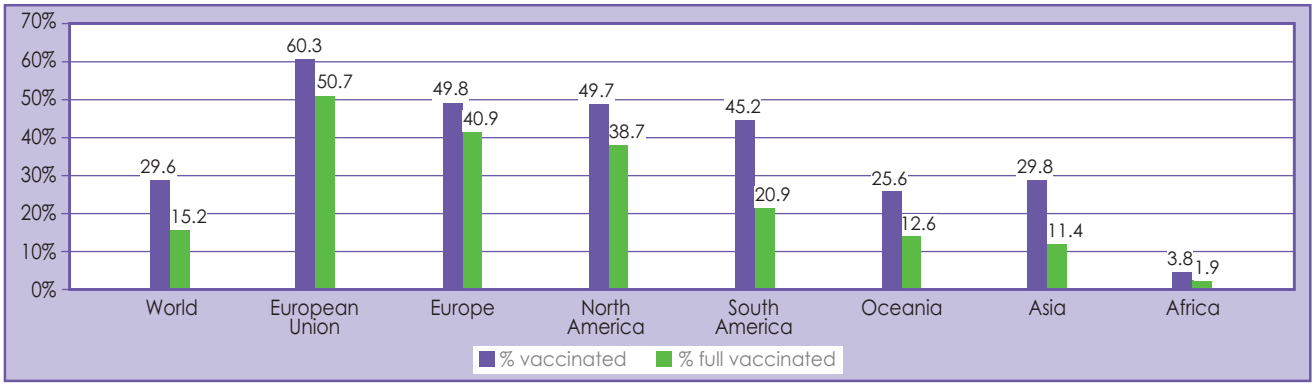
Climate change will make future disasters and epidemics, such as COVID-19 inevitable, pushing millions of women and girls even further into poverty. It will challenge the fragile **economic gains** made by women, unless the complete disruption of the economic and eco system can be used to create a "new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

Vaccine apartheid

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

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

Fig 1.1: COVID-19 "global apartheid"



Source: GitHub[15] August 2021.

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

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

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

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

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

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

A global health and human rights issue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1.3: Vaccine roll out in SADC August 2021

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

Source: GitHub[33] August 2021.

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

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



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



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

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

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

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

Vaccine allocation - *Fair, equitable and timely*

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

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

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

Table 1.4: Comparison of vaccines in use in SADC

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

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

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

Sources: Biospace and BBC News.[39]

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

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

Table 1.5: Vaccines in use in SADC

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

Source: Africa CDC.[40]

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

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

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



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

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

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

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

Civil society response



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

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

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

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

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

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

Women's rights and vaccine roll-out



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

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

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

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

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

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

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

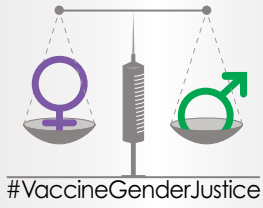
Biological sex is relevant and sex-disaggregated analysis important for a range of different reasons. A growing body of research highlights the influence of biological sex in clinically relevant health outcomes, including sex-specific differences in immunity, pharmacology, and vaccines outcomes (side-effects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

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

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

#VaccineGenderJustice call to SADC Heads of State, August 2021

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



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

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

Call on Heads of State to

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

#VoiceandChoice; #VaccineGenderJustice

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

Global commitments to gender justice



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

The specific goals referred to in this Barometer are Goals three (Good Health and Well Being), five (Gender Equality) and goal 13 (Climate Action - reducing greenhouse gas emissions and investing in climate resilience). Goal 3 of the SDG includes SRHR targets of reducing maternal mortality, child mortality, ending AIDS, tuberculosis, malaria, tropical diseases, hepatitis, and other communicable and water-borne diseases,[49] universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

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

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

GENERATION EQUALITY

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

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

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

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

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

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

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

The summit's 12 global commitments highlight three zeros:

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

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

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

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

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

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

The African context



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

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

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

Goal three of the **African Union Agenda 2063** aims to increase 2013 levels of SRHR Services to women by at least 30%. Agenda 2063 provides for equal, affordable and timely access to independent courts and judiciary that deliver justice without fear or favour. The 2009 AU Gender Policy provides for non-discrimination through its Commitment 2 on legislation and legal protection actions against discrimination, for ensuring gender equality. AU Agenda 2063 provides that all harmful social practices (especially female genital mutilation and child marriages) will be ended and barriers to quality health and education for women and girls eliminated. The measures include specific legislature to end harmful practices such as child marriages and female genital mutilation. Some of these practices include but not limited to child marriage and the betrothal of girls and boys for marriage, polygamy, wife inheritance, wife kidnapping, sexual cleansing of widows, female genital mutilation and virginity testing.[57]

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

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

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

SADC context

The **Southern African Gender Protocol Alliance** (the Alliance) is a "network of networks" that campaigned for the adoption of the SADC Protocol on Gender and Development (the Protocol) in 2008 and its updating in 2016 to align to the SDGs. Attesting to the vital role of civil society in campaigning for gender justice in the region, the SADC Gender Protocol is the only one of the 26 SADC Protocols that have been updated; also the only Protocol that is accompanied by a Monitoring, Evaluation and Results Framework. The Alliance has spearheaded women's political participation and SRHR campaigns including during the COVID-19. Each year since 2009, the Alliance has produced a Barometer, using the Protocol as the main standard setter for gender equality in the region. Although the #VoiceandChoice Barometer draws from a range of normative frameworks, the SADC Gender Protocol is the key yardstick in all barometers because this instrument incorporates all the existing continental and global commitments to gender equality.

