SADC GENDER PROTOCOL 2022

BAROMETER

Voice + Choice

including a mapping of SRHR WRO in Southern Africa

Southern Africa Gender Protocol Alliance

Colleen Lowe Morna and
Danny Glenwright

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

Gender Links coordinates the work of the Alliance.

#VoiceandChoice Barometer
ISBN

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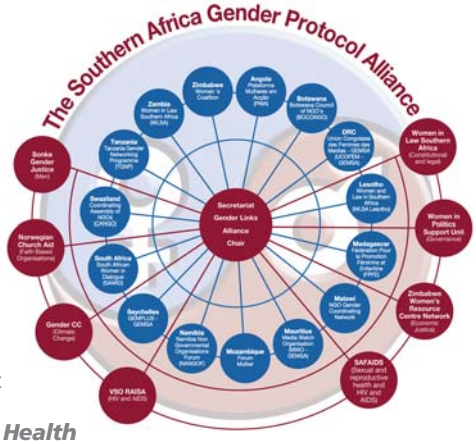

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FOR EQUALITY AND JUSTICE

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FOREWORD

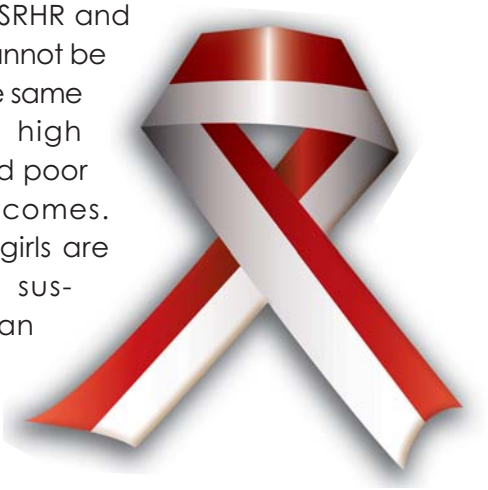
By Anne Githuku-Shongwe Director, Regional Support Team, East and Southern Africa, Joint United Nations Programme on HIV/AIDS (UNAIDS)

The #VoiceandChoice 2022 Barometer, a flagship publication of the Southern Africa Gender Protocol Alliance, is being launched in October 2022 at a time when we are emerging from the dark shadow that COVID-19 cast across our region and the world.

COVID-19 posed serious challenges and disruptions to key global, regional and national systems and services. HIV prevention, testing and treatment suffered in the midst of drug stock outs owing to supply chain challenges. The lock downs brought about heightened shadow pandemics - gender based violence, sexual violence and teenage pregnancies all increased. Hundreds of thousands of teenagers fell pregnant, and have not returned of school, with reduced options for their own future as well as that of their children. Most of the recorded "teen pregnancies" are a result of rape, defilement, and abuse yet somehow, this part of the narrative is not substantively covered in reports and other data collection avenues. Even more concerning is the fact that the perpetrators are often not held accountable. We need to do better!

East and southern Africa remains the region most heavily affected by HIV, with 20.6 million people, 54% of all people living with HIV in the world. Although substantial regional progress has been made with the number of new HIV infections among all ages declining by 44% from 2010 to 2021 (38% among women versus 52% among men), this progress is slower than what is needed to reach 2025 targets.

The UNAIDS report released in August 2022 warned that the world is *In Danger* of not being able to end AIDS as a public health threat by 2030. COVID-19 accentuated inequalities, deepened vulnerabilities and heightened the risk of HIV infection for vulnerable populations. Key populations, including adolescent girls and young women, recorded high rates of new infections. Women and girls continue to be disproportionately affected by HIV, accounting for 63% of the region's new HIV infections in 2021.



The bi-directional linkages between HIV, GBV, SRHR and gender inequality cannot be overemphasized. The same groups recording high cases of GBV, record poor HIV and AIDS outcomes. While women and girls are biologically more susceptible to HIV than men and boys, unequal gender power dynamics and harmful gender norms are the root cause. This is compounded by intersecting forms of discrimination that include income, education and access to SRHR services. Gender Inequality and GBV have been shown to increase the risk of

acquiring HIV infection for women and girls. According to our UNAIDS Data in some regions, women who have experienced physical or sexual violence are 1.5 times more likely to acquire HIV than women who have not experienced such violence.

This edition of the Barometer highlights changes in the law in Mauritius and Zimbabwe to outlaw child marriage, policies in several countries that make menstrual products more easily available; South Africa adopting sign language as an official language. These changes show that change is possible.

The Barometer also highlights that there has been no change to legislation that criminalises consensual same sex sexual acts or sex work. Further, many SADC member states cling to legislation derived from archaic colonial legislation on abortion. To protect the health and wellbeing of those that can become pregnant the World Health Organisation has recommended that abortion should be treated as a health procedure, decriminalised and not governed by penal or criminal laws.

We urgently need to realise human rights and gender equality. The human rights of women and girls, including their sexual and reproductive rights, must be upheld and violence and harmful social norms abolished. Punitive, discriminatory, and counterproductive policies, particularly against vulnerable key populations such as sex workers, gay men and people who inject drugs, must be removed and reformed.

Some of the changes that we need to make urgently include our attitudes and stigma towards those that are different in any way to us - whether that is in age, in ability, in gender, or in having a different gender identity. We need to review laws that should protect the rights of widows, those accused of witchcraft, children who are at risk of being married, those that sell sex or those who need abortion services. We need to prioritise realisation of the basic human rights to protection, education and health services of all people. We cannot allow patriarchal and outdated traditions and attitudes to force large groups to be forcefully marginalised.

In building back better, we need to embrace long term approaches that empower women and men on many different levels. One of these is the *Education Plus* initiative, launched by President of Zambia and other Heads of States in partnership with the Organisation of African First Ladies in Zambia earlier this year at the AU Summit of Heads of States, as a measure to prevent HIV. The initiative aims to enable all girls and boys to complete a free, quality secondary education with universal access to comprehensive sexuality education, fulfilment of SRHR, freedom from gender-based and sexual violence, school-to-work transitions, and economic security and empowerment for women.

We need to expand this programme to include those that have dropped out of school due to unintended pregnancy. We need to encourage boys and men to engage as equals with women in SRHR matters and to prioritise their own sexual and reproductive health.

We celebrate the launch this year by Gender Links of the Voice and Choice Southern Africa (VCSA) Fund with generous support from Amplify Change. The VCSA Fund will support grassroots activist groups working on different aspects of SRHR in Lesotho, South Africa and Zimbabwe. It will also support several approaches to building movements in member states across SADC to promote community engagement in SRHR. Voice is a prerequisite for choice. Voice and choice are prerequisites for the #GenerationEquality we work together to achieve by 2030.

CONTRIBUTORS

EDITORIAL TEAM

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

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

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Susan Tolmay (South Africa) is a feminist and human rights activist committed to social, economic and environmental justice, with 15 years' experience working in a regional and international NGO environment. She returned to Gender Links as the Governance and Justice Manager after ten years working for international women and human rights organisations AWID and Amnesty International, where she managed women's rights

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

Lynette Mudekunye MAAS, MPH (Zimbabwe/ South Africa) is public health specialist who is now an independent consultant having worked in Southern Africa with several NGOs. Her work has focused on psychosocial support, children's and adolescents' rights, HIV and SRHR. She has been involved in developing training resources, advocacy and programme development in South Africa, Zimbabwe and regionally.She wrote the HIV and AIDS as well as the Safe Abortion chapters of the SRHR Barometer under guidance from the Southern Africa AIDS Dissemination Service SAfAIDS, a regional non-profit organisation whose vision is to ensure that all people in Africa realise their sexual and reproductive health rights (SRHR) and are free from the burden of HIV, TB and other related developmental health issues. In recognition of the role that stigma and discrimination, gender inequality and related social structures and norms play in driving the epidemic and creating barriers to access to services in southern Africa. The organisation works to address gender equality and the rights of women, girls and key population groups, to access sexual reproductive health services and rights by confronting complex issues like culture, human rights and stigma.

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

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

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


WIN THE FIGHT
#WTF
RAPE
WOMEN IS
RAPE MUST
FALL
NASA
GIVE HOPE
INSPIRE LIFE

EXECUTIVE SUMMARY

Women march against GBV, South Africa 2021. Photo: Colleen Lowe Morna

This 14th #VoiceandChoice Barometer reflects slow progress in the region's Sexual and Reproductive Health and Rights (SRHR) and women's rights. SADC countries have registered the greatest progress on the minimum legal age of consent to marriage at 18 years for women and men and reduction of mother to child transmission of HIV. The region still needs to accelerate commitments to reducing HIV infections, increasing the extent of HPV vaccine dosage coverage, and ending gender based violence.

The Barometer continues to measure progress against the 100 SRHR indicators in seven thematic areas: sexual and reproductive health; adolescent SRHR; safe abortion; GBV; HIV and AIDS; harmful practices and sexual diversity.

Despite the threat of the COVID-19 pandemic to SRHR, governments in November 2021 issued their first progress report on the Southern Africa Development Community (SADC) SRHR Strategy using the **Scorecard on SRHR** adopted by Health Ministers in 2018. SADC expects Member States to report every two years on progress made against the Scorecard over the next ten years in the lead up to 2030 the target date for achieving the Sustainable Development Goals (SDGs). The SADC 2021 Milestone Scorecard is the first set of results using baseline data from 2019 and targets set in the strategy.

The SADC Score Card is a high-level peer-review accountability tool, consisting of 20 key indicators for accelerated action on the ten outcomes of the strategy. The scorecard, which is available online[1], is a graphic display of countries' progress in achieving the targets by indicating upward or downward movement and by colour coding to indicate where targets or milestones have been achieved or not.

[1] https://dev-www.sadc.int/srhrscorecard/

How the SADC Scorecard and Barometer measure progress

Since the launch of the #VoiceandChoice Barometer focussing specifically on SRHR, the Barometer has used 12 of the 20 indicators that governments measure on which reliable data could be sourced across the 16 SADC countries to rank countries and assess which areas are performing better than others. This year the Barometer drew on the governments' reports and data.

GL can now co-measure 13 out of 20 indicators with sufficient data. The newest addition, important for cancer prevention, is an indicator on Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 years of age. In most cases, we have used the data provided by governments. In some instances, we added data from our research and adjusted the colour coding to match. Where changes have been made to the entire indicators, these are highlighted in red in Table I. Modifications to figures and colour coding are explained under Table I as well.

The seven indicators that do not yet have sufficient data for robust analysis in the governments' report include:

- Percentage of obstetric and gynaecological admissions due to abortion.
- Proportion of population accessing integrated SRH services.
- Percentage of primary and secondary schools that provided life skills-based HIV and sexuality education in the previous academic year.
- Sexually transmitted infections (STIs) incidence rate, using the overall rate of syphilis, given the impact of syphilis on sexual and reproductive health outcomes.
- Non-partner sexual violence prevalence.
- Health worker density and distribution for Sexual, reproductive, maternal, new-born and adolescent health (SRMNAH).
- Proportion of services within the essential package of SRHR services covered by the public health system.

The previous #VoiceandChoice Barometers had three colour codes (Green, Yellow and Red) in keeping with the SADC SRHR strategy. The first report by governments has six colours: dark green, light green, yellow, amber, red, and grey.

SDG Target achieved
2021 Milestone achieved | Achieved target: continue existing efforts to sustain and further the gains made
-1% to -14.9% | Target not achieved: sustain and expand efforts in order to reach the target
-15% to -29.9% | Target not achieved: review existing efforts and make considerable investments in order to reach the target
30% or more | Target not achieved: review and make significant efforts to achieve the target
No target set
Not applicable
No Data | No Milestone set

SADC rates countries using a 2019 baseline score from each country's latest data source. Where there is no 2019 baseline figure, the scorecard uses the available 2021 figure as the baseline.

The following tables shows the progress for each country on the 13 indicators that the GL and the SADC Scorecard co-measure.

Table I: Overview of countries by indicators, 2022

SADC SRHR scorecard	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi
Maternal mortality (population)	288	166	172	693	452	618	335	349
Neonatal mortality	24	17.9	24	27	20	34	20	20
Adolescent birth rate, 10-19 years of age	104	43.7	32	109	87	55	103	131
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	No	No	No	Yes	Yes for 12+	Yes	Yes	Yes
Unmet need for family planning (contraception)	35.7	17.3	32	27.7	15.2	18.4	16.1	19
Percentage reduction in new HIV infections, females 15-24	26	39.1	30	50	64	58.75	-159	63.6
Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (age)	NA	52.8	n/d	n/d	NA	NA	n/d	88.5
Mother to child transmission of HIV	19.2	1.75	0	23.4	3.7	5.98	39.8	2.3
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age	32.9	n/d	70	24.3	71.4	77.1	3	64.5
Minimum legal age of consent to marriage, 18 years for all irrespective	18	21 with exceptions	18	18	18	18	18	18
Legal status of abortion (2=Abortion on demand; 1=Restricted abortion; 0=Abortion not available)	1	1	1	1	1	1	0	1
Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	21.7	28	12	4.6	4.6	0.8	38	24.3
Percentage of annual budgets allocated to health sector (Abuja Declaration recommends 15%)	5.6	12.5	12	11.4	9.4	9.5	8	9.3

SADC SRHR scorecard	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Maternal mortality (population)	61	452	385	65	121	556	252	462
Neonatal mortality	10.2	28.5	20	9.1	21	25	27	31
Adolescent birth rate, 10-19 years of age	24	153.8	82	56	46.2	123	29	69
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	14+	NA	Yes	15+	Yes for 12+	Yes	No	No
Unmet need for family planning (contraception)	9.6	22	12	n/d	19		19.7	10
Percentage reduction in new HIV infections, females 15-24	24	33	48	2.6	45	35	6	66
Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (age)	n/d	n/d	NA	97	61.2	59	60	n/d
Mother to child transmission of HIV	13.7	12.36	3.8	1	2.7	6.61	n/d	8.7
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age	n/d	n/d	52	51.3	47	33.5	41.4	56.4
Minimum legal age of consent to marriage, 18 years for all irrespective	Below 18	18	21	18	18	18	21 with exceptions	18
Legal status of abortion (2=Abortion on demand; 1=Restricted abortion; 0=Abortion not available)	1	2	1	1	2	1	1	1
Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	n/d	36	33	n/d	8.7	41.7	43	39.6
Percentage of annual budgets allocated to health sector (Abuja Declaration recommends 15%)	5.5	8.7	13.6	11.7	8.1	6.7	4.5	10

Source: SRHR indicators table computed from the SADC Scorecard[2] and global data sources.

[2] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030. https://public.tableau.com/views/SADCSRHRSCORECARD2021_EN_FR_PO_16360021643560/2021English?:embed=y&:showVizHome=no&:host_url=https%3A%2F%2Fpublic.tableau.com%2F&:embed_code_version=3&:tabs=no&:toolbar=yes&:animate_transition=yes&:display_static_image=no&:display_spinner=no&:display_overlay=yes&:display_count=yes&:language=en-US&:loadOrderID=0, accessed: 10 September 2022.

Table I applies the colour coding across 16 SADC countries for which data could be obtained. Where GL has additional information (see highlights in red) from the 2021 SRHR Audit of laws and policies on three indicators (i.e Existence of laws and policies that allow adolescents to access SRH services without third party authorisation; Minimum legal age of consent to marriage, 18 years for all irrespective; Legal status of abortion), this has been added to the governments' reports. Noting that Malawi has long had one of the highest adolescent birth rates in the region, GL resorted to using the latest available World Bank figures and not (4) colour-coded dark green on the SADC Scorecard. On percent reductions of new HIV infections in adolescent girls, the figure for Madagascar is (-159), which means the rate is increasing, not decreasing. This is therefore coded red instead of the light green code on the SADC scorecard. While rates of new infections have been going down for young people and overall, rates of new infections increased in young people between 2010 and 2020 in Zambia and there has been a steep increase overall in Madagascar which is concerning.

Table II: Summary of performance by indicator

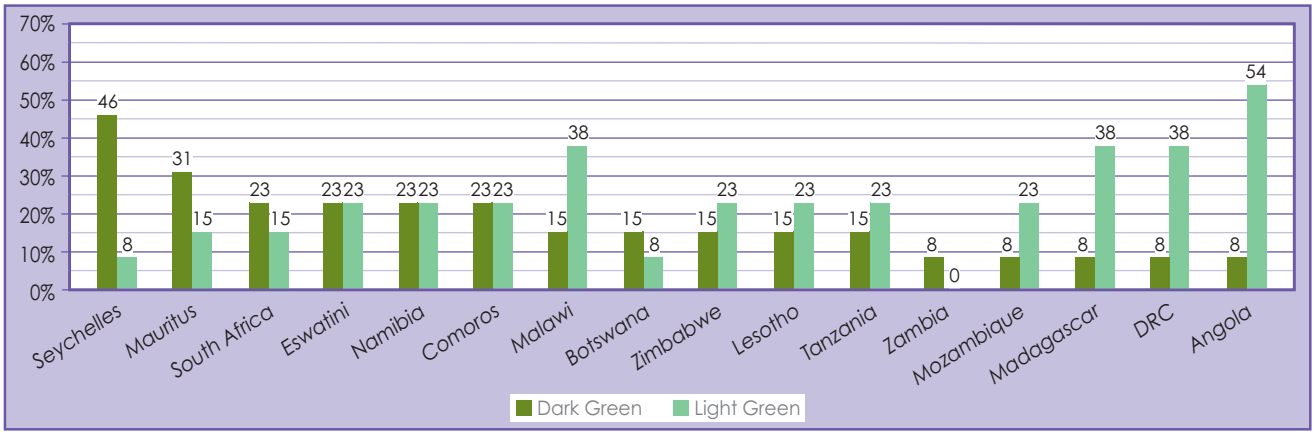
Indicators	Dark Green	Light Green	Yellow	Amber	Red	Not applicable	No data	% Dark Green
Minimum legal age of consent to marriage, 18 years for all irrespective	13	0	2	0	1	0	0	81%
Adolescent birth rate, 10-19 years of age	9	4	2	0	1	0	0	56%
Mother to child transmission of HIV	8	4	2	1	0	0	1	50%
Unmet need for family planning (contraception)	2	3	8	0	1	0	2	13%
Neonatal mortality, institutional	2	4	9	1	0	0	0	13%
Maternal mortality	2	4	3	6	1	0	0	13%
Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (age)	1	1	2	1	1	4	6	6%
Percentage reduction in new HIV infections, females 15 - 24	0	10	2	0	4	0	0	0%
Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation.	0	10	0	0	5	1	0	0%
Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	0	3	2	7	1	0	3	0%
Legal status of abortion	0	2	13	0	1	0	0	0%
Percentage of annual budgets allocated to health sector	0	2	9	3	2	0	0	0%
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age.	0	2	2	4	5	0	1	0%
Total #	***37***	***49***	***56***	***23***	***23***	***5***	***15***	
Total possible score	***208***	***208***	***208***	***208***	***208***	***208***	***208***	
Percentage of total	***18%***	***24%***	***27%***	***11%***	***11%***	***2%***	***7%***	

Table II summarises the findings per indicator, ranking these from best to least achieved. It shows that:

- Overall, only 18% of the 13 indicators that could be measured fall in the green category; 24% in the light green category;27% in the yellow category; 11% each in the amber category, and the red category; 2% in the not applicable data category, and 7% in the no data category.
- The largest percentage of dark greens across countries (81%) is on the minimum legal age of consent to marriage at 18 years for all irrespective of sex. This is followed by adolescent birth rate, 10-19 years of age (56%), and mother to child transmission of HIV (50%).
- Indicators with lower percentage of dark green include:
  - Reduction in new HIV infections in females 15 - 24 (0%);
  - The existence of laws and policies that allow adolescents to access SRH services without third-party authorisation (0%). Other low ranking areas include:

- The proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 (1%); the percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age (0%).
- The percentage of annual budgets allocated to the health sector (0%); legal status of abortion (0%);
- Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months (0%).
- Maternal mortality (13%); Neonatal mortality (13%), and
- Unmet need for family planning (13%).

Figure I: Overview of country Green SRHR scores



Source: Computed from the SADC Scorecard[3] and global data sources.

Figure I summarises each country's performance based on the 13 indicators. Seychelles (46% dark green) is in first position followed by Mauritius (31% dark green). Five countries, South Africa, Eswatini, Namibia, and Comoros (23% green) tie for third place. All the 16 SADC countries have achieved less than 50% of the targets. The lowest-ranking countries on the dark green scores are Zambia, Mozambique, Madagascar, DRC, and Angola (8% each). Angola (54%), Malawi, Madagascar, and DRC with (38%) each, have the highest light green scores, showing they are making steady progress to achieving the SDG targets set but must continue existing efforts to sustain and further the gains made. The SADC Executive secretary echoed these sentiments during the launch of the SADC Scorecard:

SADC Executive Secretary, Elias Mpedi Magosi highlighted during the launch of the Scorecard that there had already been noticeable progress in a number of indicators including the percentage reduction in new HIV and AIDS infections; Mother to Child Transmission Rate; Adolescents birth rate, as well as in the indicators related to comprehensive sexuality education and life skills. He said the development is a good sign that the scorecard is actually tracking the right metrics, and thus should potentially give the information needed for decision-making.

The Executive Secretary said areas that still require attention include the high level of GBV, high maternal mortality rates, as well as the stagnant budget resource allocation in Member States.[4]

[3] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, https://public.tableau.com/views/SADCSRHRSCORECARD2021_EN_FR_PO_16360021643560/2021English?:embed=y&:showVizHome=no&:host_url=https%3A%2F%2Fpublic.tableau.com%2F&:embed_code_version=3&:tabs=no&:toolbar=yes&:animate_transition=yes&:display_static_image=no&:display_spinner=no&:display_overlay=yes&:display_count=yes&:language=en-US&:loadOrderID=0, accessed: 10 September 2022.

[4] Relief web, https://reliefweb.int/report/angola/sadc-launches-sexual-and-reproductive-health-and-rights-scorecard-address-high accessed 5 September 2022

Table III: Overview of country SRHR scores by colour code

Country	Dark Green	Light Green	Yellow	Amber	Red	Not applicable	No data
Seychelles	46%	8%	15%	8%	8%	0%	15%
Mauritius	31%	15%	15%	8%	8%	0%	23%
South Africa	23%	15%	38%	0%	8%	0%	0%
Eswatini	23%	23%	31%	15%	0%	8%	0%
Namibia	23%	23%	23%	15%	8%	8%	0%
Comoros	23%	23%	31%	0%	15%	0%	8%
Malawi	15%	38%	38%	0%	0%	0%	0%
Botswana	15%	8%	31%	23%	8%	0%	15%
Zimbabwe	15%	23%	31%	15%	8%	0%	8%
Lesotho	15%	23%	38%	15%	0%	8%	0%
Tanzania	15%	23%	31%	15%	15%	0%	0%
Zambia	8%	0%	38%	23%	23%	0%	8%
Mozambique	8%	23%	31%	15%	0%	8%	15%
Madagascar	8%	38%	8%	15%	23%	0%	8%
DRC	8%	38%	31%	8%	8%	0%	8%
Angola	8%	54%	8%	8%	15%	8%	0%

Source: Computed from the SADC Scorecard and global data sources.

Table III shows the performance of each country in each of the six colour codes of the SADC Scorecard. As shown in Table III, four countries, South Africa, Malawi, Lesotho and Zambia with (38%) each have the highest **yellow** score. The highest **amber** scores are from Botswana and Zambia with (23%) each, while the highest **red** scores are from South Africa and Zambia with (23%) each.

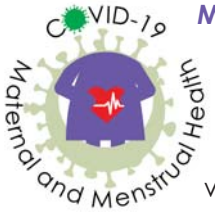
Structure of the #Voice and Choice Barometer

This 2022 Barometer follows the format of the previous editions. It contains the following chapters:

Table IV: Structure of the #Voice and Choice Barometer

Chapters
1 Introduction
2. Menstrual Health, Family Planning and Maternal Health
3. Adolescent Sexual Reproductive Health and Rights (ASRHR)
4. Safe abortion
5. HIV and AIDS
6. Gender-Based Violence
7. Harmful practices
8. Sexual Diversity

As in all the editions since the advent of the COVID-19 pandemic, each chapter of the 2022 #VoiceandChoice Barometer includes a section on how the pandemic affected women and the measures governments took to assist citizens during the pandemic. Key highlights in each theme chapter of the Barometer include:



Menstrual Health, Family Planning and Maternal Health: Five SADC countries have removed VAT from menstrual products and seven now provide menstrual ware in schools, mainly in rural and disadvantaged communities. Access to basic sanitation and handwashing facilities remains low in all countries except Mauritius and Seychelles. The regional average of the proportion of women of reproductive age with an unmet need for contraception is 19%, which is well above the global average of 9%. The lowest unmet need for contraception is Mauritius (10%) and the highest is 36% in Angola. Maternal mortality remains stubbornly high. Only Mauritius and Seychelles have met the SDG target of fewer than 70 deaths per 100,000 live births. DRC has the highest maternal mortality rate with 693 deaths per 100,000 live births. Eight countries in SADC have included Human Papillomavirus (HPV) in their national vaccination programme, though coverage varies across countries, from 97% in Seychelles to 53% in Botswana.

The prevalence rate of cervical cancer per 100,000 women per year attributable to HPV is higher than the Africa average of 26 incidences in all countries except Mauritius. Nine SADC countries have national cervical cancer screening programmes. However, this has not necessarily resulted in large scale coverage, which ranges from 3% in Mozambique to 53% of women in South Africa ever being screened for cervical cancer. Expenditure on the health sector remains lower than the recommended Abuja Declaration goal of 15% of state's annual budget to improve the health sector in all countries in SADC. Namibia has the highest (13.6%) and Zambia the lowest (4.5%) annual expenditure on the health sector.

Adolescent SRHR: Eleven SADC countries now have ASRHR policies but many need an update. A recent study[5] highlighted the impact of COVID-19 on adolescents in six SADC countries. It shows that 92% of young respondents reported facing difficulties in accessing appropriate healthcare. Three quarters of young people report experiencing loneliness, and many have made suicide attempts due to loss of income, limited prospects for employment and months of pandemic-related confinement.[6]

The COVID-19 pandemic has driven an increase in early pregnancies by as much as 65% in some SADC member states.[7] A new study[8] in South Africa shows the pandemic response shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services, especially for vulnerable populations, such as adolescents living with HIV (ALHIV). Seychelles has the worst coverage of all SADC countries for Comprehensive Sexuality Education (CSE) in primary school. Inadequate information about the nature, aim, and intended outcomes of CSE means policymakers continue to see pushback and opposition to it in some parts of the region.[9] Angola has the highest adolescent fertility rate (AFR) in the SADC region at 143 live births per every 1000 women aged 15 to 19. Mauritius is lowest at 24.

Safe Abortion: The overturning of Roe v Wade by the US Supreme Court emboldens the international anti-abortion movements. Examples of this are emerging in Southern Africa, for example in Malawi. On the other

[5] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.
[6] ibid.
[7] ibid.
[8] Van Staden, Quintin, Laurenzi, Christina A, and Toska, Elona. Journal of the International AIDS Society, vol. 25, issue 4 (2022), e25904e: https://healtheducationresources.unesco.org/library/documents/two-years-after-lockdown-reviewing-effects-covid-19-health-services-and-support, accessed 29 September 2022
[9] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

hand, in an important new development, the World Health Organisation (WHO), African Union (AU) Special Rapporteur on the Rights of Women, and the International Federation of Gynaecology and Obstetrics (FIGO) are calling for the *complete decriminalisation* of abortion. This debate is yet to take off in Southern Africa. There has been no change in any legislation related to abortion in any SADC country over the past year. However, advocacy and activism on safe abortion are gaining momentum notably in Madagascar, Lesotho and Namibia.

SAfAIDS, which leads the Alliance SRHR cluster, is working closely with the SADC Parliamentary Forum engaging parliamentarians on the urgent need for the removal of policy restrictions on access to safe abortion. The engagements with parliamentarians have documented SADC parliamentarians' recommendations on a possible model law. The *My Choice, Our Choice* campaign has identified prominent champions for safe abortion around the region, some profiled in this chapter.

A ruling by the Constitutional Court in South Africa has helped to safeguard the progressive provisions in the one out of two SADC countries (the other is Mozambique) that allows a woman to choose to have an abortion in the first trimester. There is little hard data on how COVID restrictions affected access to contraceptives or abortions, though a few studies reflect disruptions. Activists have been slow to cotton onto the growing global discussion on medication abortion that provides safe, self-managed alternatives for women in restrictive environments. Post-abortion care continues to consume a high percentage of health budgets and to make little sense of the rigid anti-abortion stances, given the age-old wisdom that prevention is better (and cheaper) than cure.

HIV and AIDS: Eswatini, Botswana and Switzerland are the three countries in the world that have been officially recognised as achieving the UNAIDS 95- 95- 95 targets[10] ahead of 2025.[11] Several other SADC member states are on course to achieve the 95- 95- 95. However, Madagascar appears to be moving towards a high prevalence epidemic which is cause for concern. The Global AIDS Update, 2022, *In Danger,* warns that the world is in danger of failing to reach the goal of AIDS no longer being a public health threat by 2030. New infections are not falling fast enough. Government are not putting those living with AIDS on Anti-retroviral treatment ART fast enough. Too many continue to die because of AIDS-related complications, despite the medical advances.

Globally, it is estimated that there were still 1,5 million new HIV infections in 2021 compared to a target of reducing new infections to under 370 000 by 2025[12]. There are glaring gaps in the treatment for children in much of the world. However, Eswatini has achieved 98% of children on treatment. Botswana achieved silver status on eliminating mother to child transmission - the first high burden HIV country in the world to achieve this. COVID-19 had a devastating impact on HIV prevention and TB programming around the world, especially on condom programming as well as Voluntary Medical Male Circumcisions. Fast adaptations, particularly introduction of community based approaches, made it possible for HIV treatment to continue.

TB is the leading cause of death in people living with HIV. South Africa, Tanzania and Malawi achieved a 75% decline in TB related deaths between 2010 and 2020. As the rate of new infections in adolescent girls and young women declines the proportion of new infections in key populations - sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons and prisoners, and their sexual partners - are on the rise.

Gender-based violence: In Madagascar, the latest Demographic Health Survey (DHS) report (2021) shows that about four in ten non-single

[10] 95% of women of reproductive age have their HIV and sexual and reproductive health service needs met; 95% of pregnant and breastfeeding women living with HIV achieve viral suppression; and 95% of HIV- exposed children are tested by 2025.
[11] Thornton, J. Botswana HIV Success. www.thelancet.com Vol 400 August 13, 2022 DOI:https://doi.org/10.1016/S0140-6736(22)01523-9 Accessed 15 August, 2022.
[12] UNAIDS. 2022. Global AIDS Update. 2022. In Danger. Geneva, UNAIDS.

women aged 15-49 (44%) experienced emotional, physical or sexual abuse by their husband or partner at some point and 27% in the 12 months prior to the survey. An Eight country study on online violence shows hate speech, misogyny, dark forms of participation, information disorders and online gender-based violence (OGBV) have also become the norm. Women journalists suffer the most of cyber bulling.

There is consensus amongst scholars that the Internet and its associated technologies have opened up doors to new and reconfigured forms of abuse such as cyber harassment, trolling, stalking, body shaming and non-consensual creation of sexual images through artificial intelligence. Research on obstetric violence in South Africa shows that women and girls seeking reproductive healthcare services in the public health system often face physical and psychological violence and mistreatment. Zimbabwe amended key legislation to fight Child marriage. In March 2022, Lesotho parliament approved the Counter Domestic Violence Bill, a move closer to enacting the bill to end the scourge of violence in the country.

Harmful practices: The negative effects of the COVID-19 pandemic continued to wreak havoc in the region, including in contributing to high numbers of girls who did not return to school due to teenage pregnancy. Zimbabwe passed a new Marriages Act that unequivocally punishes child marriage with sentences of up to five years for engaging in any action that leads to, or has potential to result in, child marriage. In a ground-breaking case, the Constitutional Court of Zimbabwe increased the age of sexual consent from 16 to 18 years in line with the age of consent to marriage and the definition of a child in its constitution. Lesotho continued with, and Botswana embarked on, a constitutional review process. Both countries still have constitutional clauses that allow for discrimination based on customary and personal law. Gender activists hope legislators will amend these during the respective review processes.

South Africa gazetted a constitutional amendment to make sign language the country's 12th official language. After 16 years of advocacy to end child marriage, activists in Mauritius celebrated when the country's lawmakers promulgated a new Children's Act, which bans the practice. In Lesotho, the Senate stalled efforts to amend the Laws of Lerotholi to provide for widows' inheritance rights, with some senators arguing they do not have authority to amend these historic laws. Zimbabwe launched a National Disability Committee to spearhead the implementation of its new National Disability Policy. New research points to increasing rates of female genital mutilation in South Africa.

Sexual diversity: Botswana joins four Southern African countries (Angola, Mozambique, Seychelles, and South Africa) to have decriminalised same-sex relationships. Legal challenges to allow for the registration of LGBTQ organisations in Eswatini and same sex marriages in Namibia were rejected. As demonstrated from the South African example legal and constitutional reform requires long term planning and campaigning. There is growing evidence that inclusivity increases productivity and business performance. Economic policies and legislation need to include affirmative action for LGBTQ persons.

Religious and cultural fundamentalism fuels violence and discrimination against LGBTQ persons. Government should design health responses to meet the ASPIRE principles: acknowledge, support, protect, prevent indirect discrimination that ensures representation and is evidence based. There is a need for discussions and strategies to address the growing prevalence of conversion therapy across the region. The intersections between LGBTQ, feminist and youth movements will strengthen each of them and create bigger impact through joint initiatives.

Introduction 1

Marian Chombo, Deputy Minister of Local Government and Public Works giving remarks at the Zimbabwe Women's Dialogue. Photo: Loverage Nhamoyebande

KEY POINTS

- This is the 14th edition of the #VoiceandChoice Barometer and third launched in the shadow of the COVID-19 pandemic.
- SADC released the first milestone SRHR scorecard in November 2021, measuring progress against 20 SRHR indicators.
- Of the 4968 measures/policies implemented by governments to assist citizens during COVID-19, UN Women and the UNDP found that only 1605 (32%) can be regarded as gender sensitive. The largest portion of these related to Violence Against Women and Girls (VAWG).
- Although the highest number of measures are related to social protection and business support, the UN Women/UNDP report found that just 10% and 14% of these respectively were gender sensitive.
- Men (82%) dominated COVID-19 task forces in 130 countries.
- Countries with powerful feminist movements, stronger democracies or higher women's representation in parliaments adopted an average of five times more gender-sensitive measures than countries without those features.
- The overturning of Roe v Wade will have far-reaching consequences, not just for the US, but for Africa as well.
- The Southern Africa Gender Protocol Alliance registered significant successes in campaigns on safe abortion and child marriages in Angola, Lesotho, Madagascar, Mauritius and Zimbabwe.
- GL with support from Amplify Change launched the Voice and Choice Fund, preceded by a mapping of SRHR organisations across the SADC region.

This is the 14th edition of the SADC Gender Protocol Barometer and the fifth to focus specifically on Sexual and Reproductive Health and Rights (SRHR). It is the third #VoicandChoice Barometer launched in the shadow of the COVID-19 pandemic. In 2022, several and other global crises add to the vulnerabilities. These include the war in Ukraine, food and fuel shortages and climate change. Now more than ever we need to protect the fragile gains made for women's rights.

The Barometer measures 100 indicators covering menstrual health, maternal health, family planning, adolescent sexual and reproductive health and rights (SRHR) HIV and AIDS, GBV, harmful practices and sexual diversity. The Barometer shows that while there has been progress across the region, many countries are far from reaching the goals laid out in the SADC Gender Protocol, the Sustainable Development Goals (SDGs) and related normative frameworks. It also shows that progress is uneven in countries across the region. It highlights the importance of the continued policy and advocacy work of the Southern Africa Gender Protocol Alliance on SRHR issues, in particular access to safe abortion, adolescent SRHR, teenage pregnancy and child marriage.

This introductory chapter lays out the current global and SADC context. It highlights the work by Southern African governments and the Gender Protocol Alliance through the #VoiceandChoice campaign. The chapter also sets out the methodology underpinning the Barometer.

COVID-19

In its third year, COVID-19 has become more normalised, with fewer new cases and deaths. However, the virus is here to stay. At the time of writing (September 2022) 610 million people around the world had been infected and 6 million had died. In Africa, the figure is approximately 13 million cases and 257,000 deaths. As the initial scare wanes, daily data collection and reporting are declining. At the height of the pandemic 181 countries provided COVID-19 data disaggregated by sex. At the time of writing, this declined to 87 countries. Only 23 countries provide vaccination data by sex.

Table 1.1: COVID-19 sex disaggregated data

	Tests		Cases		Deaths		Vaccination - 1 dose	
	M	F	M	F	M	F	M	F
World	**44%**	**56%**	**50%**	**50%**	**56%**	**44%**	**50%**	**50%**
Angola			58%	42%				
Eswatini			46%	54%			45%	55%
Mauritius			63%	37%				
Mozambique			48%	52%				
Namibia			47%	53%				
South Africa	47%	53%	44%	56%	49%	51%	44%	56%
Zambia			49%	51%				
Zimbabwe			49%	52%				

Source: Global Health 5050 .[1]

Table 1.1 shows that only eight SADC countries have sex disaggregated data for a number of cases. Two countries, Eswatini and South Africa, have sex-disaggregated data on vaccinations. Only South Africa has sex-disaggregated data on deaths. Globally there is now an equal split in number of women and men infected. In Angola and Mauritius, more men than women

[1] https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/ accessed 18 September 2022

have been infected. In the six other countries for which data is available, the opposite is true. In South Africa, women constitute the majority of those infected; those who died and those vaccinated.

Gender inequality is both a driver and a consequence of the pandemic. The pandemic has once again laid bare the gross structural inequalities that continue to pervade societies Women constitute the majority of health workers, those at the frontline of the pandemic and therefore most exposed. Women bear the brunt of caring for the sick in the home and in hospitals and of the economic downturn and increased gender-based violence.

UN Women and the United Nations Development Programme (UNDP) collaborated to produce *Government responses to COVID-19: Lessons on gender equality for a world in turmoil*.[2] The report analyses a unique global dataset of close to 5,000 COVID-19 measures from 226 countries and territories between March 2020 and August 2021. It finds that "overall government responses have not paid enough attention to gender dynamics, often failing to mitigate the pandemic's negative effects on women and girls."[3]

The 2022 report lays out some stark facts about the disproportionate impact of COVID-19 on women globally:

- In 2020, women lost 46.6 million jobs globally, a 3.6% loss compared to 2% for men.
- By 2021, there were still 19.7 million fewer jobs for women, compared to 10.2 million fewer for men.
- In 2020, women did 29% more childcare per week than men, based on data from 16 countries.
- Seven in ten women say they think that verbal or physical abuse by a partner became more common.

Nurse performs a COVID test in Village Voara, Andohotapenaka.
Photo: Zoto Razanadratefa

The UN Women/UNDP report examined government responses in four categories: social protection, labour markets, business support as well as Violence against Women and Girls (VAWG). The report measured the number of gender sensitive measures in each category.

Table 1.2: Government measure/policies to assist citizens during COVID-19

	Total	Gender Sensitive	%
Social protection	2223	226	10%
Labour market measures	876	380	43%
Business support measures	1016	146	14%
VAWG	853	853	100%
TOTAL	**4968**	**1605**	**32%**

Table 1.2 shows that of the 4968 measure/policies implemented by governments to assist citizens during COVID-19, 1605 (32%) could be classified as gender sensitive. The largest portion of these are related to VAWG. Social protection (10%) and business support (14%), scored lowest. In the social protection and labour market category, only 12% of the measures targeted women's

2 UNWOMEN and UNDP, Government responses to COVID-19: Lessons on gender equality for a world in turmoil (2022)
3 Ibid.

economic security and only 7% supported unpaid care work. The figures point to a glaring gap in policies that address women's social and economic security.

Globally, 196 out of 226 countries and territories adopted at least one gender sensitive measure. The research found that sub-Saharan Africa is the region with the third highest number of gender-sensitive measures, but also the one with the lowest measure density (221 measures across 50 countries).

Men dominated 82% of COVID-19 task forces across 130 countries. The research found that countries with powerful feminist movements, stronger democracies or higher women's representation in parliaments adopted an average of five times more gender-sensitive measures than countries lacking these characteristics.

Globally, 196 out of 226 countries and territories adopted at least one gender sensitive measure.

Global political context

Hard on the heels of the COVID-19 pandemic, the unprovoked and devastating Russian invasion of Ukraine has had a detrimental effect on many countries. The invasion and subsequent sanctions imposed by the west disrupted the import of Russian and Ukrainian commodities. Many African countries depend on Russia and Ukraine for wheat, mustard oil, and sugar imports. Across the continent, over 340 million people currently face food insecurity. This figure is 17% higher than in 2021. The continent's over-reliance on Ukraine and Russia for food importation means that the food crisis will get worse.[4]

The overturning of the 1973 Roe v Wade which upheld the protection of pregnant individuals' rights to bodily autonomy, privacy and (to a large extent) abortion in the US, will also have a devastating impact on women's rights. The landmark 1973 Constitution ruling brought hope for women's SRHR and served as a catalyst for change, inspiring nations across the globe to adopt less stringent laws. The overturning of the ruling by the US Supreme court is already having repercussions beyond the US, emboldening conservative lobby groups.

Similar to the Global Gag Rule (GGR)[5] under Republican administrations, the possible banning of abortion in at least 26 states may have implications on international US-funded organisations that receive monetary assistance to fulfil mandates of abortion healthcare, family planning and contraceptive healthcare. Constitutional review processes in other countries may be influenced by the Supreme Court's ruling.[6]

With just eight years to go before the 2030 deadline this global context and rolling back of rights will have a strong bearing on whether countries are able to meet **Sustainable Development Goals (SDGs).**

[4] News 24, https://www.news24.com/fin24/opinion/opinion-the-ukraine-war-left-millions-of-africans-food-insecure-and-a-bigger-crisis-looms-20220917, accessed 18 September 2022

[5] The GGR prohibits foreign NGOs who receive U.S. global health assistance from providing legal abortion services or referrals, while also barring advocacy for abortion law reform-even if it's done with the NGO's own, non-U.S. funds.

[6] News 24, https://www.news24.com/news24/opinions/columnists/guestcolumn/opinion-roe-v-wade-overturning-implications-on-african-states-as-beneficiaries-of-usaid-20220801 accessed 18 July 2022

Four SRHR goals cover SRHR comprehensively. These include eight targets:

SDG 3: Ensure healthy lives and promote well-being for all at all ages

- Target 3.1 - By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- Target 3.2 - By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
- Target 3.7 - By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- Target 3.8 - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- Target 3.b - Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

SDG 5: Achieve gender equality and empower all women and girls

- Target 5.6 - Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

SDG 6: Ensure availability and sustainable management of water and sanitation for all

- Target 6.1 - By 2030, achieve universal and equitable access to safe and affordable drinking water for all.
- Target 6.2 - By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.[7]

This Barometer shows that few SADC countries have met or are on track to meet the SDGs by 2030. Leaders from Argentina, India, Indonesia, Senegal and South Africa attended the **G7**[8] **Leader's Summit** held 26-28 June in Bavaria, Germany. The meeting set out a vision and a commitment to address the crises of COVID-19; the impact of the war in Ukraine as well as meet the SRHR needs of women and girls.

[7] United Nations, Sustainable development goals, https://sdgs.un.org/goals accessed 14 July 2021
[8] The Group of Seven (G7) is made up of seven developed nations Canada, France, Germany, Italy, Japan, the United Kingdom and the United States

G7 countries have called for a gender-equal global recovery following the pandemic. They reaffirmed their continuous efforts to improve women, children and adolescent health (WCAH). G7 Member States reiterated their commitment to putting gender equality at the core of their multilateral contributions to global health. They reiterated their efforts to address the particular needs of the most marginalised and those in vulnerable situations.

Leaders committed to strengthening primary health care and attaining universal health coverage (UHC) per the 2030 Agenda. They committed to support a successful Seventh Replenishment of the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund); and to contribute to the Global Financing Facility for women, children and adolescents (GFF).

> "We reaffirm our full commitment to achieve comprehensive SRHR of all individuals, and stress the importance of access to emergency sexual and reproductive health services in humanitarian crises," said the 28 June G7 outcome statement. "We recognise the essential and transformative role of SRHR in gender equality and women's and girls' empowerment, and in supporting diversity, including of sexual orientations and gender identities".[9]

SADC Context

Launch of the 2021 Barometer in Eswatini, GL and SAfAIDS.
Photo: Thandokuhle Dhlamini

In 2008, SADC became the first region in the world to adopt a legally binding Protocol on Gender and Development, bringing together African and global commitments to gender equality, updated in line with the Sustainable Development Goals in 2016. Each year since 2009, the SADC Gender Protocol Alliance has produced the Barometer to measure progress against the SADC Gender Protocol and related regional, continental and global commitments.

In 2018, Southern African Development Community (SADC) Ministers of Health developed a **SADC Scorecard on sexual and reproductive health and rights (SRHR)**, to track progress on achieving the 20 targets of the SADC SRHR strategy and the SDGs. The milestone scorecards measure progress by countries against the baseline data and show whether the SADC region and Member States are on track to meet the 10 outcomes in the SADC SRHR Strategy and the SDG targets by 2030. Member States are expected to report every two years on progress (2021, 2023, 2025, 2027 and 2029). The SADC scorecard targets are aligned with the SDGs.

In 2021 SADC Member States released the **first Milestone Scorecard** which shows noticeable progress in a number of indicators including the percentage reduction in new HIV and AIDS infections; Mother to Child Transmission Rate; Adolescents birth rate, as well as in the indicators related to comprehensive sexuality education and life skills. However, progress has been slow in other key areas, particularly in reducing maternal mortality, GBV, neo natal mortality and unmet need for contraception and low health budget allocation. It is, however, encouraging that member states are beginning to measure themselves against regional and global targets. Measuring is just the start, member states need to take significant measures if they are to meet the 2030 targets.[10]

[9] PMNCH, Women's, children's and adolescent's health, https://pmnch.who.int/news-and-events/news/item/28-06-2022-g7-commits-to-achieving-comprehensive-sexual-and-reproductive-health-and-rights , accessed 18 September 2022
[10] https://dev-www.sadc.int/srhrscorecard/

Southern Africa Gender Protocol Alliance

The **Southern African Gender Protocol Alliance** is a "network of networks" that campaigned for the adoption of the SADC Protocol on Gender and Development and its updating in 2016 to align to the Sustainable Development Goals (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 has been updated. It is also the only Protocol that is accompanied by a Monitoring, Evaluation and Results Framework. The Alliance launched the 2021 SADC Protocol Barometer on the wings of the 42nd SADC Heads of State Summit that took place in August in Malawi, and in countries around the region thereafter. The SADC Protocol Alliance issued a strong statement and petition on measure heads of states need to take to substantively advance women's SRHR.

In addition to sex, age and region disaggregated data, the petition called 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.
- Negotiate access to vaccine science, as this is a right for public health.
- Support the World Trade Organisation Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) waiver proposal on COVID-19 vaccines.

The Alliance is also calling on heads of states to:

- Remove VAT from menstrual health products and provide these free in schools.
- Redouble efforts to reduce maternal mortality, which is unacceptably high in all but two SADC countries (Seychelles and Mauritius).
- Adopt and implement stand-alone policies and strategies for ensuring access to, and participation by youth in information and services on their Sexual and Reproductive Health and Rights.
- Adopt laws and mount campaigns to end child marriages, in line with commitments to 18 as the minimum age of marriage.
- Abolish discriminatory laws and practices that deny women voice and choice in their sexual and reproductive health and rights;
- End GBV and all harmful practices that deny women their human rights.
- Ensure women's equal and effective participation in all areas of decision-making - economic, political and social, in the private and public sphere, including in the media.
- Apply the lessons on gender justice in the COVID-19 pandemic to bold and visionary approaches to achieve climate justice for the future generations of SADC.
- Recommit to the global #GenerationEquality goals by 2030.

#VoiceandChoice Campaign

Voice + Choice
SADC Protocol@Work Summit

Voix + Choix
Sommet Protocole au travail de la SADC

Vozes + Escolhas
Cimeira do Protocolo@Work da SADC

The goals of the SRHR #VoiceandChoice programme are to ensure universal access to healthcare, including reproductive healthcare, family planning, sexual health and rights through all of GL's programming. This goal is achieved through the right to access education regarding sexual and reproductive health, enabling legal and policy framework, budget allocation, capacity building and sexual practices behavioural change.

Building on successful work over the past several years, and equipped with evidence gathered from the Barometer, Southern Africa Gender Protocol Alliance members developed policy advocacy strategies on three interrelated ASRHR issues - teenage pregnancy, child marriage and safe abortion. Some key successes from the policy advocacy and campaigning include:

Alliance partner Plataforma Mulheres em Accao (PMA) in **Angola** is working with the Ministry of women's affairs to develop a strategy to end child marriage (linked to teenage pregnancy) **DRC** is in the process of revising the National Action Plan to End Child Marriage in DRC 2022-2026.

In countries where there is still strong resistance to safe and legal abortion based on cultural, religious and moral values, such as **Eswatini** and **Lesotho**, Ministries of health and women's affairs are beginning to conduct surveys to determine the magnitude of abortion at the constituency level. They are holding public gathering in an effort to solicit opinions of parents, teenagers, traditional and religious leaders of their stance regarding the enactment of an act that allows for abortion.

In **Madagascar**, the President of the Gender Committee of the National Assembly brought the Bill on therapeutic termination of pregnancy for medical reasons in the event of rape and incest to parliament.

After nearly 16 years of advocacy, **Mauritius** promulgated the Children's Act 2020 in January 2022 legally banning child marriages. Advocacy efforts will involve workshops with stakeholders to ensure proper implementation of the law. Alliance partners will train councillors, nurses and doctors to ensure accurate information is relayed to members of the public in the coming years. The Children's Act 2020 also makes provision and provides accompanying sanctions to address revenge pornography, sexual abuse on children, bullying and cybercrimes on children.

In Namibia, Health ED Ben Nangombe announced that the ministry supports the repeal of the apartheid-era abortion law. The Ministry is calling for a new law that supports the choice of women on whether or not they want to continue or terminate a pregnancy. The government has embarked on regional public hearings to gather public opinion on the issue.

In **Zimbabwe**, the case of Anna Machaya galvanised advocacy efforts. Parents forced the twelve year old out of school and into marriage. They buried her two hours after her death a result of pregnancy complications. On 8 August 2021 Alliance partner Women's Coalition of Zimbabwe (WCoZ) issued a statement calling for serious investigations into the matter, including the arrest the perpetrators and accomplices. Alliance partner WCoZ also set up an Anna Machaya Working Group as a steering committee on child marriages issues. WCoZ wrote a letter to Assistant Police Commissioner Paul Nyathi to discuss collaboration on combating child marriages and child abuse in Zimbabwe. In addition, they held two radio programmes on child marriage and amplified the #JusticeForAnna campaign. On 8 March 2022, the National Assembly passed the Marriages Bill, which also seeks to ban child marriages. The President now has to asset to the Act, a process Alliance members will be following closely.

Voice and Choice Southern Africa Fund

In March 2022, AmplifyChange announced that Gender Links (GL) Conseils et Appui pour l'Éducation à la Base (CAEB) in Mali, and UHAI EASHRI in Kenya, had been selected out 651 applicants to be an intermediary for this global fund. The Voice and Choice Fund Southern Africa Fund is for GBP1.5 million over three years.

The fund will be disbursed through two windows: movement building open to organisations in any SADC country, and the opportunity grants targeting community-based organisations that often struggle to access such funds in South Africa, Lesotho and Zimbabwe, where GL has its strongest presence and can support smaller organisations. In anticipation of the Amplify Change Partnership Grant, GL conducted a mapping exercise of the organisations working on SRHR in SADC in May 2022.

Mapping SRHR organisations

The Alliance has conducted the Voice and Choice campaign since 2018.
Photo: Colleen Lowe Morna

The mapping exercise drew organisations from country coordinating networks, their affiliates, and the regional theme clusters that drive strong Adolescent Sexual Reproductive Health and Rights (ASRHR), teenage pregnancies, child marriages and unsafe abortion campaigns nationally and regionally.

In total 61 SRHR organisations from 14 out of 16 SADC countries (all but Comoros and Seychelles) responded to the survey. The majority (87%) of these organisations are Non-governmental Organisations (NGOs) while only 13% are Community Based Organisations (CBOs). The bulk of the participant organisations were from South Africa, followed by Zimbabwe, Mauritius and Lesotho. Namibia, Mozambique, Angola, DRC, Eswatini, Madagascar, had the least responses.

Women (77%) constituted the majority of participants. Men comprised 21% and gender non-conforming persons 2% of participants. Forty two NGOs are women-led (80%) compared to 10 NGOs led by men. The same occurs for Community Based organisations (CBOs). This finding meets the basic requirements for both the ACP Movement building and Strengthening grants which will consider women-led SRHR organisations. Only one NGO is led by a gender non-confirming person. This points to the need to ensure that the call reaches organisations led by women in all their diversity.

Almost half (45%) of the organisations have annual budgets of less than $50 000. Only about 10% of the organisations have budgets of over $1 000 000. Some participants noted the need for funding to promote Alliance work; When the budgets are analysed by type of organisation, it is evident that there is a critical lack of substantial funding for CBOs.

SRHR organisations in SADC cover women's rights, men for change, gender mainstreaming, the youths, and disability areas in their work. However, the extent to which these areas are covered depends on the type of organisation. The majority of CBOs and NGOs integrate youth into their

work. Fewer NGOs (20) and CBOs (4) deal with disability issues.

The mapping study sought to identify the specific SRHR areas that organisations work in. The majority (85%) of organisations work on Adolescent SRHR and Gender-Based Violence (GBV). This is followed by HIV and AIDS (64%), Menstrual health (57%), Harmful practices (48%), Safe Abortion (38%), Sexual diversity (36%), and Maternal health (34%). A few organisations (8%) mentioned other SRHR work not categorised in the responses. These include, teenage pregnancies, Comprehensive Sexuality Education (CSE), child abuse, protection of children, all non-communicable diseases, and Adolescent friendly health services in rural areas. Organisations raised important points on the need to promote work on SRHR.

The Alliance is made up of close to 600 individuals as well as affiliate organisations working to promote gender equality through six thematic areas, including Governance, Constitutional and legal rights, Sexual reproductive health and rights, HIV and AIDS and GBV, Education and Economic Justice, Climate Change and Sustainable Development, Media, Information and Communication, and LGBTIAQ+. Most organisations (75%) focus on Sexual and Reproductive Health and Rights, and HIV and AIDS and GBV. This is followed by 13% of organisations in the Education and Economic cluster, 8% in the Governance, Constitutional and legal rights, and 3% in the Climate Change and Sustainable Development.

Most organisations (84%) are involved in advocacy work and training (77%). Over two-thirds (69%) of organisations offer services, while 53% do lobbying work most of the time. Research work constitutes less than half (44%) of both NGOs and CBO work. Only 15% of work goes to other types of work which include engage young people in community services, supporting the vulnerable population, and HIV counselling services.

The mapping study sought to understand the membership architecture of the 61 SRHR organisations that participated, by asking about membership and affiliate status. More NGOs than CBOs are membership-based organisations. Thirteen NGOs and only two organisations that participated in the mapping study are affiliate organisations. As mentioned earlier, this finding helps to inform decision-making the ACP networking grant that targets seven SRHR organisations in the SADC.

Source: Alliance SRHR Mapping Study 2022.

Improving Alliance effectiveness by 2030

Survey respondents made suggestions on how to strengthen movement building in the SADC region. These included:

- ***Walking the talk on gender equality*** The Women's Organisations could be able to influence funders and gradually with these supports the most critical sectors of the SADC protocol in each country could be supported.
- ***Leadership change and growth*** Change country leadership, especially gatekeepers that impede diversity and inclusion and engage youth and grassroots communities more meaningfully in the design, governance and partnership work of the alliance.
- ***Deliberate promotion of reproductive health*** including funding resources, advocacy, research, education and service provision on Family planning, Adolescent sexual and reproductive health, Unsafe abortion and Violence against women.
- ***Research, Learning, and sharing*** of technical resources to keep organisations informed and also provide platforms for learning in the region.
- ***Strengthening coordination of the alliance.***
- ***Regular meetings and trainings*** On-going mentoring & capacity building for NGOs and CBO's.

- ***Promote national and regional collaborations*** with regional organisations which are membership based with more organisations to form forums to assist and support each other.
- ***Promote economic empowerment of women and girls*** in under resourced communities as these have been hardest hit by the impact of COVID-19 and lockdown restrictions.
- ***Strengthening of CBOs*** and provide opportunities and strengthen organisations that do not have capacity or do not qualify for large funding calls and recognise small or start-up organisations especially those based in the rural areas
- ***Establish Joint Objectives and Goals*** to promote a continental agenda based on the aspirations of the populations.
- ***Capacity building for the Alliance membership*** in terms of Evidence-based Advocacy, Communication, Results-based Monitoring & Evaluation, and Resource Mobilisation.
- ***Increase visibility*** of the Alliance by Country Focal Point Organisations to attract new members and involve smaller organisations for higher impact at the grassroots.
- ***Work with women and men-led organisations*** as it is a crucial factor in achieving gender equality.
- ***Continuous fundraising activities*** to increase visibility and impact.

Methodology

Measuring progress against government commitments

The Barometer measures progress against government commitments as expressed in key normative frameworks including the:

- 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)

Quantitative data - using indicators

Each chapter begins with a table of key indicators for which there is reliable data across the 16 SADC countries. The primary sources of these indicators are from UN Agencies such as UNAIDS, UNFPA and UNESCO, the WHO and World Bank. In this edition of the Barometer, we have also included and commented on the indicators in the SADC SRHR Scorecard. Where possible we have provided comparative data from the last reported on.

The Barometer measures progress against government commitments...

Table 1.3: Classification of indicators

Thematic area	SADC Barometer indicators	SADC SRHR Score card indicators	Measured by both the Barometer and score card
Menstrual Health, Family Planning and Maternal Health	18	7	4
Adolescent SRHR	5	4	4
Safe abortion	8	2	1
HIV and AIDS	24	2	2
Gender-based violence	12	2	1
Harmful practices	8	0	0
Sexual Diversity	22	0	0
Budgets and services	3	3	1
TOTAL	100	20	13

Table 1.3 shows the indicators in this Barometer and the SADC SRHR Scorecard by theme area. The table shows that the Barometer (100 indicators) goes well beyond what governments (20 indicators) report on to SADC but that they are in fact committed to go through the instruments listed. The table shows that the Barometer and SADC SRHR scorecard have 13 indicators in common. The seven indicators not measured by the Barometer are ones in which there is insufficient data across all countries, an observation borne out by the first scorecard report submitted by governments in which there are several gaps.

Quantitative data

Qualitative methods include:

- ***Desktop research:*** Researchers conducted extensive desktop research on the latest trends and developments across all the SRHR themes. Sources include journals, articles, academic and activist research and UN and NGO reports on the themes.
- ***Case studies:*** Alliance members gathered case studies of their #VoiceandChoice policy and advocacy work.
- ***Media articles*** from the journalists trained in 15 countries on coverage of gender equality issues.

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

Limitations

Data is not always available for every country, nor is it necessarily collected on an annual or bi-annual basis. In some cases, data may not have changed since the last Barometer. National Summits did not take place in 2021 due to the COVID-19 pandemic and funding constraints. This reduced availability of case studies to include in this edition of the Barometer. Finally, the Barometer a dedicated team of professionals continue to produce the Barometer on an ever-shrinking budget, even as the need for evidence-for-advocacy grows. We trust however that the data and analysis will continue to guide Alliance campaigns, as well provide baselines for the new grantees of the Voice and Choice Fund.

Menstrual Health, Family Planning and Maternal Health

2

Women demonstrate contraceptive methods in Madagascar. Photo: Zoto Razanadratefa

KEY POINTS

- Five SADC countries have removed VAT from menstrual products and seven now provide menstrual ware in schools, mainly in rural and disadvantaged communities.
- Access to basic sanitation and handwashing facilities remains low in all countries except Mauritius and Seychelles.
- The regional average of the proportion of women of reproductive age with an unmet need for contraception is 19%, which is well above the global average of 9%. The lowest unmet need for contraception is Mauritius (10%) and the highest is 36% in Angola.
- Maternal mortality remains stubbornly high. Only Mauritius and Seychelles have met the SDG target of fewer than 70 deaths per 100,000 live births. DRC has the highest maternal mortality rate with 693 deaths per 100,000 live births.
- Eight countries in SADC have included Human Papillomavirus (HPV) in their national vaccination programme, though coverage varies across countries, from 97% in Seychelles to 53% in Botswana.
- The prevalence rate of cervical cancer per 100,000 women per year attributable to HPV is higher than the Africa average of 26 incidences in all countries except Mauritius.
- Nine SADC countries have national cervical cancer screening programmes. However, this has not necessarily resulted in large scale coverage, which ranges from 3% in Mozambique to 53% of women in South Africa ever being screened for cervical cancer.
- Expenditure on the health sector remains lower than the recommended Abuja Declaration goal of 15% of state's annual budget to improve the health sector in all countries in SADC. Namibia has the highest (13.6%) and Zambia the lowest (4.5%) annual expenditure on the health sector.

Introduction

Sexual and reproductive health is a lifetime concern for both women and men, from infancy to old age, though it affects women disproportionately as the bearers and principle carers of children. From adolescence to old age women have needs for menstrual health and hygiene, contraception and family planning, antenatal, safe delivery care, post-natal care, services to prevent sexually transmitted infections including HPV, and services facilitating early diagnosis and treatment of reproductive health illnesses (including breast and cervical cancer).[1]

As far back as the International Conference on Population and Development (ICPD) in 1994, Sexual and Reproductive Health and Rights (SRHR) has been recognised as integral to human rights and dignity of women central to development. At the global level there has been remarkable progress. There has been a 25% increase in global contraceptive prevalence rate around the world. Adolescent births have declined steeply, and the global maternal mortality ratio has fallen. But progress has been slow and uneven. Hundreds of millions of women around the world are still not using modern contraceptives to prevent unwanted pregnancies, and global targets on reducing maternal and neonatal deaths have not been met.[2]

States re-recommitted themselves to advancing SRHR through the Sustainable Development Goals (SDGs) adopted in 2015 with a deadline of 2030. SRHR is comprehensively covered in three SDGs with eight indicators - SDG 3 Ensure healthy lives and promote well-being for all at all ages; SDG 5 Achieve gender equality and empower all women and girls and SDG 6 Ensure availability and sustainable management of water and sanitation for all.

At the regional level SADC heads of State adopted the SADC SRHR Strategy and Scorecard

Women on the Cape Flats sew reusable pads with the support of New Heritage, a Women Voice and Leadership grantee. Photo: Colleen Lowe Morna

2019-2030 aligned with the SDGs. SADC released the first milestone report in November 2021 reflecting progress and regression across 20 SRHR indicators. While there has been some progress, the region continues to shift the needle on SRH. Positive trends include the percentage reduction in new HIV and AIDS infections; Mother to Child Transmission Rate; Adolescents birth rate, as well as in the indicators related to comprehensive sexuality education and life skills. However, progress in other critical areas such as maternal and neonatal mortality, and women's unmet need for contraception has been slow. Budget resource allocations remain stagnant.

This chapter measures progress towards achieving women's SRHR using 20 indicators related to menstrual health, family planning and maternal health. The chapter shows that progress towards achieving the goals set out in the SDGs and SADC SRHR scorecard is not linear and that even where progress has been made there is always the danger of regression if states are not vigilant and fully committed to achieving the goals. Where states have regressed it is important to interrogate and understand the causes and to adopt new strategies that address the continued and new barriers to the realisation of SRHR.

[1] UNFPA, Sexual and reproductive health, https://www.unfpa.org/sexual-reproductive-health , accessed 3 September 2022.
[2] UNFPA, International Conference on Population and Development, https://www.unfpa.org/icpd , accessed 10 September 2022.

Table 2.1: SRH indicators in 2022

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Existence of SRHR policies/guidelines	No	Guide-lines	Yes	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2019 Policy	2011 - 2015 Guide-lines	2008 Policy	2010 - 2015 Policy
Provision of free menstrual products in schools	No	Yes	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes
Removal of Value Added Tax (VAT) on menstrual products	No	No	No	No	No	Yes	No	No	Yes	No	Yes	Yes	**Yes**	No	No	Yes
Access to at least basic sanitation (%)[3] (2017 figures)	52 (50)	80 (77)	36	**15 (17)**	64 (62)	50 (45)	12 (11)	27 (26)	96	37 (32)	35 (35)	100	78 (76)	32 (29)	32 (31)	**35 (37)**
Access to basic handwashing facilities[4]	27	No data	16	19	24	6	27	8	No data	12	45	No data	44	48	18	42
Contraceptive preva-lence rate amongst all women aged 15-49 (%) any method[5]	16	57	20	26 (23)	54	**52 (53)**	42 (41)	49 (48)	43	27 (26)	52	No data	51 (50)	37 (36)	38 (37)	49
% women of reproductive age with unmet need for family planning[6]	36	17	32	28	15	18	19	16	10	22	12	No data	19	22	20	10
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[7]	62	52	21	31	49	61	74	47	No data	49	71	No data	65	47	49	60
Age of access to contraception	16	12	TBA	18	15	No age stipu-lated	12	16	16	16	12	15	12	12	16	16
Maternal Mortality Ratio (per 100,000)[8] (2019 baseline)	**288 (241)**	**166 (143)**	172	693 (846)	452	618	335 (478)	349 (439)	61	**452 (408)**	385	**65 (62)**	121	556	252	462 (651)

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Antenatal Care Visits (At least one visit) %[9]	82	94	92	82	99	**92 (95)**	85 (82)	**97 (98)**	No data	94 (87)	97	No data	94	98	97	93
Antenatal Care Visits (At least four visits) %[10]	61	73	49	43	76	77	51	51	No data	51	63	No data	76	62	64	72 (76)
Births attended by skilled health staff (% of total)[11]	50	100	82	80	88	87 (78)	46 (44)	90	100	73 (54)	88	99	97	64	80	86 (78)
Postnatal care coverage %[12]	23	No data	49	50 (44)	88	84 (62)	72	84 (42)	No data	No data	69	No data	84	34	70 (54)	82 (57)
Neonatal mortality (per 1 000)[13] (2019 baseline)	24 (29)	18 (25)	24	27 (28)	20	34	20 (26)	20 (27)	**10 (9)**	29 (30)	20	9	21	25	27	31 (29)
Nursing and midwifery personnel per 10 000 of the population[14]	4	54	15 (6)	11	**25 (41)**	33	3	7 (4)	39 (35)	5	20	98	50 (39)	6	10	21 (19)
Proportion of females who have received the recommended number of doses of the HPV vaccine prior to age 13	No data	53	No data	No data	No data	No data	No data	89	74	No data	No data	97	63	59	60	96
Universal Health Coverage index (0 worst - 100 best)[15]	39	54	44	39	58	48	35	48	65	47	62	70	67	46	55	55
Health expenditure as proportion of GDP[16]	2,5	6 (5,8)	5,1 (4,5)	3,5 (3,3)	6,8 (6,5)	11,2 (9,2)	**3,7 (4,7)**	**7,4 (9,3)**	6,2 (5,8)	**7,9 (8,1)**	8,5 (8)	5,1 (3,9)	9,1 (8,2)	3,8 (3,6)	5,3 (4,9)	7,7 (4,7)
% annual budget allocated to health sector[17] (2019 baseline)	5,6 (2,9)	12,5 (16,2)	12 (10)	11,4 (11)	9,4	9,5 (13)	8	9,3 (10)	5,5	8,7	13,6 (14)	11,7	8,1	6,7 (10)	4,5 (8,9)	10 (10,7)

3 https://data.worldbank.org/indicator/SH.STA.BASS.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ (2020 data), accessed 26 August 2022
4 https://data.worldbank.org/indicator/SH.STA.HYGN.ZS?end=2020&locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ&start=2000 accessed 31 August 2022
5 UNFPA, World Population Dashboard, https://www.unfpa.org/data/world-population-dashboard, accessed 29 August 2022
6 SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022
7 World Bank data - https://www.unfpa.org/data/world-population-dashboard, accessed 29 August 2022
8 SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/ , accessed 31 August 2022
9 UNICEF, Maternal and Newborn health coverage database, https://data.unicef.org/topic/maternal-health/antenatal-care/ , Data as of May 2022, accessed 29 August 2022
10 Ibid
11 Ibid
12 Ibid
13 SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022
14 WHO, The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/nursing-and-midwifery-personnel-(per-10-000-population), accessed 30 August 2022
15 WHO indicators, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage , accessed 29 August 2022
16 World Bank, World Development Indicators, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ accesses 30 August 2022
17 SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022

Note about data

We have attempted to collect the most up to date data, however not all the indicators have updated 2022 data, and in some cases there is data missing for specific countries. Where we have been able to find updated data we have presented the last figure in brackets. Text in red shows regression.

SADC launched its first milestone scorecard with 2021 data. We have used data from the scorecard for the following indicators in this chapter:

- Maternal Mortality Ratio (per 100,000).
- Neonatal mortality (per 1 000).
- % women of reproductive age with unmet need for family planning.
- Proportion of females who have received the recommended number of doses of the HPV vaccine prior to age 13.
- % annual budget allocated to health sector.

We have triangulated the data with other sources. Discrepancies in data, specifically maternal mortality, will require further investigation.

Table 2.1 shows that:

- Five SADC countries (Lesotho, Mauritius, Namibia, Seychelles, South Africa and Zimbabwe) have now removed VAT on menstrual products. Seven countries (up from five in 2021) provide free sanitary ware in schools, this is up from five countries in 2021. These are: Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe.
- Just one SADC country, Seychelles, provides basic sanitation to its entire population. All SADC countries except DRC and Zimbabwe have increased access to at least basic sanitation.
- The contraceptive prevalence rate (CPR) for all women aged 15-49 using all methods ranges from 16% in Angola to 57% in Botswana. Seven countries (Botswana, Eswatini, Lesotho, Malawi, Namibia, Zambia and Zimbabwe) are above the global average of 49%. All countries maintained or increased contraceptive prevalence, except Lesotho which decreased by one percentage point.
- No SADC country meets the global average for unmet need for family planning of 9%. Angola has the highest unmet need for family planning with 36% of women of reproductive age (15-49 years) having a need for family planning, but not having access to contraception. Mauritius has the lowest unmet need for contraception
- Women in SADC have limited control over decision-making on SRHR. This ranges from 21% in Comoros to 74% in Madagascar of women aged 15-49 and who make decisions on SRHR.
- Maternal mortality remains stubbornly high. Just two of 16 SADC countries, Seychelles and Mauritius have met the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. DRC has the highest MMR with 693 deaths per 100 000 live births. Five other countries (Eswatini, Lesotho Mozambique, Tanzania and Zimbabwe) have more than 400 maternal deaths per 100 000 live births. The figures show that four countries registered an increase in maternal deaths between 2019 and 2021.
- Just three SADC countries (Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 neonatal deaths per 1,000 live births. There have been marginal decreases in seven SADC countries and an increase in Mauritius.
- No country in SADC provides universal health care. Access to essential health services ranges from a score of 71 in Seychelles to 35 in Madagascar.
- Government expenditure remains lower than the recommended Abuja Declaration goal of 15% of annual expenditure on the health sector.

This chapter focuses on four key areas of SRHR - menstrual health, family planning and maternal health and cervical cancer - measuring the progress countries in realising the targets set out in the 2016 SADC Protocol on Gender and Development, the Sustainable Development Goals (SDGs), and the SADC SRHR strategy.

SRH and the COVID-19 pandemic

SDG Target 3.7 aims to ensure universal access to sexual and reproductive health-care services, including for family planning.

While not as severe as predicted, the COVID-19 pandemic, and the subsequent lockdowns in almost all countries across the globe, had an impact on women's SRHR, especially in low-and middle-income countries. At the beginning of the pandemic measures such as social distancing, lockdown and mobility restrictions, and fear of travelling to health facilities, raised concerns about women's ability to continue using contraception. Disrupted global manufacturing and supply chains and overwhelmed health facilities also threatened to reduce the availability of family planning supplies and services.

However, data from United Nations Population Fund (UNFPA) shows that the disruptions in family planning services were smaller and shorter than initially projected, largely concentrated in April and May 2020. This can be attributed to the resilience of health systems that continued to provide services. Partners also doubled down to support access to reproductive health supplies and services.[18]

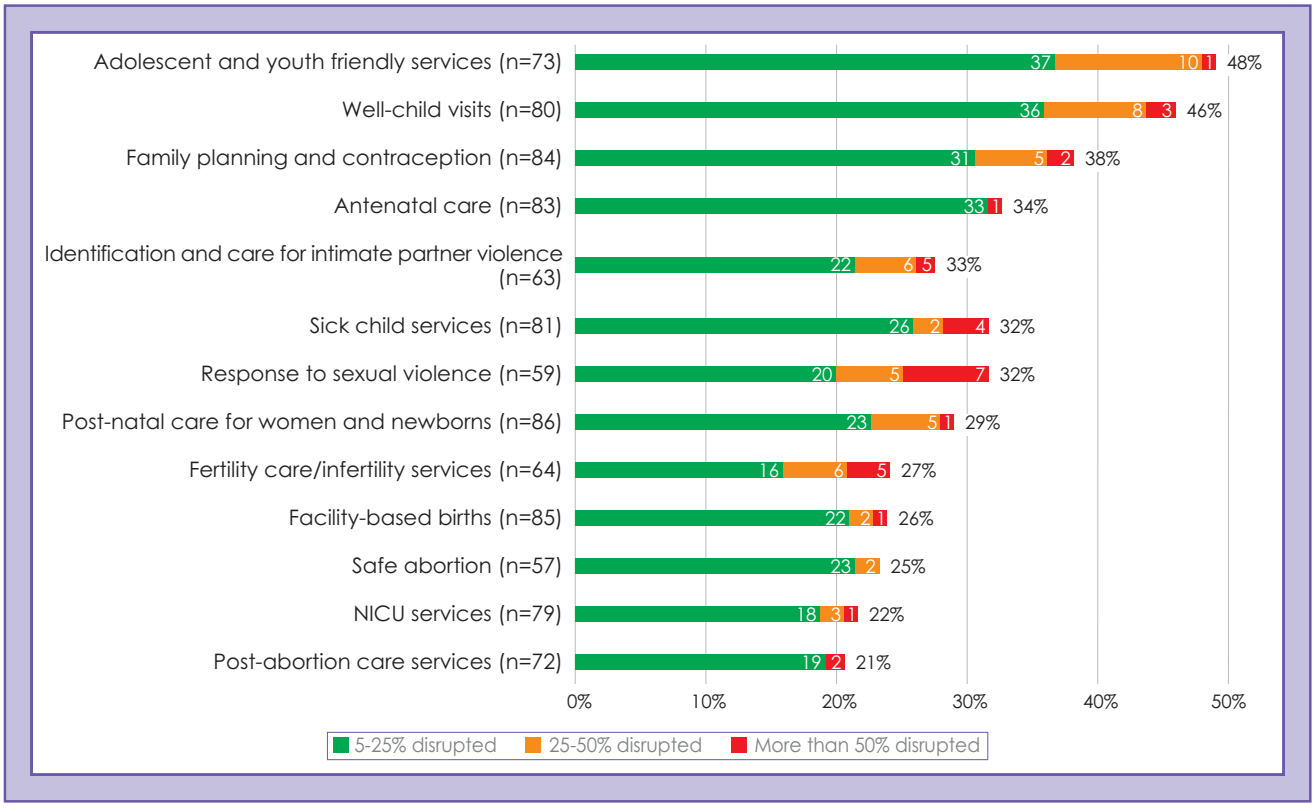
The third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic for the period November to December 2021 shows that despite early evidence of service recovery, nearly all countries are still affected by the COVID-19 pandemic. Of the 129 participating countries 92% report some kind of disruption to services during the preceding six months from the date of survey submission (June-November 2021).[19]

The survey shows that there has been a decrease in service disruptions between Q1 of 2020 and Q4 of 2021. In the first quarter of 2020, over half of the countries surveyed (55%) reported 5-50% disruptions in sexual, reproductive, maternal, new-born, child and adolescent health services. This reduced to 33% in Q4 of 2021.[20]

While not as severe as predicted, the COVID-19 pandemic, and the subsequent lockdowns in almost all countries across the globe, had an impact on women's SRHR

[18] UNFPA Technical Note Impact of COVID-19 on Family Planning: What we know one year into the pandemic
[19] Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November to December 2021, February 2022
[20] Ibid.

Figure 2.1: Percentage of countries reporting disruptions in sexual, reproductive, maternal, newborn, child and adolescent health services in Q4 2021



Source: Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November to December 2021, February 2022.

Figure 2.1. Shows that the most disrupted services were youth friendly services (49%), followed by child visits (46%) and family planning and contraception (38%).

SRHR policy and legislative framework

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

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

The vision of the SADC SRHR strategy 2019-2030 is to "ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realise and exercise their SRH

rights, as an integral component of sustainable human development in the SADC region." The strategy is aligned with the SDG, and aims to achieve ten SRHR outcomes.

1. Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG3.1.);
2. New-born mortality ratio reduced to fewer than 12 deaths per 1,000 births (SDG 3.2.);
3. HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
4. Sexual and gender-based violence and other harmful practices, especially against women and girls, eliminated (SDGs 5.1, 5.2 and 5.3);
5. Rates of unplanned pregnancies and unsafe abortion reduced;
6. Rates of teenage pregnancies reduced;
7. Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings, ensured (SDGs 3.7 and 5.6);
8. Health systems, including community health systems, strengthened to respond to SRH needs (SDG 5.6);
9. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6);
10. Barriers - including policy, cultural, social and economic - that serve as an impediment to the realisation of SRHR in the region removed (SDGs 5.1 and 5c)."[21]

Southern African Development Community (SADC) Ministers of Health developed a **SADC Scorecard on sexual and reproductive health and rights (SRHR)** in 2018, to track progress on achieving the targets of the SADC SRHR strategy and the SDGs. It is a high-level peer review accountability tool that consists of 20 key indicators that reflect areas for accelerated action if the 10 outcomes of the strategy are to be met. Four of the indicators relate to maternal health, family planning and reproductive cancers. The scorecard also measures proportion of annual budgets allocated to the health sector as well as proportion of population accessing integrated SRH services and the proportion of services within the essential package of SRHR services covered by the public health system Unfortunately there is almost no information on the last two indicators.

SADC countries developed a baseline scorecard in 2019. The milestone scorecards measure progress by countries against the baseline data and show whether the SADC region and Member States are on track to meet the SADC SRHR Strategy and SRHR SDG targets by 2030. Member States report every two years on progress (2021, 2023, 2025, 2027 and 2029).

SADC launched the 2021 Milestone Scorecard in November 2021. The tool is available online and visually presents how states are progressing in achieving the targets by indicating upward or downward movement and by colour coding to show where targets or milestones have been achieved or not. The scorecard shows country and regional trends over time against the indicators. This will help to inform member states' strategies for reviewing and increasing efforts to achieve the targets.

Status of SRHR policies in SADC

Over the last 20 years 14 of the 16 SADC countries have developed stand-alone SRHR policies or guidelines on SRHR, though many of these are now outdated.

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

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Older than ten years		
Namibia	National Policy for Reproductive Health	2001
Mauritius	National Sexual and Reproductive Health Policy	2007
Lesotho	National Reproductive Health Policy	2008
Zambia	National Reproductive Health Policy	2008
Zimbabwe	National Adolescent Sexual and Reproductive Health Strategy	2010-2015
Mozambique	National Sexual and Reproductive Health Policy	2011
Older than five years		
Seychelles	Reproductive Health Policy for Seychelles	2012
Eswatini	National Policy on Sexual and Reproductive Health	2013
Updated/ adopted in the past five years		
Madagascar	Reproductive Health and Family Planning Law	2017
Malawi	National Reproductive Health and Rights Policy	2013-2022
South Africa	National integrated SRHR Policy , ED 1	2019
SRHR guidelines		
Botswana	Policy guidelines and service standards for sexual and reproductive health	2015
Tanzania	SRHR guidelines and National Adolescent Reproductive Health Strategy	2011-2015
Comoros	Adolescent and Youth Health Strategy	2018
No SRHR policy or guidelines		
DRC	Comprehensive Public Health Bill (Including SRHR)	2018
Angola	Included in the Constitution	1975

Source: Audit of SRHR policies and laws, Gender Links (2019), additional online research.

Table 2.2 shows that 14 SADC countries have either stand-alone SRHR laws and policies or SRHR guidelines, however most of these are outdated. Ten countries adopted these five to ten years ago, Madagascar, Malawi and South Africa have SRHR laws and policies less than five years old. Angola and the DRC are the two countries that have no standalone SRHR policy or guidelines.

Role of local government

As the level of government closest to the people, local government is an important entry point for women. Local council offices are geographically closer to communities than national offices. Councillors are more accessible than parliamentarians. In many SADC countries local government, is responsible for primary healthcare services, including maternal health and family planning services; have HIV and AIDS policies, and take responsibility for ARV treatment.

The Gender Links (GL) Centres of Excellence for gender in local government is the most far-reaching, systematic and sustained effort to

Local authorities in Zimbabwe Centres of Excellence for Gender in local government have developed progressive messages on meeting SRHR needs.
Photo: Colleen Lowe Morna

promote gender mainstreaming in Local Government in SADC. Over the last decade, GL has worked with 380 local councils in ten countries - Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe. Councils have developed Gender, GBV and SRHR strategies and action plans aligned with the SADC Gender Protocol, which was updated in 2016 in line with the Sustainable Development Goals. Since then many councils have started to develop and implement programmes that directly address women's SRH needs, with increasing focus on vulnerable groups including sex workers.

City of Harare extends SRHR services to all

Walking down the Avenues of Harare at night, one is greeted by a host of sex workers of all ages going about their business. AS in many SADC countries, sex work is illegal in SADC. But the City of Harare has decided not to turn a blind eye on the SRHR needs of any of its residents. The metropole provides multiple SRH services through three dedicated health institutions: Wilkins Hospital, Edith Opperman (Mbare[22]) and the Mbare Clinic (mainly providing SRH services to sex workers).

With support from the Centre for Sexual Health & HIV/AIDS Research (CeSHHAR), the services provided to sex workers include voluntary counselling and testing; treatment of STIs; provision of contraceptives; access to information, and a plethora of SRHR services. "We come here all the time to access services because the health staff here do not stigmatise us compared to other health institutions. We are also free to talk about any issues SRH issues that are affecting us as we have all the confidentiality and privacy we need", said one of the sex workers, who preferred to remain anonymous.

Edith Opperman offers SRH services to adolescents. This includes access to information, access to contraception, and treatment for sexually transmitted infections, and HIV and AIDS testing among other services. Medecins Sans Frontieres (Doctors without Borders) supported the programme from 2015-2020. Between 2019 and 2020 the uptake of contraceptive services by female clients increased from 6.4% to 43%.[23] HIV prevalence among adolescents dropped to 2.3%.

Since the Medecins Sans Frontieres funding came to an end, the City of Harare Health Department has continued providing SRH services at the clinic though at a much lower scale. In addition to the distribution of contraceptives (both female and male condoms) to adolescents, the clinic is popularising the menstrual cup and menstrual pants as alternatives to sanitary pads. These have been readily accepted in the community; however, their uptake has been low.

Health Personnel at Edith Opperman Clinic demonstrating the use of the menstrual cup.
Photo: Tapiwa Zvaraya

Edith Opperman Clinic also serves as a referral centre for sexual gender-based violence (SGBV) cases in Harare. Health practitioners assist survivors of SGBV with the necessary services including provision of pre-exposure prophylaxis (PREP), HIV counselling and testing, and legal advice for those who need to report cases to the police.

Source: By Tapiwa Zvaraya, from a report on a study visit to SRHR services with Amplify Change facilitated by the City of Harare, a COE "hub" in March 2022.

[23] Mbare is one of the oldest suburbs of Harare, the capital city of Zimbabwe.
[24] MSF, https://www.msf.org.za/sites/default/files/2021-08/evaluation_adolescents_sexual_reproductive_health_project_zimbabwe.pdf

Menstrual health

According UNICEF: "Every month, 1.8 billion people across the world menstruate. Millions of these girls, women, transgender men and non-binary persons are unable to manage their menstrual cycle in a dignified, healthy way."[24] Menstrual health is a fundamental right for every girl and woman to live a healthy life during menstruation. Gender inequality, discriminatory social norms, cultural taboos, poverty and lack of basic services like toilets and sanitary products can all cause menstrual health and hygiene needs to go unmet.

Harmful practices and inadequate facilities to help women and girls deal with their periods continue to deny them their rights to health and dignity; limit or exclude them from productive activities such as attending school, going to work and/ or participating in sports and community activities. Many girls and young women do not have easy access to a supply of quality sanitary materials.

The **African Coalition for Menstrual Health Management (ACMHM)**, established at the 2018 African Symposium on Menstrual Health Management reported 'great progress" for menstrual health in Africa in 2021. The Coalition hosted by UNFPA East and Southern Africa Regional Office (ESARO) now has a membership of about 600 organisations and individuals from governments, CSOs, social entrepreneurs, academia, faith leaders and youth from across the continent. Its mission is to advance and sustain a collaborative platform for a diverse range of Africa-based actors working on menstrual health management.

The ACMHM positions MHM as a key development and multi-sectoral issue and work collectively to advance the ACMHM agenda globally. It aims to enhance MHM documentation and knowledge management, as well as research. They also contribute to the development, harmonisation and implementation of MHM products, standards and value chains.

Sanitary products are expensive and taxed in most countries, so many resort to using materials that are ineffective, unhygienic and uncomfortable, such as reusing rags, leaves and other safe methods of menstruation management.

Removing VAT is an important first step towards providing affordable menstrual products and governments can show their commitment to addressing women's menstrual health needs by scrapping value-added tax (VAT) on sanitary products. Providing free sanitary products to all school girls, particularly in rural areas will improve educational performance and advance their overall health. There are a growing number of countries in the SADC region that have removed VAT on sanitary products.

Learners from various school in Windhoek commemorating menstrual Health and Hygiene.
Photo: Gender Links

[24] UNICEF Menstrual Hygiene, https://www.unicef.org/wash/menstrual-hygiene accessed 31 August 2022.

Table 2.3: VAT exempted and free menstrual products in SADC

Country	NO VAT on sanitary ware	Free sanitary ware in schools[25]
Mauritius	Yes (2017)[26]	Yes (2018)[27]
Lesotho	Yes (2019)[28]	Yes (2021)[29]
South Africa	Yes (2019)[30]	Yes (2019)[31]
Zimbabwe	Yes (2020)[32]	Yes (2020)[33]
Namibia	Yes (2021)[34]	No
Seychelles	No	Yes (2022)[35]
Zambia	No	Yes (2019)[36]
Botswana	No	Yes (2017)[37]
Angola	No	No
Comoros	No	No
DRC	No	No
Eswatini	No	No
Madagascar	No	No
Malawi	No	No
Mozambique	No	No
Tanzania	No	No

Source: Constructed by Gender Links from sources in footnotes.

Table 2.3 shows that five SADC countries (Lesotho, Mauritius, Namibia, South Africa and Zimbabwe) have now removed VAT on menstrual products. Seychelles is the latest country to do so. Seven countries (Mauritius, Lesotho, South Africa, Zimbabwe, Zambia, Seychelles and Botswana) provide free sanitary ware in schools.

Belinda Groeneveldt, Principal of Cedar High School, is working with New Heritage on a new pilot project for ASRHR in schools. Photo: Colleen Lowe Morna

[25] Largely of rural schools and indigent populations
[26] The Daily Vox, ,accessed 3 September 2022
[27] Change.org accessed 3 September 2022
[28] Gender Links accessed 3 September 2022
[29] Menstrual Hygiene Day, accessed 3 September 2022
[30] Global Citizen accessed 3 September 2022
[31] Department of Women MH Day speech accessed 3 September 2022
[32] BDO Global accessed 3 September 2022
[33] Fair Planet accessed 3 September 2022
[34] Epf Web accessed 3 September 2022
[35] ZAWYA accessed 3 September 2022
[36] MH Day accessed 3 September 2022
[37] AfricaNews accessed 3 September 2022

Seychelles became the seventh country in SADC to provide free sanitary ware to all school girls at all state and private schools, as well as in professional centres across the island in January 2022. The Government took the decision to launch the national programme following a motion tabled by the Member for the National Assembly for Glacis (also the Chairperson of the Women's Parliamentary Caucus) Regina Esparon. Her intervention before the National Assembly declared menstruation a "normal health related process for women and girls." She called on Government and stakeholders to start discussions on making sanitary products tax free, more affordable and accessible for women and girls.

Zimbabwe allocated USD 12,5 million, starting in January 2020, for the provision of sanitary pads to all adolescent schoolgirls in rural areas. But young women still struggle to access sanitary ware. Young women in schools and communities are leading the cause for improving access to sanitary products.

South Africa: New Heritage Foundation - Western Cape, a Women Voice and Leadership grantee, started its ending period poverty campaign by handing out sanitary pads which was not sustainable. The organisation is now teaching girls how to make reusable sanitary pads and continues with the education around menstruation. In this phase, New Heritage will work with Cedar High School on the Cape Flats in an integrated programme of Adolescent Sexual and Reproductive Health including menstrual health with a view to replicating this programme in other schools. During the Sixteen Days of Activism, New Heritage collaborated with SAWID in the WVL-SA Sixteen Days Period Poverty Dialogue in Cape Town in December 2021. The strong message sent out in the dialogue is that period poverty is a form of gender violence.

Providing sanitary ware to girls in Umguza

Young people constitute close to 60% of the population of the SADC population. They face the most challenges in accessing Sexual Reproductive Health (SRHR) services, sanitary ware being one of them. In rural Zimbabwe, close to 60% of women and girls in rural areas including young girls have no access to sanitaryware largely due to cost.

A packet of pads costs an average of between USD$1.50 to USD$2 despite the fact Zimbabwe has exempted value-added tax on sanitary ware.

This has prompted school girls from Mahlothova Secondary School in Umguza to embark on a reusable sanitary pad production project. Initiated by the School Girls League Club in 2019, the project seeks to provide access to pads to vulnerable girls in the Umguza community. It also aims to reduce incidences of absenteeism which leads to poor academic performance. The Girls League Club consists of approximately 25 young girls both in and out of school who come from diverse backgrounds including being the sole breadwinners in their families.

Core to their activities is the production of reusable sanitary pads. These are largely distributed amongst their peers in school, other out-of-school youths, and women in the community who have no access to these products. This project has seen an improvement in the attendance of girls in school. Some girls are actively participating in extra-curricular activities. As the project grows the Club is starting to enlist boys an indication of a change in mindset.

Umguza students making reusable sanitary pads. Photo: Tapiwa Zvaraya

While their successes have contributed to an improvement in the access to sanitary ware for girls in the school, they have not gone without their challenges which include a turnover in membership, and the soaring cost of materials to produce the sanitary pads. In addition, due to their school commitments, the group barely finds time to make pads regularly which sometimes affects the beneficiaries of the project negatively. By and large, the project has proved to be a sustainable model, more so in other rural communities like Lupane, and Murehwa where such projects are being implemented.

The project seeks to secure more funding and establish an online presence that will not only market their products but also lure prospective sponsors. There is no doubt that the institutionalization of the project has been a beacon of hope for both Mahlothova school and the communities surrounding it.

Source: Gender Links News Service.

Period stigma

Period or menstruation stigma refers broadly to the discrimination people who menstruate face. From physical issues such a lack of access to sanitation supplies, to the verbal shaming of menstruating people as "dirty" or "unclean," period stigma results in a lower quality of life for those who are faced with it. In developing nations, this can be even more harmful.[39]

[39] https://www.verywellmind.com/what-is-period-stigma-5116231

Challenging menstruation stigma and taboos in Malawi

Ulemu Kupakasa wanted to give up her aspiration of being the vice president of the student's union in a higher education institution in Malawi because of the shame, stigma and ridicule she endured. Men said that the first woman candidate for the post could not be Vice President because she menstruates. Students at the university, however, proved the opposing group wrong by voting for Kupakasa as the Vice President of the students union.

This is just one example of how stigma and taboos around menstruation impact on women's participation at all levels of decision-making. Various organisations are trying to tackle this issue in Malawi.

According to Executive Director for the Coalition of Empowerment of Women and Girls (CEWAG), Beatrice Mateyu: "The negative comments are unfortunate in as far as gender equality is concerned because they are deliberately linking one's leadership capabilities to menstruation. With several legal instruments on the table aimed at ending discrimination against women, we should be moving away from looking at leadership qualities based on one's sex. We need to look at qualities and capabilities of the person to lead us neither their sex nor their gender."

CEWAG is implementing several projects targeting adolescent girls in order to demystify stigma that comes with menstruation. "Social stigma in regards to menstruation is a long-standing issue and mostly a woman is looked at as dirty, unclean and impure when menstruating. If you add poverty to it where girls and women do not have proper menstrual facilities, running water and sanitary pads things get worse and the issue of uncleanliness which has been talked about is more physical in nature rather than just imaginary social stigma," says Mateyu.

There is also a need to create dialogue and teach boys and men issues to do with menstruation and gender. "To build a more equal and just society we need to educate men and boys to view monthly periods as a natural process not a weakness or a limitation," she said.

SHRH trainer and champion for Sex Rights Africa Network, James Mamalira says inclusion of women in students' unions matters most because it is one way of mentoring them into leadership in the society adding such comments are more colonised, repugnant and a misleading patriarchal mindset. He bemoans lack of open platforms to discuss menstruation from within families to the entire community and inadequate access to menstrual hygiene products, which force women to resort to rags as some of contributing factors of menstrual induced social stigma.

"Social stigma in regards to menstruation is a long-standing issue..."

Malawi Girls Guide Association (MAGGA), executive director for MAGGA, Mphatso Baluwa Jim says their message is "Let's stop discussing issues to do with menstruation under closed doors as it allows negative myths to proliferate that usually leave girls less confident about their bodies."

Jim adds, "Menstruation is part of being a woman and should not be a taboo subject. Families and communities should create spaces where these issues can be discussed openly and give young women a chance to negotiate safe, hygienic and dignified monthly period hence ending the stigma."

Source: Malawi: End the stigma. Period by Jenipher Changwanda and Ziliro Mchulu. This story is part of the GL News Service.[40]

[40] https://genderlinks.org.za/news/malawi-end-the-stigma-period/

The discrimination faced by someone menstruating comes in a range of forms from joke or the perpetuation of a belief that is not true. From accusations of 'PSM-ing' if a person who menstruates is behaving in a sensitive, sharp, or aggressive manner, politicians claiming that menstruating people do not function well at work.

Addressing period stigma requires normalising menstruation including openly discussing periods without shame and putting in place school and workplace policies that are explicit about women not being separated or discriminated against during their period.

Sanitation and hygiene

Article 26 (c) SADC Gender Protocol: Ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.
SDG 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

The Southern African region represents an area with huge gaps on access to basic water and basic sanitation services. According to the United Nations Children's Fund (UNICEF), more than 70 per cent of the population in Eastern and Southern Africa (340 million people) have no access to basic sanitation services[41].

Kariba REDD+ Project members fetching water from the borehole Hurungwe RDC. Photo: Tapiwa Zvaraya

Safe water, sanitation and hygiene are basic human rights and critical to human health, and welfare, as well as to the economic and social development of communities and nations, yet millions of people across the globe do not have access to these basic services. Women are particularly affected as those who often bear the primary responsibility for collecting water and managing household hygiene. Women are also directly impacted by the lack of adequate sanitation facilities because of their reproductive roles and their complex WASH related needs across their life course.

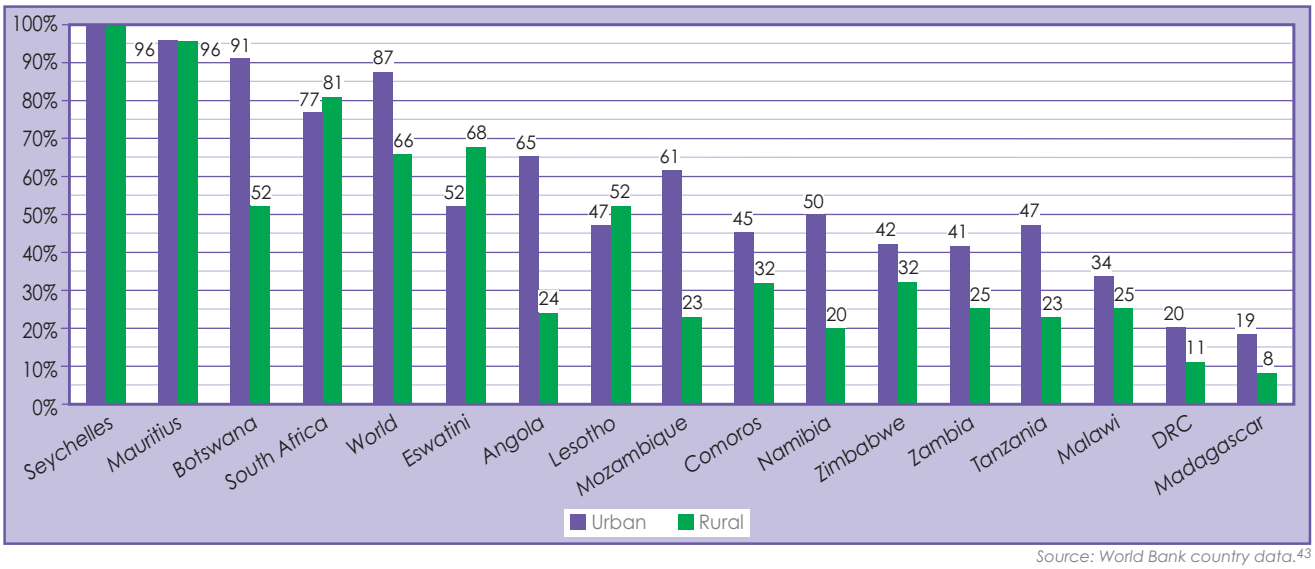
Poor access to WASH facilities also increases women and girls' vulnerability to violence[42]. Harassment, abuse, rape and other forms of violence are very real threats when travelling long distances to access water or latrines or having to use unsafe public facilities.

[41] UNICEF, Sanitation and hygiene. Available at: https://www.unicef.org/esa/sanitation-and-hygiene, accessed: 13 July 2022.
[42] House, S., Suzanne Ferron, Marni Sommer and Sue Cavill (2014) Violence, Gender & WASH: A practioner's toolkit. Making water, sanitation and hygiene safer through improved programming and services, SHARE Consortium, http://violence-wash.lboro.ac.uk/

Access to basic sanitation

There has been progress in increasing access to WASH services in the region, however progress has been sluggish in most countries. While the data is not disaggregated by sex it shows the discrepancies between urban and rural access, where it is predominantly women who are responsible for sourcing and providing water for the household.

Figure 2.2: Proportion using at least basic sanitation services - Urban/Rural



Source: World Bank country data.[43]

Figure 2.2 shows a discrepancy between urban and rural coverage in all countries except Seychelles and Mauritius where there is almost universal access. However, there is a large disparity in access for those living in urban and rural areas, where in most countries rural coverage is lower. In Lesotho, Eswatini and South Africa, on the other hand, those living in rural areas have greater coverage. In ten countries (Botswana, Angola, Mozambique, Comoros, Namibia, Zimbabwe, Zambia, Tanzania, Malawi, Madagascar and DRC) less than half the population living in rural areas have access to at least basic sanitation.