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

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

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

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

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

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

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

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

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

In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 **SADC member states approved the groundbreaking SADC Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030** and corresponding Score Card to measure progress. The Strategy provides a framework for the member states to fast-track SRHR in the

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

region. It will support the vision of the SADC Regional Indicative Strategic Development Plan (RISDP) 2015-2020 of a shared future within a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom, social justice, peace and security for its peoples.[60]

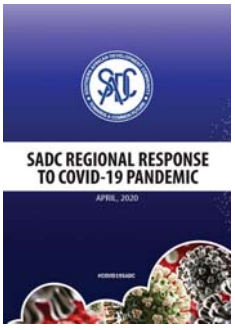
The Alliance also worked with the SADC Women's Parliamentary Caucus, SAfAIDS and the Southern African Aids Trust to lobby for the SADC SRHR strategy 2019 to 2030 and annually host national consultations on its implementation. The parallel mapping of laws for the #VoiceandChoice Barometer provides a rich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

The SADC SRHR Strategy builds on the Sexual and Reproductive Health Strategy 2006 - 2015. The current strategy moves from a service focus to a rights-based approach. This illustrates an important shift to recognising people's human rights as the centre of development and achieving higher levels of well-being in SADC. Ministers approved the first ever SADC **multi-sectoral score card** to measure progress in achieving implementation of the strategy and the sustainable development goals.[61]

The key targets of the strategy are:



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



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

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

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

The #VoiceandChoice campaign

SADC Protocol@Work Summit

Sommet Protocole au travail de la SADC

Cimeira do Protocolo@Work da SADC

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

The campaign aims to:

- Ensure that SADC citizens including key populations have access to an essential package of SRHR services and that these are included into Universal Health Care strategies.
- Contribute towards positive policy change that will ensure equal access to good quality SRHR across SADC.
- Contribute towards the attainment of the SRHR regional and global commitments.
- Foster a culture of inclusivity through embracing key populations and other vulnerable groups.
- Hold governments accountable on investment in health through ongoing monitoring, lobbying and advocacy.
- Use multi-media platforms to raise awareness of effective SRHR to key populations, women and adolescents.
- Create a strong network of SRHR advocates through the SADC Protocol Alliance SRHR cluster.
- Build a body of knowledge on good SRHR practices through national *#VoiceandChoice* summits.



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

In August 2018 the Alliance focal networks in 15 SADC countries[63] and representatives from the 400 Centres of Excellence (COEs) for Gender in Local Government[64] met to map out joint strategies for attaining SRHR in SADC countries. Over the last two years, with the support of the Amplify Change Fund, national and local partners have developed SRHR campaigns in eight thematic areas including menstrual health; maternal health; comprehensive sexual education (CSE) and services; teenage pregnancy, safe abortion; HIV and AIDS; child marriage; GBV and sexual diversity.

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

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

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

N=National; L=Local

Source: Southern Africa Gender Protocol National Reports.

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

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

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

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

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

The Eswatini Young Women Alliance

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



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

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

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

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

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

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

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

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

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

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

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

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

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

Methodology

Table 1.7: Structure of the #VoiceandChoice Barometer

Chapters	Relation to previous Barometer Chapters
1. Introduction	Introduction
2. Sexual and Reproductive Health	Health
3. ASRHR	Education
4. Safe abortion	Constitutional and legal Rights
5. HIV and AIDS	HIV and AIDS
6. Gender Based Violence	Gender Based Violence
7. Harmful practices	Constitutional and legal rights
8. Sexual Diversity	New since 2019
9. Women's Political Participation	Gender and Governance
10. Gender and media	Gender and media
11. Climate Justice	Climate Change

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

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

Normative frameworks

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

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

Updated Audit of SRHR Laws and Policies in SADC

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

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

Developing indicators - quantitative measures

Each chapter begins with a table of key indicators for which data could be reliably obtained across the 16 countries. The three primary sources of these indicators are:

- **Empirical data** from credible sources to establish baselines and measure progress. This comes from UN Agencies such as UNAIDS, the WHO; UNFPA and UNESCO.
- **Gender attitudes:** Each year Alliance partners administer the Gender Progress Score (GPS) or Attitudes Survey that gauges prevailing gender attitudes amongst the public using a 25-question survey. Eight of these questions are relevant to SRHR. They help to gauge public attitudes on topic issues such as safe abortion and sexual diversity that in turn play a critical

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

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

Table 1.8: Classification of SRHR indicators

Thematic area	Emperical data	Public attitudes	GRA	TOTAL	Quantitative indicators from the SADC SRHR Scorecard for which data could be sourced	Quantitative indicators in the SADC SRHR Score card
Sexual and reproductive health	20	0		***20***	5	11
Adolescent SRHR	5	0		***5***	1	1
Safe abortion	3	1		***4***	1	2
HIV and AIDS	23	1		***26***	3	3
Gender-based violence	12	4		***16***	1	2
Harmful practices	5	0	7	***12***	1	1
Sexual Diversity	15	2		***17***	0	0
TOTAL	***85***	***8***	***7***	***100***	***12***	***20***

Table 1.8 shows that:

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

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

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

Qualitative data

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

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

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

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

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

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



Rapid response on SRHR

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

Limitations

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

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