Coverage of sanitation in primary and secondary schools in SADC is patchy. The SADC Hygiene strategy presents data for just four countries - Madagascar, Malawi, Mauritius and Seychelles. Mauritius and Seychelles are the only countries with universal access in both primary and secondary schools. Coverage is lower in Madagascar and Malawi with coverage of 62% and 75% respectively, in primary schools. Coverage is even lower in secondary schools with 52% coverage in Madagascar and 56% in Malawi.[44] States need to address the gaps in access to basic sanitation facilities in schools, especially in secondary schools where adolescent girls require access to sanitation facilities to be able to manage their menstruation in a safe and dignified manner. Lack of access to these facilities prevents adolescent girls from attending school during their period, resulting in them missing up to five days of school per month.

[43] https://data.worldbank.org/indicator/SH.STA.HYGN.ZS
[44] SADC Hygiene Strategy 2021-2025.

Access to hygiene

The World Health Organisation (WHO) estimates that a new-born in low- and middle-income countries dies every minute from infections related to lack of clean water and an unclean environment. Providing adequate water, toilets and hygiene in homes and health facilities help to reduce preventable new-born and maternal deaths due to sepsis and other infections due to unhygienic conditions.[45]

Progress towards the SDG target on hygiene is monitored through indicator 6.2.1b, 'the proportion of the population with handwashing facilities with soap and water at home. Data on access to basic handwashing facilities including soap and water only started being recorded from 2010 and it is not available for all countries or years. The data show that progress has been exceptionally slow, and coverage remains low.

Figure 2.3: Proportion with basic handwashing facilities including soap and water

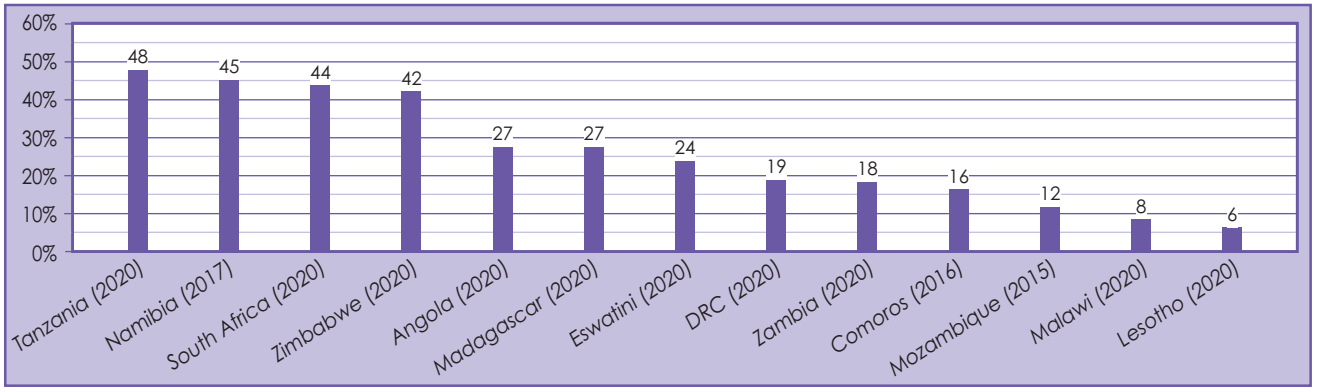


Figure 2.3 shows that with less than half of the population, in the 13 countries for which there is data, having access to these at least basic handwashing facilities including soap. There is no accurate data on the breakdown of access to basic hygiene in urban and rural areas.

Access to contraception

SDG 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
CEDAW: Article 14 (b): To have access to adequate health care facilities, including information, counselling and services in family planning.

Access to voluntary family planning and reproductive health (FP/RH) services is vital for safe motherhood and healthy families. Having a choice of modern contraceptives allows couples to plan and space births, ensuring families have the means to properly care for their children.

[45] Ibid.

Male and Female Condoms, Antananarivo, Madagascar.
Photo: Zoto Razanadratefa

Contraception is a lifesaver for women trying to prevent unplanned or unwanted pregnancies. Access to contraception improves maternal health and child survival, reduces the number of abortions overall, especially unsafe abortions and it empowers women and promotes social and economic development and security.

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

The proportion of the need for family planning satisfied by modern methods, Sustainable Development Goals (SDG) indicator 3.7.1, has plateaued globally at around 77% from 2015 to 2020. In the Africa region the need for family planning met by modern methods grew from 55% to 58%.[46] Among the 1.9 billion women of reproductive age group (15-49 years) worldwide in 2019, 1.1 billion have a need for family planning; of these, 842 million are using contraceptive methods, and 270 million have an unmet need for contraception.[47]

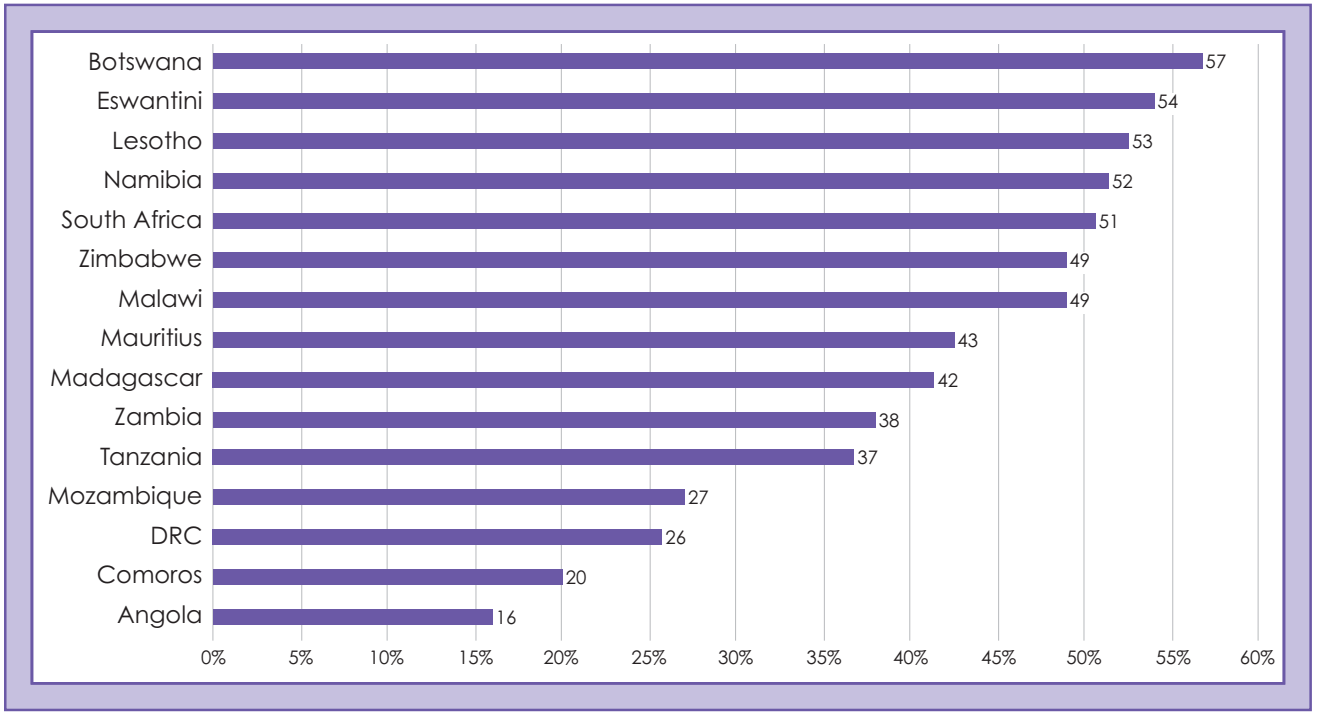
Contraceptive prevalence rates (CPR)

Contraceptive prevalence rate in this report, refers to the percentage of all women[48] of reproductive age (15-49) who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used.[49] In East and Southern Africa the contraceptive prevalence rate is low, with just 35% of all women aged 15-using any method of contraception.[50] This is lower than the global average of 49%.[51]

> Contraception is a lifesaver for women trying to prevent unplanned or unwanted pregnancies

[46] https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception
[47] Ibid
[48] This is often reported for married/in union women only, which is how we have reported on it previously. In this report we use the broader definition, which includes all women of reproductive age using any method of contraception.
[49] WHO, Sexual and Reproductive Health, https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/ accessed 27 July 2021
[50] UNFPA dashboard, https://www.unfpa.org/data/world-population-dashboard, accessed 8 September 2022
[51] https://www.unfpa.org/data/world-population-dashboard, accessed 8 September 2022

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



Source: UNFPA, World Population Dashboard, 2022.[52]

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

Unmet contraception need

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

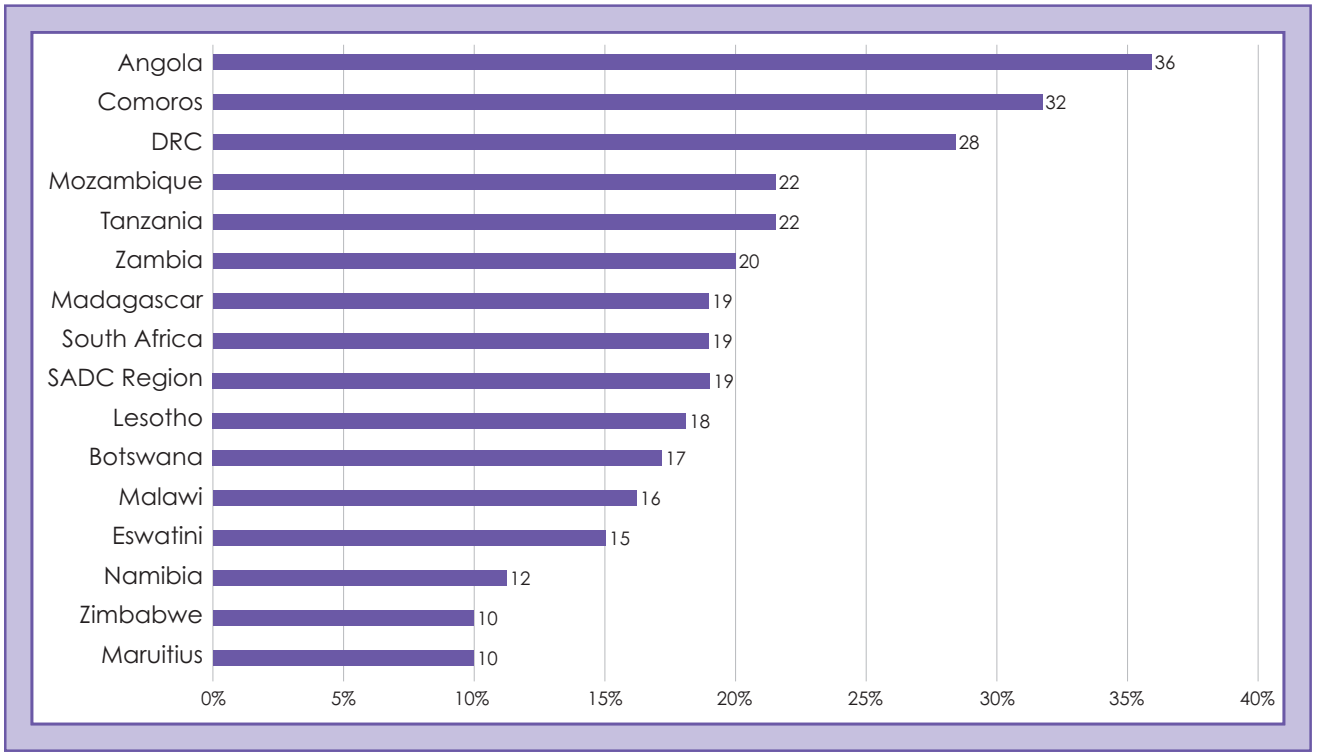
More than one out of every ten married women in the world, and one out of every five women in Africa, have unmet family planning needs. Despite this, studies concerning sub-Saharan Africa as well as the community-level factors that may influence the unmet need for family planning are scarce.[53] One study was conducted using data between 2015 and 2020 to assess factors associated with unmet need for family planning in sub-Saharan Africa.[54]

The study identified individual and community factors. "Women's age, education, age at co-habitation, heard about family planning through media, parity, number of under-five children, and knowledge about modern contraceptive methods were among the individual-level factors that were associated with both the unmet need for spacing and limiting. Place of residence, community level of women illiteracy, and region

[52] https://www.unfpa.org/data/world-population-dashboard accessed 31 August 2022
[53] Teshale AB (2022) Factors associated with unmet need for family planning in sub-Saharan Africa: A multilevel multinomial logistic regression analysis. PLOS ONE 17(2): e0263885. https://doi.org/10.1371/journal.pone.0263885, accessed 9 September 2022
[54] Ibid.

were among the community-level factors that were associated with both unmet needs for spacing and limiting. Household size and visiting the health facility in the last 12 months were associated with unmet need for spacing only and husband education was associated with unmet need for limiting only."[55]

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



Source: SADC SRHR scorecard, 2021.[56]

Figure 2.5 shows the proportion of women who have unmet needs for contraception. Angola has the highest unmet need with 36% of women of reproductive age (15-49 years) having a need for family planning not met. Two countries (Mauritius and Zimbabwe) are below the global average of 10%. Seven countries equal or are less than the SADC average of 19%. These are Madagascar, South Africa, Lesotho, Malawi, Eswatini, Namibia, Zimbabwe and Mauritius.

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

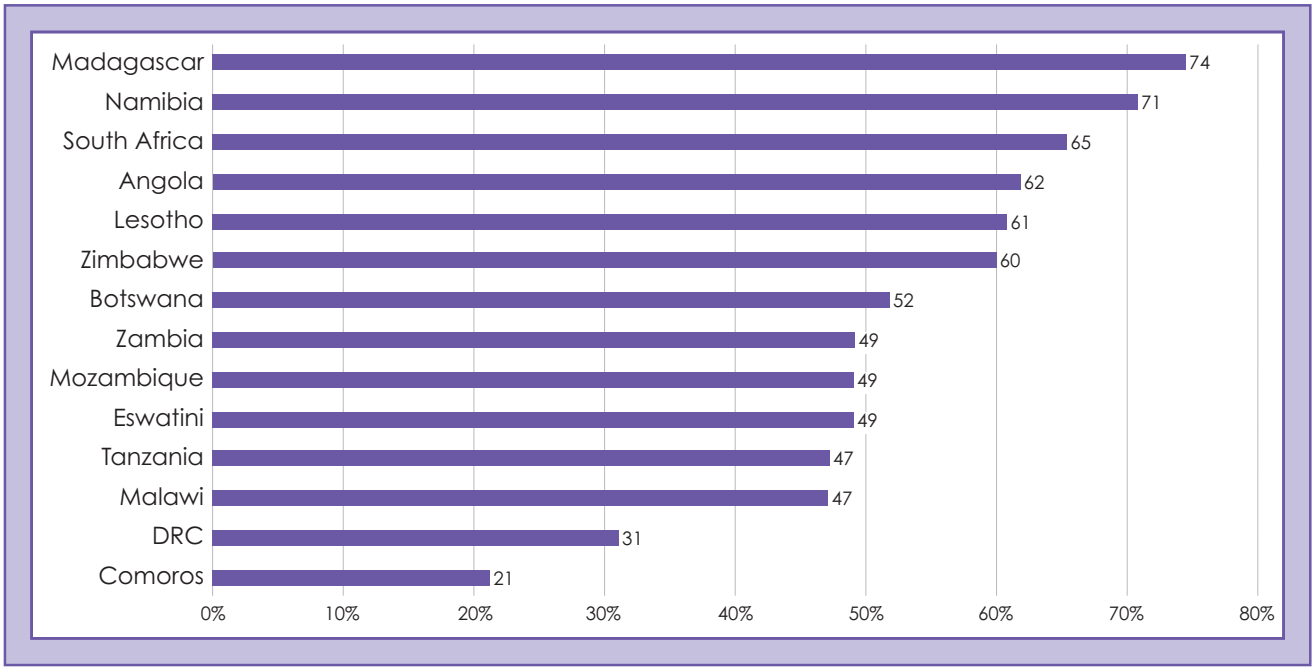
[55] Ibid.
[56] https://dev-www.sadc.int/srhrscorecard/ accessed 31 August 2022

Female decision making on SRHR

SDG Indicator 5.6.1: Proportion of women, aged 15-49 years, who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

Women's right to make decisions about their own bodies is pivotal to gender equality and universal access to sexual and reproductive health and rights in three areas. There are three main considerations for women to be empowered to exercise their reproductive rights - seeking reproductive health care for themselves, contraceptive use, and consensual sexual relations.

Figure 2.6 : Female decision-making on SRHR (%)



Source: UNFPA, World Population Dashboard, 2007-2020.[57]

Figure 2.6 shows that there is no country in which all women have control over decision-making on SRHR. Eight countries are below the global average of 57% and seven below the average for East and Southern Africa of 52%. Madagascar has the highest proportion of women involved in decision-making on SRHR at 74%, followed by Namibia (71%), South Africa (65%), Angola (62%), Lesotho (61%) and Zimbabwe (60%). In eight countries less than 50% of women are involved in decision-making on SRHR, with DRC and Comoros well below 50% at 31% and 21% respectively.

[57] https://www.unfpa.org/data/world-population-dashboard Accessed 31 August 2022.

Maternal health

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

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

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

a) The right to control their fertility;
b) The right to decide whether to have children, the number of children and the spacing of children; and
c) The right to choose any method of contraception.

Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being.

Maternal mortality

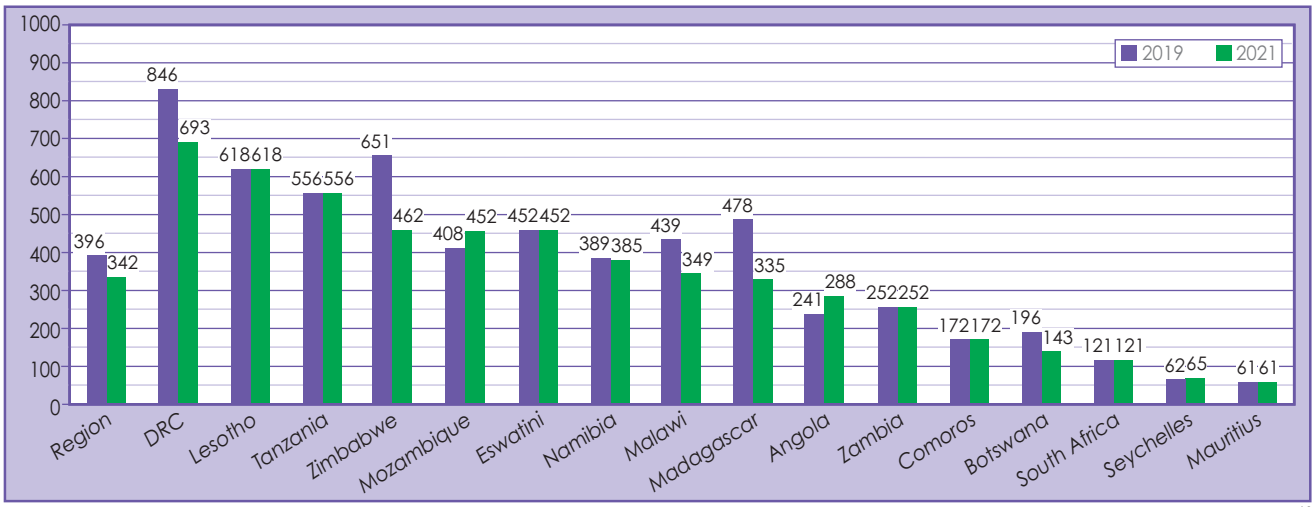
Maternal mortality refers to deaths due to complications from pregnancy or childbirth. Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anaemia, malaria, and heart disease.[58]

Globally there has been a significant decrease in maternal deaths over the last 20 years. Globally maternal mortality dropped from 342 deaths per 100,000 live births in 2000 to 152 deaths per 100,000 live births in 2020.[59] Low income countries have a significantly higher maternal mortality rate (462 per 100,000) compared to 11 per 100,000 in high income countries.[60]

Most countries in the SADC region are still far from reaching the SDG target 3.1 by 2030. There are a range of factors contributing to this including high unmet need for contraception and early and unintended pregnancies, poor access to maternal health services and standard of care, as well as socio-economic and demographics factors such as geographical location, poverty, age and gender inequality.

[58] Ibid
[59] UNICEF maternal mortality database https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 14 July 2021
[60] https://theconversation.com/most-maternal-deaths-are-preventable-how-to-improve-outcomes-in-south-africa-181282#:~:text=The%20past%2020%20years%20have,of%20these%20deaths%20are%20preventable

Figure 2.7: Maternal Mortality ratio per 100,000 deliveries



Source: SADC SRHR Scorecard.[61]

Note: The figures here have been extracted from the SADC SRHR milestone scorecard. It should be noted that some of the figures differ from those published by UNICEF on trends between 2000 and 2017, and in most cases the SADC scorecard figure are higher than those published by UNICEF.

Figure 2.7 shows progress in reducing maternal deaths in SADC since the completion of the SADC SRHR scorecard in 2019 and the first-year milestone 2021. Maternal mortality remains stubbornly high in SADC. The regional average is 396 deaths per 100 000 deliveries. Just two of 16 SADC countries, Seychelles and Mauritius have met the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Maternal mortality decreased in DRC and Zimbabwe but increased in Mozambique and Angola. It is not clear if these marked differences are due to real changes, or better data collection. Overall, maternal mortality remains a major concern in the region, as illustrated in the case study that follows from Lesotho.

High rate of maternal mortality a cause for concern[62]

The high rate of maternal mortality particularly among young girls aged between 15-24 due to complications of unwanted pregnancies, often results in them dropping out of school. This is of great concern to UNFPA, the United Nations Population Fund in Lesotho.

UNFPA Lesotho seeks to prevent unwanted pregnancies through contraception, giving women an opportunity to decide when to become pregnant and spacing of their pregnancies. Safe motherhood is the second pillar while the third pillar is, midwifery, particularly skilled midwives who are able to perform life-saving interventions and deal with complications.

UNFPA has supported the Government of Lesotho through the Ministry of Health to change the midwifery curriculum. With the new curriculum training has been upgraded from a 12 months' diploma course to an 18 months post basic diploma.

According to the most recent State of the World's Midwifery report, well-trained midwives could help avert roughly two thirds of all maternal and new-born deaths globally and also deliver 87 per cent of all essential sexual, reproductive, maternal and new-born health services.

[61] https://dev-www.sadc.int/srhrscorecard/ accessed 1 September 2022
[62] UNFPA, https://lesotho.unfpa.org/en/news/high-maternal-mortality-great-concern-unfpa-0

Access to maternal health services

Table 2.5: Provision of antenatal and postnatal care

Country	Antenatal care coverage: at least one visit %	Antenatal care coverage: at least four visits %	Post-natal check-up for mothers %
Angola	82	61	**23**
Botswana	94	73	No data
Comoros	92	**49**	**49**
DRC	82	**43**	**50**
Eswatini	99	76	88
Lesotho	91	77	84
Madagascar	85	51	72
Malawi	97	51	84
Mozambique	94	51	No data
Namibia	97	63	69
South Africa	94	76	84
Tanzania	98	62	34
Zambia	97	64	70
Zimbabwe	93	72	82

Source: Maternal and Newborn Health Coverage Database updated May 2022.

Table 2.5 shows that no country in the region has all women being attended at least once during pregnancy by skilled health personnel. Angola has the lowest proportion of mothers having at least one visit to a skilled health worker, with just 82% of pregnant women having access to this health service. Eswatini has the highest proportion of women attending at least one visit.

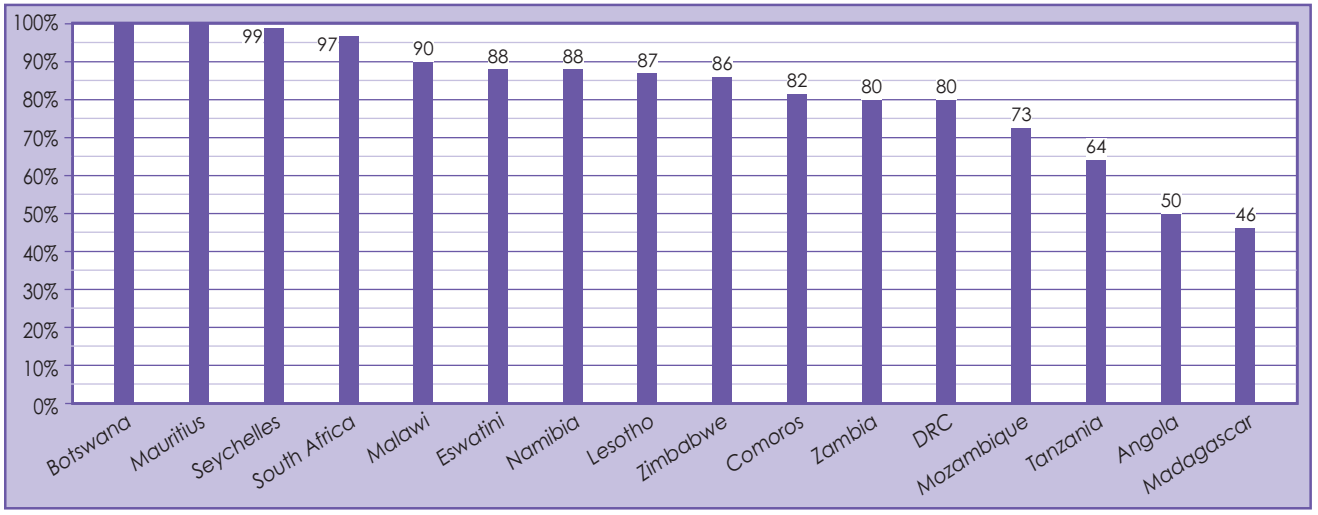
A much lower proportion of women have at least four antenatal visits. In five countries (Botswana, Lesotho, Eswatini, South Africa and Zimbabwe) over 70% of pregnant women have at least four antenatal visits. In almost all countries the urban/rural divide is bigger, partly as a result of access to clinics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

Maternity ward in Befelatanana, Madagascar. Photo: Zoto Razanadratefa

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

There is no data for antenatal and postnatal care for Mauritius and Seychelles.

Figure 2.8: Percentage of births delivered by a skilled health personnel (typically doctor, midwife and/or nurse)



Source: Maternal and Newborn Health Coverage Database updated May 2022.[63]

Figure 2.8 shows that only in Mauritius and Botswana do all women have access to skilled birth attendants during delivery. Angola and Madagascar have exceptionally low proportions of pregnant women having a skilled attendant during delivery, with just 50% and 46%, respectively.

Neonatal mortality

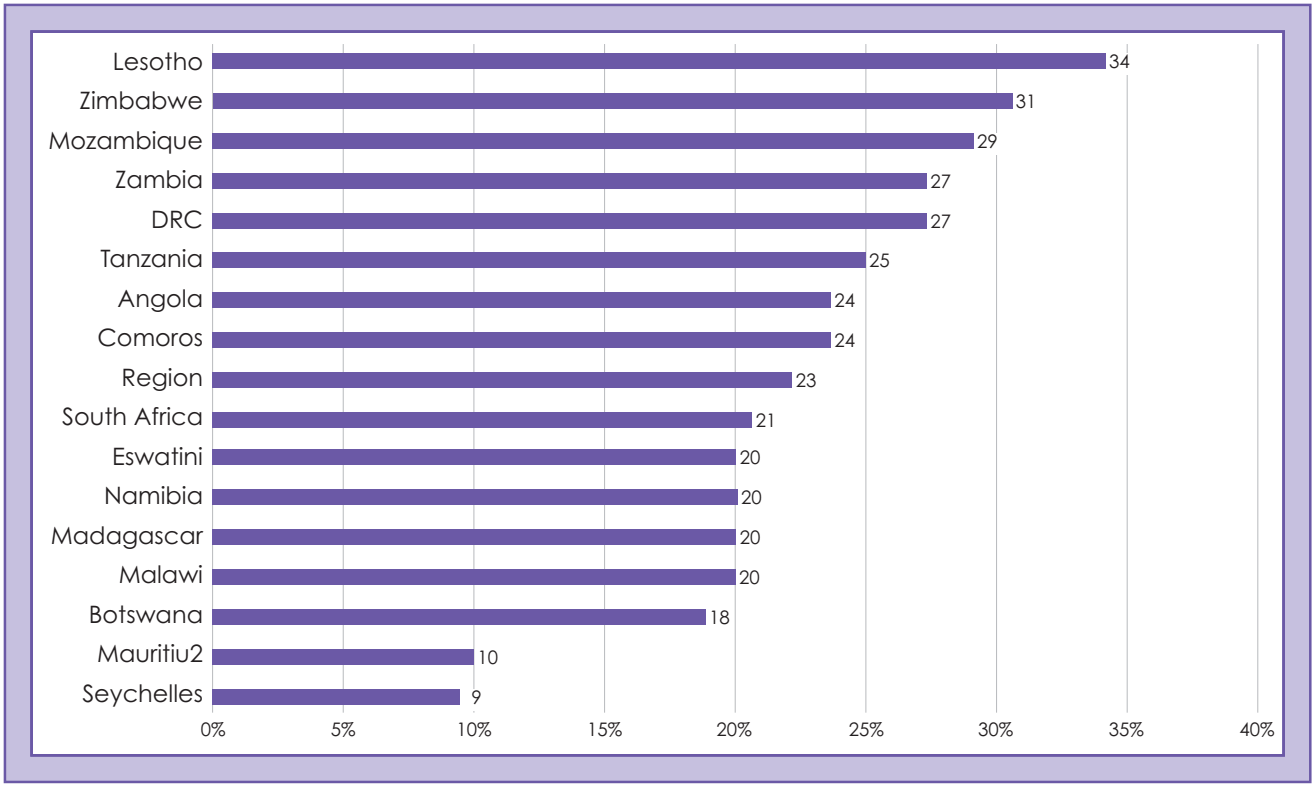
SDG Target 3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

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

By 2030, end preventable deaths of new-borns and children under 5 years of age

[63] https://data.unicef.org/topic/maternal-health/newborn-care/ , accessed 2 September 2022
[64] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf , accessed 2 September 2022
[65] https://data.unicef.org/topic/child-survival/neonatal-mortality/ , accessed 2 September 2022

Figure 2.9: Neonatal mortality rate per 1000 live births



Source: SADC SRHR Scorecard.[66]

Figure 2.9 shows that the regional average for neonatal deaths is 23 per 1000. Just two SADC countries (Seychelles and Mauritius) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 34 deaths per 1,000 live births.

Human papillomavirus (HPV) and Cervical cancer

Human papillomavirus (HPV) is the most common sexually transmissible infection (STI). In their lifetime, sexually active women and men will be infected at least once without necessarily developing any pathologies. HPV infection is now a well-established cause of cervical cancer. There is growing evidence of HPV being a relevant factor in other anogenital cancers (anus, vulva, vagina and penis) as well as head and neck cancers. More than 42 million people globally are currently infected with HPV types that cause disease.[67]

Risk factors for HPV include a history of tobacco use, lack of condom use at high risk sex and HIV infection. Male circumcision and the use of condoms have shown a significant protective effect against HPV transmission.

HPV types 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide. HPV vaccines that prevent HPV 16 and 18 infections are now available and have the potential to reduce the incidence of cervical and other anogenital cancers[68].

[66] https://dev-www.sadc.int/srhrscorecard/ accessed 2 September 2022
[67] https://www.cdc.gov/hpv/parents/about-hpv.html
[68] Ibid.

Cancer of the cervix uteri is the 4th most common cancer among women worldwide, with an estimated 604,127 new cases and 341,831 deaths in 2020. This is an increase from 570,00 cases and 311,00 deaths: an incidence rate of approximately 13 per 100,000 women. Current estimates indicate that every year 117,316 women are diagnosed with cervical cancer and 76,745 die from the disease in Africa.[69]

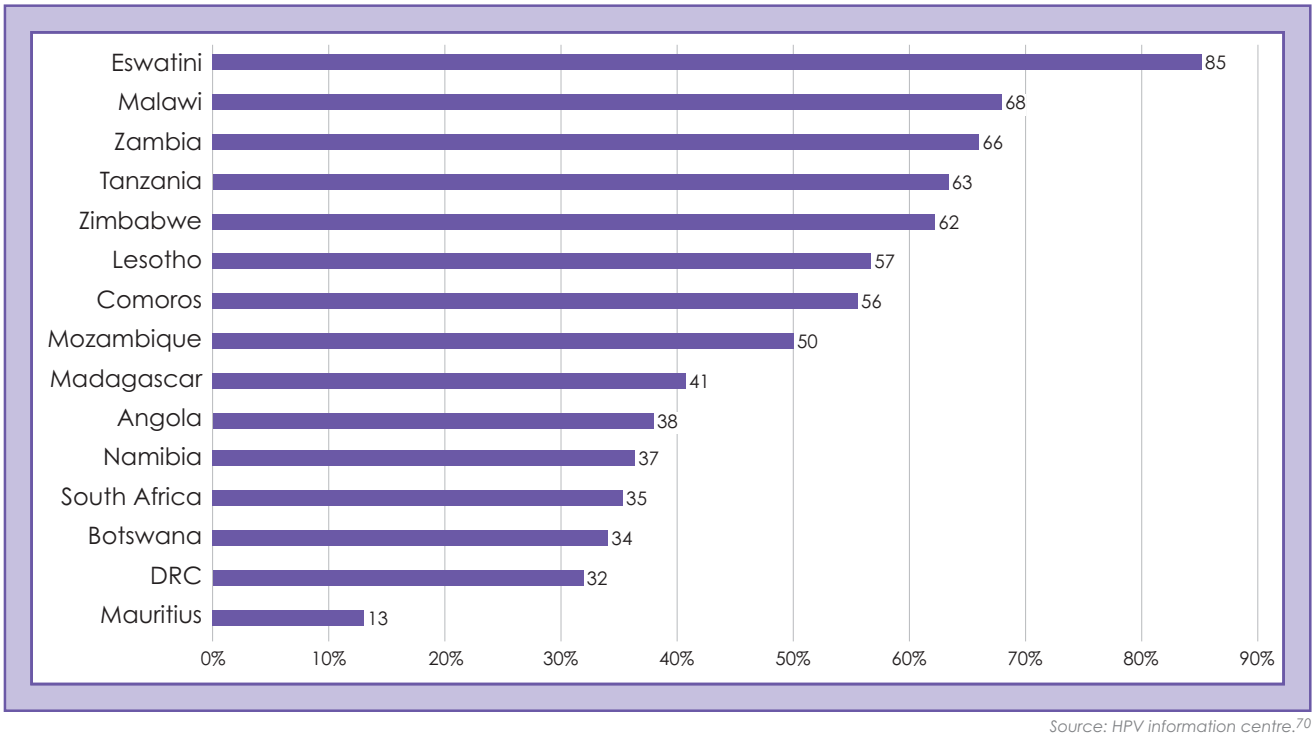
The WHO has launched a Global Initiative to scale up preventive, screening, and treatment interventions to eliminate cervical cancer as a public health challenge in the 21st century. WHO Cervical Cancer Elimination Strategy Targets for 2030 include:

- 90% of girls fully vaccinated with the HPV vaccine by the age of 15.

Primary School girls in Hwange being vaccinated for Human Papiloma Virus (HPV). Photo: Tapiwa Zvaraya

- 70% of women are screened with a high-performance test by 35 years of age and again by 45 years of age.
- 90% of women identified with cervical disease receive treatment.

Figure 2.10: Incidence of cervical cancer due to HPV in SADC (2020 estimates)



Source: HPV information centre.[70]

The incidence of cervical cancer attributable to HPV is extremely high in many SADC countries. Figure 2.10 shows that the prevalence rate of cervical cancer per 100,000 women per year, attributable to HPV is higher than the African average of 26 incidences in all countries except

[69] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, G_mez D, Mu_oz J, Bosch FX, de Sanjos_ S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 22 October 2021.

[70] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, G_mez D, Mu_oz J, Bosch FX, de Sanjos_ S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 22 October 2021.

Mauritius. Of the 10 countries in Africa with the highest cervical cancer prevalence rate seven are in SADC (Eswatini, Malawi, Zambia, Tanzania, Lesotho, Comoros and Mozambique). Mauritius is the only country with a prevalence rate equal to the global average of 13.

Eight SADC countries rate in the top ten of the incidence of cervical cancer cases attributable to HPV. Effective primary (HPV vaccination) and secondary prevention approaches (screening for, and treating precancerous lesions) will prevent most cervical cancer cases. When diagnosed, cervical cancer is one of the most successfully treatable forms of cancer, as long as it is detected early and managed effectively. However, 84% of new cases occur in low-and-middle income countries due to poor access to all three prevention strategies. Cancers diagnosed in late stages can also be controlled with appropriate treatment and palliative care.

Primary prevention: HPV Vaccination

The World Health Organization (WHO) recommends a two-dose schedule of the HPV vaccine administered 6-12 months apart to girls aged 9-14 years as the primary target for prevention of cervical cancer. WHO has set a target 90% of girls fully vaccinated with the HPV vaccine by the age of 15.[71] One of the recommendations of the WHO is for states to include the HPV vaccination as part of the national vaccination programme. Only Seychelles and Zimbabwe have achieve the WHO goal target 90% of girls fully vaccinated with the HPV vaccine by the age of 15.The SADC SRHR scorecard includes an indicator to prevent HPV - Proportion female received recommended does by age 15.

Table 2.6 shows that eight countries in SADC have included HPV in their national vaccination programme, though coverage varies across countries. Seychelles, which started the vaccination programme in 2014 has the highest coverage (97%) whereas Botswana which started in 2015 has the lowest coverage (53%. Zimbabwe and Malawi have performed best starting their programmes in 2018 and 2019 and have a coverage of 96% and 89% respectively. With two of the highest incidences of cervical cancer attributed to HPV this is an important step towards eliminating cervical cancer as a public health problem. Eswatini, which has the highest prevalence of cervical cancer attributable to HPV is among the eight SADC countries that have not included HPV in their national vaccination programme.

Table 2.6: HPV vaccination programmes

Country	HPV included in national vaccination programme:	Proportion female received recommended does by age 15
Seychelles	Yes (2014)	97%
Zimbabwe	Yes (2018)	96%
Malawi	Yes (2019)	89%
Mauritius	Yes (2016)	74%
South Africa	Yes (2014)	63%
Zambia	Yes (2019)	60%
SADC region		60%
Tanzania	Yes (2018)	59%
Botswana	Yes (2015)	53%
Angola	No	No data
Comoros	No	No data
DRC	No	No data
Eswatini	No	No data
Lesotho	No	No data
Madagascar	No	No data
Mozambique	No	No data
Namibia	No	No data

Source: SADC SRHR Scorecard, Cervical Cancer profiles.

[71] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8841655/

Secondary prevention: Cervical cancer screening

Cervical cancer screening is the secondary prevention strategy for cervical cancer. This is yet to be fully integrated into existing reproductive health and HIV care services. The result is low coverage of cervical cancer screening and treatment. Other factors contributing to the low uptake of the screening services are long distances to health facilities, lack of awareness of the disease and the role of screening; failure of women to avail themselves for screening; low budget allocation for screening purposes; the demands of competing health needs such as HIV infection, tuberculosis and other common diseases and no consumer demand and therefore no political will to establish screening programmes.[72]

Table 2.7 shows that nine SADC countries have national cervical cancer screening programmes but coverage is patchy especially in Madagascar and Mozambique where just 8% and 3% of women have ever been screened for cervical cancer. No country in SADC is near to the WHO target of 70% of women are screened with a high-performance test by 35 years of age and again by 45 years of age.

Table 2.7: Screening for cervical cancer

Country	National Screening programme exists	Screened ever	Screened in last five years
South Africa	Yes	53%	43%
Botswana	Yes	50%	39%
DRC	Yes	42%	36%
Zambia	Yes	20%	17%
Zimbabwe	Yes	20%	19%
Eswatini	Yes	19%	15%
Malawi	Yes	19%	15%
Madagascar	Yes	8%	5%
Mozambique	Yes	3%	3%
Mauritius	No	42%	25%
Namibia	No	39%	29%
Seychelles	No	32%	26%
Angola	No	25%	20%
Lesotho	No	17%	14%
Tanzania	No	13%	11%
Comoros	No	10%	10%

Source: WHO cervical cancer country profiles.[73]

Universal health care (UHC)

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

According to the WHO "UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."[74] Sexual and reproductive health services are considered essential and are therefore included in this definition. Protecting people from the financial

[72] SA Journal of Gynaecological Oncology 2009 Vol 1 No 1, Cervical cancer in Southern Africa: The challenges
[73] Ibid.
[74] WHO, Fact Sheet: Universal Health Coverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 12 July 2021

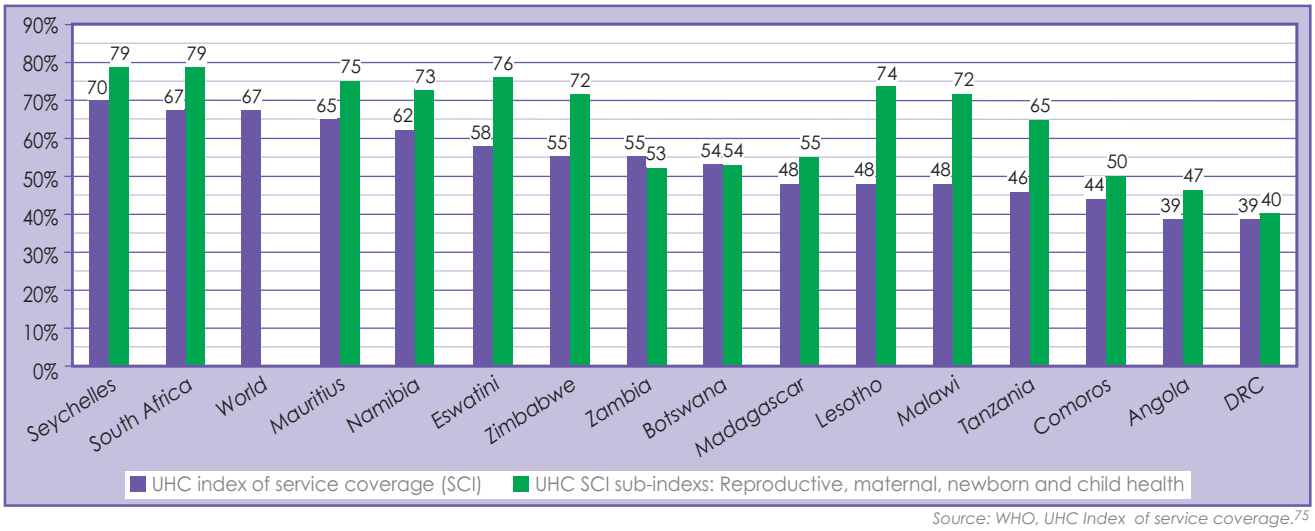
consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow - destroying their futures and often those of their children.

Monitoring progress towards UHC should focus on:

- The proportion of a population that can access essential quality health services (SDG 3.8.1).
- The proportion of the population that spends a large amount of household income on health (SDG 3.8.2).

The Universal Health Coverage (UHC) Index is measured on a scale from 0 (worst) to 100 (best) based on the average coverage of essential services including reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access.

Figure 2.11: Universal Health Coverage



Source: WHO, UHC Index of service coverage.[75]

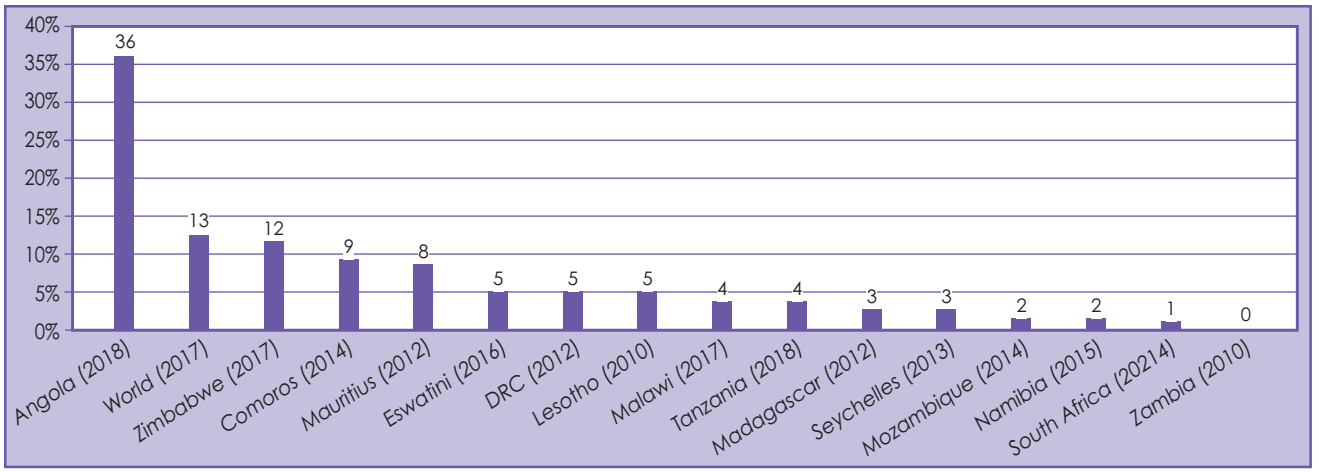
Figure 2.11 shows that no country in SADC provides universal health care. The universal health coverage index ranges from 71 in Seychelles to 39 in DRC. Only Seychelles and South Africa are above the global average of 67. Mauritius and Namibia have between rate between 60 and 65 while Madagascar, Lesotho, Malawi, Tanzania, Comoros, Angola and DRC rate below 50 on the UHC index.

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

UHC means that all individuals and communities receive the health services they need without suffering financial hardship

[75] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage , Accessed 3 September 2022.

Figure 2.12: Proportion of population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%)



Source: World Bank data.[76]

Figure 2.12 shows that all countries are lower than the world average of 13%, except Angola where an exceptionally high proportion of the population (35%) are spending more than 10% of household consumption or income on health care. However the year of data collection ranges from 2010 to 2018. Figures could be higher based on more recent data.

Health expenditure on health sector

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

There are two measures to assess health financing: the level of health spending as a proportion of the total government spending and health spending as a proportion of a country's Gross Domestic Product (GDP). The GDP represents the total value of everything produced in the country. It does not matter if citizens or foreigners produce it - if they operate within a country's boundaries, research includes this production in GDP.[77]

Health expenditure is an important indicator of a government's commitment to the health and wellbeing of citizens. Increasing expenditure on health is associated with better health outcomes, especially in low-income countries. When a government attributes proportionately less of its total expenditure on health, this may indicate that health, including nutrition, is not regarded as a priority.

[76] https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-TZ-ZM-ZW-1W
[77] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038

Table 2.8: Health financing analysis

Country	% annual budget allocated to the health sector[78]	Health expenditure as % of GDP[79]
Namibia	13.6	8.5
Botswana	12.5	6
Comoros	12	5.1
Seychelles	11.7	5.1
DRC	11.4	3.5
Zimbabwe	10	7.7
Lesotho	9.5	11.2
Eswatini	9.5	6.8
Malawi	9.3	7.4
Mozambique	8.7	7.9
South Africa	8.1	9.1
Madagascar	8	3.7
Tanzania	6.7	3.8
Angola	5.6	2.5
Mauritius	5.5	6.2
Zambia	4.5	5.3

Source: SADC SRHR Scorecard, World Bank Data.

Table 2.8 shows that no SADC countries have met the recommended Abuja Declaration goal of 15% of state's annual budget to improve the health sector.[80] Namibia has the highest annual expenditure with 13.6% of the annual budget being allocated to the health sector. Six countries spend between 10% and 14% on health; seven countries spend between 6% and 10% and four countries spend less than 6% of the annual budget on the health sector. Only Lesotho spends more than 10% of its GDP on health.

More worrying, however, is that health spending in six countries (Botswana, Lesotho, Malawi, Namibia, Zambia and Zimbabwe) has regressed between 2019 and 2021. The biggest cut is in Botswana, where expenditure decreased from 16.2% to 12.5% of annual budget expenditure.

Hwange students received free menstrual health products. Photo: Tapiwa Zvaraya

[78] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022
[79] World Bank, World Development Indicators, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ accesses 30 August 2022
[80] WHO, Abuja Declaration - Ten years on https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf

Next steps

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

Polices and frameworks

- Update dated policies in line with international standards on SRHR and the SADC SRHR strategy and scorecard.
- Improve implementation and monitoring of frameworks and policies and hold governments accountable.

Menstrual health

- Scrap VAT on menstrual products and provide free sanitary ware in schools, especially in rural and underprivileged areas.
- Commit to investing more in water, sanitation and hygiene in all settings, including household, communities, schools and health care facilities, with a particular focus on rural areas, where access to these services is substantially lower than in urban areas.

Maternal health

- Explore the reasons for the persistently high levels of maternal mortality and address these through policy and practice.
- Implement programmes to increase access to maternal health services such as antenatal care, skilled birth attendance and neonatal care especially in rural areas.

Contraception and family planning

Identify areas and communities where women have a high unmet need for family planning and develop access and provision strategies.

HPV and cervical cancer

- Include the HPV vaccine in the national vaccination programme; conduct education and awareness programmes on HPV, and step up the rate of vaccination especially in schools.
- Implement the cervical cancer programme in schools; develop strategies to speed up coverage of screening, including allocating budgets and raising awareness about cervical cancer and how it can be prevented.

Universal health care coverage

Invest in and develop partnerships to facilitate roll out of UHC including SRHR services.

Investment and expenditure

Recommit to increasing investment in the health sector to 15% of their annual budget in line Abuja Declaration goal.

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Adolescent Sexual and Reproductive Health and Rights (ASRHR)

3

Youth take part in an ASRHR campaign march in Beitbridge, Zimbabwe, in 2021. Photo: Tapiwa Zvaraya

KEY POINTS

- Eleven SADC countries now have ASRHR policies but many need an update.
- A recent study[1] highlighted the impact of COVID-19 on adolescents in six SADC countries. It shows that 92% of young respondents reported facing difficulties in accessing appropriate healthcare.
- Three quarters of young people report experiencing loneliness, and many have made suicide attempts due to loss of income, limited prospects for employment and months of pandemic-related confinement.[2]
- The COVID-19 pandemic has driven an increase in early pregnancies by as much as 65% in some SADC member states.[3]
- A new study[4] in South Africa shows the pandemic response shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services, especially for vulnerable populations, such as adolescents living with HIV (ALHIV).
- Seychelles has the worst coverage of all SADC countries for Comprehensive Sexuality Education (CSE) in primary school.
- Inadequate information about the nature, aim, and intended outcomes of CSE means policymakers continue to see pushback and opposition to it in some parts of the region.[5]
- Angola has the highest adolescent fertility rate (AFR) in the SADC region at 143 live births per every 1000 women aged 15 to 19. Mauritius is lowest at 24.

1 MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.
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4 Van Staden, Quintin, Laurenzi, Christina A, and Toska, Elona. Journal of the International AIDS Society, vol. 25, issue 4 (2022), e25904e: https://healtheducationresources.unesco.org/library/documents/two-years-after-lockdown-reviewing-effects-covid-19-health-services-and-support, accessed 29 September 2022
5 The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

Introduction

In the 28 years since policymakers adopted a Programme of Action at the 1994 International Conference on Population and Development (ICPD), the Southern African Development Community (SADC) region has made significant progress on sexual and reproductive health and rights (SRHR). The ICPD centred reproductive health and the empowerment of women and introduced the concepts of SRHR.

Yet millions of people - especially young people, who comprise more than 1.2 billion of the world population and up to 60% of SADC's population - still do not have access to SRH information and services. Further, in recent years, the COVID-19 pandemic has highlighted the fragility of gains made in this area over the past three decades.

To address widening ASRHR gaps, the World Health Organisation (WHO) has increased its research portfolio, set norms and standards, encouraged country support and advocacy - all of which it sets out in the first report in a new series on adolescent health, titled *Working for a Brighter, Healthier Future*. Alongside the challenges, the report highlights how people around the world have been coming together to improve the health and well-being of adolescents. WHO has also broadened the scope of its work at regional and country level.[6] In terms of data, the WHO collects and analyses data by age and sex; supports the creation of national strategies and plans that take into account the needs of adolescents; and helps shape high-level policies to address the environmental, economic, and other factors that affect adolescents' health.[7]

Regionally, the SADC SRHR Policy advocates for early access to adolescent SRHR (ASRHR) as a means of postponing sexual debut. At the national level, SADC countries have ASRHR programmes and policies that, while often outdated, promote adolescent sexual health. Punitive policies and restrictive laws against vulnerable groups, including youth, create barriers to their access to ASRHR services across the region. This chapter highlights these and other regional ASRHR challenges, including:

- The significant number of sexually active adolescents younger than 16;
- High numbers of multiple concurrent sexual relations;
- Increasing instances of inter-generational sexual relationships;
- Low levels of consistent condom usage;
- High levels of maternal mortality amongst young mothers;
- Compromised quality of antenatal care for young mothers compared to older mothers;
- High levels of HIV and AIDS among young people, especially young women;
- High levels of violence against women and girls (VAWG);
- Increasing numbers of child marriages;
- High adolescent fertility rates; and
- High unmet need for contraception.

[6] First WHO report highlights efforts to improving health and well-being of adolescents worldwide, https://www.who.int/news/item/18-01-2022-first-who-report-highlights-efforts-to-improving-health-and-well-being-of-adolescents-worldwide, accessed: 30 September 2022.
[7] ibid.

Table 3.1: Key CSE and Teenage Pregnancy Indicators

Countries/Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum reflects international standards	Yes[8]	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Yes	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives[9]	16	12	No data	18	15	No data	12	16	16	16	12	15	10	12	16	16
Legal age to consent to sex (M)	18	16	13	18	16	16	14	16	16	18	14	18	16	18	16	16
Legal age to consent to sex (F)	16	16	13	14	16	16	14	16	16	18	14	18	16	15	16	16
Adolescent fertility rate (per 1000 women, 15-19 years of age)[10]	143	44	61	119	92	92	104	131	24	142	58	60	62	114	115	77
Adolescent birth rate (births per 1000 women, 15-19 years of age by %)[11]	104	43.7	32	109	87	55	103	4	24	153.8	82	56	46.2	123	29	69

Table 3.1 highlights important ASRHR indicators in the SADC region and incorporates new data for adolescent birth rates obtained from the SADC Scorecard[12] and based on 2019 baseline figures for each country.

Countries calculate birth rate (BR) as total live births (for a specific area and time), divided by the total population (for the same area and time) multiplied by 1000. While the fertility rate (FR) represents the total number of pregnancies (for a specific area and time) divided by the female population at the ages specified. The data continues to show very high birth rates among young women between the ages of 15 and 19. Other noteworthy findings include:

- Only South Africa adheres to the SADC SRHR Strategy 2019-2030 target on contraception, which notes that states should provide for it from age 10. This is a best practice in the region and South Africa's National Contraception Clinical Guidelines enshrine it.[13]
- Four out of 16 SADC countries have higher adolescent birth rates than fertility rates. Those highlighted in red indicate a higher rate, while those in green indicate lower birth rates compared to fertility rates.
- The data on age of consent to sexual activity and the age of access to contraceptives remains much the same as past years. Overall, there is a need to harmonise the age of consent to sex for boys and girls: they should have the same minimum age. Another gap requiring action is in the DRC, where legislators have yet to align the age of access to contraceptives (18) and the age of consent to sex for females (14). All other countries make contraceptives available at the same age or earlier than the age of consent.
- The low birth rate figure for Malawi requires further analysis as it is drastically lower than the country's adolescent fertility rate, shown as 131 per 1000 live births.

Local council teams take part in ASRHR action planning at Victoria Hotel in Maseru, Lesotho, in 2022. Photo by Ntolo Lekau

[8] UNFPA regional data, https://www.unfpa.org/data/AO Accessed 10 June 2021.
[9] Gender Links, Audit of SADC ASRHR Policies and Laws 2021.
[10] World Bank, https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BW-CD-AO-LS-MG-MW-MU-NA-MZ-ZA-SC-SZ-TZ-KM-ZM-ZW Accessed 26 September 2022.
[11] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, accessed: 10 September 2022.
[12] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, Workbook: SADC SRHR SCORECARD 2021_EN_FR_PO (tableau.com), accessed: 10 September 2022.
[13] South Africa National Contraception Clinical Guidelines, 2019. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Contraception%20Clinical%20Guidelines_Final_2021.pdf, accessed 30 September 2022.

According to the United Nations Educational, Scientific and Cultural Organisation (UNESCO) 2021 Global report, resistance to comprehensive sexuality education (CSE) remains a challenge in some settings. The report provides a snapshot of progress toward school-based CSE around the world. Resistance to CSE often stems from misunderstandings about the nature, purpose, and outcomes of this type of education. When delivered properly, CSE aids in the prevention of GBV and HIV among young people.

ASRHR and COVID-19

> Limited access to mobile phones and internet connectivity is widening the education gap for girls in rural and remote areas

The COVID-19 pandemic, which wreaked global havoc between 2020 and 2022, left an indelible imprint on national health and education response systems. While most countries have contained the virus through ongoing vaccination and hygiene efforts, the severity and scale of the crisis affected adolescent access to reproductive health care - a critical area of health care that challenged policymakers even before the pandemic. Once again, ASRHR fell off the list of top priorities as governments shifted funding and attention to COVID-19 vaccination and containment and healthcare staffing shortages. Meanwhile, local movement restrictions limited the cohort's ability to access contraception or attend school. Many young people who normally have easy access to SRHR within school settings faced even greater barriers to care due to frequent and unpredictable school closures over the past two years.

In response, this year's chapter delves into youth-friendly health education and services, particularly as the region recovers from the pandemic. In keeping with the tradition of the SADC Gender Protocol Barometer #VoiceandChoice publications, it also includes case studies of how local governments have stepped up their efforts to promote CSE and adolescent sexual health.

Regional: Youth face numerous health and education setbacks linked to COVID-19

Significant and worrying gaps in education and healthcare provision have left millions of young people behind in Southern Africa as the region struggles to address the fallout from the COVID-19 pandemic, according to a 2021 study conducted by the Media in Education Trust (MIET) Africa. [14]

Researchers carried out the study on the impact of COVID-19 on adolescents and young people in the SADC region in six countries: Lesotho, Madagascar, Malawi, Namibia, Zambia, and Zimbabwe.

[14] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.

A young woman receives a COVID-19 vaccination in Madagascar in 2021. Most governments shifted funding and attention to COVID-19 vaccination and containment, which negatively affected ASRHR in the region. Photo: Zoto Razanadratefa

Other key findings on adolescent education and health during the COVID-19 pandemic include:

- School closures affected 127 million learners in Eastern and Southern Africa.
- COVID-19 led to a huge increase in early pregnancies: as much as 65% in some SADC member states. Around one million girls in sub-Saharan Africa got pregnant during COVID-19, which means many may not return to school.
- The weeks of school closures in SADC meant that learning declined and dropouts increased, especially among the most disadvantaged. Projected school dropouts could wipe out recent gains made in reducing the number of out-of-school young people.
- Most (92%) young respondents reported that the pandemic affected their access to healthcare.
- Mental health and psychological wellbeing are a concern in the region: 74% of youth reported feelings of loneliness, distance, or suicide attempts due to loss of income, limited prospects for employment and months of confinement.
- The pandemic added to the number of those dealing with drug and substance abuse and it accelerated the growth of cyberbullying.
- Three out of five learners lost access to important SRHR services.
- Routine measles and other immunisations have fallen far behind, increasing the risk of young people acquiring secondary diseases. At least 14 million children in sub-Saharan Africa will miss routine immunisation: 60% of these children live in the SADC region.
- Due to the disruption of SRHR supply chains, the region struggles with shortages of antiretroviral treatments (ART), condoms and other contraceptives, which will increase disease burdens (including higher risks of HIV infections), and unintended pregnancies in the SADC region.

For the most vulnerable young people, including those with disabilities and those living in poor or marginalised communities, education represents a life-changing and often life-saving opportunity. Beyond the classroom, schools provide spaces of support, offering young people nutrition through school meals and critical psychosocial and SRHR support for their wellbeing and healthy development.

Researchers found that linking education with SRHR support has proved a useful model, with "youth corners" or spaces for young people providing a safe and enabling environment. CSE provided in schools is also a critical support and service for adolescents and young people. In the absence of these in-person opportunities, the report noted that governments and civil society organisations should invest in innovative, digitally based and remote SRH information and services for adolescents and young people.

Bridging the digital divide is crucial for SADC's development. The study found that limited access to mobile phones and internet connectivity continues to widen the education gap, particularly for girls living in rural and remote areas. Governments should improve e-governance by investing in modern ICT infrastructure and supporting the education sector to use blended approaches to teaching and learning to suit learner needs.

As the COVID-19 infection curve flattens, governments must urgently and safely open schools, focusing on equity-based access to education to ensure that SADC truly builds back better by leaving no one behind.

Source: MIET AFRICA .[15]

[15] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.

Across the region, the COVID-19 pandemic disrupted ASRHR services and limited access to HIV and AIDS prevention services, including condoms and pre-exposure prophylaxis. As the MIET Africa study and others have noted, this is especially challenging for at-risk groups like adolescents living with HIV (ALHIV).

South Africa: COVID-19 healthcare shifts affecting adolescents living with HIV

The Joint United Nations Programme on HIV and AIDS (UNAIDS) 95-95-95 global targets for epidemic control aim to ensure by 2030 that 95% of HIV-positive people know their HIV status, 95% of people diagnosed with HIV receive sustained ART and 95% of people on ART have viral suppression.

South Africa's progress towards the 95-95-95 goals has been significantly slower among adolescents living with HIV (ALHIV), according to the Journal of the International AIDS Society. Among this group, ART adherence, retention in care and viral suppression remain a concern.

After two years of living with COVID-19, policymakers need to examine the direct and indirect effects of the pandemic on healthcare resources, access to HIV services and availability of support structures, to assess their impact on HIV care for ALHIV.

The COVID-19 response in South Africa has shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services. The healthcare system's response to COVID-19 has threatened to diminish fragile gains in engaging ALHIV with HIV services, especially as this group relies on overburdened public health facilities for their HIV care.

Reallocation of limited health resources utilised by ALHIV disrupted healthcare workers' capacity to form and maintain therapeutic relationships with ALHIV and monitor ALHIV for ART-related side effects, treatment difficulties and mental health conditions, affecting their ability to retain ALHIV in HIV care.

Prevailing declines in HIV surveillance meant missed opportunities to identify and manage opportunistic infections and HIV disease progression in adolescents. Lockdown restrictions have also limited access to healthcare facilities and healthcare workers for ALHIV by reducing clinic appointments and limiting individual movement. ALHIV have had restricted access to social, psychological and educational support structures, including national feeding schemes. This limited access, coupled with reduced opportunities for routine maternal and sexual and reproductive health services, may place adolescent girls at greater risk of transactional sex, child marriages, unintended pregnancy and mother-to-child HIV transmission.

Policymakers often overlook adolescent HIV care in South Africa; however, ART adherence among ALHIV in South Africa is particularly susceptible to the consequences of a world transformed by COVID-19. Disruptions to health structures, new barriers to access health services and the limited available education and psychosocial support systems have reshaped the current structures in place to support HIV testing, ART initiation and adherence. Reflecting on these limitations can drive considerations for minimising these barriers and retaining ALHIV in HIV care.

Source: Journal of the International AIDS Society.[16]

[16] Van Staden, Quintin, Laurenzi, Christina A, and Toska, Elona. Journal of the International AIDS Society, vol. 25, issue 4 (2022), e25904e: https://healtheducationresources.unesco.org/library/documents/two-years-after-lockdown-reviewing-effects-covid-19-health-services-and-support, accessed 29 September 2022.

CSE frameworks and indicators

Sustainable Development Goal (SDG)-4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
SDG 5.6.2 measures the "number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education."

International Conference on Population and Development (ICPD) paragraphs 4.29, 7.37, 7.41, and 7.47: Sexuality education to promote the well-being of adolescents specifies key features of such education.

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

The East and Southern Africa (ESA) Ministerial Commitment: 15 SADC countries signed the Commitment, which 20 countries endorsed and affirmed in 2013 (the ESA-CSE commitment). Education and health ministers from these countries committed to accelerate access to CSE and health services for young people in the region. Comoros is the only SADC country that is not part of this commitment.

SADC Gender Protocol Article 11: Ensure that the girl and the boy child have equal access to information, education, services and facilities on sexual and reproductive health and rights. Adopt laws, policies, and programmes to ensure the development and protection of the girl and the boy child.

The SADC SRHR Strategy for ensuring CSE notes that member states should accelerate and improve delivery of quality comprehensive sexuality education for in and out of school youth by the education and youth sectors. The strategy further specifies:

- Member states should ensure that young people and adolescents are prepared, supported and provided with education and all the information and skills to make safe and healthy decisions about their life and future. This includes ensuring that adolescents and young people both in and out of school have access to quality, comprehensive, age-appropriate, scientifically accurate life skills-based CSE with linkages to youth-friendly SRHR services and the youth sector more broadly.
- The importance of strengthening the capacity of educators at all levels, specifically to provide age, gender and culturally appropriate rights-based CSE that includes core elements of knowledge, skills and values as preparation for adulthood and, wherever possible, the creation of intra-curricula school CSE programmes.
- The need to build and strengthen the skills of those working in wider youth and community interventions to expand capacity within member states to reach out-of-school youth.
- That stakeholder should explore creative approaches to build the capacity of media, including radio, to reach out-of-school youth.

CSE helps young people to protect and advocate for their health, well-being and dignity by providing them with a necessary toolkit of knowledge, attitudes and skills. It is a precondition for exercising full bodily autonomy, which requires not only the right to make choices about one's body but also the information to make these choices in a meaningful way.[17]

[17] Comprehensive sexuality education, United Nations Population Fund, https://www.unfpa.org/comprehensive-sexuality-education, accessed: 28 September 2022.

The International Technical Guidance on Sexuality Education is a technical tool that presents the evidence base and rationale for delivering CSE to young people to achieve the global Sustainable Development Goals (SDGs).[18] It states that CSE must be scientifically accurate; incremental; age and developmentally appropriate; curriculum-based; comprehensive; based on a human rights approach; based on gender equality; culturally relevant and contextually appropriate; transformative; and able to help develop life skills needed to support healthy choices.

The lack of basic SRHR education exacerbates gender inequities and contributes to negative SRH outcomes, such as STIs, unwanted pregnancies, and HIV and AIDS. Adolescents and youth have the biggest chance for economic and social development in the region as they represent the basis for progress and stability in all SADC countries. To maximise youth participation in national and regional economic growth and development, decision-makers must ensure their education, health, and participation potential. Regional and national policies that promote CSE and ASRHR ensure that today's educated, healthy, and empowered youth will become tomorrow's productive and intelligent adults who contribute to the bright futures of all SADC member states.

Table 3.2: Status of CSE in SADC[19]

Country	Education policies on life skills-based HIV and sexuality education in both primary and secondary	Gender responsive life skills-based HIV and sexuality education forms part of the curriculum in primary and secondary education	Mandatory curriculum for both primary and secondary education	Coverage of primary schools (%)	Coverage of secondary schools (%)	Teacher training policy/programme/ curriculum
Angola	Yes	Yes	Yes	76-100	76-100	Yes
Botswana	Yes	Yes	Yes	76-100	76-100	Yes
Comoros	Yes	No data	No data	51-75	51-75	Yes
Democratic Republic Of Congo	Relevant legal frameworks, laws, decree, acts and policies (levels of education are not specified)	Yes	Yes	76-100	76-100	Yes
Eswatini	Yes	Yes	Yes	76-100	76-100	Yes
Lesotho	Yes	Yes	Yes	76-100	76-100	Yes
Madagascar	Yes	Yes	Optional curriculum for both primary and secondary education	51-75	51-75	Yes
Malawi	Yes	Yes	Mandatory curriculum for primary education only	76-100	76-100	Yes
Mauritius	Education policies on life skills-based HIV and sexuality education in secondary education only	No data	No data	No data	76-100	Yes
Mozambique	Yes	Yes	Optional curriculum for both primary and secondary education	76-100	76-100	Yes
Namibia	Yes	Yes	Yes	51-75	76-100	Yes
Seychelles	Yes	No data	No data	26-50	51-75	Yes
South Africa	Yes	Yes	Yes	76-100	76-100	Yes
Tanzania	Yes	Yes	Yes	51-75	51-75	Yes
Zambia	Yes	Yes	Yes	76-100	76-100	Yes
Zimbabwe	Yes	Yes	Yes	76-100	76-100	Yes

Source: UNESCO Journey towards Comprehensive Sexual Education, 2021 Global Status Report.

[18] International technical guidance on sexuality education, United Nations Population Fund, https://www.unfpa.org/publications/international-technical-guidance-sexuality-education, accessed: 28 September 2022.
[19] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

Table 3.2 uses data from the UNESCO (2021) Global Status Report on CSE[20] to show the state of CSE among SADC states. It illustrates that many countries have committed to CSE in primary and secondary curriculum, teacher training, and monitoring and evaluation. It also shows that:

- All 16 SADC countries have CSE included in their teacher training curriculum;
- Madagascar and Mozambique make their curriculum optional, while Malawi mandates it in primary only.
- At between 26-50% of use in primary schools, Seychelles has the least coverage of CSE.

Factors affecting the implementation of CSE

Resistance to CSE is frequently the result of incorrect information about its nature, purpose, and outcomes.[21] Anti-CSE activists in SADC member states continue to disagree on the definition of CSE and the language surrounding it. The following examples demonstrate the nature and forms of resistance to CSE.

In **South Africa**, #LeaveOurKidsAlone[22] is one of several group that has publicly condemned CSE. The South African Department of Basic Education came under fire from anti-CSE activists in 2020 for using CSE-focused teaching materials. Other organisations in the country have gone as far as proposing their own models of sexual health education that they claim are both safe and credible.[23]

In the **DRC**, the National Reproductive Health Programme and the National Adolescent Health Policy both cover CSE. This highlights the DRC's integrated approach to CSE. However, patriarchal attitudes and structures make it hard to teach about sexuality and CSE. For example, some traditionalists in the country still frown on the use of condoms as a method of birth control. DRC has one of the highest adolescent fertility rates (119 per 1000 women 15-19) in the region. The Guttmacher Institute found that the DRC has the fourth lowest use of birth control in the world, which helps explain the high number of teens who get pregnant there.[24]

Despite significant opposition to CSE, the UNESCO (2021) Global Status Report on CSE[25] finds that communities everywhere, including parents, school administrators, religious leaders, the media, and young people themselves, have helped foster a conducive atmosphere for CSE.

> Resistance to CSE is frequently the result of incorrect information about its nature, purpose, and outcomes

[20] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.
[21] ibid.
[22] #LeaveOurKidsAlone: Leader of anti sex ed group says they'll bring the country to a standstill, https://www.news24.com/parent/Learn/Learning-difficulties/leaveourkidsalone-anti-sex-ed-group-gathers-over-50-000-fb-members-in-just-two-weeks-20191113, accessed: 5 October 2022.
[23] Admin (2020) 'Breakthrough Against CSE - Major Doors Open At United Nations!', JOY! News, 29 September. Available at: https://joynews.co.za/breakthrough-against-cse-major-doors-open-at-united-nations/ (Accessed: 29 September 2022).
[24] Guttmacher Institute, 2021. https://www.guttmacher.org/report/unintended-pregnancy-abortion-kinshasa-drc [accessed 22 June 2021]
[25] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

Zimbabwe: Local council rolls out comprehensive plan to expand ASRHR support

Youth in Rimuka, a suburb of Kadoma, take part in sex education classes coordinated through the city council. Photo: Alfred Maruma

Recent findings that show knowledge gaps among youth and low uptake of ASRHR services have spurred policymakers at the City of Kadoma to embark on a drive to ensure more adolescents learn about SRHR, ideally through CSE.

Evidence drawn from a rapid assessment of ASRHR conducted by GL in 2020 suggests that adolescents in the community lack sexual reproductive health knowledge and do not make good use of ASRHR services such as contraception. For instance, the assessment showed that just 35% of young people requested contraceptives, 29% of young women had requested a pregnancy test, and 5% of those were pregnant at the time.[26]

In response to these challenges, Kadoma lawmakers have employed multiple strategies to educate adolescents on SRHR. These included conducting SRH awareness campaigns in the local authority's health centres, schools, and communities; forming adolescent school health clubs; and establishing adolescent and youth-friendly centres. The City also works with some churches to provide SRHR information to their congregations. It runs the activities in partnership with the Ministry of Health and Child Care, and the Ministry of Youth; both groups represent critical partners for sharing information on legislative policies and other health-related policies.

Junior councillors help implement the city's youth-led SRHR campaigns on teenage pregnancies, HIV and AIDS, and GBV. Critically, the council used the media and arts to spread awareness to adolescents, including a partnership with Berina Community Radio to publicise issues on ASRH. Local dramas have also proved effective in raising awareness: 1142 youths benefitted from these engagements (girls comprised 55% of the total).

"As adults and community members we need to empower and protect our children and youths from all forms of gender-based violence, including sexual violence, and equip them for a better tomorrow," said Raphael Nyadenga, a member of the Budiriro youth arts group.

The City hopes its awareness campaigns lead to a decline in teenage pregnancies, STI infections and new cases of HIV. Despite its early successes, staff faced numerous challenges in implementing the project. These include religious and cultural barriers associated with SRHR; limited political support and will; and in some instances, poor coordination between partners. The council, however, leveraged its institutional strength to overcome some of these challenges.

Source: Sikhanyisiwe Moyo, Gender Focal person, Kadoma City Council, Zimbabwe.

[26] GL Rapid Assessment of ASRHR 2019-2020- Zimbabwe Pamphlet.

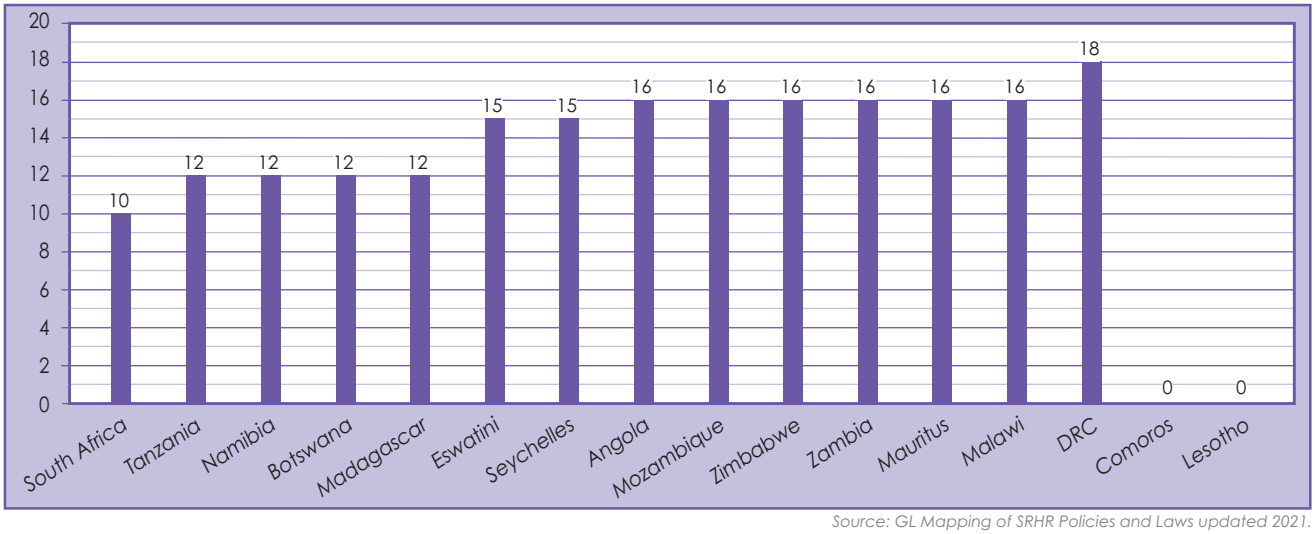
Access to contraceptives and age of consent to sex

Adolescents have reproductive health rights just as adults do, entitling them to reproductive health needs without any barriers. Adolescents are particularly vulnerable to early marriages, early child bearing, rape and sexual violence, unsafe abortions and risk of contracting HIV and AIDS. Requiring third party authorisation for ASRHR services and information prevents adolescents from exercising their basic human rights.

Promoting sexual health is a building block to the attainment of SDG 3: *Ensure healthy lives and promote well-being for all at all ages, and, specifically, Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.*

This requires that countries align their laws and policies on access to contraceptives and the age of consent to sex. This legal and policy environment is critical in avoiding adolescent pregnancy and fatherhood.

Figure 3.1: Age of access to contraception



Source: GL Mapping of SRHR Policies and Laws updated 2021.

Figure 3.1 shows that only South Africa follows the SADC SRHR Strategy 2019-2030, which provides for contraception from age 10. This represents a best practice in the region and South Africa's National Contraception Clinical Guidelines 2019 include it.[27] Four SADC countries (Botswana, Madagascar, Namibia and Tanzania) provide contraceptives to young people from the age of 12. Seychelles and Eswatini start at age 15. The remaining countries allow for contraception from age 16, with DRC as the outlier at 18. In the case of DRC, this highlights a significant gap of four years between this basic right and the legal age for girls to consent to sex in the country, at 14 years.

[27] South Africa National Contraception Clinical Guidelines, 2019. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Contraception%20Clinical%20Guidelines_Final_2021.pdf, accessed 30 September 2022.

While there is no data for Lesotho and Comoros, the SADC Scorecard shows that the unmet contraceptive need in the 15-49 age cohort in both countries stood at 18% and 32%, respectively, in 2021.[28] Given the increasing numbers of early pregnancies in the region, legislators should urgently lower the age of consent for contraception to help address this challenge.

Table 3.3: Existence of laws and policies that allow adolescents to access SRH services without third party authorisation

Country	Yes	Yes, if 12 and older	Yes, if 14 and older	Yes, if 15 and older	No laws and policies	Data not available
DRC	✗					
Lesotho	✗					
Madagascar	✗					
Malawi	✗					
Namibia	✗					
Tanzania	✗					
Eswatini		✗				
South Africa		✗				
Mauritius			✗			
Seychelles				✗		
Angola					✗	
Comoros					✗	
Botswana					✗	
Zambia					✗	
Zimbabwe					✗	
Mozambique						✗

Source: SADC Scorecard.[29]

Table 3.3 shows that the DRC, Lesotho, Madagascar, Malawi, Namibia, and Tanzania have laws and policies that allow adolescents to access SRH services without third party authorisation. Other countries have laws that allow access to ASRHR services only at certain ages. For instance, South Africa and Eswatini require third party authorisation for youths younger than 12; the same applies in Mauritius for those younger than 14 years. Meanwhile, adolescents in Seychelles must be 15 or older to access SRHR without third party authorisation. No laws and policies exist on this in Angola, Botswana Comoros, Zambia and Zimbabwe, and there is no data for Mozambique.

Requiring third party authorisation for ASRHR services and information prevents adolescents from exercising their basic human rights

[28] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, Workbook: SADC SRHR SCORECARD 2021_EN_FR_PO (tableau.com), accessed: 10 September 2022.
[29] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2022).

Enhancing ASRHR

Although most adolescent health issues are preventable or treatable, adolescents face multiple barriers to accessing health care and information. ASRHR experts consider a society or community youth-friendly when its health systems provide services based on an in-depth understanding of the desires and requirements of the young people living in that society or community.

According to the International Planned Parenthood (IPP), elevating youth-friendly services should include the following:

- Trained providers who work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs;
- Confidential, non-judgmental and private services;
- Convenient clinic opening hours for adolescents and young people: such times include late afternoons (after school), evenings and weekends;
- Accessible services for all adolescents and young people irrespective of their age, marital status, sexual orientation or ability to pay;
- An effective referral system;
- Opportunities for adolescents and young people to be involved in designing, implementing and evaluating the programme; and
- Services should seek to involve and gain the support of those important in the lives of young people and in the local community, such as partners, parents/guardians and schools.

Adolescents and young people may not get the care they need because of strict rules, laws and policies, parental or partner control, lack of knowledge, distance, cost, lack of privacy, and provider bias. GL's rapid assessment in Botswana, Eswatini, Lesotho, Madagascar, Mauritius, South Africa, Zambia, and Zimbabwe from November 2019 to December 2020 showed how these factors affect access and quality of care for ASRHR in each of the countries under investigation.

Young girls take part in a 2022 campaign to promote SRHR services in churches in Zimbabwe's Zibagwe district. Photo: Tapiwa Zvaraya

Some of the key findings from these assessments include:

Cost of ASRHR services

- The average fee is $2 across the four countries (Eswatini, Lesotho, Madagascar, and Zimbabwe) in which respondents pay fees.
- Fees for health services range from $1 in Lesotho to $3 in Zimbabwe.
- In Zimbabwe, where respondents paid the highest fees, this represents 15% of the average daily income (and 5% of the average daily income in Lesotho).
- In Eswatini, the $2 fee constitutes 22% of the average daily income of $9, while the $2 in Madagascar constitutes 18%.

Quality of care

- In Lesotho, 62% of respondents did not receive services because they arrived without an adult third party present.
- Between 46% and 57% of respondents did not receive services in Zimbabwe, South Africa, Zambia and Zimbabwe.
- Lower proportions of respondents in Madagascar and Botswana did not receive services without third party authorisation.
- In Eswatini, only 13% reported not receiving services without third party authorisation.

The relatively high fees for ASRHR services and the requirement for parental consent, among other factors, limit the voice and choice for adolescents. They represent a disincentive to young people seeking out help and critical information from these facilities.

Lesotho: Siloe Council introduces youth-friendly SRH infrastructure

Some members of the Siloe Council in Lesotho described the recent Gender Links ASRHR rapid assessment as a wake-up call that immediately spurred them to respond.

GL conducted the study, which uncovered several barriers for youth trying to access SRH services, in nine Centres of Excellence for Gender in Local Government (COEs), including the Siloe Council.

It covered three clinics - Liphiring, Mofumhali oa Rosari and Mohalinyane Health Centre - with 61 respondents: 49% female and 51% male.

The report found that Mohalinyane and Mofumahali oa Rosary clinics do not open after school hours or on weekends: a worrying finding that likely prevents many young people from accessing their services.

Following the results of the study, Siloe Council worked with clinics to prioritise young people's access and ensure they receive reliable health-care advice.

The council also turned one of its offices into a youth corner where young people can come after school and on weekends for all their health needs. Young people seem to appreciate the initiative as many have used the facility since it opened. Tlotliso Mosala, a local youth, said the youth corner provides an alternative space within the council for those youth who worry about the stigma of visiting an SRH clinic.

A nurse observes a participant learning about the female condom at a workshop in Lesotho in 2020. Photo: Ntolo Lekau

The centre offers antenatal services, HIV testing and counselling, prevention and treatment of STIs, and sexuality and contraception education. Apart from these services, many activities at the centre help young people release stress and share leisure time together. The Council regularly trains its healthcare workers to ensure they understand how to deliver better services to young people and evaluate the impact of their service delivery on youth SRH outcomes.

The Government of Lesotho, along with United Nations Children's Fund (UNICEF) and other partners, has also responded to the ASRHR gaps by introducing other innovative projects to provide young people an opportunity to shape the healthcare services they receive. This includes a tool that allows them to rate the services they receive at healthcare facilities.

Source: Ntolo Lekau Gender Links Lesotho.

The health centre in Anjozorobe, **Madagascar**, where GL conducted an ASRHR rapid assessment in 2020, provides youth-friendly ASRHR services to adolescents including, counselling, ASRHR information, orientation, education, advice, free access to contraception, quality care and treatment, as well as referrals to other nearby hospitals in the event of HIV positive tests. In addition, health teams work closely with schools within the districts to run an annual campaign called Proximity Care. During this campaign, health workers share information about ASRHR and explain the importance of prenatal consultation. In 2021, thanks to their involvement in this campaign, 90 young pregnant women aged 18 and younger gave birth without complications.

Enhancing ASRHR through policy provisions

Providing youth with high-quality, timely services that allow them to make free and informed decisions about their sexuality and reproductive lives begins at the policy level and progresses to the institutional and community levels. Countries in the SADC region need adequate policy provision to ensure access to information, education, and adolescent-friendly comprehensive services.

Table 3.4: SADC countries with adolescent and youth SRHR policies[30]

Country	Stand-alone ASRHR policy or strategy reported in 2021	Additional ASRHR policies or strategies updated in 2022
Botswana	Adolescent Sexual and Reproductive Health Implementation Strategy (2012-2016)	
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth (2016-2020)	
Lesotho	Yes, National Health Strategy for Adolescents and Young People (2015-2020)	
Madagascar	Yes, Adolescent and Youth Health Strategy (2016-2020)	
Malawi	Yes, National Youth Friendly Health Services Strategy (2015-2020)	
South Africa	Yes, Adolescents and Youth Health Policy (2016-2020)	
Zambia	Yes, National Adolescent and Youth Health Strategy (2016-2020)	
Zimbabwe	National Adolescent Sexual and Reproductive Health Strategy (2016-2020)	
Angola	No	The National Strategy on Comprehensive Healthcare for Adolescents and Youth, Family Planning and Reproductive Health
Mozambique	No	Integrated Package of Services for Youth (2010)
Tanzania	No	SRHR guidelines and National Adolescent Reproductive Health Strategy (2011-2015)
Comoros	No	No
Eswatini	No	No
Mauritius	No	No
Namibia	No	No
Seychelles	No	No

Source: GL Mapping of SRHR Policies and Laws updated 2021, and MIET AFRICA 2021.[31]

Table 3.4 provides an updated review of SADC countries, showing those with stand-alone ASRHR policies and strategies. The previous Barometer reported that eight out of 16 countries had ASRHR policies. Further research and desktop reviews over the past year concluded that 11 countries have ASRHR policies, adding Angola, Mozambique and Tanzania to the list. Comoros, Eswatini, Mauritius, Namibia, and Seychelles do not have stand-alone SRHR policies or guidelines. Updating ASRHR policies represents a critical step to improving ASRH outcomes because it enables member states to conform to the provisions of their national, regional, and global ASRHR obligations.

[30] Updated 2022 to include Angola ASRHR strategy, Mozambique's integrated package for Youth 2010, and Tanzania's SRHR guidelines and National Adolescent Reproductive Health Strategy 2011-2015.

[31] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.

Eswatini: Civil society groups celebrate new policies to address ASRHR gaps

A concerted advocacy push to pressure government and community leaders to improve ASRHR in Eswatini bore fruit over the past year, says the Eswatini Young Women's Alliance (EYWA).

Members of the group met with representatives from the ministries of justice, health, and social welfare, as well as UN bodies, the Eswatini National Youth Council, and others to understand and advocate for ASRHR policy and legislative provisions for Eswatini.

They also took part in several debates on the National Youth Policy (2020) and the Education Sector Policy for the Prevention and Management of Learner Pregnancy (2021). The government later adopted both policies along with a new bill to address safe abortion services.

EYWA says consultations with various stakeholders suggested that policymakers must align legal frameworks to implement the new legislation. The Ministry of Health highlighted ASRHR gaps in hospitals, including inadequate youth-friendly clinics.

The group also saw positive change stemming from their discussions with community leaders, during which their members requested that local leaders play a bigger role in preventing illegal child marriages. The Ministry of Education has completed a draft policy on adolescent pregnancy and is finalising a policy to allow pregnant girls to continue attending school without interruption. EYWA says it will conduct follow-up checks to monitor the implementation process.

According to the Eswatini National Youth Council, along with the new policies, the government has integrated some health services, trained new health workers, and introduced mobile clinics (known as Dreams on Wheels) in rural areas. Initially, the health ministry mandated the Dreams on Wheels clinics exclusively for HIV prevention services, but they have since expanded their offerings to include all health services, including SRHR. In addition, the Ministry of Health began providing school SRHR services as part of its school health programming.

Members of the Eswatini Young Women's Alliance march against GBV in 2019. The group recently appealed to policymakers to improve SRH services and access to safe abortion.
Photo: Gender Links

UNICEF worked with the Ministry of Education to develop the Education Sector Policy for the Prevention and Management of Learner Pregnancy (2021) and support life skills education. Furthermore, they began assisting pregnant girls with financial support when they return to school to prevent girls from dropping out.

Meanwhile, the Ministry of Health is conducting a survey to determine the extent of abortion on the ground at the constituency level. Civil society groups hope it will use the findings to make policy decisions based on evidence rather than the views of a few individuals. During the policy tracking meetings, government stakeholders emphasised the importance of legal and safe abortion.

The Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) said that, despite the government's evolving stance on safe abortion, backstreet abortion increased during COVID-19. The group has engaged champions (advocates) and conducted training for policymakers and health practitioners in response to this challenge.

Source: Eswatini Young Women's Alliance.

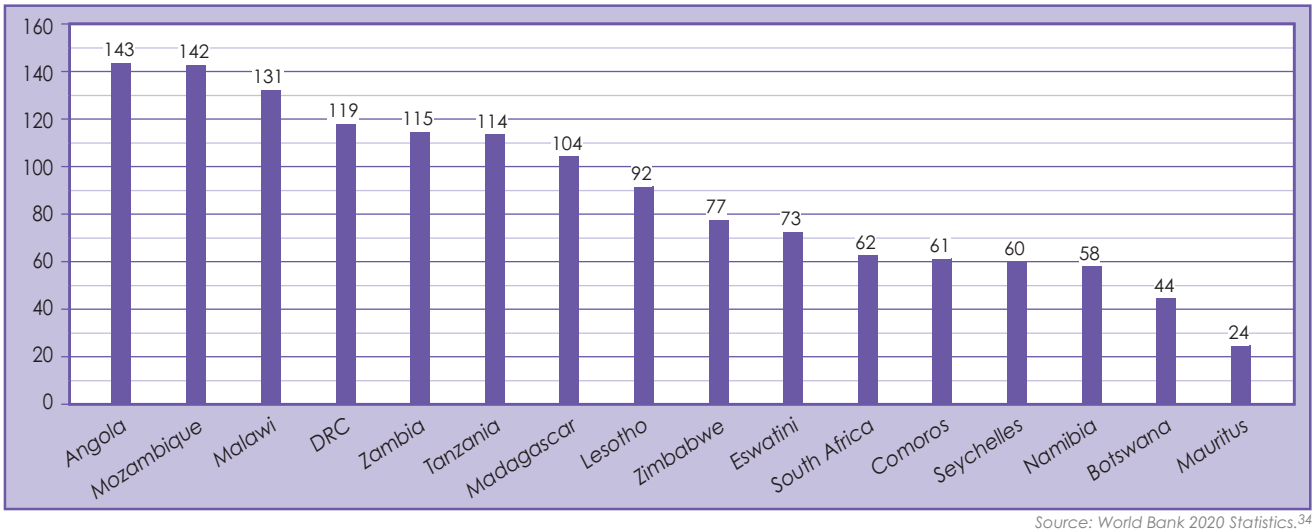
Early unwanted pregnancy

A low adolescent fertility rate (AFR) can indicate a country's dedication to reproductive health and family planning

One of the most important indicators of a nation's reproductive health is the adolescent fertility rate (AFR). The AFR assesses the prevalence of early pregnancy at the national level. A low AFR can indicate a country's dedication to reproductive health and family planning, while a high AFR indicates a country's low level of social and economic development, as well as its lack of access to reproductive health care.[32]

Gender activists use the AFR to monitor Goal 3.7.2 of the SDGs, which includes a target to reduce adolescent birth rates.[33] Countries determine their AFR, measured in births per 1000 women, by dividing the number of live births to women aged 15-19 in a given year by the total female population of the same age group.

Figure 3.2: Adolescent fertility rate (per 1000 women 15-19)



Source: World Bank 2020 Statistics.[34]

Figure 3.2 shows the state of adolescent fertility in the region using the most recent figures for each country. Angola has the highest adolescent fertility rate in the SADC region at 143 live births per every 1000 women aged 15 to 19. Fertility rates remain high in several other countries, including Mozambique, Malawi, DRC, Zambia, Tanzania and Madagascar. A high AFR also corresponds to high rates of child marriages and early pregnancies. At least one in ten girls (14%) in Mozambique has given birth before the age of 15, with this indicator rising to 57% before the age of 18.[35] With 24 live births per every 1000 women aged 15 to 19, Mauritius has the lowest

[32] Collins, I. (2022) 'Adolescent Fertility Rate Definition | You Getting Pregnant', 30 June, https://www.yougettingpregnant.com/adolescent-fertility-rate-definition/, accessed: 28 September 2022.
[33] SDG Goal 3.7.2 Adolescent Birth Rate, Global SDG Indicator Platform, https://sdg.tracking-progress.org/indicator/3-7-2-adolescent-birth-rate/, accessed: 7 October 2022.
[34] World Bank, https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BW-CD-AO-LS-MG-MW-MU-NA-MZ-ZA-SC-SZ-TZ-KM-ZM-ZW Accessed 26 September 2022.
[35] Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), e ICF. 2019. Inquérito de Indicadores de Imunização, Malária e HIV/SIDA em Moçambique 2015: Relatório Suplementar Incorporado os Resultados de Biomarcadores de Antiretrovirais. Maputo, Moçambique. Rockville, Maryland, EUA: INS, INE, e ICF. Online: https://www.dhsprogram.com/pubs/pdf/AIS12/AIS12_SP.pdf

adolescent fertility rate in the region, showing the country's dedication to addressing ASRH concerns.

These figures highlight the urgent need for accessible, youth-friendly SRH programmes that include contraceptive education. Increasing CSE and youth access to contraceptives are two solutions activists suggest for addressing the high incidence of adolescent fertility. The following case study illuminates the challenges of teenage pregnancies in South Africa's Free State Province.

South Africa: Officials respond to early pregnancy spike in Free State

The Free State Health Department has recorded an alarming 150 births in just four months of 2022 for girls between age 10 and 14. Statistics show that more than 4 700 teens aged between 15 and 19 gave birth in 2021. In the same year, the department recorded 2 100 pregnancy terminations among girls between ages 10 and 19.

The South African Medical Research Council reports that, even before the COVID-19 pandemic, 16% of young women aged 15 to 19 had given birth to a child. The figure ranges between 11% in urban and 19% in rural areas. In the Free State, the Thabo Mofutsanyana District recorded the highest cases of early pregnancies.

In June 2022, Lindiwe Zulu, Minister of Social Development, called on government departments to work together to address the scourge of high early unwanted pregnancies.

Social Development Minister Lindiwe Zulu has urged government departments to enhance collaboration to reduce high rates of early unwanted pregnancy.

Credit: SA Government

A spokesperson for the Free State Department of Health, Mondli Mvambi, noted that youth-friendly zones and clinics cater for sex education for young people. Mvambi says the department encourages contraceptive use to avoid unwanted pregnancies, noting, "We've got a high rate of children that are having children, from 10 to 16 years of age."

But Buyiswa Mpini, a national programme officer for UNESCO, says this age group faces many challenges in accessing SRH services, which should concern decision makers. "Let's talk to young men and men in general and ask what role you can play to protect our girls from falling pregnant, which is don't rape our girls. If you are engaging in relationships with our girls, make sure you allow them to protect themselves."

Meanwhile, Bukelwa Qwelane, director of the Life Skills prevention programme in the province, notes that rape and abuse often contribute to high teenage pregnancies. "You will agree that social and economic issues render learners vulnerable to pregnancies where learners are being abused and raped. The numbers that we see are statutory rapes where learners do not consent to sexual engagements."

Reproductive healthcare expert Sebabatso Tsaoane says teenagers face elevated pregnancy risks. "So in pregnancy, what happens is that the women's body has to cater for the needs of the growing foetus. So in the case of early unwanted pregnancy, nutrients that are supposed to be used for the development of this specific teenager now have to be diverted to the growing foetus."

Source: Konelo Lekhafola, SABC News.[36]

[36] Teenage pregnancies on the rise in Free State: Health Dept stats (2022) SABC News, https://www.sabcnews.com/sabcnews/teenage-pregnancies-on-the-rise-in-free-state-health-dept-stats/, accessed: 7 October 2022.

SADC Gender Protocol Alliance takes stock on ASRHR

Southern Africa
Gender Protocol Alliance

At its meeting in May 2022, the Alliance undertook a stock taking exercise of its campaign and advocacy work on SRHR in 2021. The SRHR 2021 efforts aimed to amplify the Southern Africa #VoiceandChoice campaign in the face of the COVID-19 pandemic by casting the spotlight on ASRHR and three closely related themes: early unwanted pregnancy, child marriage and unsafe abortion. The meeting reflected on the actual progress, or lack thereof in some cases, in advancing SRHR policy; identified challenges and obstacles; developed strategies to address these; and reviewed country priorities on SRHR. Participants presented on the three themes.

Kevin Chiramba, Gender Links associate, shared the current context of ASRHR policy in the SADC region, as well as findings from the ASRHR rapid assessments. Anne Githuku-Shongwe, director of the UNAIDS regional support team for Eastern and Southern Africa, presented her team's work on ASRHR issues and opportunities to work with Alliance. This includes the Education Plus Initiative, which includes a big push to keep girls in school up to the completion of secondary school; universal access to CSE; fulfilment of SRHR rights; safety from GBV; and school-to-work transitions.

The Alliance meeting highlighted an essential point about language, noting that the term "teenage pregnancy" places a burden on the teenager, especially as many of these pregnancies result from rape and violence. The group agreed to use the term "early unwanted pregnancy" whenever possible. Adolescent mental health represented another critical emerging issue.

The Alliance country partners resolved to work on the following ASRHR priorities over the coming year.

Eswatini

- Integrate ASRHR services with economic development and capacity building on ASRHR for implementers with a focus on adolescents and youth organisations.
- Improve political will on ASRHR through capacity building for the parliament committees on health, youth and gender and ASRHR policies and legislation.
- Sensitise and raise awareness on the importance of CSE.
- Conduct public sensitisation on the new Education Sector Policy for the Prevention and Management of Learner Pregnancy.
- Collaborate with development partners on girl empowerment programmes to eliminate the practice of child marriage.
- Develop a digital media advocacy plan on safe abortion.

The Education Plus Initiative, which includes a big push to keep girls in school up to the completion of secondary school; universal access to CSE; fulfilment of SRHR rights; safety from GBV; and school-to-work transitions

Lesotho

- Renew ASRHR strategies (with a key focus on the age of consent to general health/SRH services).
- Review CSE/Life Skills curricula.
- Review of Penal Code to expand access to safe abortion.
- Increase policy literacy on ASRHR and safe abortion to strengthen demand and access to services and information within the current policy and legal context.
- Improve access to services and quality service delivery (ASRH and safe abortion).

Mauritius

Focus on menstrual health and work with Ripple Association and Raise Brave Girls.

Mozambique

- Lead training on professional health and young women's abortion rights.
- Expand community sensitisation to promote laws about preventing and combatting child marriage.
- Promote actions to engage and empower young women in GBV situations and provide professional and business management advice.

Namibia

- Review the country's SRHR strategy.
- Plan a consultative meeting with parliament to sensitise them on the issues of SRHR and scale up prevention of unsafe abortions through policy review. This includes creating a conducive policy environment that enables positive SRHR outcomes through the provision of judgement-free, safe, legal and effective abortion services and information.
- Advocate for men and boys to support women's desire for autonomy over their bodies and support their decisions on whether to have an abortion or not.
- Work with the Ministry of Education to train teachers on CSE.
- Work with junior majors to lead and take up the campaigns in their towns and villages.
- Intensify youth-led campaigns on social media.

South Africa

- Host community dialogues (churches, traditional leaders, media, social clubs) on early unwanted pregnancy, safe abortion and child marriage.
- Increase stakeholder collaboration.
- Draw up and implement poverty alleviation strategies.

Tanzania

- Improve re-entry guidelines for schools to address the newborn child and teachers.
- Enshrine the re-entry strategy into a policy.

Zimbabwe

- Intensify CSE in schools.
- Advocate for more youth-friendly clinics.
- Assist with the review of the Termination of Pregnancy Act.
- Review the National ASRHR Strategy.

Next steps

Adolescents in SADC face an array of sexual and reproductive health issues. These range from rape, forced prostitution, forced marriage and female genital mutilation to unwanted pregnancies and the risk of contracting STIs such as HIV and AIDS. Policymakers need to recognise, protect and respect their unique needs so adolescents can fully exercise their reproductive health and rights.

CSE is essential for the effective management of adolescent reproductive health issues. It provides them with the knowledge and skills they require to make healthy and responsible decisions in their lives.

Governments must also address the capacity and resource constraints that prevent the achievement of quality education. This includes ensuring teacher capacity, updating curriculum content, and incorporating the necessary assessment, monitoring, and evaluation tools. Youth will be empowered to access necessary services if teachers are aware of policy provisions and protection for adolescent rights to contraception and age provisions in their respective countries.

Social determinants to adolescent health influence the age of access to contraception and the implementation of CSE in many countries. Young people face a greater risk of abuse and are more likely to remain ignorant about SRH issues that could keep them healthy and safe if specific policies and laws that ensure their health, education and protection do not exist or legislators take too long to update them.

The continuous threats of gender inequality, poverty, climate change, COVID-19, and emerging viruses like monkey pox, represent interconnected challenges that require gender activists and governments in SADC to strengthen collaboration to ensure that adolescents throughout the region have voice and choice on their reproductive health. Some important next steps will need to include the following:

- ***Update ASRHR policies:*** Activists should lobby for updated, inclusive and youth-friendly ASRHR policies in all 16 SADC countries that include current information and research.
- ***Governments need to invest in ICTs for CSE education and stop the spread of COVID-19.*** Governments should improve e-governance by investing in modern ICT infrastructure and supporting the education sector to use blended approaches to teaching and learning that suits learner needs. This will help educate youth on SRHR issues and ways they can help combat the spread of COVID-19 and other diseases.
- ***Integrate age of consent to SRH services and contraceptive use*** into universal health coverage metrics and measures, as well as HIV and AIDS prevention strategies.
- ***Restrictions on accessing ASRHR services:*** Member states should remove age restrictions on the right to access services, including contraceptives, HIV testing and other SRH information. All adolescents should be able to access youth-friendly integrated SRHR services, including the full suite of HIV services.
- ***Standardise youth-friendly health facilities:*** Approve a regional set of standards that sets out best practices and approaches for youth-friendly health facilities. These must include accessibility, respect, privacy, provision of peer counsellors, quality SRH services, standards for health worker conduct and follow up care.
- ***Early unwanted pregnancy response:*** Member states need to strengthen multi-stakeholder collaborations to reduce teenage pregnancies. This includes amplifying the role of men and boys in protecting young girls from falling pregnant.

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Van Staden, Quintin, Laurenzi, Christina A, and Toska, Elona. Journal of the International AIDS Society, vol. 25, issue 4 (2022), e25904e: https://healtheducationresources.unesco.org/library/documents/two-years-after-lockdown-reviewing-effects-covid-19-health-services-and-support, accessed 29 September 2022.

World Bank, https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BW-CD-AO-LS-MG-MW-MU-NA-MZ-ZA-SC-SZ-TZ-KM-ZM-ZW, accessed 26 September 2022.

Safe Abortion 4

She decides: Across Southern Africa, there is a groundswell of support for women to be able to make their own choices. Photo: Colleen Lowe Morna

KEY POINTS

- The overturning of Roe v Wade by the US Supreme Court emboldens the international anti-abortion movements. Examples of this are emerging in Southern Africa, for example in Malawi.
- On the other hand, in an important new development, the World Health Organisation (WHO), African Union (AU) Special Rapporteur on the Rights of Women, and the International Federation of Gynaecology and Obstetrics (FIGO) are calling for the *complete decriminalisation of abortion*. This debate is yet to take off in Southern Africa.
- There has been no change in any legislation related to abortion in any SADC country over the past year. However, advocacy and activism on safe abortion are gaining momentum notably in Madagascar, Lesotho and Namibia. SAfAIDS, which leads the Alliance SRHR cluster, is working closely with the SADC Parliamentary Forum engaging parliamentarians on the urgent need for the removal of policy restrictions on access to safe abortion. The engagements with parliamentarins have documented SADC parliamentarians' recommendations on a possible model law. The *My Choice, Our Choice* campaign has identified prominent champions for safe abortion around the region, some profiled in this chapter.
- A ruling by the Constitutional Court in South Africa has helped to safeguard the progressive provisions in the one out of two SADC countries (the other is Mozambique) that allows a woman to choose to have an abortion in the first trimester.
- There is little hard data on how COVID restrictions affected access to contraceptives or abortions, though a few studies reflect disruptions.
- Activists have been slow to cotton onto the growing global discussion on medication abortion that provides safe, self-managed alternatives for women in restrictive environments.
- Post abortion care continues to consume a high percentage of health budgets and to make little sense of the rigid anti-abortion stances, given the age-old wisdom that prevention is better (and cheaper) than cure.

Introduction

Between 4.7% and 13.2% of maternal deaths worldwide are a result of unsafe abortions. The United Nations Fund for Population (UNFPA) calls the 45% of all abortions that are unsafe a "public health emergency". According to the World Health Organisation (WHO), almost 75% of abortions in Latin America and Africa are unsafe. Nearly 50% of abortions in Africa are least safe or dangerous (the highest proportion that is least safe of any of the regions in the world).[1]

The Programme of Action of the International Conference on Population and Development (ICPD) adopted in 1994 recognised that human rights and dignity, including rights to universal access to Sexual and Reproductive Health information and services are a fundamental condition for sustainable development.

Sustainable Development Goal (SDG) Goal 3 (ensure healthy lives and promote well-being for all at all ages) aims in 3.1 to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. SDG Goal 5 (achieve gender equality and empower all women and girls) aims in 5.6 to: "ensure universal access to sexual and reproductive health and reproductive rights."

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (commonly known as the Maputo Protocol), adopted by African Union in 2003, was the first human rights treaty to explicitly recognise abortion as a human right, under some circumstances. The SADC Gender Protocol boldly aims to eliminate maternal mortality. Yet governments are slow to translate these commitments into action.

Globally, the overturn by the US Supreme court of Roe v Wade, which guaranteed the right to abortion in the United States, is a major reversal.

The ripple effects of Roe v Wade in the United States

The US Supreme court decision to overturn Roe v Wade on 24 June 2022 sent shock waves around the globe. That the self-proclaimed global custodian of human rights would so easily trample on the rights of those who can become pregnant seems incomprehensible. Many have expressed dismay and solidarity with women in the United States and many others expressed delight and hope that they also can bring similar changes in their countries.

Dr Alvaro Bermejo, Director of the International Planned Parenthood Federation warned, "The fallout from this calculated decision will also reverberate worldwide, emboldening other anti-abortion, anti-woman and anti-gender movements and impacting other reproductive freedoms. The justices who put their personal beliefs ahead of American will, precedent and law will soon have blood on their hands, and we are devastated for the millions of people who will suffer from this cruel judgment".[2]

> The fallout from the overturn of Roe v Wade will reverberate worldwide

[1] WHO, 2022. Abortion Fact Sheet. https://www.who.int/news-room/fact-sheets/detail/abortion accessed 15 August, 2022.
[2] IPPF Africa Region, 25 June, 2022. U.S Supreme court overturns Roe v. Wade in biggest blow to women's health and rights in recent history. https://africa.ippf.org/media-center/us-supreme-court-overturns-roe-v-wade-biggest-blow-womens-health-and-rights-recent accessed 30 June, 2022.

Dr Veena JS, an Indian activist who is known for her social media presence on reproductive health issues, says the Roe v Wade ruling will have a cascading effect around the world. "America is generally a model for the world and I fear, at some point, India could take a cue from them and bring in similar legislation. And we will be forced to raise children we don't want. Research has shown that post-partum psychosis and depression increases in women who are forced against their will to give birth. The quality of life of these 'unwanted' children will also be poor."[3]

In SADC, unwanted pregnancy can often be the result of sexual violence. In South Africa alone, 11,000 women reported that they had been raped between January and March 2022,[4] while New Zimbabwe reports that an average of 21 women report that they have been raped in Zimbabwe daily[5]. As rape is almost always under-reported, the true picture is much worse. With such alarming rates of violence against women, moving backward on abortion is absurd.

Laws that outlaw abortion do not stop the demand for, or access to, abortions. They do make safe abortion unavailable, forcing women to resort to illegal and less safe forms of abortion. Globally, in the year under review, the World Health Organisation (WHO) released a new, updated and consolidated Abortion Care Guidelines in 2022[6]. The WHO 2022 Guidelines note that abortion is a "safe and non-complex health-care intervention that can be effectively managed using medication or a surgical procedure in a variety of settings".[7] The guidelines further state that all who need abortion care should receive quality of care that is effective, efficient, accessible, acceptable/patient centred, equitable and safe. The WHO classifies abortions as safe, unsafe and dangerous. The least safe, or dangerous, abortions often result in serious illness, infertility and sometimes even death.

UNFPA calls the 45% of all abortions that are unsafe a "public health emergency". Unsafe abortion results in expensive hospitalisation of about seven million women a year in developing countries and resulted in an estimated 193,000 maternal deaths between 2003 and 2009[8]. The rate of deaths is between 30 deaths per 100 000 unsafe abortions in developed countries to 220 per 100 000 unsafe abortions in developing countries.[9]

Laws do not stop abortions. They make safe abortion unavailable

[3] Pandey, G. June 25, 2022. 'America is a model for the world' https://www.bbc.com/news/world-us-canada-61788929 accessed June 27, 2022.
[4] Charles, M. June 4, 2022. Brutal start to the year for SA with nearly 11 000 rape cases in just the first 3 months. https://www.news24.com/news24/southafrica/news/rape-in-sa-a-brutal-start-to-the-year-for-women-and-children-20220604 accessed 21 July, 2022.
[5] Chibamu, A. July 13, 2022. Parliament told 21 women raped everyday; MP calls for castration of rapists. https://www.newzimbabwe.com/parliament-told-21-women-raped-everyday-member-calls-for-castration-of-rapists/ accessed 21 July, 2022
[6] World Health Organization. 2022. Abortion care guideline. Geneva, World Health Organization. https://apps.who.int/iris/handle/10665/349316. License: CC BY-NC-SA 3.0 IGO accessed 21 June, 2022
[7] WHO, 2022: https://srhr.org/abortioncare/
[8] UNFPA, 2022. Op Cit.
[9] WHO, 2022. Abortion Fact Sheet. https://www.who.int/news-room/fact-sheets/detail/abortion accessed 15 August, 2022.

Table 4.1: Key facts on abortion in Southern Africa

Country	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Laws	Penal Code 2017	Penal Code 1991	Penal Code 1995	Penal Code 2004	Constitution 2005	Penal Code 2010	Penal Code 1998, Criminal Procedure Law	Penal Code	Criminal Code Act 2012	Penal Code 2015	Abortion and Sterilisation Act 1975	Termination of Pregnancy Act 1994	Choice of Termination of pregnancy Act (92/11996) amended in 2008	Penal Code	Termination of Pregnancy Act 2005 and Penal Code 2014	Abortion Law 1977
Abortion on request	Yes	Not specified	No	No	No	No	No	Not specified	No	Yes	No	Not specified	Yes	Not specified	Not specified	No
Unmet Need for Modern method of Contraception																
% of unmarried sexually active women 15 - 49 with unmet need	45		58	64	30	22	51	41		41	15		24	33	43	21
% of married women 15 - 49 with unmet need	39		38	40	28	19	29	20		24	18		15	29	22	11
Unintended Pregnancy and Abortion rates																
Unintended pregnancy rate per 1000 women 15 -49	120	97	95	117	111	99	95	115		88	104		81	105	123	74
Abortion rates per 1000 women 15 - 49	33	31	31	33	29	23	60	31		40	29		30	38	35	18
% of unintended pregnancies which end in abortion	28	32	32	28	27	24	63	27		47	28		37	36	28	25
Post Abortion Care guidelines																
		Yes						Yes		Yes	Yes		Yes	Yes	Yes	Yes
Attitudes																
% who say a woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy	40	36		24	20	26	18	28	41	24	16	33	35	25	47	22

Sources: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey. WHO, Global Abortion Policies Database: https://abortion-policies.srhr.org/ accessed 15 April 2020. Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019. BMJ Global Health 2022;7:e007151. doi:10.1136/bmjgh-2021-007151. https://gh.bmj.com/content/7/3/e007151 accessed 20 June, 2022

Table 4.1 shows that no country has made progress in expanding access to legal and safe abortion or post abortion care, despite courageous efforts in a few countries. Reasons for failing to translate SRHR commitments into accessible services include:

- Insufficient political will and leadership, especially around upholding the rights of girls and women.
- Strong opposition which is often well resourced by international anti-abortion groups.
- Weak health systems made even weaker by the COVID pandemic.

As there are no new DHS surveys in any SADC country since 2018 (the most recent DHS survey was in Zambia in 2018), there is no new comparative data on access to contraception.

Table 4.1 includes estimates of unintended pregnancy rates, abortion rates and the proportion of unintended pregnancies that end in abortion for most countries in SADC. Researchers from Guttmacher and the UNDP/UNFPA/ UNICEF/ WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Sexual and Reproductive Health and Research, based in the WHO, developed a model to estimate unintended pregnancy and abortion rates.

The complex model uses information on contraceptive needs and use, contraceptive method mix, birth rates, the proportions of births from unintended pregnancies and abortion incidence data to estimate the rates of unintended pregnancy and abortion. The researchers were able to produce estimated rates in five-year bands for 150 countries and territories. WHO published the model online to make it available for scrutiny and questioning. National focal points had the opportunity to review the data for their countries through a WHO country consultation process, which does not mean that countries have endorsed the estimates. The data, published in the BMJ Global Health[10], includes estimates for the period 2015 to 2019. Some important points to note from this data are:

- The estimated rates of unintended pregnancy per 1000 women aged 15 - 49 range from a low of 74 in Zimbabwe (which has had a community based family planning programme for a long time) to a high of 123 in Zambia.
- The estimated abortion rates per 1000 women aged 15 - 49 range from a low of 18 in Zimbabwe to a high of 60 in Madagascar, which has the most stringent law against abortion in SADC.
- The proportion of unintended pregnancies that end in abortion range from 24% in Lesotho to 63% in Madagascar.

Unintended pregnancy: The root cause of abortion

A call to end unintended pregnancies at the launch of the 2021 Barometer in Eswatini. Photo: Gender Links

UNFPA's 2022 report on the State of the World's Population is titled: *Seeing the Unseen: The Case for Action in the Neglected Crisis of Unintended Pregnancy*. Despite commitments of the ICPD, the SDGs and impressive gains in developing new methods of contraception, close to 50% of all pregnancies in the world are unintended. Dr Natalie Kanem, UNFPA Executive Director, claims "Every human being has the right to bodily autonomy, and perhaps nothing is more fundamental to the exercise of that right than the ability to choose whether, when and with whom to become pregnant."[11]

[10] Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019. BMJ Global Health 2022;7:e007151. doi:10.1136/ bmjgh-2021-007151 https://gh.bmj.com/content/7/3/e007151 accessed June 20, 2022.
[11] UNFPA, 2022. State of World Population 2022. Seeing the Unseen: The Case for Action in the Neglected Crisis of Unintended Pregnancy. New York, UNFPA.

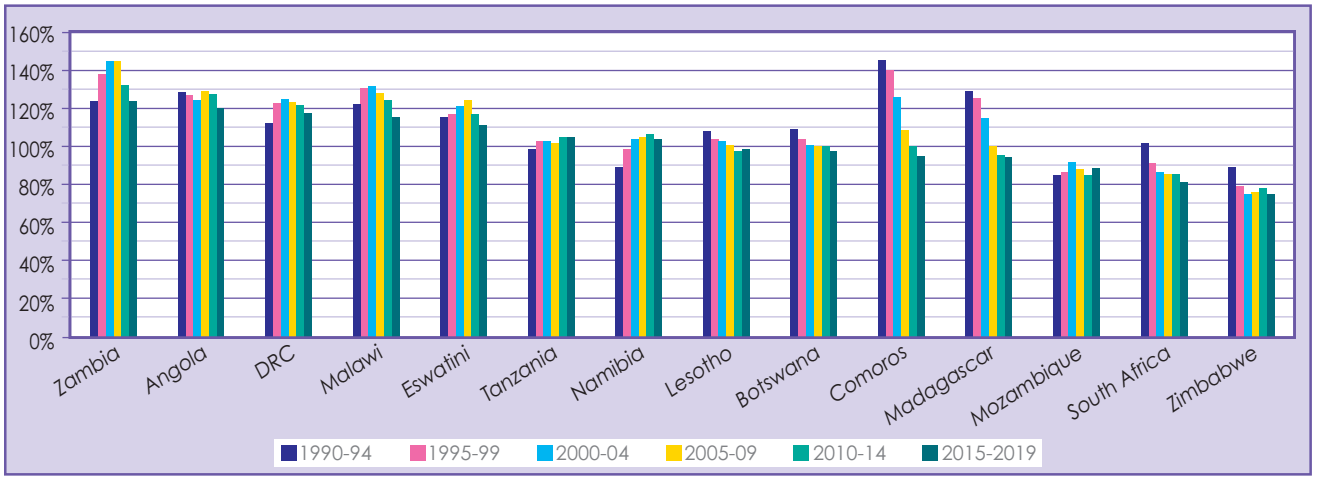
Every human being has the right to bodily autonomy

UNFPA defines unintended pregnancy as "A pregnancy that occurs to a woman who was not planning to have any (more) children, or that was mistimed, in that it occurred earlier than desired. This definition is applied independent of the outcome of the pregnancy (whether abortion, miscarriage or unplanned birth)." The UNFPA defines unwanted pregnancy as "1. A pregnancy that a woman does not want to have. 2 (academic) When measured in surveys, a pregnancy that occurred when a woman did not want to have any children at all, or any more children. The academic definition does not recognise that a woman might decide she wants the pregnancy after it occurs, even if she was not planning to have any (more) children." An unintended pregnancy may be wanted or unwanted.

Table 4.2: Unintended Pregnancy per 1000 women aged 15-49 in SADC[12]

Country	1990-94	1995-99	2000-04	2005-09	2010-14	2015-19
Zambia	123	123	145	145	132	123
Angola	128	128	125	129	127	120
DRC	113	113	127	124	121	117
Malawi	124	124	132	127	124	115
Eswatini	115	115	121	124	117	111
Tanzania	97	97	103	102	105	105
Namibia	89	89	104	105	107	104
Lesotho	108	108	103	101	98	99
Botswana	109	109	101	100	100	97
Comoros	145	145	125	109	100	95
Madagascar	129	129	115	100	96	95
Mozambique	84	84	92	87	84	88
South Africa	102	102	86	85	85	81
Zimbabwe	89	89	74	76	78	74

Figure 4.1: Unintended Pregnancy per 1000 women aged 15-49 in SADC



[12] Source: Gender Links compiled from Country sheets data in https://www.guttmacher.org/geography

Table 4.2 and Figure 4.1 shows the estimated annual rates of unintended pregnancy, in five-year bands, for SADC member states, as determined from the Guttmacher / WHO model. The table and its graphical representation show rates of unintended pregnancy in SADC range from 74 in Zimbabwe to 123 in Zambia. In Africa, the range is 49 in Niger to 145 in Uganda. Globally the range is 11 in Montenegro to 145 in Uganda.

The data reflects differences between the member states of SADC. Comoros and Madagascar show a dramatic reduction, South Africa and Zimbabwe fairly steady reduction and Lesotho and Botswana, steady but smaller reduction. Namibia has witnessed a steady increase. These variations in SADC differ from other regions that reflect a consistent decline between 1990 and 2019.

In Europe and North America, the rates of unintended pregnancy declined by 50%; in Southern and Central Asia and Latin America by 28%. Overall in Sub Saharan Africa the rate of unintended pregnancy declined by only 12%[13].

Women in all age groups experience unintended pregnancy, though there is often an assumption that adolescents are more likely to have unintended pregnancies. The costs of unintended pregnancy are however, higher for adolescents than older women.[14]

The UNFPA report ascribes the continued high rates of unintended pregnancy to women's lack of agency to make and act on informed decisions regarding their own child bearing. A number of factors contribute to improved agency, including:

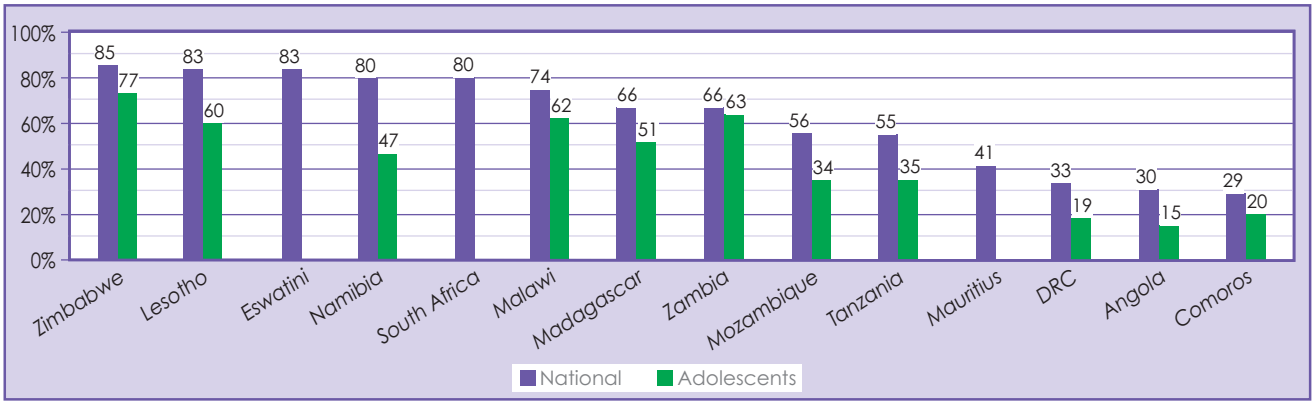
- Education of both women and men (in Sub Saharan Africa women with primary and secondary education were found to be 26 and 29% less likely to have an unintended pregnancy than those without any education).
- More equitable gender attitudes and gender equality.
- Higher income and access to services.
- Ability of couples to articulate and negotiate fertility preferences (in general men in Sub Saharan Africa want to have more children than women).

Factors, which reduce agency, include:

- Inconsistent and incorrect use of contraceptives.
- Failure of contraceptive method.
- Sexual violence.

SADC has high rates of unintended pregnancy: 74 - 123 per 1000 women aged 15 - 49

Figure 4.2: Demand for family planning met by modern methods, 2021



Source: Gender Links compiled from Maternal and Newborn Health Coverage Database.[15]

[13] UNFPA, 2022. Op Cit.
[14] UNFPA, 2022. Op Cit.
[15] https://data.unicef.org/topic/maternal-health/antenatal-care/ accessed 19 July, 2022

Figure 4.2 illustrates that the rate of provision of modern contraception varies in SADC from a low rate of 30% of all women's demand for contraception met in Angola to a high of 85% in Zimbabwe. Botswana and Seychelles did not share data. There is considerable variation within countries in the rate of access for adolescents and access for all women, with the largest discrepancies being in Angola and Namibia where coverage for all women and that for adolescents is 30% to 15% in Angola and 80% to 47% in Namibia.

The model developed by Guttmacher[16] and WHO estimated the following annual rates of abortion (in five year bands from 1990 to 2019) for SADC member states:

Table 4.3: Estimated annual abortion rates per 1000 women aged 15 - 49 in SADC

Country	1990-94	1995-99	2000-04	2005-09	2010-14	2015-19
Madagascar	60	66	63	56	59	60
Mozambique	27	33	35	34	38	40
Tanzania	27	34	33	32	36	38
Zambia	24	33	34	33	35	35
Angola	27	30	31	32	34	33
DRC	26	30	32	31	33	33
Botswana	22	27	28	27	30	31
Comoros	28	34	31	28	30	31
Malawi	19	25	25	24	29	31
South Africa	21	25	26	26	29	30
Eswatini	19	25	28	28	30	29
Namibia	16	23	27	26	29	29
Lesotho	18	23	24	22	23	23
Zimbabwe	14	17	17	17	19	18

Source: Gender Links compiled from Country sheets data.[17]

Figure 4.3: Estimated annual abortion rates: Trends from 1990-95 to 2015-19

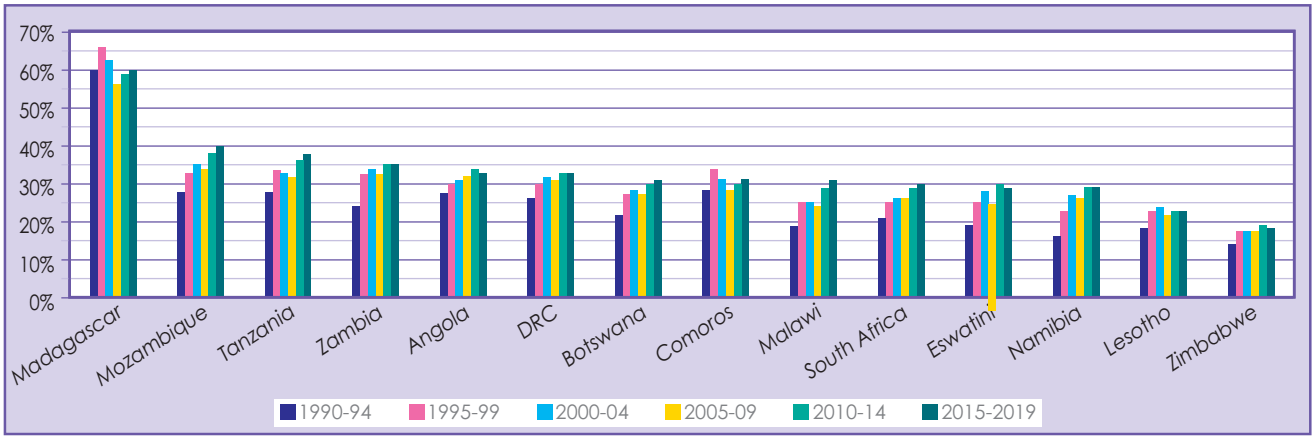
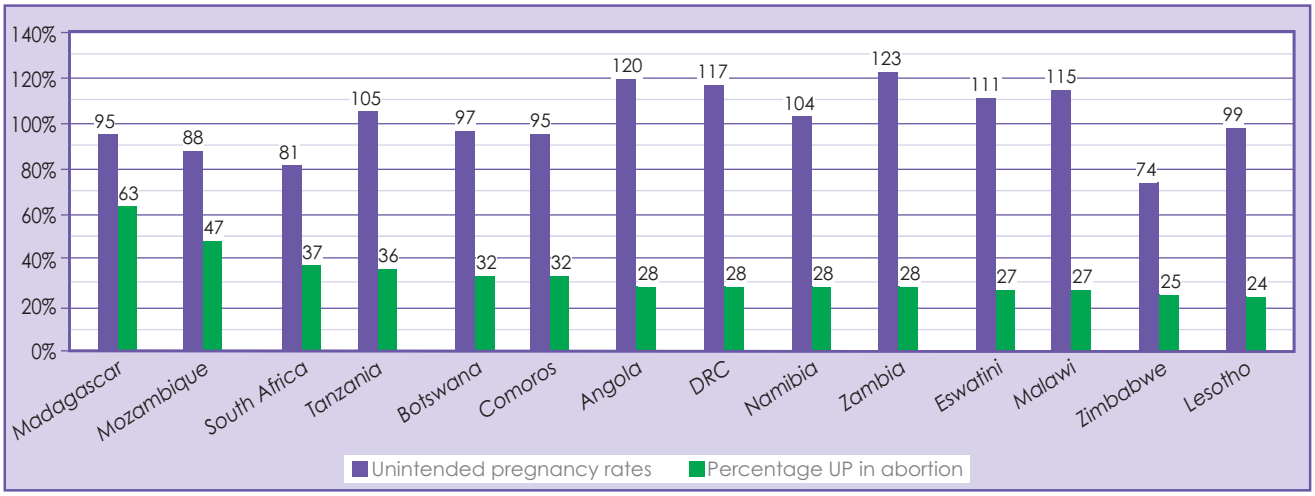


Table 4.3 and Figure 4.3 show that Madagascar, with the most stringent law against abortion, has the highest annual rate of abortion at 60 per 1000 women aged 15 - 49. The rates in other member states range from 40 per 1000 women in Mozambique to 18 per 1000 women aged 15 - 49 in Zimbabwe.

[16] Bearak et al, 2022, Op Cit.
[17] https://www.guttmacher.org/geography

All countries, except Madagascar (that has remained quite constant) reflect steady increases in the rates of abortion between 1990 - 1995 and 2015 - 2019. The highest rates of increase have been in Malawi (19 to 31 per 1000 women aged 15 - 49) and Namibia (16 to 29 per 1000 women aged 15 - 49). The population average abortion rate in Africa is 34; compared to Central and Southern Asia (46); Europe and North America (17); Latin America and the Caribbean (32); Asia (43), and Oceania 21. Guttmacher also estimated the proportion of unintended pregnancies that ended in abortion:

Figure 4.4: Proportion of Unintended Pregnancies (UP) that end in abortion



Source: Gender Links from data in the Supplementary material, Bearak J et al.[18]

Figure 4.4 shows that the proportion of unintended pregnancies that end in abortion is highest in Madagascar (63%) and lowest in Lesotho (24%). These are lower proportions than the global average. However, lower proportions of a high rate of unintended pregnancy is still a high overall abortion rate.

The impact of COVID-19

The restrictions imposed to curtail the spread of COVID-19 resulted in supply chain challenges in the production and distribution of contraceptives; disruption of contraceptive service delivery from health centres and increased gender based violence. Many people in Sub Saharan Africa moved deeper into poverty, owing to reduced employment opportunities. There is little hard data on how COVID restrictions affected access to SRH services in general and contraceptives or abortions in particular, though a few studies reflect disruptions.

A study conducted in Malawi, Burkina Faso, Ethiopia, Kenya, and Uganda found that restrictions and lockdowns in response to COVID-19 resulted in reduced access to SRH services[19], including contraceptives, antenatal care, Post-Abortion Care (PAC), HIV prevention and care as well as disruptions to other sectors, such as transport, health, trade, and security.

Some health facilities closed or converted to COVID-19 isolation and treatment centres during the pandemic. Clients reported that the longer distances, combined with a fear of contracting the virus, elevated costs of healthcare. Negative attitudes of some providers impeded access to SRH services. Many stopped visiting health facilities, delayed or postponed care seeking, or utilised non-facility-based care. Some treated themselves with over-the-counter medications, while others sought alternative care sources (traditional healers and birth attendants).

[18] Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019.
[19] African Population & Health Research Center, 2021. Impact of the COVID-19 Pandemic on Sexual and Reproductive Health Services in Burkina Faso, Ethiopia, Kenya, Malawi and Uganda. https://aphrc.org/wp-content/uploads/2022/05/APHRC-COVID-Report-Final-3.pdf accessed 15 July, 2022.

Health providers reported reduction in the availability of some SRH services due to supply shortages; an absence of trained personnel and the closure of health facilities. Some facilities implemented innovative strategies to ensure continuity of SRH services, including telemedicine, self-care approaches, changes in timing for services, and altering referral patterns for care services. Members of marginalised communities such as the LGBTQI communities experienced even more restrictions to access of services.

The human toll of illegal abortions during COVID-19

Twenty-nine year old Chikondi in peri-urban Lusaka, Zambia became pregnant during the COVID-19 lockdown. Chikondi already had two daughters that she was struggling to provide for, as the occasional agricultural work that had sustained them was scarce during COVID-19 lockdown. Her boyfriend was supportive but unable to provide financially for a child. COVID restrictions had made it difficult for her to get to the health centre, 70 kilometres away, for contraceptives. The mobile services that used to come to her village were suspended and her friends could not afford to go to Lusaka and bring contraceptives back for her.

Though abortions are legal in some circumstances in Zambia they are difficult to obtain. Chikondi resorted instead to a bitter mixture of herbs recommended by a friend who had used it. After several days of severe bleeding her boyfriend managed to get her to hospital, where doctors removed the foetus and cleaned the blood out of her uterus. She also had a blood transfusion.

Dr Mulindi Mwanahamuntu, head of clinical care at the Lusaka University Teaching Hospital's Obstetrics and Gynecology department, is quoted as saying emergency gynecological admissions spiked during the pandemic. More than half were linked to non-clinical abortions. "I am imagining how many women are out there that have failed to access post-abortion care, those that are silently dying," he said.

Source: Phiri, Prudence. February 27, 2022. "Bitter Brew: Pandemic Spurs Uptick in Abortions".[20]

Table 4.4: Deliveries and terminations of pregnancy in girls aged 10 - 19 years in the public sector, South Africa, 2017/18 - 2021/22

	2017-18	2018-19	2019-20	2020-21	2021*	Increase 2017-18 to 2021 %
Population 10 - 14 years, n	2 546 451	2 628 874	2 689 346	2 769 793	2 806 206	8.8
Population 15 - 19 years, n	2 304 256	2 373 843	2 316 027	2 371 690	2 439 133	2.9
Population 10 - 19 years, n	4 850 707	5 001 717	5 005 373	5 141 483	5 245 339	6
Deliveries 10 - 14 years, n	2 726	3 527	3 870	4 053	2 226	48.7
Deliveries 15 - 19 years, n	114 329	121 059	127 028	134 267	70 656	17.4
Deliveries 10 - 19 years, n	117 055	124 586	130 898	138 320	72 882	16.8
Terminations 10 - 19 years, n	12 896	14 441	16 301	13 972	7 211	8.3

*Data for 2021 is for 6 months 1 April 2021 to 30 September 2021.[21]
**all rates are per 1000 girls of the same age band.

South Africa: Abortion is legal in South Africa. Pregnancy in the 10 - 14 age group is, by definition, evidence of statutory rape. As reflected in Table 4.4 terminations of pregnancies in public facilities increased between 2017 and 2020 and then

[20] https://globalpressjournal.com/africa/zambia/bitter-brew-pandemic-spurs-unsafe-abortions/
[21] Ibid.

dropped quite dramatically between 2020 and 2022, even as pregnancies in both 10 - 14 year olds and 15 - 19 year olds increased. This suggests a curtailment in access to abortion services due to the COVID-19 restrictions[22]. An October 2021 article described the lengths that girls and women had to go to, queueing for more than 24 hours in the open in freezing weather to be one of the 21 that would be served on a Monday or Wednesday at an Mthatha clinic[23]. The humiliating and expensive experience for the women forced some who failed to access the service to illegal and unsafe providers. News stories provide details of some of the struggles that women had to endure during the COVID-19 lock downs.

Normative frameworks

BPFA+25 Africa declaration 9: Accelerating the implementation of Sustainable Development Goal (SDG) 3 on universal health and well-being for all, to reduce the prevalence of disease in women and girls, and to mitigate the disproportionate burden of care affecting women: (b) Ensure universal access to good-quality health care, including testing and treatment for HIV and AIDS, and sexual and reproductive health; (d) Reduce maternal mortality rates and prevent deaths of newborn babies and children under the age of five years.[24]

Nairobi Statement on ICPD25: Accelerating the Promise[25]
2. Zero unmet needs for family planning information and services, and universal availability of quality, accessible, affordable, and safe modern contraceptives.

3. Zero preventable of maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national Universal health coverage (UHC) strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights.[26]

Maputo Protocol Article 14 1: States parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.
14.2. States Parties shall take all appropriate measures to:
c) Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

SADC SRHR Strategy 2019-2030: Rates of unplanned pregnancies and unsafe abortion are reduced.

Ironically the continent with the first human rights instrument to recognise abortion, under certain conditions, as women's human rights is still also a region of extremely restrictive legislation and practice on abortion.

[22] Barron P, Subedar H, Letsoko M, Makua M, Pillay Y. Teenage births and pregnancies in South Africa, 2017 - 2021 - a reflection of a troubled country: Analysis of public sector data. S Afr Med J 2022;112(4):252-258. https://doi.org/10.7196/SAMJ.2022.v112i4.16327
[23] Sizani M and Jubase H.-Pregnant women resort to sleeping rough outside abortion clinic. Daily Maverick 21 Oct 2021. https://www.msn.com/en-za/news/other/pregnant-women-resort-to-sleeping-rough-outside-abortion-clinic/ar-AAPMZP8?ocid=entnewsntp accessed 22 October, 2021.
[24] UNECA African Regional Conference on Women Beijing+25 Political Declaration and key messages and priority actions on the implementation of the Beijing Declaration and Platform for Action https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf accessed
[25] https://www.nairobisummiticpd.org/content/icpd25-commitments accessed 27 May, 2020.
[26] UNFPA, 2020. Accelerating the Promise. The Report on the Nairobi Summit on ICPD25. New York. https://www.nairobisummiticpd.org/sites/default/files/Nairobi%20Summit%20Report%20on%20ICPD25_0.pdf accessed May 31, 2020.

Table 4.5: Legal provisions regarding abortion in SADC[27]

Country	Law	Conditions under which an abortion may be granted	Gestational limits	Consent	Provided by	Penalties for an illegal abortion
ABORTION AVAILABLE ON DEMAND						
South Africa	Choice of Termination of pregnancy Act (92/1996) amended in 2008[28]	N/A Available on demand	Within the first trimester	Right to terminate without consent of other parties apart from medical practitioners		Yes, for the woman, provider, and person who helps a woman obtain abortion
Mozambique	Amended Penal Code	N/A	On demand to 12 weeks; in the case of incest, 16 weeks; in the case of foetal anomalies, 24 weeks	Parental consent for minors; a health unit committee determines legal grounds[29]	A certified practitioner must perform termination at designated facilities[30]	Yes, for the woman, provider, and person who helps a woman obtain abortion
ABORTION AVAILABLE IN FOUR CIRCUMSTANCES						
Zambia	Termination of Pregnancy Act, 13 October 1972, amended in 2005 and Penal Code	If the pregnancy will cause death to the mother, mental or physical damage to the woman, or if the child is at risk of mental and physical deformities		Once three medical practitioners have agreed		Seven years for person who administers; seven years for woman who administers own abortion
Botswana	Penal Code (Amendment) Act, 1991 - Section 160	In cases of rape or incest, if the mother's life is at risk, or the pregnancy may cause mental harm; if the unborn child will suffer or later develop physical or mental abnormality; in cases of defilement	Termination must be performed before 16 weeks[31]	Consent of parent or next of kin for minors; two doctors	Licensed facility	Three years for procurement; seven years for aiding
ABORTION AVAILABLE IN THREE CIRCUMSTANCES						
Angola	Penal Code 2017[32]	To save the life of a woman; If there are strong reasons to believe the foetus is unfeasible; If the pregnancy is the result of a crime against freedom and sexual self-determination	16 weeks to preserve health, foetal impairment no limit specified	Parental consent for minors	Licensed facility and one doctor	Four to ten years in prison

Country	Law	Conditions under which an abortion may be granted	Gestational limits	Consent	Provided by	Penalties for an illegal abortion
Comoros	Comoros-Penal-Code-1995	In the case of rape or incest; for a very serious medical reason, if a mother's mental state is at risk, or the child's life is at risk	Not specified	Two doctors	One doctor	Penalties for the woman and provider
DRC	Penal Code 2004, superseded by Maputo Protocol, 2018	In cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus		Parental consent for minors		Yes, for the woman, provider, and person who helps a woman obtain abortion
Zimbabwe	Termination of Pregnancy Act of 1977, Chapter 15: 10[33]	In cases of incest, or rape, but not marital rape, under circumstances where the life of the mother is in danger, if the child will suffer from complications after birth		A magistrate must grant permission		Five years in prison and/or fine not exceeding $5000
Lesotho	The Penal Code (2012)[34]	In cases of incest or rape; to save the woman's life, to prevent the birth of a child who will be seriously physically or mentally handicapped		By a registered medical profes-sional, with the written opinion of another regis-tered medical professional		A fine of M5000-M10 000 or imprisonment of up to three years
Mauritius	Penal Code 1983; Criminal Code Amendment Act 2012[35]	To save the life of the woman; or prevent permanent physical damage; If the foetus may suffer severe mal-formation or abnormalities; if the woman younger than 16	If a pregnancy is within 14 weeks and the girl is younger than 16	Parental consent for minors		Imprisonment of up to ten years
Namibia	Abortion and Sterilisation Act 2 of 1975	When two other medical practitioners confirm that the woman has been raped or is a victim of incest; If the pregnancy poses a threat to the physical and mental health of the pregnant woman;[41] If the woman is deemed to be an idiot or imbecile as per the Immorality Act 1957, which criminalises sex with her ; If the unborn child is at risk of a serious mental or physical deformity and handicap		Two medical practitioners must approve in writing that the preg-nancy is a risk	Licensed facility	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both

Country	Law	Conditions under which an abortion may be granted	Gestational limits	Consent	Provided by	Penalties for an illegal abortion
ABORTION AVAILABLE IN ONLY TWO CIRCUMSTANCES, EXCLUDING SEXUAL ASSAULT						
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	If the woman's life is deemed to be in danger or the cost of carrying the foetus is greater than the pregnant woman's physical and mental health; Termination can be carried out if the child is at risk of serious mental and physical deformities[37]		If three medical practitioners agree in good faith, termination can be under-taken at Victoria Hospital in Mahe		Imprisonment up to 14 years
Tanzania	Penal Code 1981[38]	If a woman is at risk of death, or the preg-nancy threatens her mental and physical wellbeing; If a pregnancy threatens the mental and physical wellbeing of the pregnant woman				Seven years for procurement; three years for suppliers
Eswatini	The Constitution	Only if the life of the woman is in danger[39] Or in cases of unlawful intercourse with mentally retarded female		One doctor		Life imprisonment
ONLY ONE GROUND FOR TERMINATION						
Malawi	Penal Code	Only to save a woman's life				14 years for having an abortion; 3 years for supplying instruments to conduct an abortion
Madagascar	Reproductive Health and Family Planning Law 2017	In Criminal Procedure law, an abortion can be performed to save the life of a woman				Not explicit, but death, forced labour or life are most severe punishment

27 This table is reproduced from Gender Links 2019 Abortion Fact Sheet, with some additions from WHO Global Abortion Policies Database https://abortion-policies.srhr.org/ accessed 15 April 2020.
28 http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
29 https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
30 https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
31 http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions, https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm http://www.wipo.int/wipolex/en/text.jsp?file_id=238601
32 http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf
33 http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
34 https://lesotholii.org/ls/legislation/num-act/6
35 https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
36 https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
37 https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
38 https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
39 http://srhr.org/abortion-policies/country/swaziland/

Table 4.5 shows that almost all member states in SADC still have very restricted abortion legislation. South Africa has the most modern Choice of Termination of Pregnancy Act (1996) allowing for safe abortion on demand within the first trimester. Mozambique has modernised its Penal Code. There are six main grounds for allowing abortion that apply in most countries (see table below):

Table 4.8: Grounds for obtaining an abortion in SADC countries

Country	Stand alone law/Penal Code	1. Risk to life	2. Rape or sexual abuse	3. Serious foetal anomaly	4. Risk to physical and sometimes mental health	5. Social and economic reasons	6. On request
South Africa	SAL	1	1	1	1	1	1
Mozambique	PC	1	1	1	1	1	1
Zambia	SAL	1	1	1	1		
Namibia	SAL	1	1	1	1		
Botswana	PC	1	1	1	1		
Angola	PC	1	1	1	1		
Comoros	PC	1	1	1	1		
DRC	PC	1	1	1			
Zimbabwe	SAL	1	1	1			
Lesotho	PC	1	1	1			
Mauritius	PC	1	(statutory rape)	1			
Seychelles	SAL	1		1			
Tanzania	PC	1		1			
Eswatini	Const	1			1		
Malawi	PC	1					
Madagascar	SAL	1					
Total		16	10	13	8	2	2

Legislation in SADC is often archaic, based on inherited colonial legislation not changed in decades, and which does not uphold commitments to women made in multiple forums. The table shows that only South Africa and Mozambique permit abortion on all six grounds. Zambia, Namibia, Botswana, Angola and Comoros permit abortion on four out of six grounds. DRC, Zimbabwe, Lesotho and Mauritius permit abortion on three out of six grounds. Seychelles, Tanzania and Eswatini permit abortion on two out of six grounds. Malawi and Madagascar permit abortion on just one ground - risk to life. Such restrictive legislation has been described as "compulsory childbearing"[40].

> Restrictive legislation is compulsory childbearing

[40] UNFPA, 2022. Op Cit

Southern Africa: Movement for safe abortion gains momentum[41]

The Southern Africa Gender Protocol Alliance marches for #VoiceandChoice. Photo: Colleen Lowe Morna

Members of the Southern African Gender Protocol Alliance commemorated International Safe Abortion Day on 28 September 2021 in a dialogue on the prevention of unsafe abortion in SADC. The dialogue provided an opportunity for sharing experiences from across the region, on challenges, strategies, advocacy and initiatives to end unsafe abortion.

The Alliance is a network of national women's rights networks in 15 SADC countries that campaigned for the SADC Protocol on Gender and Development in 2008, and now its implementation. Gender Links, a Southern African women's rights organisation based in Johannesburg coordinates the Alliance and the annual Barometer measuring progress on gender equality in the region.

Rather than decreasing, as is the case in many parts of the world, the abortion rate in Africa has increased since 1994 as described in the preceding paragraphs. Unsafe abortions affect mostly poorer, unmarried women and adolescents fuelling high maternal mortality rates in the region. The risk of dying from an unsafe abortion is much higher in Africa than in any other region. Africa accounts for 62% of the global deaths resulting from abortion.

Lintle Ramatla, of Bokamoso 974 FM in Lesotho highlighted the important role of the media: "Most media are not giving women the opportunity to talk about this issue". According to Pansi Katenga of Ipas, a non-governmental organisation that advocates for access to safe abortions and contraception, "when we start reflecting on why we should make unsafe abortion history, we start realising it is about someone's life."

Katenga shared the experience of Malawi where Ipas is working with government, parliamentarians, chiefs, religious leaders and the media to help them appreciate that "unsafe abortion is a crisis in Malawi and that something needs to be done… we need to start talking about experiences and why law reform is needed."

Highlighting the root causes of unsafe abortion such as unmet needs for contraception, sexual violence and teenage pregnancy is important.

[41] Gender Links News, 27 October 2021. Susan Tolmay, "Southern Africa: Women call for an end to unsafe abortion".

The 48 participants from across the SADC region who joined the debate on International Safe Abortion Day noted that abortions happen whether it is legal or not. It is a time-sensitive medical service that is a basic human right and should be provided without restriction to save the lives and livelihoods of women and girls.

Alliance members in 15 SADC countries are crafting national advocacy strategies on Adolescent Sexual and Reproductive Health and Rights (ASRHR) policy and teenage pregnancy, safe abortion and child marriage, targeting key policy makers and influencers, with a strong focus on youth involvement. Amplify Change, a global fund to promote SRHR, supports these campaigns.

SAfAIDS leads the SRHR cluster of the Alliance. SAfAIDS and the SADC Parliamentary Forum (SADC-PF) jointly hosted a hybrid side event on SRHR during the 51st Plenary Assembly of the SADC-PF in April 2022. The joint meetings built on the Regional Policy Advocacy Dialogue held with Parliamentarians on 1 April 2021 which resulted in key recommendations passed by Members of Parliament towards a Regional Roadmap on Ending Unsafe Abortion and Early and Unintended Pregnancy (EUP).

The side event during the Plenary Assembly was a first of its kind. It brought together representatives from 15 SADC countries representing SADC-PF Standing Committees on Gender Equality, Women Advancement and Youth Development (GEWAYD); Human and Social Development and Special Programmes (HSDSP), the Regional Women's Parliamentary Caucus and representatives of the SADC-PF Secretariat.

Forty-nine delegates participated in the regional event (38 MPs).

Members of Parliament (MPs) present acknowledged that unsafe abortion and related consequences continue to deter efforts to improve maternal and reproductive health for women and adolescent girls, and negatively affect their health and wellbeing. The MPs called for advocacy and capacity strengthening to support parliamentarians to take bold steps towards policy review to remove restrictions on access to safe abortion in the respective Member States. Recommendations and proposed action plans included:

- SADC-PF should consider a Model Law on Safe Abortion to guide Member States on reviewing current policies and laws in favour of removal of legal restrictions.
- The need for increased efforts to build, strengthen and sustain the capacity of MPs, and support them to be champion is safe abortion in their parliaments and constituencies.
- SADC-PF, SAfAIDS and other key stakeholders should strengthen support for MPs pushing for abortion laws and policies to be tabled in Madagascar, Malawi, Eswatini, Zimbabwe and Lesotho, to strategically push back on and counter opposition.
- The need for cross learning and experience sharing for SADC Parliamentarians with a view to adopting best practices in advocacy for ending unsafe abortions and early and unintended pregnancies.
- Ensuring Member States domesticated Article 14 of the Maputo Protocol, and increase investments to strengthen implementation of the SADC SRHR Strategy and Sustainable Development Goals.

The section that follows details measures taken at national level to advance access to safe abortion in Madagascar, Lesotho, Malawi and Eswatini. Despite the slow progress, collaboration between civil society, Members of Parliament (MPs) and the media is gradually bearing fruit in these particularly conservative SADC countries. Meanwhile, a Constitutional court test case in South Africa showed just how fragile liberal provisions are in the few countries where these exist.

Madagascar: Section 317 of the penal code prohibits termination of pregnancy for any reason. Any abortion can expose women to two years in prison. Madagascar inherited this provision from the Napoleonic Penal Code of 1817. Despite French law changing, the provision remains in place in Madagascar.

Marie Jeanne d'Arc Masy Goulamaly a member of Parliament in Madagascar and vice-president of the Gender Equality, Promotion of Women and Youth Development Committee of the Parliamentary Forum of the Community of Southern African States, tabled a proposed law PPL 004-2021/PL on Therapeutic Termination of Pregnancy (ITG) on 18 October 2021 in the National Assembly, for inclusion in the Parliamentary agenda.

The proposed bill allows for therapeutic abortion in cases where the pregnancy is a danger to the life of the mother, foetal impairment, where pregnancy is the result of rape or incest as well as for women who are mentally incapable of assuming the role of a parent. A similar bill tabled in 2017, as part of a bill on family planning, failed to gain traction. Despite civil society demonstrations, parliament has still not debated the bill.[42]

An estimated 75,000 abortions take place in Madagascar annually, many unsafe. Since 2017 various organisations have challenged the existing law and organised events to highlight the damaging impact that the law has on women's lives and health. Nifin'Akanga, a leading advocate for decriminalisation of therapeutic abortion in Madagascar, celebrated World Safe Abortion Day in 2021 by sharing the results of the largest national survey on abortion practices in Madagascar. The survey, conducted in late 2020, covered 4,478 people (3,568 women and 910 practitioners). Selected results included:

- Women of all ages have abortions. The age range was between 14 and 50.
- Women have abortions regardless of their level of education. Those with education up to secondary school represent 38.5% and university graduates were more than 42%.
- Women who have/have had a stable relationship represent more than 51% of those accessing abortions.
- Christians constituted just over 81% of respondents, even though Christians adopt the most virulent and closed discourse when it comes to the decriminalisation of abortion.
- Fifty two percent of abortions take place in inappropriate settings, such as women's homes or the homes of practitioners.
- People with no medical training perform 31% of abortions. Paramedics perform 29.5% doctors 22% and matrons 18% of abortions.
- Eighty eight percent of women in Madagascar do not use any contraceptive method.
- Reasons given for abortion were: 23,2% pregnancy too early; 20,1% unwanted pregnancy and 20,3% other (including medical or therapeutic, rape and incest)

The stories were, above all, of courage and demands for change in the law

Nifin'Akanga has also compiled a booklet with stories of 15 women who have undergone abortions and survived. The stories are of love, loss, abuse, incest, pain, but above all courage and demands for change in the law to respect the bodily autonomy of women. A few were able to access medication abortion but without expert advice on how to use it. Some needed post abortion hospitalisation and for some this ended in hysterectomy. Many knew of women who had died because of abortion but it did not deter them.

[42] Compiled from: Safe Abortion: Women's Right, "Madagascar - New Therapeutic abortion bill tabled in Parliament", News: Madagascar. https://www.safeabortionwomensright.org/news/madagascar-new-therapeutic-abortion-bill-tabled-in-parliament/ accessed 7 July, 2022. Amnesty International, "Report Madagascar", https://www.amnesty.org/en/location/africa/southern-africa/madagascar/report-madagascar/ accessed 9 July, 2022. Tétaud, Sarah, Afrique 4 June, 2022,"Madagascar: the law on therapeutic termination of pregnancy again excluded from the Assembly" https://www.rfi.fr/fr/afrique/20220604-madagascar-la-loi-sur-l-interruption-th%C3%A9rapeutique-de-grossesse-%C3%A0-nouveau-%C3%A9cart%C3%A9e-de-l-assembl%C3%A9e accessed 9 July, 2022. Ramavonirina, Patricia. LaVerite, 13 Mai, 2022, "Proposition de loi sur l'interruption médicale de grossesse - Manifestation de la société civile devant l'Assemblée nationale", https://laverite.mg/societe/item/16213-proposition-de-loi-sur-l-interruption-m%C3%A9dicale-de-grossesse-manifestation-de-la-soci%C3%A9t%C3%A9-civile-devant-l-assembl%C3%A9e-nationale.html accessed 9 July, 2022

[43] Safe Abortion: Women's Right, News, Madagascar https://www.safeabortionwomensright.org/news/madagascar-lets-continue-the-legacy-of-mireille-rabenoro-28-september-2021/

His Eminence Great Mfuti of Zambia, Sheikh Assadullah Mwale and Her Royal Highness Princess Mihanta Ramanantsoa of Madagascar during the SAfAIDS Regional Religious and Traditional Leaders Sectoral Policy Advocacy Dialogue on Preventing Unsafe Abortion. Photo: SAfAIDS, My Choice Our Choice

The SAfAIDS champion, Her Royal Highness Princess Mihanta Ramanantsoa, a traditional leader has been supporting Marie Jeanne d'Arc Masy Goulamaly, the parliamentarian who tabled the Therapeutic Abortion Bill in parliament. The Bill will enable Malagasy women and adolescent girls to legally access safe abortion in selected circumstances. She is arguing that unsafe abortions have a negative impact on lives and wellbeing of women and girls. They are collaborating with Nifin'Akanga.

In 2010, **Lesotho** promulgated the Penal Code 2010, which legalised abortion in the case of rape; where the life of the mother is in danger; or where the fetus is extremely deformed. This resulted in uproar and anger in some quarters. In 2018, the parliament social cluster committee, civil society organisations, non-governmental organisations and individuals began the arduous campaign for legalisation of abortion in Lesotho.

Despite evidence that illegal and unsafe abortions are taking a heavy toll on the health and wellbeing of girls and women, there is stiff resistance to relaxing the legislation that governs the provision of this service, particularly from traditional communities and fundamentalist Christians. The parliament social cluster has mounted countrywide consultations on the need for Lesotho to act on legal and safe abortion for all who need the service.

In light of the backlash experienced in 2010, many parliamentarians fear that their constituents may turn against them. The hope is for a policy or law on safe abortion even though it is not clear when parliament or responsible ministries intend to develop legislation on safe abortion. Activists hope that a bottom-up approach will have more chances of being accepted.

However, with many of the hospitals and clinics run by churches, activists face several challenges.

Parliamentarians in Lesotho agreed with SAfAIDS that they need to take the discussion on safe abortion to different regions of the country. Evidence suggests that doctors are offering unsafe abortions in Lesotho under the counter. Those with means to cross into South Africa where they can access safe and legal abortion. COVID-19 lockdowns hampered this access.

Parliamentarians arranged to visit three regions of the country where they spoke with traditional leaders to assess sentiments to changing the law and expanding the circumstances under which a woman can access a safe abortion. This led to a recommendation for an inter-ministerial task force to look at the options for liberalising the law and expanding the circumstances under which women can access legal abortion.

One of the SAfAIDS champions in Lesotho, MP Ts'epang Mosena, argues that Lesotho has committed to many regional, continental and international protocols that bind it to improving the lives and wellbeing of women. She says Lesotho can only honour these commitments by expanding the circumstances under which safe abortions can be accessed.

Lesotho: Taking the campaign to the airwaves

Lintle Ramatla is a radio presenter on Bokamoso FM who champions safe abortion in Lesotho by involving and engaging with radio listeners and social media followers. Herself a teenage mother, Ramantla works closely with SAfAIDS, IPAS and Gender Links on safe and legal abortion. On her radio programme, women and girls share their lived realities. They speculate on how legalising abortion could change their lives.

The radio programme aims to curb the stigma associated with abortion and to assist with trauma counselling for women and girls who have undergone abortion are charged and imprisoned or must pay a fine. Failure to pay a fine results in imprisonment and a criminal record that affect employability.

Feedback from the programme suggests that even older people want abortion to be legal in Lesotho. One of the reasons that listeners give for legalising abortion is that it has social and economic implications for young girls. For instance, some church schools do not allow pregnant girls to remain in school. In some cases, they do not allow teenage mothers to attend their schools. This denial of access to education for teenage mothers has negative economic and social impacts for the mothers and their children.

Listenership to the programme on safe abortion has increased. Listeners give positive feedback regarding the need for legalisation of abortion in Lesotho. More people are advocating for legalising abortion on social media. Activists plan to use the responses to advocate with government to develop and implement a policy on safe abortion in Lesotho.

Political parties throughout the world will need to emancipate women by allowing them access to abortion when needed. As such, the next campaigns on safe abortion are targeting the leaders and women's leagues of political parties that are in parliament and make laws. Political parties should include issues of safe abortion in their manifestos.

Lintle Ramatla receiving an award from the Former Deputy Minister Marefuoe Muso during the 2020 SADC Protocol@Work Summit. Photo: Ntolo Lekau

Though COVID-19 restrictions and low levels of funding have limited campaigning on safe abortion, the campaign will be re-energised to close follow up on the Parliamentary motion on safe abortion.

Source: Gender Links News Service, July, 2022. Safe Abortion in Lesotho.

In October 2021, the Parliament of **Namibia** opened public hearings on a petition brought to parliament in 2020 to liberalise the law governing abortion and sterilisation. Namibia inherited its restrictive 'Abortion and Sterilisation Act No2 of 1975' from the apartheid administration. South Africa legalised abortion in 1996, through the Choice in Termination of Pregnancy Act. Namibia is clinging to the old Act.

There has been significant press coverage of the hearings with one opinion piece decrying the hypocrisy of lawmakers who have already made their anti-abortion sentiments public collecting allowances to traverse the country and listen to those in authority who will validate these positions. The article claims that "the same people fail to take action against those who abuse and rape young girls and women or to alleviate the emotional trauma and suffering of vulnerable women and young girls." Further, the writer says that those who support campaigns against comprehensive sexuality education in schools also support punishing young girls who resort to illegal and unsafe abortions but there is no support for vulnerable girls who are forced into pregnancy. "Those lawmakers know that the people who most need safe abortions will struggle to make their voices heard in a society that has no tolerance for women (even the oldest ones) to express their sexuality matters openly and freely," the article concludes.[44]

Senior sociology lecturer at the University of Namibia Lucy Edwards said, "it's a woman's right to choose whether she wants to terminate a pregnancy or not. Traditional leaders, who are mostly men, do not support abortion because they will never have to face this decision. It undermines a woman's right to choose, and the right to her bodily autonomy. I don't know why we are always peddling tradition when it comes to upholding women's rights... A lot of traditional views are deeply entrenched in patriarchy and the desire to control women's bodies."[45] The Voices for Choices and Rights Coalition (VCRC) is a nationwide movement of voices in Namibia, advocating for the choices reflective of bodily autonomy and freedom from the structural violence of restrictive abortion laws.

Malawi: There has been little progress in parliament with regard to the proposed Termination of Pregnancy Bill tabled in 2021 and then tactically withdrawn. An example of the ultra-conservative resistance to the bill in Malawi is the following extract of an article released by an American Catholic organisation:

"Fr. Z. got to work right away rallying pro-lifers in parliament and the Malawian people. With support from our donors, he built strong opposition to the bill through Radio and TV programs. This strategy still works, but it's getting more and more difficult.

Pro-abortion groups paid some networks not to run any pro-life material. On others they bought up the airtime, driving prices out of our budget range. Thanks be to God, the Catholic networks in Malawi did not accept any of their blood money. And they have a long reach. The pro-life message made a serious impact through these channels.

After Fr. Z. started talking about the bill, Malawians shouted for parliament to drop it. Lawmakers listened, and the abortion bill died before reaching the discussion stage. Thanks to all our donors for making this victory possible!

[44] Women's Law Centre. 18 October, 2021. Press Release. WLC supports liberalisation of abortion laws in Namibia - Women's Legal Centre (wlce.co.za) accessed 20 June, 2022.
Nthengwe, Ndilewa, 23 April, 2022. Abortion on Demand in Namibia. https://www.namibian.com.na/6219872/archive-read/Abortion-on-Demand-in-Namibia accessed 12 July, 2022
[45] Namibia. Traditional Leaders Oppose Abortion Law Reform. 24 January, 2022. https://allafrica.com/stories/202201240530.html accessed 12 July, 2022.

The Plan to Keep Pre-born Malawians Safe Long-term

The impact through the Catholic stations did the trick this time, but the pro-aborts aren't giving up. They'll be back next year with another scheme. With your pro-active support now, we can be ready for them…

But to stay ahead of the pro-aborts we need to step up our efforts. And you can help. Our donors made it possible to stop abortion from spreading in Malawi this year. And with your support, pre-born Malawians will be safe for years to come."

Source: Human Life International, October 19, 2021. Malawi's Secret Abortion Bill Exposed.[46]

SAfAIDS and the Coalition for the Prevention of Unsafe Abortion (COPUA) have been supporting the Chair of the Portfolio Committee on Health, Dr Matthews Ngwale, to lobby more parliamentarians, as many are new since the last elections. The strategy is to engage with parliament as an institution to build the capacity of all parliamentarians. Parliamentarians are conducting safe abortion dialogues at constituency level to mobilise support as Malawi is extremely conservative. One of the SAfAIDS champions, Senior Chief Inkosi Jere Mabulabo is a Traditional leader who is speaking on the need to expand circumstances in which safe abortion is allowed, and prevent the needless loss of lives of women and adolescent girls.

One of the SAfAIDS **Eswatini** SRHR champions, MP MacFord Sibandze, steered the debate on inclusion of access to safe abortion in the Public Health Bill. Although he faced much backlash for his stance, including personal attacks, he remained resolute in his advocacy, calling on other Parliamentarians to address policy restrictions to safeguard the health and wellbeing of women and adolescent girls in Eswatini. Following a presentation to parliament by opponents of abortion in the Public Health Bill, a group of CSOs, led by SAfAIDS and including Gender Links, held a dialogue with the Portfolio Committee on Health to advocate for inclusion of Safe Abortion in the Public Health Bill.

In **South Africa**, in the case, "CCT 120/21 Voice of the Unborn Baby NPC and Another v Minister of Home Affairs"[47], representatives of two anti-abortion groups and the Catholic Church sought to give the parents of an unborn child or foetus the right (though not obligation) to bury the remains. Although the law is silent on this issue, the regulations for birth and death registration consider a miscarriage to be of a foetus before 26 weeks and a stillbirth after 26 weeks. The procedure for a miscarriage is incineration of the remains in the hospital while remains of a stillbirth can be buried. The Women's Legal Centre argued that allowing burial of foetal remains could be a barrier to access of abortion services.[48]

The case originally brought to court in June 2018, went before the Constitutional Court in November 2021 with judgement in June 2022. The Constitutional Court rejected the application, accepting that the right to foetal burial might impact on the health care sector in South Africa. As things stand, access to abortion services is impacted by:

- Stigma and discrimination when seeking the service at health facilities;
- Lack of open and accessible information about where to access abortion services in South Africa;
- Poor supplies of reproductive health commodities and regular stock-outs of contraception and medical abortion drugs; and
- Limited numbers of trained and willing health personnel to provide the service and limited numbers of facilities designated to offer the service.

[46] https://www.hli.org/2021/10/malawis-secret-abortion-bill-exposed/ accessed 20 July, 2022.
[47] https://www.safeabortionwomensright.org/news/south-africa-voice-of-the-unborn-baby-constitutional-court-hearing-on-fetal-burial-after-miscarriage/ accessed 30 June, 2022.
[48] https://www.youtube.com/watch?v=qiqjYAzBmng accessed 30 June, 2022. WLC, June 2022. Press Statement on Safeguarding access to safe and legal abortions - Constitutional Court Judgment handed down in the matter of Voice of the Unborn Baby NPC and another v Minister of Home Affairs and another. https://wlce.co.za/safeguarding-access-to-safe-and-legal-abortions-voice-of-unborn-baby/?fbclid=IwAR2wEU93JF7sMOy7gbyHYbuBBh_Yc-PapmrGAdwx9opD7h24_Dvml_FzuV0 accessed 20 June, 2022.

A movement for the total decriminalisation of abortion

Decriminalisation means removing abortion from all penal / criminal laws

Local efforts continue to advocate for liberalisation of abortion laws with more grounds for safe abortions. Globally there is now a growing movement towards complete decriminalisation of abortion founded in notions of gender equality and human dignity, challenging legal restrictions to women's bodily autonomy. Legal campaigns for the decriminalisation of abortion embrace criminal, health, constitutional, and international law.[49]

Only a very few countries, such as China (1979), Canada (1988), Northern Ireland (2019), New Zealand (2020), and Australia (2021), have removed abortion from their penal laws completely. In a bold statement on this matter by a UN body, the first recommendation in the WHO 2022 Abortion Care Guidelines is "the full decriminalisation of abortion."[50] The guidelines say that decriminalisation:

- Means removing abortion from all penal/ criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.
- Would ensure that a woman who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care.
- Does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assaults as these would be non-consensual interventions.[51]

The guidelines further recommend against laws and other regulations that restrict abortion by grounds and that abortion should be available on the request of the woman, girl or other pregnant person. The final recommendation on legislation is that abortion should not be restricted based on gestational age limits.

FIGO (the International Federation of Gynaecology and Obstetrics) describes decriminalisation as "the removal of specific criminal sanctions against abortion from the law so that no one is punished for providing safe abortion or for having an abortion. In practice, decriminalisation means that the police and the legal system are not involved in the investigation or prosecution of safe abortions. Instead, abortion care is treated like any other essential health issue in medicine, for which the standard of care is based on best practice guidelines, training and delivery, with regulation by health authorities."[52]

FIGO's statement in Feb 2022 called for "the total decriminalisation of safe abortion, and for the promotion of universal access to abortion, post-abortion care and evidence-based, non-biased abortion-related information, free of force, coercion, violence and discrimination. Abortion should be removed from criminal law and regulated by laws consistent with every other medical procedure, and with the wellbeing of women and girls placed at the centre of their care."

[49] Malagodi M, Gender Equality and the Complete Decriminalisation of Abortion , Int'l J. Const. L. Blog, Nov. 10, 2021, at:http://www.iconnectblog.com/2021/11/gender-equality-and-the-complete-decriminalisation-of-abortion/ accessed June 30, 2022.
[50] WHO, 2022. Op Cit.
[51] Ibid
[52] International Federation of Gynecology and Obstetrics. 2022. FIGO Calls for the Total Decriminalisation of Safe Abortion . Available from: www.figo.org/resources/fig52statements/figo calls total-decriminalisation safe abortion

On the Global Day of Action for Access to Safe and Legal Abortion, 28 September 2021, the AU Special Rapporteur on the Rights of Women, Honourable Commissioner Maria Teresa Manuela, reminded "African States of their obligations under the Maputo Protocol." She said these included their obligations to put in place appropriate measures to realise women's access to reproductive health care services. The Special Rapporteur further *called on States to decriminalise abortion*[53] and empower women and girls to make their own choices about their reproductive health."[54]

AU Special Rapporteur on the Rights of Women calls on States to decriminalise abortion

Medication Abortion

Since women began using Misoprostol for abortions, its use has expanded around the world. The WHO recommends a combination of Mifepristone and Misoprostol for medication abortion. Medication abortion is easier, less invasive and has similar results to other forms of safe abortion, particularly when used before nine weeks gestation. Misoprostol is generally cheaper and more readily available as it is used for other conditions as well. Misoprostol alone seems to have similar efficacy to the combination of the two drugs.

The move to self-management of abortion care accelerated rapidly to counter the compromises in abortion care during the COVID lockdowns. Global Doctors for Choice categorise SMMA (Self-Managed Medication abortion) as:

- Abortions using mifepristone and/or misoprostol, self-sourced and ingested without reliable support.
- Abortions obtained outside the formal health-care system using social networks, at pharmacies, or online, where some non-health system support is provided such as an accompaniment service or a safe abortion hotline.
- A "harm reduction" approach in legally restricted settings, where physicians date pregnancy, provide information about medications, warning signs of complications and post-abortion care, but medication is self-sourced. This approach was pioneered in Uruguay, when abortion was severely restricted.
- Abortions in a restricted context, with drugs prescribed by a clinician via telemedicine outside the formal healthcare system, with no in-person clinical encounters. An example is Women on Web, through which women obtain abortion medications online with support from a physician. Medications are sent via mail with support from a 24 hour telephone hotline with trained non-medical staff. Clients are advised to visit emergency services for symptoms of serious complications.
- Abortions with drugs prescribed within the formal healthcare system by a clinician via telemedicine, with medication taken at home.
- Abortions using drugs prescribed within the formal healthcare system, by a clinician in person, where at least one medication is taken at home. This includes outpatient medical abortion, where screening and mifepristone administration is in clinic, misoprostol is at home and post-abortion evaluation is in-clinic.[55]

Several studies have assessed the efficacy of self-managed abortion care (often with some

[53] Emphasis Gender Links.
[54] African Commission on Human and Peoples' Rights, 28 September, 2021. "Statement of the Special Rapporteur on the Rights of Women on the Occasion of the Global Day of Action for Access to Safe and Legal Abortion", 28th September 2021 https://www.achpr.org/pressrelease/detail?id=602 accessed 6 July, 2022.
[55] Global Doctors for Choice. 2021. Integrating Self-Managed Medication Abortion with Medical Care: A Briefing Paper. https://globaldoctorsforchoice.org/wp-content/uploads/SMMA-BP-7-6-21.pdf accessed July 10, 2022.

advice or accompaniment)[56]. Generally, women have found the process effective, with abortion outcomes achieved. A study to examine the availability of Misoprostol and Mifepristone in 44 countries around the world[57], including 17 in Sub Saharan Africa (of which DRC, Mozambique, South Africa, Tanzania, Zambia are in SADC) found that these were quite readily available in all countries, but with wide variation in pricing. Misoprostol is much cheaper than Mifepristone, which is relatively expensive and would be difficult for many poor women to access. In many cases, researchers could not verify the quality of the available medication.

WHO emphasises that all individuals engaging in self-management of medical abortion need accurate information, quality-assured medicines including for pain management, the support of trained health workers and access to a health-care facility and to referral services if they need or desire it.

A cursory google search of "abortion" and any one of the countries that neighbours South Africa produces details for abortion clinics in South Africa where abortion is legal. There is no data to confirm how many women from neighbouring countries seek abortion services from private providers in South Africa, some of whom advertise the availability of pills that can be delivered. There is also no information on the quality of information and instructions that are shared with women about use of the pills, or when to seek help. Those with economic means - who are often older and urban, have more options for quality abortion care.

Post Abortion Care

Even where abortions are not legal, most countries provide some access to post abortion care (PAC). This is often as a last resort, when less and least safe abortions have resulted in serious complications such as sepsis and excessive bleeding. A number of SADC countries have policies and guidelines on the provision of post abortion care (see Table 4.7).

Table 4.9: Policies and guidelines on post-abortion care

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

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

[56] See for instance: Moseson H, Jayaweera R, Egwuatu I, Grosso B, et al (2021) Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls. Lancet Glob Health 2022; 10: e105-13 https://doi.org/10.1016/S2214-109X(21)00461-7 accessed 28 June, 2022.
Bercu C, Filippa S, Jayaweera R, Egwuatu I, et al. (2022) A qualitative exploration of how the COVID-19 pandemic shaped experiences of self-managed medication abortion with accompaniment group support in Argentina, Indonesia, Nigeria, and Venezuela, Sexual and Reproductive Health Matters, 30:1, 2079808, DOI: 10.1080/26410397.2022.2079808 accessed 28 June, 2022.

[57] Durocher J, Kilfedder C, Frye L J, Winikoff B & Srinivasan K (2021) A descriptive analysis of medical abortion commodity availability and pricing at retail outlets in 44 countries across four regions globally, Sexual and Reproductive Health Matters, 29:1, 196-213, DOI: 10.1080/26410397.2021.1982460 accessed 28 June, 2022.

Madagascar: Human resources norms and procedures for PAC include emergency care, counselling, and integrated services with direct links to the community. Public and private clinics, such as those operated by international organisations (e.g., Marie Stopes and Population Services International [PSI]) have PAC protocols and clinical guidelines for doctors and midwives. Government has not adopted these. Women face multiple barriers to accessing PAC services including: a restricted policy environment; limited access to poor quality health services with only 40% of the Malagasy population living within five kilometres of most health centres; lack of awareness of PAC services and stigma from the community and providers.[58]

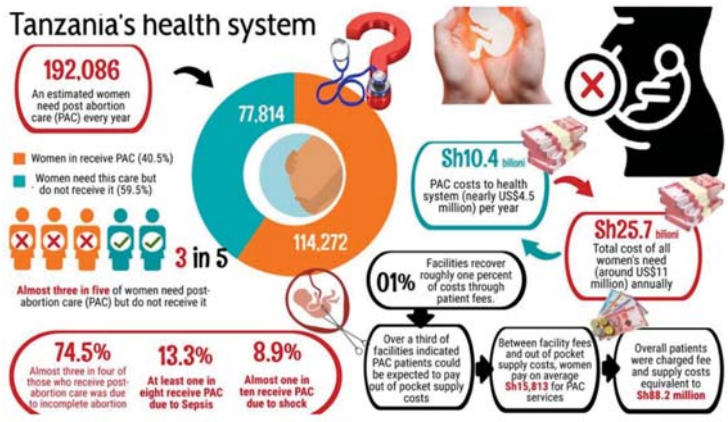
Malawi: Ipas is supporting the Ministry of Health in Malawi to provide capacity to health centres to provide PAC. Ipas is also raising awareness about the dangers of unsafe abortions and encouraging women to access PAC.[59] While PAC is available in most primary and secondary health facilities, the quality and quantity of equipment and service is often inadequate.

Zimbabwe: A qualitative study among young women who sell sex[60] found that 151 of the 198 young women, aged 16 - 24, had ever been pregnant and 44 of these had had an abortion. Of these 10 had experienced complications and 18 had had more than one abortion. Reasons that the young women gave for having an abortion included:

- Socio economic - not being able to care for a child.
- Not knowing the father of the baby.
- Still being in school.

Socio economic constraints drove women to less safe abortion methods. Many knew of safer services, including access to misoprostol, but chose old women who use a variety of traditional, mostly unsafe mechanisms. Few knew of formal PAC services or willingly accessed these for fear of the legal implications of reports that they had an abortion. They were aware of the need for "cleansing the uterus" and did this as best they could at home, with traditional remedies. An earlier study found that adolescents aged 15 - 19 comprise at least 12% of PAC patients in Zimbabwe.[61]

Tanzania: A study conducted by Guttmacher and Muhimbili University of Health and Allied Sciences (MUHAS) in Dar es Salaam, Tanzania[62], estimated the health system costs of offering PAC in Tanzania in 2018, at existing levels of care and when hypothetically expanded to meet all need. The study found that 77 814 women received PAC nationally at a cost of $4,5m. It is estimated that 192 086 women needed care and approximately 40% received it. Thus, the total cost could be over $11million. Public facilities bore the majority of PAC costs, and recovered about 1% of costs through charges to patients. The study concluded that government needs to do more to prevent unintended pregnancies.



Source: Gregory, S. The costs of post-abortion care for Tanzania. The Citizen. November 1, 2021.[63]

[58] Engender Health, 2021. Madagascar PAC-FP Country Brief. https://www.engenderhealth.org/wp-content/uploads/2021/12/PAC-FP-Country-Brief_Madagascar.pdf accessed 28 June, 2022

[59] Malawi24, September 8, 2021. Lack of access to post-abortion care leading to maternal deaths. https://malawi24.com/2021/09/08/lack-of-access-to-post-abortion-care-leading-to-maternal-deaths/ accessed July 5, 2022

[60] Chareka S, Crankshaw TL, Zambezi P Economic and social dimensions influencing safety of induced abortions amongst young women who sell sex in Zimbabwe. Sexual and Reproductive Health Matters. Volume 29, 2021 -Issue 1. https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1881209 accessed 17 July, 2022

[61] Madziyire MG, Polis CB, Riley T, et al. Severity and management of postabortion complications among women in Zimbabwe, 2016: a cross-sectional study. BMJ Open. 2018;8(2):e019658.

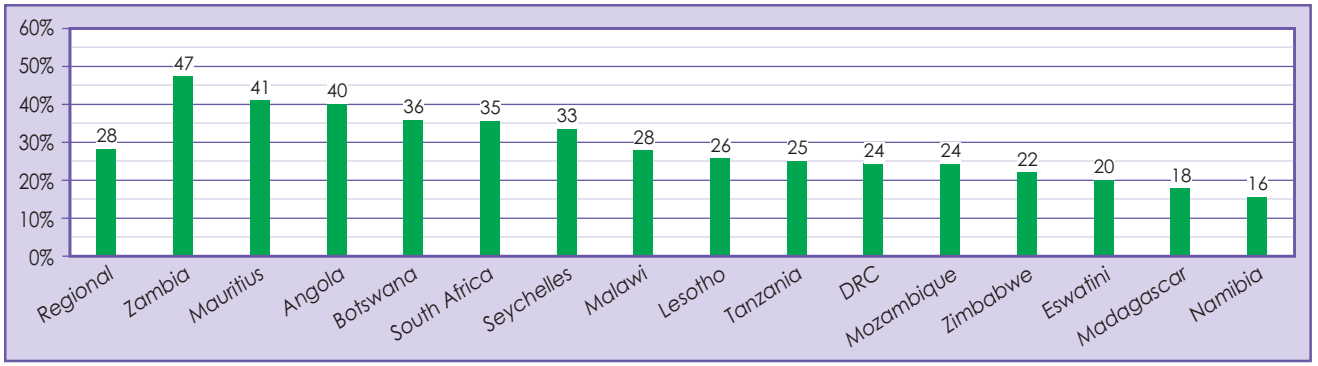
[62] Lince-Deroche, N et al. The Health System Costs of Post Abortion Care in Tanzania. BMC Health Services Research (2021) 21:720 https://doi.org/10.1186/s12913-021-06688-7 accessed July 7, 2022.

[63] https://www.thecitizen.co.tz/tanzania/magazines/health-/the-costs-of-post-abortion-care-for-tanzania-3604068

Changing attitudes

SADC Gender Protocol Alliance partners regularly conduct attitude surveys to gauge, and measure changes in, public opinion on relevant issues. Some questions help guide advocacy efforts. For example, the findings on the statement, "A woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy" suggest that there is need for continued discussion and debate on this issue to raise awareness about women's sexual and reproductive rights.

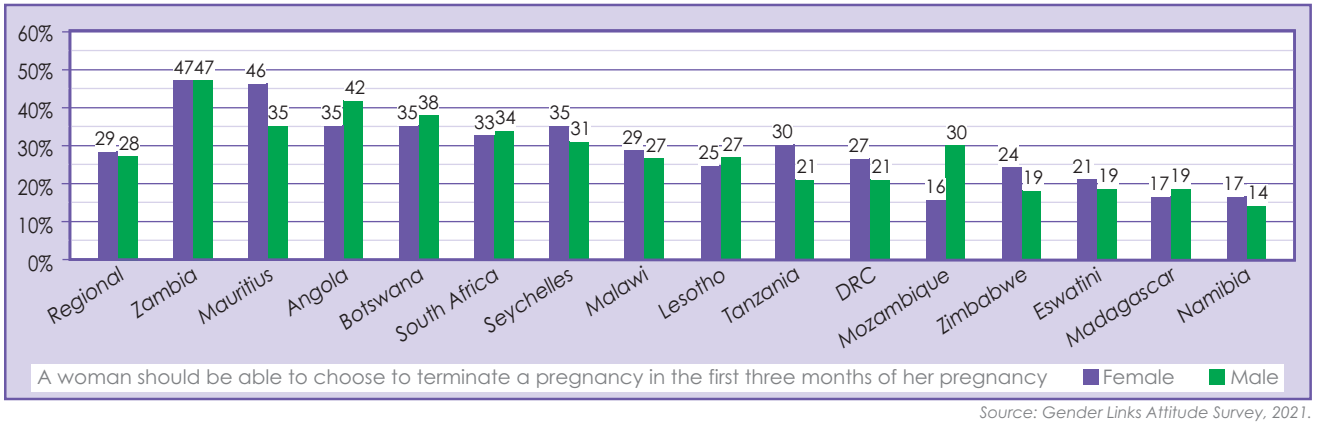
Figure 4.5: A woman should be able to choose to terminate a pregnancy, 2021



Source: Gender Links Attitudes survey, 2021.

Figure 4.5 shows that those who agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months across SADC is only 28% which is a slight shift from the last survey in 2019 of 26%. No country in the survey had 50% or more agreeing. This is a strong indication of the high levels of stigma that still exist in relation to abortion.

Figure 4.6: Attitudes on abortion by sex



Source: Gender Links Attitude Survey, 2021.

Figure 4.6 shows the differences in attitudes between men and women in 2021 in relation to the question. The regional average is very similar between women and men with some differences between them in different countries.

Next steps

Key recommendations include:

- SADC governments must pay attention to the high levels of unsafe abortion and implement urgent measures to reduce the need for abortion, particularly amongst younger women, including through:
- Finding innovative ways to ensure that comprehensive sexuality education is available for both boys and girls - in and out of school.
- Expanding access to modern contraception for all, especially women in groups that governments often overlook, such as sex workers, those in remote communities, the disabled, and poorest.
- Improved protection from sexual violence and work with communities to build safe communities that do not tolerate gender norms which perpetuate such violence
- Community leaders and health care professionals need to pay attention to the high levels of stigma that prevent young and other marginalised women from accessing SRH services. There should be open dialogue between service providers and users of services.
- SADC Member states need to pay attention to medical experts in the WHO that are advocating for decriminalisation of abortion and critically consider why they believe it is necessary to keep such laws.
- To save lives, all SADC member states should provide post-abortion care to all women with abortion complications and train staff in the safest and most up to date approaches as well as provide the necessary equipment and drugs.
- Activists and political leaders need to work together to share information about the conditions under which abortion can be accessed and ensure that both those that need abortions and those that provide abortions are aware of these circumstances.

Source: SAfAIDS, My Choice Our Choice

- There is an urgent need for much better data to inform decision-making on the issue of abortion. Data needs to include: access (or lack of access) to contraception by all who need it (not only women and men in marriage); rate of legal abortions performed; demand for abortion and reason for the demand; rate of illegal abortions performed; and rate of unsafe abortions.
- Activists and governments should seek to expand access to medication abortion in as many different settings as possible. This is much safer and less invasive than traditional methods.

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HIV and AIDS 5

Marching to a better future: World Aids Day in Kabwe, Zambia. Photo: Albert Ngosa

KEY POINTS

- Eswatini, Botswana and Switzerland are the three countries in the world that have been officially recognised as achieving the UNAIDS 95 95 95 targets ahead of 2025.[1]
- Several other SADC member states are on course to achieve 95 95 95. However, Madagascar appears to be moving towards a high prevalence epidemic which is cause for concern.
- The Global AIDS Update, 2022, In Danger, warns that the world is in danger of failing to reach the goal of AIDS no longer being a public health threat by 2030. New infections are not falling fast enough, more people are not being put on ART fast enough and there are still too many deaths as a result of AIDS. Globally, it is estimated that there were still 1,5 million new HIV infections in 2021 compared to a target of reducing new infections to under 370 000 by 2025.[2]
- There are glaring gaps in the treatment for children in much of the world. However, Eswatini has achieved 98% of children on treatment.
- Botswana achieved silver status on eliminating mother to child transmission - the first high burden HIV country in the world to achieve this.
- COVID-19 had a devastating impact on HIV prevention and TB programming around the world, especially on condom programming as well as Voluntary Medical Male Circumcisions. Fast adaptations, particularly introduction of community based approaches, made it possible for HIV treatment to continue.
- TB is the leading cause of death in people living with HIV. South Africa, Tanzania and Malawi achieved a 75% decline in TB related deaths between 2010 and 2020.
- As the rate of new infections in adolescent girls and young women declines the proportion of new infections in key populations - sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons and prisoners, and their sexual partners - are on the rise.

[1] Thornton, J. Botswana HIV Success. www.thelancet.com Vol 400 August 13, 2022 DOI:https://doi.org/10.1016/S0140-6736(22)01523-9 Accessed 15 August, 2022.
[2] UNAIDS. 2022. Global AIDS Update. 2022. In Danger. Geneva, UNAIDS.

Introduction

UNAIDS 2022 Global AIDS Update, *In Danger*, warns that the world is not on track to end AIDS as a public health threat by 2030.[3] New infections have not fallen fast enough in regions such as East and Southern Africa. The rates are even increasing in some regions. As a result of COVID-19 restrictions millions of children were not in school, there was increased GBV and teenage pregnancy, with continued high rates of new infections in adolescent girls. Globally, it is estimated that there were still 1,5 million new HIV infections in 2021 compared to a target of reducing new infections to under 370 000 by 2025. The number of deaths due to HIV is still too high. The rate at which deaths are falling is too slow. Globally the rate of increase of people on ART has slowed. While three quarters of those living with HIV are on ART, at least ten million people are not on ART.

The Update is a critical call for more action, more investment and greater urgency to meet the targets which were set in the Global AIDS strategy, 2021 - 26[4]:

The strategy builds on three interlinked strategic priorities:

- Strategic Priority 1: maximize equitable and equal access to HIV services and solutions;
- Strategic Priority 2: break down barriers to achieving HIV outcomes;
- Strategic Priority 3: fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

The ten result areas of the five-year plan are:

1: Primary HIV prevention for key populations, adolescents and other priority populations, including adolescents and young women and men in locations with high HIV incidence.

2: Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being.

3: Tailored, integrated and differentiated vertical transmission and paediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence.

4: Fully recognised, empowered, resourced and integrated community led HIV responses for a transformative and sustainable HIV response.

5: People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination.

6: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV.

[3] UNAIDS. 2022. Op Cit.
[4] UNAIDS. 2021. End Inequalities and AIDS. Global AIDS Strategy 2021 - 2026. Geneva. UNAIDS.

7: Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS.
8: Fully funded and efficient HIV response implemented to achieve the 2025 targets.
9: Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.
10: Fully prepared and resilient HIV response that protects people living with, at risk of, and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks.

The cross-cutting issues include:

i. Leadership, country ownership and advocacy: leaders at all levels must renew political commitment to, ensure sustained engagement with, and catalyse action from key and diverse stakeholders.
ii. Partnerships, multisector approaches and collaboration: partners at all levels must align strategic processes and enhance strategic collaboration to fully leverage and synergize the contributions to ending AIDS.
iii. Data, science, research and innovation: data, science, research, and innovation are critically important across all areas of the Strategy to inform, guide and reduce HIV related inequalities and accelerate the development and use of HIV services and programmes.
iv. Stigma, discrimination, human rights and gender equality: human rights and gender inequality barriers that slow progress in the HIV response and leave key populations and priority populations behind must be addressed and overcome in all areas of the Strategy.
v. Cities, urbanization and human settlements: cities and human settlements as centres for economic growth, education, innovation, positive social change and sustainable development to close programmatic gaps in the HIV response.

UNAIDS 2022 Global AIDS Update, In Danger, warns that the world is not on track to end AIDS as a public health threat by 2030

Across SADC all efforts are needed to achieve the goal of 95% of all those living with HIV knowing their status; 95% of all those who know their status being on antiretroviral treatment (ART) and 95% of those on ART becoming virally suppressed. Eswatini and Botswana, have demonstrated the best results. There is much work to continue to maintain these achievements and to reach these goals in all countries and across all sub populations.

The Global Strategy has 3 goals for enablers (referred to as the three tens). These include:

- Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence;
- Less than 10% of people living with HIV and key populations experience stigma and discrimination;
- Less than 10% of countries have punitive legal and policy environments that deny or limit access to services.

Table 5.1 overleaf is based on data from the most recently available UNAIDS estimates. It is important to note that estimates vary slightly from one year to another. In 2022 there were no estimates for Mozambique.

Table 5.1: Key HIV data 2021

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV and AIDS Prevalence																
Overall prevalence adults aged 15 - 49 (%)	1.6	18.6	<0.1	0.7	27.9	20.9	0.4	7.7	1.4	11.5	11.8		18.3	4.5	10.8	11.6
Women who are HIV positive as a % of total	59	61	50	56	59	59	53	58	41	57	59		64	59	60	58
Women aged 15 to 49 HIV prevalence rate	2.1	23.8	<0.1	0.9	36.1	26.1	0.4	9.4	1.2	14.4	15.1		24.5	5.7	13.8	14.4
Men aged 15 to 49 HIV prevalence rate	1.0	13.4	<0.1	0.6	19.4	15.7	0.3	5.7	1.5	8.6	8.4		12.1	3.2	7.7	8.7
Prevalence women/ prevalence men	2,1	1,8	1,0	1,5	1,9	1,7	1,3	1,6	0,8	1,7	1,8		2,0	1,8	1,8	1,7
HIV prevalence among young women (15-24)	0.8	6.6	<0.1	0.3	12.6	8.9	0.1	3.2	0.3		6.1		9.1	1.9	5.0	4.7
HIV prevalence among young men (15-24)	0.3	3.5	<0.1	0.2	4.0	3.9	<0.1	1.8	0.2		2.7		3.0	1.0	2.0	2.6
Prevalence young women/ prevalence young men	2,7	1,9	1,0	1,5	3,2	2,3	1,0	1,8	1,5		2,3		3,0	1,9	2,5	1,8
Sex workers																
HIV prevalence (%)	8	42.2	0.8	7.5	60.8	71.9	5.5	49.9	15		29.9	4.6	62.3	15.4	48.8	45.1
Condom use (%)	71.7	75.7	35.8	73.9	50	62.3	62.8	65	67,2		42.3	16	86.1	72.4	78.5	43.4
Men who have sex with men																
HIV prevalence (%)	2	14,8	0.4	7.1	27.2	32.9	14.9	12.9	17.2		7.8	13.2	29.7	8.4		21.1
Condom use (%)	59.1	77.5	56.2	50.6	79.6	46.4	57.2	85.5	53.1		54,8		71.8			83.4
Prevention																
Proportion of people age 15+ who know their HIV status																
Percent of people living with HIV who know their HIV status	57	94	86	82	93	92	15	93	56	81	90		94	88	91	96
Condom use at last high risk sex																
Condom use at last high risk sex - women	32.1		28.4	22.6	53.9	76.0	5.0	49.9		42.0	65.5		61.4	30.3	34.5	66.7
Condom use at last high risk sex - men	63.3		59.7	30.7	67.3	76.6	13.1	76.3		46.5	79.7		73.1	46.5	53.5	85.4
Elimination of mother-to-child transmission																
Coverage of pregnant women who receive ARV for PMTCT (%)	75	>98		61	>98	86	15	93	>98	>95	>98		96	80	97	87
Mother to child transmission rate	15.9	2.2		22.6	3.1	7.9	41.3	7.6	5.3	13.5	4.6		3.5	10.9	7.4	8.7
Knowledge																
Comprehensive knowledge of HIV and AIDS	32.3	47.2	20.4	20.4	49.5	35.5	24.1	41.9	31.8	30.6	58.3		45.8	43.1	41.7	46.4
Knowledge about HIV prevention among young women aged 15-24	32.5	47.4	19.1	18.6	49.1	37.6	22.9	41.1	4.4	30.8	61.6		46.1	40.1	42.6	46.3
Knowledge about HIV prevention among young men aged 15-24	31.6	47.1	23.9	24.9	50.9	30.9	25.5	44.3	30	30.2	51.1		45.6	46.7	40.6	46.6
Attitudes																
% of women who say a woman has the right to insist on a man using a condom	36	47		46	60	63	50	59	54	17	23	68	50	49	63	67
% of men who say a woman has the right to insist on a man using a condom.	47	43		41	53	67	49	62	46	30	17	62	47	50	55	71
Treatment - Antiretroviral therapy (ART)																
% of those living with HIV who are on ART	41	92	61	82	91	81	15	91	26	68	91		74	86	90	91
Women aged 15 and over receiving ART	47	95	58	90	94	85	16	98	19	73	95		78	93	93	94
Men aged 15 and over receiving ART	36	87	67	84	85	76	15	83	31	62	85		68	77	89	91
Children aged 0 to 14 receiving ART	19	69		38	>98	64	7	74	82	64	81		48	60	67	73
Viral Suppression																
Percent of people living with HIV who have suppressed viral loads (73% indicates achievement of 90-90-90 and 86% of 95-95-95)		90			89	79		85	18		84		67	83	87	85

Source: Gender Links computations and UNAIDS data, 2022, https://aidsinfo.unaids.org/ accessed 28 July, 2022.

New HIV infections among young girls and women is worrying.
Photo: Gender Links

Table 5.1 shows:

- HIV prevalence rates in Southern Africa continue to fall slowly, but remain the highest in the world. Eswatini, Lesotho, Botswana, South Africa, Namibia, Zimbabwe, Mozambique, Zambia (which have prevalence rates above 10%) have the highest prevalence rates in the world. Malawi, Equatorial Guinea, Uganda, Tanzania, Kenya and Congo have the next highest HIV prevalence levels.
- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV. This is now the case even in Madagascar. In Comoros, Mauritius and Seychelles transmission is mainly within key populations. Small populations in Comoros and Seychelles result in sparse data for these two countries.
- Prevalence in women is generally 1.5 times higher than in men; two times higher in South Africa and 2.1 times higher in Angola. This is indicative of an epidemic that is expanding, as the prevalence increases rapidly in women before it begins to increase in men. The difference is even more marked between young women and young men. Prevalence is 3.2 times higher in young women than young men in Eswatini and three times higher in South Africa. Prevalence is about the same for women and men in Comoros, higher generally in men than women in Mauritius but now higher among young women than young men in Mauritius. This suggests that the epidemic in Mauritius is beginning to move from one that is driven by infections in key populations to one that is expanding in the heterosexual population.
- The percentage of people who know their HIV status is over 90 in Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe. It is between 80 and 90 in Comoros, DRC, Mozambique and Tanzania; but as low as 15 in Madagascar and only 56 in Mauritius and 57 in Angola.
- Coverage of adults and children receiving Antiretroviral Therapy (ART) has improved dramatically, but ranges from 15% in Madagascar and 26% in Maurituis to over 90% in Botswana, Eswatini, Malawi, Namibia, Zambia and Zimbabwe. There is a major disparity between coverage of adults on ART and children on ART, with one notable exception being Eswatini where over 98% of children living with HIV are on ART.
- Women are generally much more likely than men to be on ART. The exceptions are Comoros and Mauritius where higher percentages of men living with HIV are on ART.
- Data on viral suppression is not available for all countries. However, for those countries that do have this data, there is good progress. Botswana, Eswatini, Lesotho, Malawi, Namibia, Tanzania, Zambia and Zimbabwe all have suppression rates over 73% which is the target for 90-90-90 coverage.
- Coverage of ART for Prevention of Mother to Child Transmission (PMTCT) is improving rapidly even in post conflict countries such as Angola and DRC. Where coverage is over 95% the transmission rate from mother to child is falling - South Africa's achievement of 3,5% transmission is notable given the size of the South African epidemic. However, transmission rates from mother to child remain unacceptably high in Angola (15.9%), DRC (22.6%) and Madagascar (41.3%) - pointing to the need for continued vigorous efforts to prevent transmission.
- Positive responses among women to the question "a woman has the right to insist on a man using a condom" varies widely, from 17% in Mozambique to 68% in Seychelles. Amongst men there was similar variation of 17% in Namibia to 71% in Zimbabwe.

COVID-19, HIV and AIDS

SADC experienced several waves of COVID between March 2020 and the end of 2021, with extended school closures, times when health services were not accessible and severe economic impact on many millions. Several countries experienced severe levels of illness and mortality resulting from COVID-19. People living with HIV experienced worse outcomes than those who were HIV negative. COVID had a negative impact on prevention, testing and initiation on ARV. Many treatment programmes were able to make quick adaptations to community-based responses to maintain those on treatment.

A shared lesson from both HIV and COVID-19 is that inequalities must be addressed - a pandemic can only be addressed effectively when its impact on all is prioritised. There have been distinct similarities in the impact of both pandemics across socio-economic, gender and other societal fault lines, with the weakest and most marginalised being the most affected:

- More women have been affected by both HIV and COVID in Southern Africa (while men have been more impacted by both in other regions);
- Men have been more hesitant to seek health care and support;
- Women and girls have been responsible for a disproportionate amount of unpaid care work in the home as well as paid formal sector care work;
- Many have been left behind due to stigma and discrimination, and been afraid to access health care, which has worsened both pandemics;
- The better off generally are able to protect themselves better and have suffered less from both pandemics than those from poorer socio economic groups.

Some recommendations that were made to reduce the impact of COVID-19 are very applicable for HIV as well[5]:

a. **Address the different needs of women and girls**, paying attention to the most marginalised.
b. **Recognise and guarantee access to essential health services** particularly SRHR, ante- and post-natal care.
c. **Address the neglected epidemic of gender-based violence against women and girls** Without attention this epidemic has simmered around the world and has soared during lockdowns where relationships have been strained due to poor mental health, security and income and cramped living conditions. This epidemic has contributed to increased spread of HIV.
d. **Stop misuse of criminal and punitive laws**, especially those that criminalize sex work, LGBTQ and drive these people away from services.
e. **Prioritise adolescent girls' and young women's education, health and well-being** Adolescent girls are more likely than boys to drop out completely after school closures and to face early marriage or trafficking. Being in school is an important measure to prevent spread of HIV in adolescent girls and boys.
f. **Value women's work and make unpaid care work everybody's work**: During the COVID-19 crisis unpaid care work has increased tremendously. Even before COVID-19 women did at least two and a half times more unpaid care work than men.

Some of the adaptations to HIV service delivery, which it is suggested should be maintained, post COVID-19 were[6]:

- Virtual support on mobile phones can accelerate ART initiation and facilitate monitoring in both facilities and communities.

[5] UNAIDS. 2020. Six Concrete Measures to Support Women and Girls in All Their Diversity in the Context of the COVID-19 Pandemic. Geneva. UNAIDS.
[6] Grimsrud A et al. Silver linings: how COVID-19 expedited differentiated service delivery for HIV. Journal of the International AIDS Society 2021, 24(S6):e25807 https://doi.org/10.1002/jia2.25807 Accessed 3 March, 2022.

- Differentiated Service Delivery (DSD) for HIV treatment can benefit those recently started on ART and those on second-line regimens - with dispensing happening in the community.
- Extended ART refill durations or Multi month dispensing (for three to six months) should be a new standard of care.
- Expand access to community-based services.
- DSD for HIV is relevant even in more highly resourced settings.
- DSD and telephone communication can also be used for HIV prevention, such as access to PrEP, and for tuberculosis (TB) treatment.

The first year of COVID-19 set TB gains back by more than 10 years

Lessons learnt in the COVID response that may be useful in the HIV response[7] include:

- More effort including push (investment) and pull (advance orders) may help to develop a vaccine for HIV;
- In addition to investing in developing a vaccine there is need to prioritise planning and effort for roll out and distribution of vaccines;
- Clinical trials of vaccines and therapeutics were conducted in shorter than normal time spans, showing that there are adaptations that can be used to shorten times for trials;
- There are adaptations to testing - especially home testing - that can be adopted to improve testing for HIV;
- The energetic and innovative engagement of non-health sectors in the COVID-19 response was critical.

The COVID-19 response highlighted how little has been invested in TB. Governments invested US$104 billion into COVID-19 research developed within 11 months, compared to only $5.5 billion in TB research in ten years. As immunisation has reduced TB in much of the world it is now a disease associated with poverty - poor nutrition, poor and overcrowded living conditions and poor access to good health care. The lower investment in TB research reflects the fact that this disease is of less concern to rich countries. In the first year, COVID-19 resulted in setbacks to the TB programme of over ten years.[8]

Testing in any pandemic is key: GL Eswatini facilitator Thandokuhle Dlamini tests for HIV at Mbabane Clinic. Photo: Gender Links

HIV Prevalence

The HIV prevalence in SADC is generally beginning to decline slowly. However, SADC still has the highest prevalence rates in the world (the only countries with prevalence over 10%). Eswatini and Lesotho have prevalence rates above 20% while six other SADC countries (Zambia, Mozambique, Zimbabwe, Namibia, South Africa and Botswana) have adult prevalence rates which are between 10 and 20%.

[7] The International AIDS Society. 2022. Lessons from the structural innovations catalysed by COVID-19 for the HIV response. Geneva, Switzerland https://www.iasociety.org/sites/default/files/IAS-Lessons-from-COVID-for-HIV_report_2022.pdf accessed 4 August, 2022.

[8] Rangaka, M. Hamada, Y. Abubakar, I. Ending the tuberculosis syndemic: is COVID-19 the (in)convenient scapegoat for poor progress? Lancetresp Vol 10 June 2022. Published Online March 23, 2022 https://doi.org/10.1016/S2213-2600(22)00123-0 Accessed 25 June, 2022.

Figure 5.1 HIV Prevalence in SADC 2021

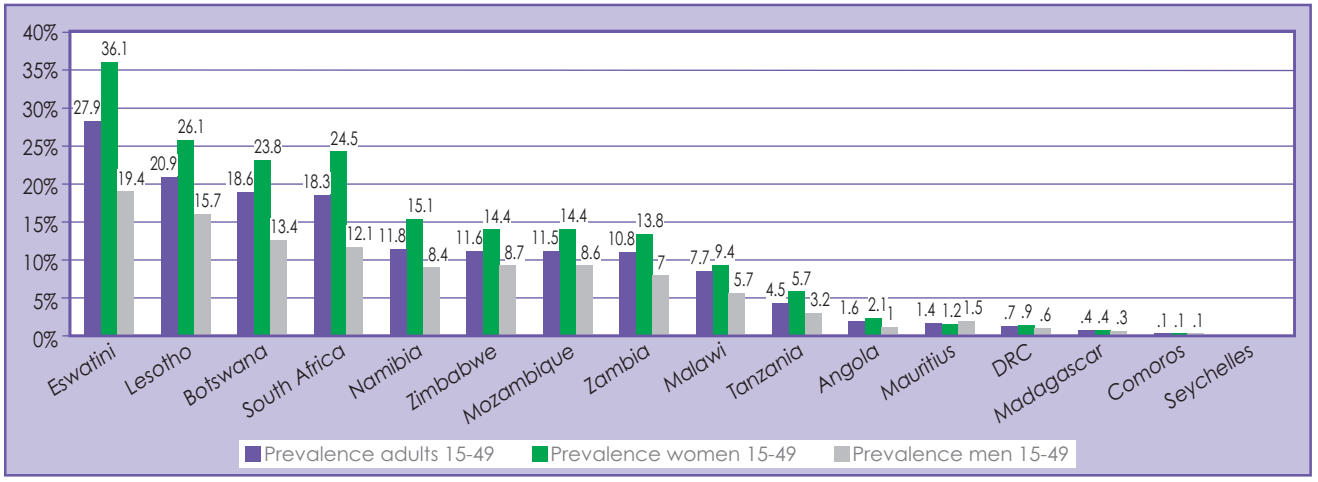


Table 5.2 HIV Prevalence in SADC, 2021

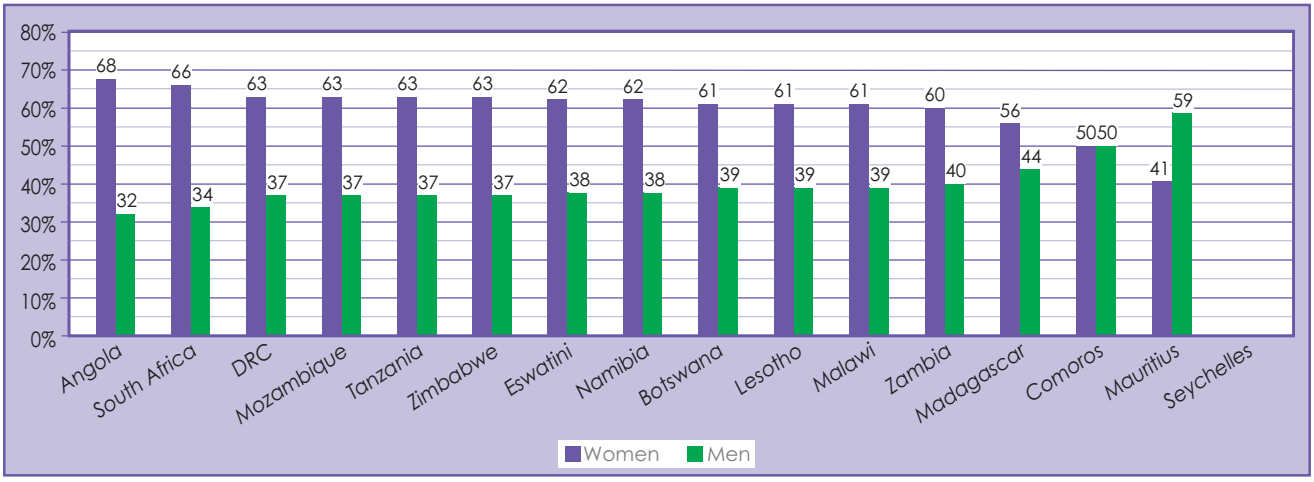
Country	Prevalence Adults 15 - 49	Prevalence Women 15 - 49	Prevalence Men 15 - 49	Prevalence Young women	Prevalence young men	Ratio Young women: young men
Eswatini	27,9	36,1	19,4	12,6	4	3,2
Lesotho	20,9	26,1	15,7	8,9	3,9	2,3
Botswana	18,6	23,8	13,4	6,6	3,5	1,9
South Africa	18,3	24,5	12,1	9,1	3	3,0
Zimbabwe	11,8	15,1	8,4	6,1	2,7	2,3
Namibia	11,6	14,4	8,7	4,7	2,6	1,8
Mozambique	11,5	14,4	8,6	6	3	2,0
Zambia	10,8	13,8	7	5	2	2,5
Malawi	7,7	9,4	5,7	3,2	1,8	1,8
Tanzania	4,5	5,7	3,2	1,9	1	1,9
Angola	1,6	2,1	1	0,8	0,3	2,7
Mauritius	1,4	1,2	1,5	0,3	0,2	1,5
DRC	0,7	0,9	0,6	0,3	0,2	1,5
Madagascar	0,4	0,4	0,3	0,1	0,1	1,0
Comoros	0,1	0,1	0,1	0,1	0,1	1,0
Seychelles						

Source: Compiled from UNAIDS 2022 Data https://aidsinfo.unaids.org/ accessed 30 July, 2022.

Figure 5.1 and Table 5.2 show wide variations in the HIV pandemic across SADC. The data shows that:

- Adult prevalence rates range from 0.1% in Comoros to 27.9% in Eswatini (which is slightly higher than in 2021).
- Seychelles, which has a total population of under 100 000 and a very low prevalence rate, has such small total numbers of people living with HIV that percentages are of little value. Thus, very little data is available and Seychelles is missing from much discussion in this chapter. Comoros and Mauritius have higher populations and thus have more data available.
- The island nations have pandemics that have been largely driven by key populations. Most of SADC has a generalised, heterosexual pandemic. The pandemic in Madagascar is becoming generalised and prevalence is now higher in women than in men, where it has been higher in men than women. Prevalence in young women in Mauritius is now higher than in young men though overall prevalence is still higher in men than women.
- The differences in prevalence rates are particularly high for young women as compared to young men. HIV prevalence is three times higher in young women than young men in Eswatini and South Africa and at least double in Angola, Zambia, Lesotho, Zimbabwe, and Mozambique.

Figure 5.2: Proportion of Women and Men Living with HIV in 2021



Source: Gender Links, derived from UNAIDS Data 2022 https://aidsinfo.unaids.org/ accessed 28 July, 2022.

Figure 5.2 shows the proportion of women and men living with HIV across SADC. There are more women living with HIV in most of SADC. The highest proportions are in Angola and South Africa. There are now more women than men living with HIV in Madagascar. Mauritius is the only member state that has more men than women living with HIV.

HIV transition Metrics

The incidence to prevalence ratio comprises two desirable outcomes: long, healthy lives for people living with HIV and a rapid reduction in new infections. The metric assumes an average life expectancy of 30 years after a person acquires HIV infection. The calculations show that the AIDS epidemic (or total number of people living with HIV) will decline when there are fewer than three new HIV infections per 100 people living with HIV per year. This is an incidence to prevalence ratio of three.

Table 5.3 shows that the transition metrics have continued to improve. Data for 2021 indicate that Zimbabwe, Botswana, Malawi, Lesotho, South Africa and Zambia have achieved the tipping point of three and should all experience a decline in the HIV epidemic. Namibia, Eswatini and Tanzania are very close to the tipping point. The only countries which are experiencing increase in the metric are Madagascar and Mauritius. Globally the incidence to prevalence ratio declined to 3.85.

Table 5.3: Transition Metrics - Incidence: Prevalence ratio

Country	2000	2020	2021
Zimbabwe	7,86	1,9	1,75
Botswana	10,74	2,12	1,96
Malawi	10,02	2,13	1,99
Lesotho	12,96	2,79	2,59
South Africa	17,44	3,01	2,83
Zambia	10,6	3,21	2,85
Namibia	13,14	3,07	3,07
Eswatini	14,48	3,4	3,12
Tanzania	9,76	3,57	3,13
DRC	9,66	4,43	3,8
Comoros	15	4,79	4,73
Angola	19,55	5,94	5,41
Mauritius	28,54	5,4	5,63
Madagascar	32,62	15,37	15,81
Mozambique	17,9	4,76	na
Global	11,12	4,05	3,85

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/

Policies, laws and resources

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

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

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

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

Table 5.4: Most recent HIV and AIDS policy or strategy

Country	Most recent HIV strategy	Year
Mozambique	Plano Estratégico do Nacionale de combate HIV e SIDA - PEN V 2021 - 25	2021
Malawi	Malawi National Strategic Plan for HIV and AIDS 2020-2025	2020
Zimbabwe	Zimbabwe National HIV and AIDS Strategic Plan IV (2021-2025)	2020
Angola	National strategic plan (NSP) for HIV, viral hepatitis, and other sexually transmitted infections. 2019-2022	2019
Botswana	Third National Strategic Framework for HIV/AIDS 2019 - 2023	2019
Seychelles	Third multi sectoral National Strategic Plan for HIV, AIDS & Viral Hepatitis 2019 - 2023	2019
Eswatini	National Multisector HIV & AIDS Strategic Framework 2018 - 2023	2018
Lesotho	National HIV and AIDS Strategic Plan 2018/19 - 2022/23	2018
DRC	Plan Strategique National De La Riposte au VIH/SIDA 2018-2021	2018
South Africa	Let our actions Count: South Africa's National Strategic Plan for HIV, TB and STI's 2017 - 2022	2017
Tanzania	Health Sector HIV & AIDS Strategic Plan 2017 - 2022 (HSHSP IV)	2017
Zambia	National HIV & AIDS Strategic Framework 2017 - 2021 National Comprehensive Condom Strategy and Operational Plan 2020 - 2025	2017 2020
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 - 2021/22 National HIV Action Plan 2017-2021	2017
Mauritius	Plan Strategique National de Reponse aux Infections Sexuellement Transmissibles et au SIDA a	2017
Madagascar	Madagascar 2013 - 2017	2014
Comoros	National Strategic Plan 2011 - 2015	2011

Source: GL Audit of SRHR Policies and Laws 2020.

Table 5.4 shows that all the SADC countries have an HIV and AIDS policy, strategy or plan. With the exception of Mauritius, the HIV and AIDS policies for all countries include other STIs and often also include TB. There are some plans that should have been reviewed, and others that require review now. The Global Strategy 2021 - 26 will give impetus to policy reviews at country level.

All countries have a strategic HIV and AIDS plan

Table 5.5: SADC HIV and AIDS laws scorecard

Country	Criminalising trans-gender people	Criminalising sex work	Criminalising same sex sexual acts	Drug use/ possession an offence	Parental consent for adolescents HIV test	Criminalising transmission/ non-disclosure of HIV	Restricted entry/stay of PLHIV	Mandatory HIV test for marriage/ work
Angola								
Botswana								
Comoros								
DRC								
Eswatini								
Lesotho								
Madagascar								
Malawi								
Mauritius								
Mozambique								
Namibia								
Seychelles								
South Africa								
Tanzania								
Zambia								
Zimbabwe								

KEY
- Not criminalised. Parental consent not required
- No data
- Criminalised. Parental consent required. Testing required for some permits
- No, but prosecutions exist based on general criminal laws. Prohibit short and/or long stay and require HIV testing or disclosure for some permits

Source: UNAIDS. 2022. Global AIDS Update. 2022. In Danger. Geneva, UNAIDS.

Table 5.5 shows that the legal framework in SADC generally fails to protect the rights of key populations such as sex workers and people in same sex relationships. There have been no changes from 2021 in this regard. Though the HIV epidemic in SADC has been largely driven by new infections in adolescents, new infections among key population groups is on the rise. In 2021, the proportion of new infections in different groups in East and Southern Africa consisted of[9]:

- 13% sex workers;
- 3% people who inject drugs;
- 3% gay men and other men who have sex with men;
- 2% transgender women;
- 25% clients of sex workers and sexual partners of all key populations.

One of the goals of the global strategy is three tens for societal enablers. One of these is to ensure that less than 10% of countries have restrictive legal and policy environments that lead to the denial or limitation of access to services. Criminalisation of key populations hinders their access to services and will continue to fuel the HIV epidemic. This issue requires attention in the next five years.

[9] UNAIDS. 2022. Op Cit.

Article 27. 3: State Parties shall:
a) Develop gender sensitive strategies to prevent new infections.
BPFA +20 Africa Declaration: (h) Scale up combined preventive HIV/AIDS measures for young women and girls and expand programmes to eliminate mother-to-child transmission;

SADC SRHR Strategy: HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
ICPD: 7.32 Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

The SADC-sponsored UN Resolution on women, girls, HIV and AIDS

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

Achieving 95-95-95 by 2025

The Global AIDS Strategy 2021 - 26 puts much focus on those who have not been reached so far. These include adolescents and young women who are at greater risk in SADC of contracting HIV than boys and young men; men in general who are much less likely to access any HIV services than women; children (particularly those aged 5 to 14) and members of key populations. Other disparities are between rural and urban areas, poorer and better off, those with less or more education. The strategy emphasises better understanding of why men are not accessing services, how to reach children and key populations.

The global strategy focuses on reaching those that are not being reached

Table 5.6: Progress towards achieving the 95-95-95 goals in SADC

Country	Progress 95-95-95 Adult women 2021	Progress 95-95-95 Adult men 2021
Zimbabwe	>98 >98 94	95 95 >98
Malawi	98 >98 95	89 92 >98
Botswana	95 >98 >98	93 94 >98
Namibia	95 >98 94	88 96 >98
South Africa	95 >98 92	92 75 95
Eswatini	94 >98 98	91 94 >98
Lesotho	94 90 >98	92 82 92
Zambia	94 >98 97	90 >98 >98
Tanzania	93 >98 98	85 91 >98
DRC	90 >98	84 >98 >98
Comoros	85 68 93	95 71 >98
Mozambique	81 68 55	
Angola	64 73	55 66
Mauritius	40 47 67	67 47 55
Madagascar	17 97	15 97 >98
Global	89 >98 92	82 86 >98

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 29 July, 2022.

Table 5.6 shows the progress towards achievement of 95 95 95 for women and men. Many countries in SADC have made great progress, especially for women. These include Zimbabwe, Malawi, Botswana, Namibia, South Africa, Eswatini, Lesotho and Zambia. Madagascar, Mauritius and Angola have lower levels of achievement. There are marked differences in achievements for women and men with percentages of men who have accessed testing, treatment and are adhering to treatment generally lower than those of women. However, in Mauritius and Comoros the percentages of men are higher than of women.

Recognising the need to engage more men, UNAIDS East and Southern Africa developed a Framework for Male Engagement in HIV Testing, Treatment and Prevention which was launched in 2022[10]. The framework is responding to lower levels of testing, initiating ART and adhering to ART in men than in women. The proportion of men that are dying is also higher than that of women. The strategy promotes intentional creation of an enabling environment to encourage men to access health services (structural enablers) and seeks to accelerate action at many levels to reach men and boys with HIV services (programmatic strategies).

Botswana: Three countries have been officially recognised as reaching the 95 95 95 targets already. These are Eswatini and Switzerland in late 2021 and Botswana recently. Madisa Mine, former head of the Botswana National HIV Reference Laboratory presented findings of the fifth Botswana HIV/AIDS Impact Survey (BAIS V), 2021 to the International AIDS Conference in Montreal in late July, 2022. The study included a nationally representative survey of 14,763 adults aged 15 - 64 years old. The results showed 95.1% of people living with HIV (men: 93.0%; women: 96.4%) knew what their status was; 98.0% (men: 97.2%; women: 98.4%) of those aware were on ART, and 97.9% (men: 96.6%; women: 98.6%) of those on ART were virally suppressed. The percentages were lower for young people living with HIV (aged 15 - 24).[11]

HIV and AIDS features strongly in all Botswana campaigns. Photo: Mboy Mswabi

Strong political will is at the heart of this success. Former President Festus Mogae introduced the Masa (New Dawn) programme in 2002 when Botswana had an adult prevalence of 35, 8%. He is credited with setting Botswana on the path to where it can realistically plan to end the AIDS epidemic by 2030. This has been achieved without politicising the HIV response.[12]

All member states need to put much more emphasis on reaching 95 95 95 targets for all sub populations, such as adolescent girls and young women, sex workers and other key populations. The challenges of doing this are illustrated in the media article by Lungelo Ndhlovu, reporting from Zimbabwe:

[10] UNAIDS. 2022. Male engagement in HIV testing, treatment and prevention in eastern and southern Africa - A framework for action. Geneva, UNAIDS.
[11] https://www.unaids.org/en/resources/documents/2022/male-engagement-hiv-testing-treatment-prevention-eastern-southern-africa Accessed 20 June, 2022. Mine, M et al, Botswana achieved the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets: results from the Fifth Botswana HIV/AIDS Impact Survey (BAIS V), 2021. https://programme.aids2022.org/Abstract/Abstract/?abstractid=12921 Accessed 30 July, 2022
[12] Thornton, J. Botswana HIV Success. www.thelancet.com Vol 400 August 13, 2022 DOI:https://doi.org/10.1016/S0140-6736(22)01523-9 Accessed 15 August, 2022.

New HIV infections among young women worrying

The prevalence of new HIV infections among young girls and women is a cause for concern in Zimbabwe, with 1,705 new HIV infections recorded among females in Bulawayo-Metropolitan province alone, according to the National Aids Council of Zimbabwe (NAC). The HIV prevalence rate among adults in Bulawayo between the ages of 15 and 49 years is 13.77%, higher than the national prevalence of 12.9% which corresponds to approximately 1.23 million adults in Zimbabwe living with HIV in 2020. The 2020 Zimbabwe Population-based HIV Impact Assessment (ZIMPHIA) indicates that HIV prevalence was higher among women (15.3%) than men (10.2%).

Speaking at the signing ceremony for the Fast-Track Cities, a UNAIDS initiative, in Bulawayo recently, city Mayor, Councillor Solomon Mguni, said new infections in women were double the number of infections in men, though infections have declined by about 50% between 2010 and 2020. Prevalence of HIV in key populations and vulnerable communities are also of grave concern. 19 clinics in Bulawayo offer HIV and AIDS integrated programming with a special focus on key populations, as a show of commitment towards HIV programming. The clinics prioritise non-bias in all staff.

Director of Operations, National AIDS Council (NAC), Raymond Yekeye, indicated that although Zimbabwe was moving in the right direction towards ending HIV by 2030, there were still some gaps in achieving the United Nations General Assembly's Political Declaration on Ending AIDS' 90-90-90 targets. Yekeye further indicated that having a generation who has never been exposed to the hard-hitting impact of HIV is a risk in itself. He stated that alcohol and substance abuse, early child marriages, cases of gender based violence also contributed to new infections - particularly during COVID-19.

The Southern African Gender Protocol 2020 Voice and Choice Barometer indicates that though the world missed the UNAIDS 2020 "90-90-90" targets, four of the eight countries which did achieve the targets are in Africa: Eswatini, Botswana, Malawi and Uganda. A further 11 countries globally reached the overall 73% viral suppression target, including Zimbabwe, Lesotho, Namibia and Zambia in SADC; but did not achieve one of the three 90s, the gender protocol indicated.

Sophia Mukasa, the UNAIDS Country Director commended the city of Bulawayo's progress on the HIV response. She welcomed the city on joining 350 other cities and municipalities globally which have joined the Fast-Track Cities Initiative since its inception in 2014. She also spoke of the importance of making sure that all marginalised and vulnerable groups in society had access to healthcare services.

Nothando Hadebe, the Public Relations Officer for the Youth Initiative for Empowering Leadership and Development (YIELD) said the City of Bulawayo should prioritise young people's Sexual and Reproductive Health and Rights (SRHR). YIELD focuses on young people in the age range between 18-24 years and believes that emphasis on SRHR is needed to reduce the prevalence of new infections amongst girls.

"The city of Bulawayo should establish health booths as per wards. In as much as we have Econet booths (for cell phone airtime), health booths are ideal for easy access to SRHR services. In this case, people don't really need to go to the clinics or hospitals where they are tormented," she said.

Source: Ndlovu, Lungelo. 10 February, 2022. New HIV Infections Among Young Women Worrying' GL Sixteen Days of Activism News series[13].

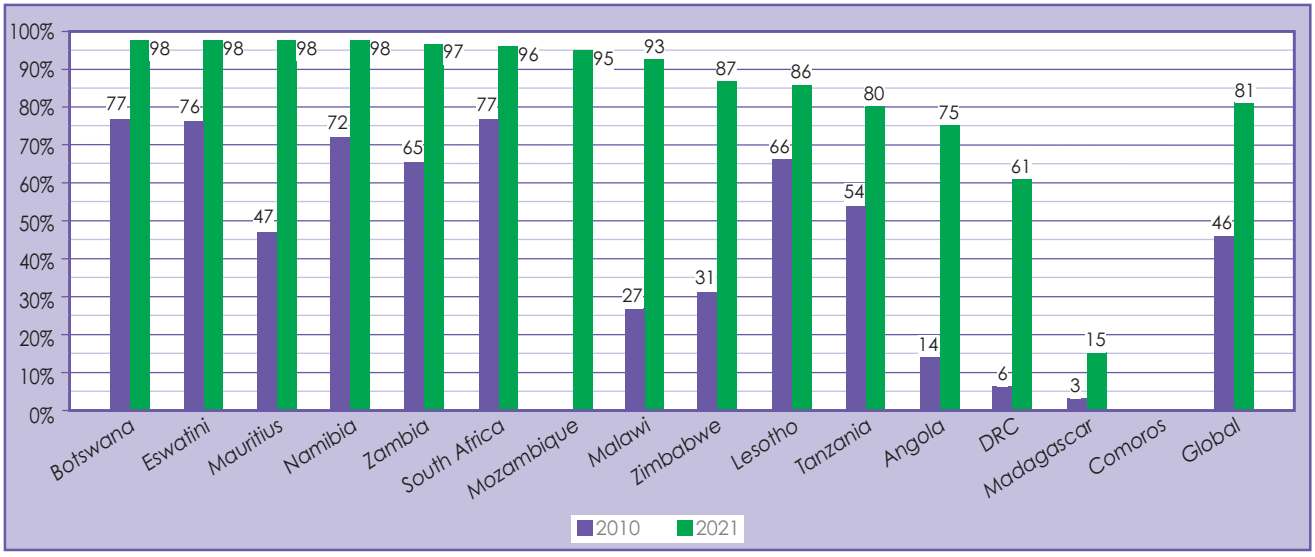
[13] https://genderlinks.org.za/news/zim-new-hiv-infections-among-young-girls-and-women-worrying/

Elimination of Mother to Child Transmission

Recognising that one of the most glaring gaps in the AIDS response has been prevention and access to treatment for children, a Global Alliance to End AIDS in children by 2030 was launched during the 2022 International AIDS Conference. Founding members of the Alliance include UNAIDS, UNICEF, PEPFAR, the Global Fund, the Global Network of People living with HIV. It also includes twelve countries, of which Angola, DRC, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe are in SADC. The Alliance will focus on four pillars for collective action:[14]

1. Closing the treatment gap for pregnant and breastfeeding adolescent girls and women living with HIV and optimizing continuity of treatment;
2. Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women;
3. Accessible testing, optimized treatment, and comprehensive care for infants, children, and adolescents exposed to and living with HIV;
4. Addressing rights, gender equality, and the social and structural barriers that hinder access to services.

Figure 5.3: ART Coverage for Pregnant women 2010 and 2021



Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 30 July, 2022.

Figure 5.3 reflects tremendous progress between 2010 and 2021 in access to ART for pregnant women living with HIV. Seven member states have achieved at least 95% coverage. Angola and DRC have made marked progress even though their rate of coverage is still only 75% and 61%. Increased effort is needed in Madagascar.

[14] UNAIDS. New global alliance launched to end AIDS in children by 2030. 1 August, 2022. https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2022/august/20220801_new-global-alliance-launched-to-end-AIDS-in-children-by-2030 accessed 2 August, 2022 and UNAIDS. 2022. The Global Alliance to End AIDS in Children. Geneva. UNAIDS.

Table 5.7: Pregnant Women on ART 2010 - 2021, Vertical Transmission

Country	Coverage Pregnant women for PMTCT %		Vertical transmission rate %		No of HIV Exposed Uninfected Children	
	2010	2021	2010	2021	2010	2021
Botswana	77	98	9	2	5700	180000
Eswatini	76	98	12	3	200	140000
Mauritius	47	98	17	5	100	1700
Namibia	72	98	13	5	2100	140000
Zambia	65	97	21	8	27000	640000
South Africa	77	96	13	4	14000	4100000
Mozambique		95		13		
Malawi	27	93	29	8	43000	550000
Zimbabwe	31	87	24	9	76000	780000
Lesotho	66	86	17	8	1000	140000
Tanzania	54	80	22	11	64000	950000
Angola	14	75	32	15	2600	260000
DRC	6	61	39	23	52000	280000
Madagascar	3	15	48	41	100	10000
Comoros						
Total SADC					287800	8171700
Global	46	81	24	12	860000	15900000
SADC as % of Global					33%	51%

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ Accessed 30 July 2022.

Table 5.7 shows how increased coverage of ART for pregnant women has been accompanied by declining rates of transmission to babies - these are now 5% or lower in five member states. South Africa's achievement of 4% is remarkable in view of the extent of the epidemic in South Africa. Mozambique, Tanzania and Angola are still over 10%, while DRC at 23% and Madagascar at 41% are cause for concern and action.

In December 2021 the World Health Organization announced that **Botswana** was the first country with a high HIV burden to have been certified to have achieved "silver tier" status, on the path to elimination of Mother to Child transmission. This status means the mother-to-child HIV transmission rate is below five percent, more than 90 percent of pregnant women receive antenatal care and antiretroviral treatment, and the HIV case rate is fewer than 500 per 100,000 live births[15].

Table 5.7 also shows that as fewer children are being born infected by HIV, there is a huge increase in the numbers of HIV Exposed but Uninfected (HEU) children. In 1990 SADC accounted for at least 287 800 or 33% of the global total of 860 000, while in 2021 SADC accounts for 8 171 700 or 51% of the global total of 15 900 000 of HIV exposed and uninfected children.

Botswana has been granted silver status on the path to elimination

In 2018,[16] five countries accounted for 50% of the 14·8 million children who were HEU globally: 3·5 million (23·8%) in South Africa, 1·1 million (7·5%) in Uganda, 1·0 million (6·6%) in Mozambique, 910 000 (6·1%) in Tanzania, and 880 000 (6·0%) in Nigeria. Zimbabwe, Malawi and Zambia had between 500 000-850 000 HEU children. While

[15] Mbewa, D. Botswana edges closer to closer to eliminating mother-to-child HIV transmission. December 2, 2021. https://africa.cgtn.com/2021/12/02/botswana-edges-closer-to-closer-to-eliminating-mother-to-child-hiv-transmission/

absolute numbers are lower in other countries, the rate of increase between 1990 and 2021 is very high.

The national prevalence of children that are HEU is highest in Eswatini - 32, 4%; Botswana - 27, 4%, South Africa - 21, 6%, Lesotho - 21, 1% and Namibia - 16, 4%.

Evidence suggests[17]:

- Children that are HEU have poorer development outcomes than those that have not been exposed to HIV.
- Infants who are HEU and also born preterm or small-for-gestational age, or experience nutritional deficits (stunted, wasted or being underweight-for-age), or those cared for by women experiencing mental health challenges are at the highest risk of developmental delays.
- Risk factors for mental health disorders among adolescents who are HEU are similar to those in adolescents and youth living with HIV (AYLHIV). Depression, anxiety, trauma, difficulty in psychosocial adjustment with significant loss of self-esteem, as well as suicidal behaviours have been reported among adolescents and youth who are HEU.
- HEU adolescents are largely invisible, as healthcare systems are not aware of their HIV-exposure status. The multidisciplinary care and support for AYLHIV does not exist for HEU adolescents.
- Research from South Africa has shown that adolescents whose parents/caregivers are living with HIV have poorer school outcomes compared with those from HIV-unaffected households and experience high rates of stigma.
- In a South African study, 57% of adolescent girls living with a parent with advanced HIV, who did not have enough to eat and were physically or emotionally abused, were engaging in transactional sex compared with only 7% of girls living with a parent with advanced HIV but who were not hungry or abused.
- Adolescent mothers living with HIV face challenges with ART adherence during pregnancy, which increases the risk of perinatal HIV transmission.

Prevention

2025 TARGETS AND COMMITMENTS in the 2021 Political Declaration on AIDS

- Reduce new HIV infections to under 370 000 by 2025.
- Ensure that 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, have access to and use appropriate, prioritized, person centred and effective combination prevention options.
- Tailor HIV combination prevention approaches to meet the diverse needs of key populations, including among sex workers, men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings and all people living with HIV.
- Reduce the number of new HIV infections among adolescent girls and young women to below 50 000.
- Ensure availability of PrEP for people at substantial risk of HIV and post-exposure prophylaxis for people recently exposed to HIV.
- 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people centred and effective combination prevention options.

[16] Slogrove, A, Powis, K, Johnson, L. Stover, J. Mahy, M. Estimates of the global population of children who are HIV-exposed and uninfected, 2000-18: a modelling study. Lancet Glob Health 2020;8: e67-75 Published Online November 29, 2019 https://doi.org/10.1016/S2214-109X(19)30448-6 Accessed 15 March, 2022.
[17] Udedi, E. 2020. Surviving and Thriving HIV-Free: Report of the 4th HIV-Exposed Uninfected Child and Adolescent Workshop. International AIDS Society. Cipher Paediatric HIV Matters. https://www.academia.edu/es/63062420/Surviving_and_Thriving_Hiv_Free_Report_of_the_4TH_Hiv_Exposed_Uninfected_Child_and_Adolescent_Workshop Accessed 15 March, 2022.
[18] UNAIDS. 2021. Global AIDS Update. 2021. Confronting Inequalities Lessons for pandemic responses from 40 years of AIDS.

The Global Prevention Coalition (GPC) for HIV Prevention brings together the 25 highest HIV burden countries or the high priority countries, donors, civil society and implementers to strengthen and sustain political commitment for primary prevention. The coalition focuses on generating commitment, speed, investment and accountability towards large-scale, high coverage and good-quality implementation. Twelve SADC countries: Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe are included in the high priority group.

Table 5.8 Overall Prevention Score Card for SADC countries in the GPC *(scores 0 to 10)*

Country	AGYW and partners	Sex workers	MSM	PWID	Condoms	VMMC	VMMC	PrEP
Angola	3	3	3				3	
Botswana	6	4	6			2	9	5
DRC	4	2	3	0	2		7	3
Eswatini	7	2	9	6	7	3	10	8
Lesotho	8	5	4			4	8	8
Malawi	4	6	7		6	1	9	4
Mozambique	4	3		0	4	3	7	4
Namibia	5				9	5	9	
South Africa	5	8	5	2	6	4	7	6
Tanzania	2	3	4	5	2	10	8	5
Zambia	3	5		0	3	10	8	8
Zimbabwe	4	6	5		7	3	9	8

KEY Not applicable; Insufficient data; Very low (0-4); Low (5-6); Medium (7); Good

Source: Gender Links compiled from HIV Prevention Score Card 2021.[19]

Table 5.8 shows that prevention programming is not satisfactory. The only aspect of prevention programming that is good is HIV treatment. Scores for programmes on Adolescent Girls and Young women (AGYW) have not changed greatly. Only Lesotho's programme is rated as good.

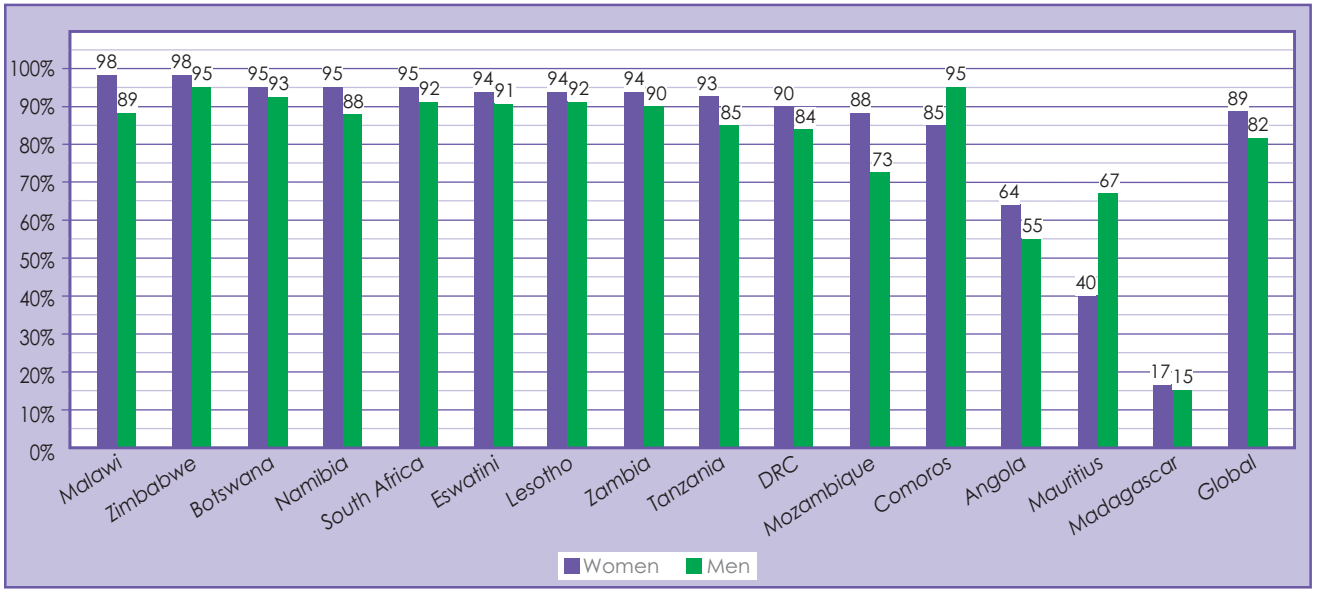
Table 5.8 shows that insufficient attention is being given to prevention programming amongst key populations. Scores for sex worker programming have generally declined, with some increases in Lesotho, Malawi and South Africa. Nine countries reported on programmes for men who have sex with other men, two more than in 2020, with improved scores in Eswatini and Malawi. Prevention programmes which were seriously derailed by COVID-19 - including condom supply and distribution as well as the Voluntary Medical Male Circumcision (VMMC) programmes - are taking time to recover. Six countries had condom programmes rated as good in 2020. In 2021, only Namibia is good and Eswatini medium.

Five key findings from the score card include:

1. New HIV infections are declining in most countries, but too slowly.
2. Major gaps persist in programmes and data on HIV prevention among key populations.
3. Prevention among adolescent girls and young women and their male partners shows increasing effort but insufficient coverage.
4. Access to prevention tools (such as condoms) remains uneven and suffered disruptions.
5. More emphasis and support are needed to improve and consolidate national and implementing partner programme data for analysis at the national level.

[19] Geneva, UNAIDS. Global HIV Prevention Coalition. 2022. Key Findings from 2021 Scorecards of the Global HIV Prevention Coalition. Geneva. UNAIDS. https://www.unaids.org/sites/default/files/media_asset/key-findings-2021-scorecards-global-hiv-prevention-coalition_en.pdf Accessed 30 July, 2022.

Figure 5.4 Women and Men Living with HIV who know their status



Source: Genderlinks compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 30 July, 2022.

Figure 5.4 shows that the proportion of women who know their HIV status is generally high across SADC. Zimbabwe, Botswana, South Africa Eswatini, Lesotho, and Zambia have achieved over 90% knowledge of HIV status in both women and men. In Malawi, Namibia, Tanzania and DRC over 90% women and 89%, 88%, 85% and 84% respectively of men know their HIV status. Comoros has achieved 95% of men and 85% of women with knowledge of their HIV status. Testing and knowledge of HIV status is an important first step in prevention of HIV and managing HIV infection.

Table 5.9 New Infections and HIV incidence, 2021

Country	HIV Incidence			Change in number of people acquiring HIV 2010 - 2020	
	Young people 15 - 24	Adults 15 - 49	Adults 50 & over	Adolescent Girls /Young Women 15-24*	All
Eswatini	10,37	14,88	4,96	-57	-64
Lesotho	6,98	8,1	2,58	-53	-59
South Africa	7,51	6,9	2,79	-48	-45
Botswana	4,96	6,03	1,04	-39	-37
Namibia	5,33	5,16	1,44	-46	-48
Zambia	3,83	4	1,45	+12	-6
Zimbabwe	2,36	2,37	0,63	-65	-66
Malawi	1,69	1,93	0,59	-52	-64
Tanzania	1,36	1,55	0,79	-25	-35
Mauritius	0,66	0,92	0,2		-24
Angola	0,83	0,86	0,25	-16	-26
Madagascar	0,3	0,6	0,12		+159
DRC	0,22	0,26	0,09	-51	-50
Comoros	0,01	0,01	0,01		-30
Mozambique				-20	-33
Global	**0,34**	**0,31**	**0,06**		**-31**

*Data only from Global HIV Prevention Coalition focus countries.

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022 and HIV Prevention Scorecard 2021.

Table 5.9 shows that while the epidemic is beginning to slow, incidence or new infections per 1000 population, remain high in much of SADC and especially in Eswatini, Lesotho, South Africa, Botswana, Namibia, Zambia and Zimbabwe. Incidence for adults aged 15 to 49 is higher than for young people aged 15 to 24 in most countries, but it is higher in young people in South Africa and Namibia and very similar in Zimbabwe, Angola and DRC.

Generally, rates of new infections have been going down for young people and overall. But between 2010 and 2020 rates of new infections increased in young people in Zambia. The steep increase in rates of new infections in Madagascar is concerning. There are still new infections in adults over 50, though incidence is much lower than in younger adults, which means that continuous testing is needed.

None of the SADC member states met the target of reducing new infections by 75% between 2010 and 2021. Zimbabwe, Eswatini and Malawi reduced new infections by over 60%. Among SADC member states only Zimbabwe had a 60% decline in new infections among AGYW. Zambia had increased AGYW new infections and Madagascar had increased new infections overall between 2010 and 2021.

Education plus Initiative launched

The Organisation of African First Ladies (OAFLAD) launched the "Education Plus", 2021-2025 initiative in the margins of the 2022 African Union (AU) Mid-Year Summit in Lusaka, Zambia. The initiative focuses on enabling all girls and boys to complete a free, quality secondary education with universal access to comprehensive sexuality education, fulfilment of SRHR, freedom from gender-based and sexual violence, school-to-work transitions, and economic security and empowerment for women. The commitments made through this initiative signals major investment in education as an HIV prevention strategy for adolescent girls. Eswatini, Lesotho, Malawi and South Africa in SADC are amongst the ten initial country members of the programme.

Analysis of HIV incidence in **Botswana**, following a policy change in 1996 to make universal secondary education available, found that each additional year of secondary schooling resulting from the policy change led to an absolute reduction in the cumulative risk of HIV infection of 8.1% (11, 6% for women). The study concluded that increasing access to secondary school could be a cost effective HIV prevention measure in HIV endemic settings[20]. Increased access to education also reduces poverty, improves health outcomes and stimulates social and economic development.

President Hakainde Hichilema of **Zambia** said at the launch, "Education is the greatest equalizer and with appropriate education, everyone is given an opportunity to explore their full potential and be able to participate in the development process. Access to education empowers both girls and boys as it enhances their ability to access decent jobs and other means of production thus alleviating poverty."[21]

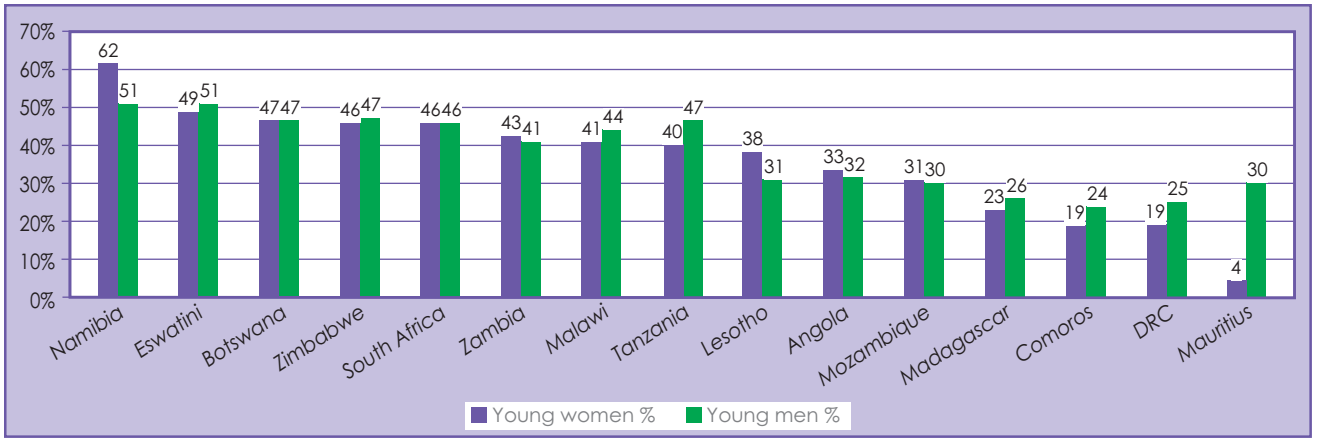
[20] De Neve JW, Fink G, Subramanian SV, Moyo S, Bor J. Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. Lancet Glob Health. 2015;3(8):e470-e477. Accessed 17 July, 2022.

[21] UNAIDS Press Release. African leaders launch the Education Plus initiative - a huge step forward for girls' education and empowerment in Africa, 18 July, 2022. https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2022/july/20220717_continental-launch-education-plus-initiative accessed 27 July, 2022.

Comprehensive, accurate knowledge of HIV and AIDS

The goal is to ensure that at least 90% of adolescents and young people receive comprehensive sexuality education in schools, in line with UN international technical guidance.

Figure 5.5: Knowledge on HIV prevention among young people



Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 28 July, 2022.

Figure 5.5 illustrates that levels of knowledge about HIV are still well below the goal of 90%, indeed below 50% for both males and females in all countries except Namibia and Eswatini. Poor knowledge contributes to low levels of risk awareness and poor prevention of HIV at a time when we need to redouble our efforts in prevention. New approaches and programmes are necessary to increase access to accurate information particularly in view of COVID-19 school disruptions as teachers focus on the core curriculum rather than extra-curricular concerns.

Condoms

Condom programming is still one of the most cost effective prevention measures available, though focus on condoms has declined since ARVs became available. It is critical that continued focus is given to both male and female condoms.

Table 5.10: Number of Condoms distributed or sold in 2019/2020

Country	2019	2020	% of condom distribution need met (2020) for selected GPC members
Namibia		34 000 000	100
Eswatini	12 144 576	14 809 730	86
Zimbabwe	94 849 706	82 720 989	67
South Africa	635 981 213	558 190 486	65
Malawi	154 442 236	81 219 283	60
Mozambique	95 715 852	84 273 291	30
Zambia	19 392 644	17 252 787	11
DRC		36 169 500	6
Tanzania	32 664 445	26 828 131	6
Angola	19 782 000		
Botswana	41 148 720	26 932 500	
Comoros	930 007	650 064	
Lesotho	4 018 032		
Madagascar	17 682 860	11 469 917	
Mauritius	975 119		
Seychelles	452 772	223 447	

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022 and HIV Prevention Scorecard 2021.

Table 5.10 maps the number of condoms distributed in SADC countries in 2019 and 2020 against the percentage of condom distribution need met in 2020 for selected focus countries. The table shows the impact of COVID-19 production and distribution challenges in reduced numbers of condoms distributed in 2020 in all countries except Eswatini. The GPC and Global Fund created a strategic initiative on condom programming benefited four GPC focus countries, including Malawi, Mozambique and Zambia in SADC, to expand their condom programmes.

The GPC score card rated only Namibia and Eswatini as having good or medium condom distribution.[22]

> Numbers of condoms distributed declined between 2019 and 2020 in all countries except Eswatini

Voluntary Medical Male Circumcision (VMMC)

Voluntary medical male circumcision (VMMC) provides partial lifelong protection against female-to-male HIV transmission. VMMC can have a major impact on HIV epidemics in high-prevalence settings. Ten of the 15 priority countries identified by UNAIDS for intense effort to increase levels of VMMC are in SADC (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe). COVID-19 restrictions on access to health facilities had a negative impact on VMMC programmes. As a result several countries only provided less than one third of their targeted VMMCs[23]. However, Tanzania and Zambia achieved 100% of their VMMC targets in 2020. VMMC uptake seems to be higher in urban and higher socio economic groups.[24]

[22] Global HIV Prevention Coalition. 2022, Op Cit.
[23] UNAIDS. 2022. In Danger. Op Cit.
[24] Global HIV Prevention Coalition. 2022. Op Cit.

Pre-Exposure Prophylaxis (PrEP)

PrEP is one of the five prevention pillars in the Prevention Roadmap of the Global HIV Prevention Coalition. PrEP is recommended for discordant couples (where one is positive and the other negative), sex workers, MSM, young women or others at high risk of contracting HIV.

Table 5.11: PrEP Coverage SADC

Country	2017	2018	2019	2020	2021
Botswana		38	1954	2259	5149
Eswatini				9125	
Lesotho	853	7279	35 478		15 749
Malawi			459		10 971
Mauritius		3			19
Mozambique	303	1934		18 513	57 717
Namibia	190				
Seychelles	2	4	26	3	1
South Africa	3189	8184		106 401	346 667
Tanzania					41 335
Zambia		3823		110 714	147 397
Zimbabwe	2714	4982	8351	48 583	7061
Total					632 066

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022.

Table 5.11 showing the uptake of PrEP (a daily ARV pill taken as prevention) illustrates that coverage is still relatively low. In 2020 six countries, including South Africa, Zambia and Zimbabwe in SADC, accounted for more than 80% of PrEP users in GPC countries. The GPC rated six countries (including Eswatini, Lesotho, Zambia and Zimbabwe in SADC) as good on their PrEP score, which included regulations, guidelines and coverage. The 632 066 PrEP users in SADC in 2021 is 69% of the global total of 911 825. South Africa alone accounted for 38% of the global total.

The 2022 International AIDS Conference witnessed major progress on providing long-acting injectable cabotegravir (CAB-LA), which is administered by injection once in two months.[25] Key wins included:

- Further evidence of the efficacy of CAB-LA as a prevention method for those at high risk of HIV infection, including cis and trans women and men who have sex with men;
- Guidelines provided by WHO on the use of CAB-LA as a prevention tool. Only the United States has so far approved CAB-LA for PrEP but ViiV, who developed cabotegravir, has submitted applications for its approval to other regulators;
- The announcement of a voluntary licensing agreement between ViiV and the Medicines Patent Pool which will promote production of generic CAB-LA thus making it available to 90 low and middle income and Sub Saharan African countries at a more affordable rate;
- The launch of a coalition led by WHO, Unitaid, UNAIDS and The Global Fund to make CAB-LA more accessible. Until now CAB-LA has only been available in study sites.

As SADC member states have been amongst the early adopters of PrEP, it is anticipated that SADC will benefit from such progress.

[25] IAS. Momentum builds to deliver long-acting PrEP for HIV prevention. 28 July 2022. https://aids2022.org/2022/07/28/momentum-builds-to-deliver-long-acting-prep-for-hiv-prevention/ accessed 30 July, 2022.

Prevention among key populations

Key populations are sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons and prisoners[26]. The goal is that 95% of members of all key populations access HIV combination prevention services and that those that test positive will access treatment, with ongoing support to be virally suppressed. Key populations face much higher rates of HIV than the general population. Punitive laws and policies, police harassment, stigma and discrimination within health settings all deter members of Key Populations from accessing needed services. The largest proportion of new HIV infections within key populations is found in clients of sex workers and other partners of key populations (25%). HIV thus spreads into the general population. The paucity of data about the epidemic in key populations is indicative of the low priority that members of key populations have received so far in the HIV battle in SADC.

Stigma and Discrimination

One of the three ten targets is: Less than 10% of people living with, at risk of and affected by HIV and key populations experience stigma and discrimination

Stigma and discrimination are pervasive amongst people that are living with and affected by HIV. Such stigma is compounded by intersecting forms of stigma related to HIV. Data on stigma and discrimination are sparse although more is being done to try to quantify it. Table 5.13 presents data that has been gathered from Demographic Health Surveillance (DHS) surveys, some UNICEF national Multiple Indicator Cluster Surveys as well as from some country level Behavioural Surveillance surveys. These ask the questions outlined in table 5.12.

Table 5.12: Stigma and Discrimination

Country	I	II	III	IV	V
Angola	31	20,9	34,6		
Botswana					
Comoros					
DRC	49,2				
Eswatini	5,7			34	
Lesotho	13,9			8	8
Madagascar	63,4	58,5	72,2		
Malawi	14,9	8,5	17,6	49	12,9
Mauritius					
Mozambique					
Namibia	13				
Seychelles					
South Africa	12,6	7,5	16,9		
Tanzania					
Zambia	18				
Zimbabwe	26	10,1	28,7	39,3	8,3

[26] UNAIDS. 2022. In Danger. Op Cit.

Where:
I. Percentage of adults (15-49) who responded No to the question: Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?
II. Percentage of adults (15-49) who responded No to the question: Do you think that children living with HIV should be able to attend school with children who are HIV negative?
III. Percentage of adults (15-49) who responded No to both questions
IV. Sex workers: Avoidance of health care because of stigma and discrimination (%)
V. Men who have sex with men: Avoidance of health care because of stigma and discrimination (%)

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022.

Table 5.12 underscores the high incidence of stigma and discrimination across SADC. The table also shows how stigma is impacting on access to services for sex workers. For example 49% of sex workers in Malawi avoid health care as a result of stigma. Nearly 13% of men who have sex with men also avoid health services in Malawi due to stigma. The Global Network of People living with HIV (GNP+) is leading in assessing levels of stigma in many countries around the world using the global Stigma Index. A number of SADC countries that have participated in this survey are using the results to advocate for changes in policy and practice to create more enabling and inclusive environments, where people living with HIV in all their diversity are able to access the services that are their right.

The **Eswatini** Stigma Index report, compiled in 2019, found that fewer than 10% of respondents had experienced HIV related stigma and discrimination in the last 12 months. Those that did experience stigma were the object of derogatory remarks which portrayed them as being promiscuous, sick and unproductive. About 4% of the respondents identified as sex workers and half of these reported experiencing stigma and discrimination as a result both of being sex workers as well as due to their HIV status[27]. The report found that significant progress has been made in addressing stigma in Eswatini. The report recommended that Eswatini develop a national strategy to combat stigma and discrimination with a campaign to combat stigma and to promote caring and nurturing families.

In **Zimbabwe** 25% of people living with HIV said that they experience discrimination in health care settings, while 30% experience it in community settings.[27] In Zambia discriminatory attitudes towards people living with HIV are more common in low income and rural communities.

More needs to be done to address stigma at all levels

The Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination (Global Partnership), established in 2018[29], is convened by UNAIDS and receives technical support from a number of civil society partners. To date 31 countries have joined it, including Angola, Botswana, Democratic Republic of the Congo, Lesotho, Mozambique, and South Africa in SADC. The partnership is focusing on addressing stigma in Health care, Education, the workplace, Legal and justice systems as well as communities and emergency and humanitarian settings.

The media article by Keamogetse Motone goes more deeply into how fear of stigma and discrimination make it difficult for people living with HIV to speak openly about their status. This undermines disclosure, including support for adherence to treatment.

[27] Kingdom of Eswatini. 2019. Stigma Index Report. https://www.stigmaindex.org/wp-content/uploads/2022/04/Eswatini-Stigma-Index-Report-2019.pdf accessed 8 August, 2022.
[28] UNAIDS. 2022. In Danger. Op Cit.
[29] UNAIDS website https://www.unaids.org/en/topic/global-partnership-discrimination accessed 6 August, 2022.

Botswana: Discrimination on disclosure of status

Gaborone, 1 December: Despite Botswana's global reputation as a leader on rolling back HIV and AIDS, stigma abounds. Even though disclosure can assist in the battle against HIV and AIDS, it has a dire potential to awaken stigma and discrimination not only against those infected but also against those affected by HIV. This in turn may lead to suicide, cyber bullying, emotional distress, depression and more.

A report by Botswana Network on Ethics, Law and HIV/AIDS (BONELA), noted that disclosure has the potential to de-stigmatise HIV and AIDS by normalising it as a health condition like any other. "Public figures, influencers and celebrities may choose to disclose their HIV status with the view to address stigma associated with HIV/AIDS and this should be celebrated and encouraged," the report said.

Neo Nono Simon is an HIV Advocate at Botswana Networks for People Living with HIV (BONEPWA), who has been living with HIV for 14 years. She said disclosing HIV status is very important. "The benefit of disclosing your HIV status is that you are able to live in peace with your family members. You don't have to hide when it is time for you to take your medication or go for your regular check ups. You will be given the moral support you need," she explained.

According to her, people are generally accepting when people disclose their HIV status. "People still assume that being HIV positive means someone was having many sexual partners.

Botswana's stigma discrimiation hinders disclosure of HIV status.
Photo: Gender Links

Forgetting that people contract HIV in different ways. So before disclosing people should be emotionally ready to be stigmatized. Some will want to discriminate you. It is still hard for people to admit that there are people living with HIV in our midst," she said.

By going public about her HIV status, Neo sought to try and normalise living with HIV. She stated that she is not encouraging people to get infected with HIV but rather trying to change the mind sets of people.

Ditshupo Phiri, a 32 year old man disclosed his HIV status after realising that many people are struggling to accept and adhere. "Accepting yourself is very crucial. If you have done so it is very easy to adhere and that alone can inspire others. If we all do this we will be able to protect others and set a good example to society." He highlighted that when people accept themselves they are simply saying no to more HIV infections.

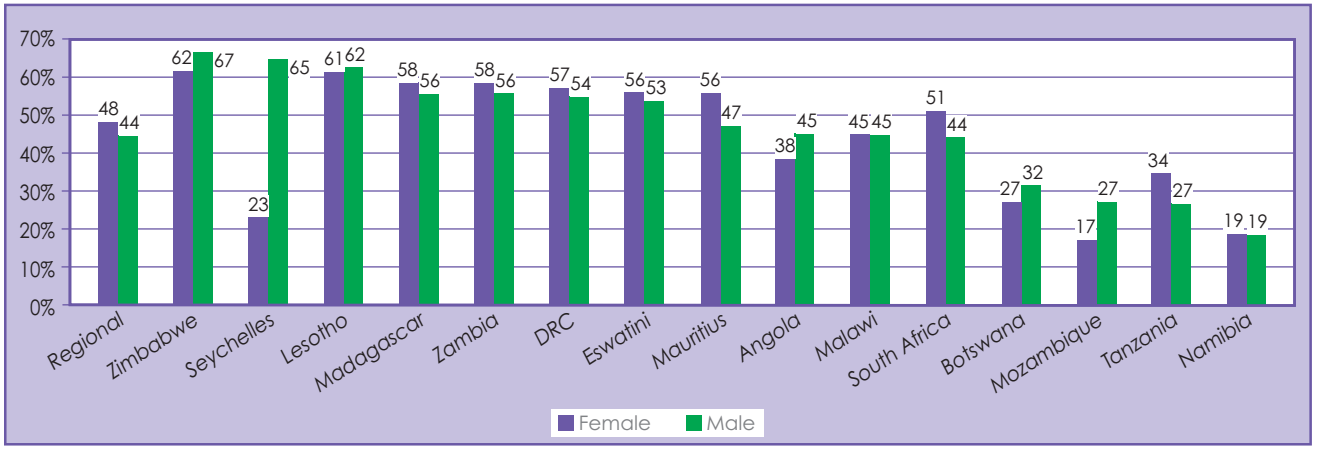
Source: Motone, Keamogetse. January 10, 2022. Bots: Discrimination on Disclosure of Status. GL News Service Sixteen Days of Activism News series[30].

Attitudes

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

[30] https://genderlinks.org.za/news/botswana-stigma-discrimination-hinder-disclosure-of-hiv-status/

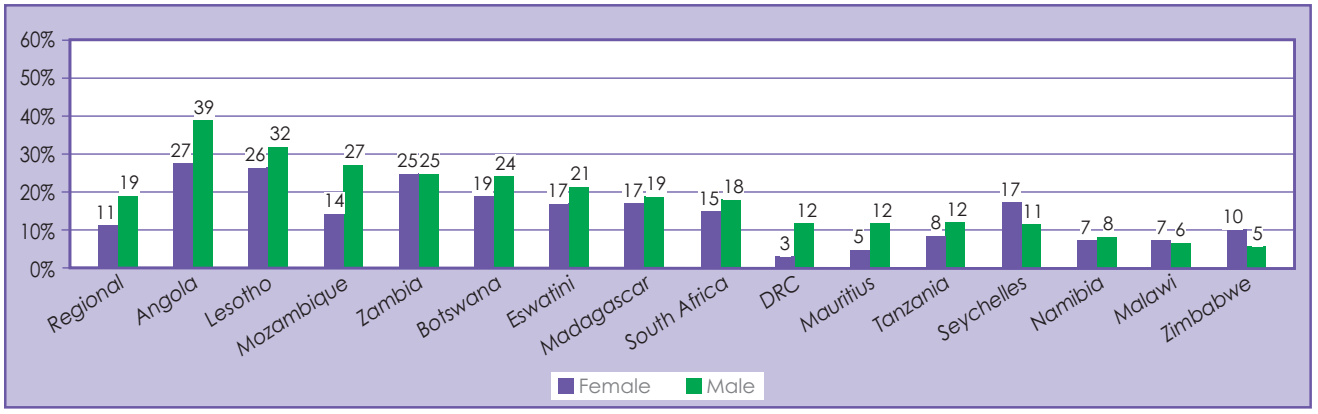
Figure 5.6: A woman can refuse to have sex with her husband



Source: Gender Links Attitudes Survey, 2021.

The attitudes on whether a woman can refuse to have sex with her husband range quite widely. Sixty two percent of female respondents in Zimbabwe strongly agreed with the statement compared to 19% men in Namibia. Overall men and women had similar views. Over 50% of both women and men in Zimbabwe, Lesotho, Madagascar, Zambia, DRC and Eswatini agree with the statement. More females agreed with the statement in South Africa and more men in Angola.

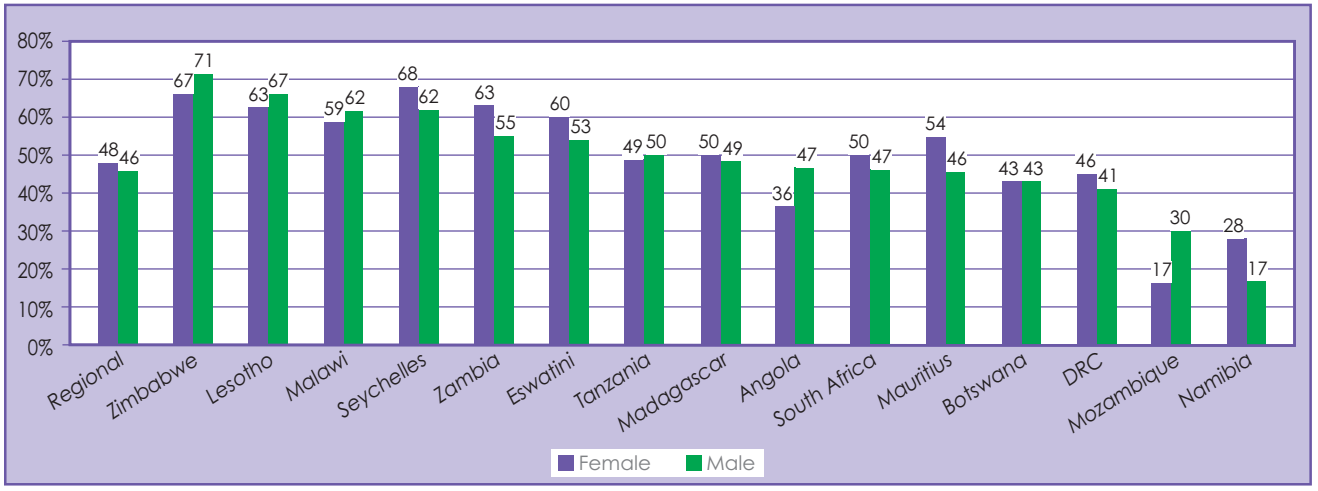
Figure 5.7: Nothing a woman can do if her husband wants to have girlfriends



Source: Gender Links Attitudes Survey, 2021.

A minority of women and men agreed that "there is nothing that a woman can do if her husband wants to have girlfriends", which means that the majority believe that a wife can do something. Across the region, only 11% women and 19% men agreed with this statement. The highest rate of agreement in both females and males is in Angola (27% females and 39% males) and lowest for both is Malawi (7% females and 6% males). Women were generally less likely to agree with the statement than men.

Figure 5.8: A woman can insist on a man using a condom



Source: Gender Links Attitudes Survey, 2021.

Over 50% of female respondents in Zimbabwe, Lesotho, Malawi, Seychelles, Zambia and Eswatini believe that a woman can insist on using a condom. It is disturbing that rates of agreement drop to as low as 17% of female respondents in Mozambique with a regional average of only 48% for women and 46% for men. In Zimbabwe, Lesotho, Malawi, Tanzania, Angola and Mozambique more males than females agree that women have a right to insist on a man using condom. This reflects some changes in attitude, especially at the local level.

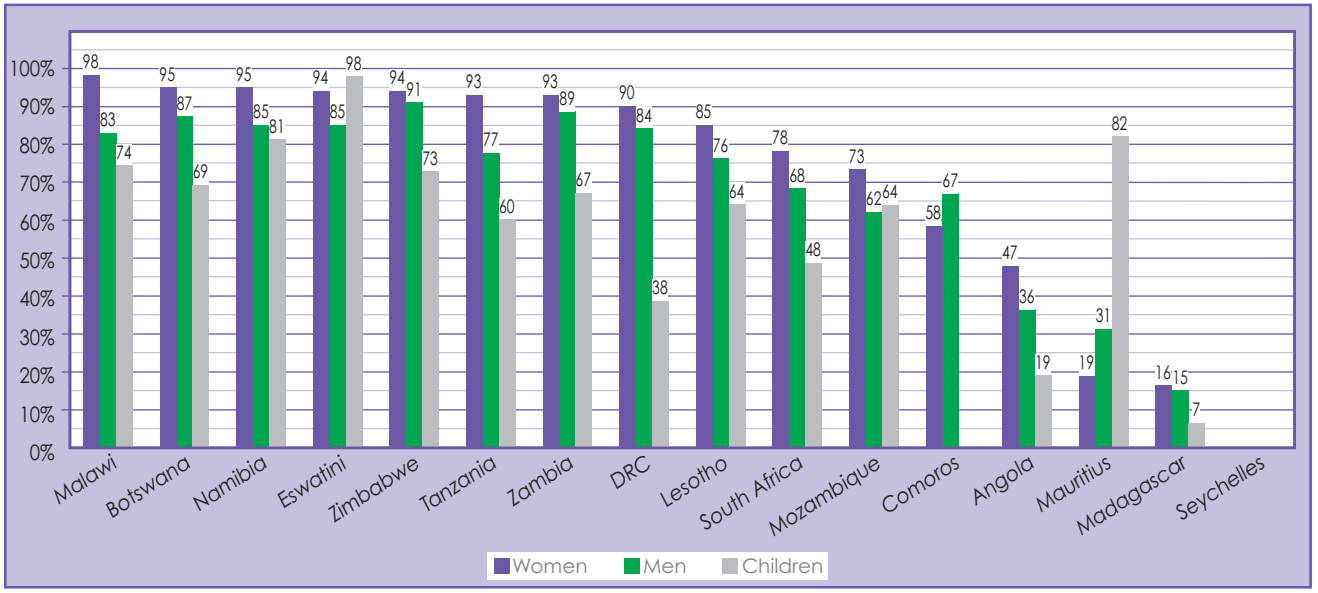
Treatment

Article 27.3
b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and
UNAIDS 95/95/95: Target (2) By 2025, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 95% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.9 overleaf shows the remarkable progress that has been made in expanding access to ART across much of SADC. Countries with lower levels of coverage generally have relatively small epidemics and these are also making progress. Clearly, there is need to accelerate action in Angola, Mauritius and Madagascar. In most countries coverage for women is higher than for men, except in Comoros and Mauritius.

Celebrating successes in the HIV/AIDS Campaign, South Africa.
Photo: Susan Mogari

Figure 5.9: ART Coverage for those living with HIV



Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022.

Children on Treatment

Figure 5.9 also illustrates the discrepancy between treatment levels for children and those for adults. Even in South Africa, which is making great progress in reducing the levels of new infections in children, only 48% of children living with HIV are on ART.

Working with UNITAID and the Clinton Health Access Initiative (CHAI), **Zimbabwe** is one of six African countries (including Malawi in SADC) that have piloted paediatric dolutegravir.[31] A new formulation, which can be easily dissolved in a small amount of water and has a strawberry flavour that children enjoy, is now available at a reasonable price that was negotiated with producers of generic dolutegravir. The formulation is taken once a day with two other ARVs and has proven to have fewer side effects than other medications. The pilot was conducted at 13 high volume urban and rural health services from May 2021, involving training of doctors, nurses, primary counsellors, pharmacists, and health information officers. COVID-19 restrictions delayed roll out. Community outreach mitigated these delays. Zimbabwe began national roll out to all health facilities in February, 2022. In 2020 Zimbabwe had 79 000 children aged 0-14 living with HIV; 73% on ART.

There is urgent need to prioritise ART for children

Viral suppression

UNAIDS TARGET 3: 95% of all people receiving antiretroviral therapy will have viral suppression.

[31] Makoni, M. The promise of paediatric dolutegravir in Zimbabwe. The Lancet HIV. 2022, Sept , 9,9:E603-E604. DOI: https://doi.org/10.1016/S2352-3018(22)00223-5

Figure 5.10 People living with HIV who have suppressed viral loads

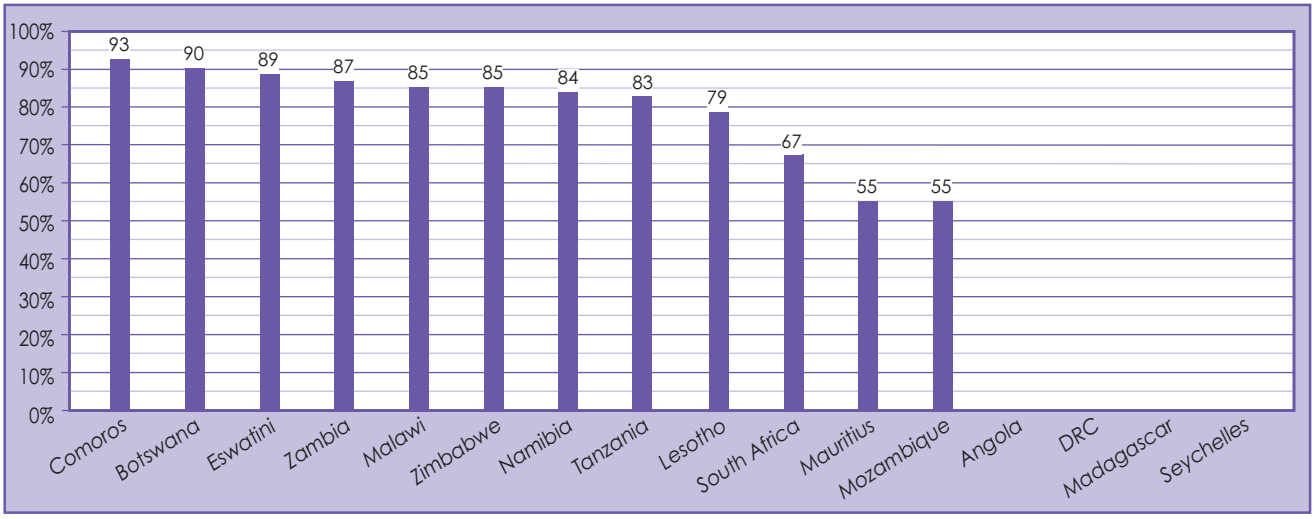


Figure 5.10 shows progress being made towards viral suppression. Data on suppression is not available from Angola, DRC or Madagascar. Mozambique and Mauritius have low rates of suppression. All other countries are making good progress towards this target.

HIV activists in the USA launched the U = U (undetectable equals un-transmittable) campaign in 2016. The campaign highlights that people that are on ART with suppressed viral load cannot transmit the virus through sexual or other contact. The campaign:

- Encourages people that are not aware of their HIV status to be tested;
- Encourages those that are positive to access treatment to protect themselves and their partners;
- Reduces the shame and fear of sexual transmission;
- Helps to challenge stigma at community, clinical and personal levels.[32]

HIV and TB Co-infection

The UN High level meeting on TB in 2016 committed to ending TB, which is both preventable and curable by 2030. TB is still the leading cause of death among people living with HIV. The COVID-19 pandemic had a devastating impact on TB control programmes. In 2020, TB case finding, numbers initiated on treatment and on preventive treatment all declined[33]. Increasing poverty, poorer nutrition and more crowding all increased the chances of spread of TB. Globally, the number of deaths from TB increased for the first time since 2005 and there were an estimated 1·32 million tuberculosis deaths worldwide[34]. TB was the second leading cause of death (to COVID-19) from a single infectious agent. Different models predict that the number of TB cases

[32] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.
[33] WHO. 2022. Global Tuberculosis report 2021. Geneva. WHO. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2021 accessed 5 August, 2022.
[34] Dheda, K. et al. Tuberculosis in the time of COVID-19: The intersecting pandemics of tuberculosis and COVID-19: population-level and patient-level impact, clinical presentation, and corrective interventions. Lancet Respir Med 2022; 10: 603-22 Published Online March 23, 2022 https://doi.org/10.1016/S2213-2600(22)00092-3 Accessed 5 July, 2022.

will increase at least until 2025 if urgent action is not taken to bring the levels of new cases back at least to the 2019 levels.

The WHO has defined three High Burden Country (HBC) lists for 2021-2025 - for TB overall, for HIV associated TB and for MDR/rifampicin-resistant TB (MDR/RR-TB). The criteria for the three lists are:

- "the top 20 countries in terms of their estimated absolute number of new (incident) cases in 2019"; plus
- "the 10 countries with the most severe burden in terms of the incidence rate (new cases per 100 000 population in 2019) that are not already in the top 20 and that meet a minimum threshold in terms of their absolute number of cases"[35]. The thresholds are 10 000 new cases per year for TB; and 1000 new cases per year for HIV-associated TB and rifampicin-resistant TB.

A total of 49 countries around the world, including twelve SADC member states, are on at least one of the lists. The twelve and the lists that they are on are illustrated in Table 5.13. DRC, Mozambique, South Africa and Zambia are on all three of the lists, indicating that they have high burdens of TB overall, of HIV associated TB and of MDR/rifampicin-resistant TB.

Table 5.13: SADC Countries in any of the WHO HBC lists of TB for 2021 - 26

Country	TB	TB/HIV	MDR/RR-TB
Angola	■		■
Botswana		■	
DRC	■	■	■
Eswatini		■	
Lesotho	■	■	
Malawi		■	
Mozambique	■	■	■
Namibia	■	■	
South Africa	■	■	■
Tanzania	■	■	
Zambia	■	■	■
Zimbabwe		■	■

KEY ■ Indicates that the country is on this TB list

Source: GenderLinks compiled from WHO. World Tuberculosis Report 2021[36].

These lists provide an indication of the countries that need the greatest support and political commitment to fighting TB.

Table 5.14: TB-related deaths in people living with HIV

Country	2000	2010	2019	2020	Change 2010-2020
South Africa	116000	158000	36000	36000	77%
Tanzania	53000	40000	12000	9800	76%
DRC	24000	18000	9600	9100	49%
Zambia	20000	14000	9500	9100	35%
Mozambique	20000	21000	5600	6100	71%
Zimbabwe	14000	8000	4600	5900	26%
Malawi	13000	18000	4200	4200	77%
Lesotho	4300	7900	3600	3400	57%
Angola	1900	9100	2600	2900	68%
Botswana	3700	2000	1100	1500	25%
Namibia	4500	3800	1300	1300	66%
Eswatini	2400	2300	710	640	72%
Madagascar	36	54	280	290	-437%
Mauritius	7	2	9	9	
Comoros	0	0	0	1	
Seychelles	0	0	0	0	
Total SADC	276843	302156	91099	90240	70%
Global	**680000**	**590000**	**210000**	**210000**	**64%**

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 6 August, 2022.

[35] WHO. 2022. Global Tuberculosis report 2021. Geneva. WHO. Op Cit.
[36] WHO. World Tuberculosis Report 2021. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2021 accessed 5 August, 2022.

TB Programmes were severely impacted by COVID-19

Table 5.14 compares the number of TB related deaths in people living with HIV in 2000, 2010, 2019 and 2020. The table shows that declining deaths halted in the wake of COVID-19 in 2020. Deaths increased in Mozambique, Zimbabwe, Angola, Botswana and Madagascar; were at very similar levels for South Africa, Malawi and Namibia and continued slow declines in other countries. Only South Africa, Tanzania and Malawi achieved the global target of reducing TB related deaths (between 2010 and 2020) in People Living with HIV by 75% or higher by 2020. Mozambique and Eswatini were between 70 and 75%. SADC overall had a reduction of 70% compared to a global reduction of 64%.

The health authorities of the Western Cape and City of Cape Town in **South Africa** have collaborated with Médecins Sans Frontières (MSF) for some years to improve TB management. In Khayelitsha it is estimated that 200 people are diagnosed with drug resistant TB (DR-TB) every year, making it a global DR-TB hotspot. COVID-19 lock downs increased overcrowding and poorer nutrition: ideal conditions for the spread of TB. Initial responses by the health system, included health education on the signs and symptoms of COVID-19 and TB; integrated screening and testing for COVID-19 and TB and support for clinics to continue TB work. Partners introduced community and family based outreach to provide testing, treatment and prevention services in the households of those diagnosed with TB. This approach enabled even children to be provided with DR TB treatment and care at home.[37]

HIV and Cervical Cancer Co-Infection

A study that pooled data from 24 other studies on Cervical Cancer around the world developed estimates of the global cervical cancer burden associated with HIV.[38] Women living with HIV have a six fold higher risk of developing cervical cancer than women that are HIV negative. Cervical cancer is considered an AIDS defining illness. The study found that 85% of women living with HIV who also have cervical cancer are in East and Southern Africa. While the proportion of women who have cervical cancer that are living with HIV was 5% or less in 122 countries, in ten countries of East and Southern Africa the proportion was over 40%. As shown in Table 5.15 overleaf, eight of these ten countries are in SADC.

It is recommended that as much as possible pre-adolescent girls in high HIV burden countries are vaccinated against the human papilloma virus (HPV) which pre disposes women living with HIV to develop cervical cancer. Further, all women living with HIV should have regular screening for cervical cancer.

Girls in countries with high HIV prevalence should be vaccinated against HPV

[37] Apolisi, I et al. Supporting families with tuberculosis during COVID-19 in Khayelithsa, South Africa. Lancet Respiratory. 2022, June, 10, Published Online March 23, 2022 https://doi.org/10.1016/S2213-2600(22)00121-7 Accessed March 30, 2022.
[38] Stelzle, D. et al. Estimates of the global burden of cervical cancer associated with HIV. Lancet Glob Health. 2021 Feb; 9(2): e161-e169. Published online 2020 Nov 16. doi: 10.1016/S2214-109X(20)30459-9: 10.1016/S2214-109X(20)30459-9 Accessed 6 March, 2022.

Table 5.15: HIV infection and Cervical Cancer

Country	# new cervical cancer cases 2018	Proportion of new cervical cancer patients who are living with HIV (%)	# cervical cancer patients living with HIV (2018)	Population attributable fraction for HIV (%)	# cervical cancer cases attributable to HIV (2018)
Eswatini	380	75,03	284	62,61	237
Lesotho	477	69,3	330	57,85	275
Botswana	333	66,47	221	55,51	184
South Africa	12983	63,35	8223	52,93	6866
Zimbabwe	3186	52,19	1660	43,58	1386
Namibia	2,36	50,22	118	41,9	98
Mozambique	4291	50,21	2151	41,91	1793
Zambia	2994	49,57	1481	41,32	1234
Malawi	4163	43,04	1787	35,94	1492
Tanzania	9772	26,73	2611	22,29	2177
Angola	2949	13,61	401	11,41	335
DRC	5762	6,3	363	5,26	302
Mauritius	120	4,03	5	3,36	4
Madagascar	4353	0,94	41	0,78	34
Comoros	141	0,13	0	0,11	0

Source: Gender links derived from Stelzle, D. et al. Estimates of the global burden of cervical cancer associated with HIV. Lancet Glob Health. 2021 Feb; 9(2).

AIDS related deaths

Table 5.16: AIDS related deaths, 2021

Country	All deaths		Deaths in young people 15 - 24		Deaths in children 0 - 14	
	2004	2021	2004	2021	2003	2021
South Africa	270000	51000	30000	5700	34000	2800
Mozambique		51000		4600		8200
Tanzania	120000	29000	3900	2600	24000	6100
Zimbabwe	130000	20000	4800	2100	22000	2800
Zambia	70000	19000	2900	2500	16000	2400
Angola	10000	15000	500	1000	3500	3600
DRC	56000	14000	1900	1200	12000	4300
Malawi	81000	13000	2600	1400	18000	1500
Botswana	17000	4600	1000	500	2800	200
Lesotho	18000	4500	1000	500	3500	1000
Madagascar	200	2900	100	100	100	1000
Namibia	12000	2900	500	500	2500	500
Eswatini	10000	2600	500	500	2200	200
Comoros	100	100	100	100		
Mauritius						

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/

Table 5.16 compares the number of deaths as a result of AIDS for all people, young people and children between either 2003 or 2004 (the year of highest deaths) and 2021. Globally there were still 650 000 deaths as a result of AIDS in 2021 and the rate of decline has slowed. Overall there has been remarkable progress, though Madagascar and Angola have increasing numbers of deaths, and rates of decline for other countries have been uneven. Noteworthy declines include: in

total deaths in Zimbabwe and Malawi, in deaths in young people in South Africa as well as deaths of children in South Africa, Malawi and Botswana.

Care work

Article 27.3
a) Develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care givers, the majority of whom are women, the allocation of resources and the psychological support for care givers as well as support for care givers as well as support of people for people living with AIDS.
Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.
SADC sponsored UN resolution on Women, Girls and HIV: Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognise, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure.
BPFA +20 Africa declaration: Reduce, recognise and redistribute unpaid care work, which falls disproportionately on women and girls, by investing in infrastructure and time-saving technology and emphasizing shared responsibilities between women and men, girls and boys;

Community Care Givers

Even though the history of the HIV response is rooted in voluntary contributions of community members to provide services when the formal health system could not cope, the Global AIDS Strategy 2021 - 26 targets of HIV services to be community led by 2025 seem ambitious. The targets are:

- 30% of HIV testing and treatment services,
- 80% of HIV prevention services for high-risk populations and
- 60% of programmes to achieve societally enabling environments.

Research shows that peer education is a powerful way of reaching populations who are marginalised and impacted by stigma, such as adolescents and key populations that are led by members of these populations are more accepted by their peers. Further, community led responses are of similar quality to those provided by the formal health sector but are cheaper than external programmes. During COVID-19 restrictions community led initiatives were able to quickly re-organise their service delivery to make sure that clients received their medicines, food and other support.[39]

Reasons given for low levels of support to community led responses include[40]:

- Lack of clear definition of what constitutes a community led programme. A process led by UNAIDS has now defined this as, "…*actions and strategies that seek to improve the health and human rights of their constituencies, that*

[39] UNAIDS. 2022. In Danger.
[40] Ayala G, Sprague L, van der Merwe LL, Thomas RM, Chang J, Arreola S et al. Peer- and community-led responses to HIV: a scoping review. PLoS One. 2021;16(12):e0260555.

are specifically informed and implemented by and for communities themselves and the organisations, groups, and networks that represent them.

Community-led responses are determined by and respond to the needs and aspirations of their constituents. Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organizations, groups, and networks. Community-led responses can take place at global, regional, national, subnational, and grassroots levels, and can be implemented virtually or in person. Not all responses that take place in communities are community-led."

- Community led programmes include an emphasis on the meaningful inclusion of people living with HIV, gay and bisexual men, people who use drugs, sex workers, and transgender people in designing, implementing, managing, and evaluating programmes.
- Insufficient evidence of the impact of community led programmes - these programmes seldom have the resources to conduct rigorous research or even to document their impact.
- Poor involvement of communities and those most affected by HIV in the development, implementation or monitoring of programmes that are meant to benefit them.

Community led responses are more effective in engaging whole communities, creating community cohesion to respond to challenges faced and building networks of support for those that are most marginalised. National strategies and processes must include mechanisms for channelling consistent funding to community led responses. Such mechanisms must mitigate the impact of regressive laws and policies, intersecting social stigmatizations, discrimination against groups of people most affected by HIV. They must also support these to manage and account for funds.

National mechanisms should also prioritise:

1. Supporting community led responses to expand their operations in prevention including outreach; HIV testing- with self-testing; STI testing and treatment; comprehensive sexuality education; condom and lubricants distribution; pre- and post-exposure prophylaxis (PrEP and PEP); behavioural interventions; harm reduction, including needle and syringe programmes; peer support; risk reduction counselling; and drop-in centres for those most at risk
2. Supporting community led responses to continue their critical role in treatment access; treatment adherence (which is crucial in a post COVID era of multi month dispensing of ART) and peer support
3. Supporting community led responses which interface with health services to monitor services and make suggestions for improvements; advocate and mobilise community members to access services.

The critical role of the community, community-based organisations and community care-giving in different forms is widely recognised as being crucial in the fight against HIV and AIDS. The new cadres of community caregivers - peer educators and supporters, mentor mothers, and others - are being called upon to play increasingly complex roles to ensure that HIV services continue and expand to reach all people. Recognition, appreciation, support, training and remuneration for this critical work force remains paramount.

[54] Tuberculosis deaths among people living with HIV are declining globally, but worrying gaps in TB care persist, https://www.unaids.org/en/resources/presscentre/featurestories/2021/march/20210324_tuberculosis-deaths-people-living-with-hiv, accessed 10 August 2021.

Next steps

The Global AIDS Update has warned the world that we are in Danger. In Danger of failing to eradicate AIDS as a public health threat. This is a clarion call to redouble efforts at prevention, testing, access to ART and adherence to ART. The urgent next steps that are required for SADC to eradicate AIDS as a public health threat by 2030 include:

Redoubling efforts for HIV prevention: including programmes that are delivered at scale and

- Stop ignoring the crisis of HIV sub epidemics in key populations, use human rights based approaches to remove legal and programmatic impediments to members of key populations accessing HIV care;
- Urgently address stigma and discrimination at all levels;
- Mobilise political will at all levels to address the epidemic of GBV that faces girls and women in SADC;
- Continue to focus on prevention of mother to child transmission, especially in children of adolescent and young mothers;

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

- Give more attention to the situation of children and adolescents who were exposed to HIV in utero and are uninfected;
- Embrace traditional approaches such as the Education Plus Initiative with comprehensive sexuality education;
- Be prepared to roll out new technologies such as long acting PrEP swiftly.

Generate new impetus for HIV control in member states where the epidemic is expanding, especially Madagascar.

The search for an effective vaccine still requires investment, even as new therapies and treatments are developed,

Continue efforts to ensure that men and other groups that are not accessing testing and treatment do so.

Expand programmes to control Cervical cancer and redouble efforts to control TB: including vaccination against the human papilloma virus (HPV) which pre disposes women living with HIV to develop cervical cancer for pre adolescent girls and regular screening for cervical cancer for all women living with HIV; TB case finding and treatment.

Support and effectively resource community-led responses as the health sector cannot address HIV alone. The need for multi sectoral collaboration is very clear. Health services must collaborate with community initiatives. National mechanisms must find ways to channel support to these initiatives. This might be the opportunity to "build back better" and acknowledge the critical role of the community in HIV prevention, care and support.

Continue domestic resource mobilisation for the HIV response.

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Gender-Based Violence

6

South Africans march to raise awareness about gender-based violence in 2021. The country has seen a spike in violence against women over the past two years.
Photo: Gender Links

KEY POINTS

- According to new research, four in ten women aged 15-49 in Madagascar have experienced emotional, physical or sexual abuse perpetrated by a husband or partner.[1]
- An eight-country study on online violence shows worrying increases in hate speech, misogyny and online gender-based violence (OGBV).[2]
- A growing group of scholars and activists has observed that the internet and its associated technologies perpetuate new and reconfigured forms of abuse, such as cyber harassment, trolling, stalking, body shaming and non-consensual creation of sexual images through artificial intelligence.
- New research shows that women and girls seeking reproductive healthcare services often face physical and psychological violence and mistreatment, known as obstetric violence.[3]
- In March 2022, Lesotho's parliament approved the Counter Domestic Violence Bill, a move that aims to address the scourge of violence against women and girls in the country.

[1] Statistique (INSTAT), I.N. de la and ICF (2022) 'Enquête démographique et de santé à Madagascar (EDSMD-V) 2021', https://dhsprogram.com/publications/publication-FR376-DHS-Final-Reports.cfm, accessed: 2 September 2022.
[2] Understanding-Online-GBV-In-Southern-Africa: An Analysis of eight country prevalence of digitally enabled gender-based violence.
[3] Commission for Gender Equity 2019 Report to the United Nations Special Rapporteur. https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Commission for Gender Equality South Africa.pdf.

Introduction

This 2022 chapter continues the #Voiceand Choice campaign, with its focus on Sexual and Reproductive Health and Rights (SRHR). It assesses progress on reducing gender-based violence (GBV) in the region, including the extent, prevention, response, and support across all 16 SADC countries.

The Barometer measures this against commitments made in several normative frameworks, including the SADC Protocol on Gender and Development (the "SADC Protocol); Beijing Platform for Action (BPFA) +20 Africa Declaration; Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW); UN Sustainable Development Goals (SDGs); The Maputo Protocol; International Conference on Population and Development (ICPD); and the Commission on the Status of Women (CSW) Resolution 60/2 on Women, the Girl Child, and HIV.

While the previous edition of the Barometer noted a dearth of recent GBV data, researchers across institutions collected new figures and information over the past year. Recent studies include an eight-country study commissioned by Meta (formerly Facebook) and the Public Policy Department for Southern Africa called *Understanding Online Gender Based Violence in Southern Africa*.

Additionally, the 2021 Demographic and Health Survey (DHS) in Madagascar measured domestic violence there.[4] It showed that about four in ten women aged 15-49 (44%) had experienced emotional, physical or sexual abuse perpetrated by a husband or partner and 27% reported such experiences in the 12 months prior to the survey.[5] Most women in Madagascar do not seek help for this. Among those in this group who experienced physical or sexual violence, 50% did not seek help or mention the abuse to anyone other than researchers for this study; 19% never sought help, but did tell someone about it; and only 32% sought help.[6] This finding is consistent with others from Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe, where Gender Links (GL) conducted GBV studies from 2010 to 2018.

> In Madagascar, four in ten women aged 15-49 reported experiences of emotional, physical or sexual abuse perpetrated by a husband or partner

These studies, conducted during the height of the COVID-19 pandemic, highlight that GBV remains endemic in Southern Africa and has spread to new terrain. The 2021 Meta study found that widespread use of the internet in the region has led to normalisation of hate speech, misogyny, and other dark forms of participation. It also pointed to a rise in information disorders, which involve the sharing or creation of false and potentially harmful information. Further, female journalists have reported an escalation in cyber bullying and harassment. Most countries do not have specific legislation to respond to the growing issue of online GBV (OGBV).[7]

New research on the mistreatment of women and girls in healthcare settings, known as obstetric violence, shows that women and girls seeking reproductive healthcare services in South Africa's public health system often face violence and

[4] Statistique (INSTAT), I.N. de la and ICF (2022) 'Enquête démographique et de santé à Madagascar (EDSMD-V) 2021', https://dhsprogram.com/publications/publication-FR376-DHS-Final-Reports.cfm, accessed: 2 September 2022.
[5] Ibid.
[6] Ibid.
[7] Understanding-Online-GBV-In-Southern-Africa: An Analysis of eight country prevalence of digitally enabled gender-based violence.

harm. This includes physical, emotional, psychological, and even sexual violence perpetrated by healthcare practitioners. Power disparities between providers and patients keep women from objecting to, or speaking out against, these abusive practices.[8]

Despite these and other challenges, SADC member states have made progress in addressing GBV by implementing multi-sectoral approaches that include legislative and criminal justice responses. In March 2022, the Lesotho parliament approved the Counter Domestic Violence Bill, which will help address the scourge of violence and help the country fulfil its regional and global commitments to end GBV. With the passing of this bill in Lesotho, 14 SADC countries now have domestic violence laws. Only the Democratic Republic of the Congo (DRC) and Tanzania remain without this critical legislative tool to eradicate GBV.

In Zimbabwe, the government collaborated with the Spotlight Initiative, a global partnership led by the UN to eliminate all forms of violence against women and girls (VAWG), to launch a High-Level Political Compact to ending GBV and Harmful Practices (HLPC) in October 2021.[9] According to the Spotlight Initiative, the Compact will promote political commitment at the highest level to respond to VAWG.[10] In Southern Africa, the Spotlight Initiative works in Malawi, Mozambique and Zimbabwe.

Human trafficking in SADC, exacerbated, according to the UN, by the COVID-19 pandemic, represents one issue that policymakers have done little to address.[11] Namibia remains the only African country in the Tier 1 ranking on trafficking of persons in 2022, which means it complies with the minimum standards for elimination of severe forms of trafficking in persons. The four tiers (Tier 1, Tier 2, Tier 2 watch list, and Tier 3) align with the Trafficking Victims Protection Act (TVPA), an anti-trafficking United States Federal Law.[12] SADC countries in Tier 2 - Angola, Botswana, Lesotho, Mauritius, Malawi, Mozambique, Seychelles and Tanzania - are not fully compliant but making "significant efforts" to comply. The remaining countries sit on the Tier 2 Watch list.[13] Other countries need to emulate Namibia's level of commitment and consistency in fighting trafficking.

A banner shares information about a GBV awareness campaign led by the Municipal Council of Mbabane in Eswatini. Photo: Thandekuhle Dhlamini

COVID-19 and GBV prevalence

The most acute effects of the COVID-19 virus, which ravaged the region over the past two years, have subsided. Several mutations of the virus challenged healthcare and other regional and state systems throughout the region, killing tens of thousands and devastating economies and social supports across the region and around the world. At the time of writing, as SADC countries continued to loosen restrictions, a new global threat known as monkeypox began emerging. The global outbreak of this viral disease, with symptoms similar to those seen in the past in smallpox patients, had yet to affect most parts of the SADC region.

[8] Thelwell, K. (2020) 6 Things to Know About Obstetric Violence, The Borgen Project, https://borgenproject.org/obstetric-violence/, accessed: 7 September 2022.
[9] Africa Regional. Available at: https://spotlightinitiative.org/africa-regional, accessed: 15 September 2022.
[10] Spotlight Initiative High Level Compact on ending Gender Based Violence and Harmful Practices Officially Launched. | United Nations Development Programme, https://www.undp.org/zimbabwe/news/spotlight-initiative-high-level-compact-ending-gender-based-violence-and-harmful-practices-officially-launched, accessed: 8 September 2022.
[11] COVID-19 an accelerator of human trafficking - UN, https://globalinitiative.net/analysis/covid-19-human-trafficking-un/, accessed on 18 September 2022.
[12] United States Department of State (2022),Trafficking in Persons Report, https://www.state.gov/reports/2022-trafficking-in-persons-report/, accessed: 30 August 2022.
[13] Ibid.

Despite decreasing prevalence of COVID-19, governments mostly failed to address the pandemic's impact on GBV, especially the increase in abuse against women and children during lockdowns. As reported in the 2021 Barometer, reliable data on this topic remains scarce: either unreported or underreported. However, the variation in police data from South Africa over the last two years provides a good indicator of the extent of GBV.

Table 6.1: Total sexual offences from April 2020 to March 2022[14, 15]

Crime category	April to June 2020	July to September 2020	October to December 2020	January to March 2021	April to June 2021	July to September 2021	October to December 2021	January to March 2022
Rape	5805	8922	12 218	9518	10006	9556	11315	10818
Sexual assault	1070	1758	2390	1910	1900	1753	2069	2165
Attempted sexual offences	271	451	625	433	514	400	524	547
Contact sexual offences	150	292	362	272	282	255	280	269
Total sexual Offences	7296	11 423	15 595	12 133	12702	11964	14188	13799

Source: South African Police Services sexual offences statistics.

Table 6.1 provides comparative data on rape, sexual assault and other sexual offences in South Africa between April 2020 and March 2022: two years marked by COVID-19 lockdowns and restrictions. The worst increases of rape occurred in the second quarter of 2021, with the country logging a 72% increase compared to the previous year.

South Africa reported 6083 murders in the first three months of 2022, which works out to 77 murders a day

In both years, the last quarter saw the most sexual offences. The figures and times correlate to periods with the strictest lockdowns in the country. South African police have not yet shared comprehensive data for the second quarter of 2022, although Police Minister Bheki Cele said that police opened 9516 rape cases between April and June 2022. "This is almost 500 less rape cases reported, compared to the same period last year," he said, noting rape cases declined in all provinces except the North West and Northern Cape.[16]

While researchers have not yet analysed this recent data against other regional information and trends, it aligns with concerns about a rise in GBV due to lockdowns expressed by many in civil society during the pandemic's early days. The sharp increase in reported rape cases throughout 2020 and 2021 reflects a worrying trend as the country takes stock of progress to implement its National Strategic Plan on Gender Based Violence and Femicide (GBVF).

[14] South African Police Services sexual offences statistics, https://www.saps.gov.za/services/crimestats.php, accessed 16 September 2022.
[15] Ibid.
[16] South Africa: SAPS Records 6.7 Percent Decrease in Sexual Crimes, https://allafrica.com/stories/202208190505.html, accessed on 18 September 2022.

South Africa: Toxic masculinity drives violent war against women

South Africa saw more murders over the 79-day period representing the first quarter of 2022 than civilian deaths during the first 100 days of Russia's invasion of Ukraine, making the country a more dangerous place to live than an active war zone.

On 3 June 2022, Bheki Cele, minister of police, presented crime statistics for the period 1 January to 31 March 2022, noting that it was an especially brutal three months for women and children.

The statistics present a number of worrying trends. Overall, police noted a 9.3% increase in reported crimes. This number masks even more alarming spikes in violent crime, especially against women and children, which saw double-digit increases.

There were 6083 murders in the first three months of 2022, 1107 more murders - or a 22% increase - compared to the same period last year. This works out to 77 murders a day. Of these, women represented 898 (15%), an increase of 134 (17%) from 2021. The murder of children younger than 17 increased 37% to 306 murders in the three-month period.

Police said the most commonly reported causative factors for murder include arguments and misunderstandings (not domestic-related); road rage/provocation; vigilantism/mob justice; and retaliation/revenge/punishment - crimes largely perpetrated by men that point to the effects of toxic masculinity in South African society.

Masculinity is a social construct, rooted in power and patriarchy and built on the idea that men should act in a certain way according to notions of the "ideal man," - physically strong, sexually virulent, the protector of the family, and partaker of masculine activities and risky behaviours. These notions can lead to dire consequences for the man himself and/or for the people around him, representing toxic masculinity: one of the major reasons for high rates of sexual and gender-based violence (SGBV).

Toxic masculinity plays out in the home, the workplace, public spaces and politics; perhaps best evidenced in the shockingly high number of rapes and sexual assaults that take place daily. Women accounted for 95% of rape survivors and 96% of sexual assault survivors. In total, sexual offences increased by 13 percentage points to 13 799, with rape representing the majority of the reported offences. In the first three months of 2022, 10 818 rapes took place, that is 137 rapes a day, or six per hour. This does not include the many survivors who did not report to police. Almost half of these rape cases took place at either the home of the rape survivor or the rapist.

The war on women often takes place in the home. Sex-disaggregated data on selected domestic violence-related crimes during the reporting period underscores this. Men perpetrated 88%, or 12 314 incidents, of common assault in the home against women. Sex disaggregated data on victims of all crimes, as well as their sexual orientation and gender identity and data on the perpetrators of these crimes, would shed more light on the gender dimensions of crime in the country.

Source: Susan Tolmay, GL Gender and Governance Associate, for the Gender Links news series in 2022.

Turning Point Qhakaza, a group that supports physical, mental and emotional wellbeing of trauma victims, marches against GBV in Durban, South Africa, in 2020. Photo: Mboyi Maswabi

Table 6.2: Key data on extent, response, support, and prevention of GBV in SADC

INDICATORS	Region	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Proportion (%) of women and girls aged 15-49 who experienced intimate partner violence (IPV) in the previous 12 months (2016)[17]	All 16 countries	50	35	40	58	43	41	42	43	25	48	39	30	31	47	47	43
Proportion (%) of ever-partnered women aged 15-49 years experiencing IPV and/or sexual violence at least once in their lifetime (2013)[18, 19]	Nine countries	N/A	N/A	6	64	N/A	N/A	44[20]	31	N/A	33	N/A	N/A	26	43	49	42
Proportion (%) of women and girls aged 15 years and older subjected to physical and sexual violence by a partner in the previous 12 months [21]	14 countries	21.7	28	12	4.6	4.6	0.8	27[22]	24.3	n/d	36	33	n/d	8.7	41.7	43	39.6
Proportion (%) of women aged 15-49 years experiencing physical and/or sexual violence perpetrated by someone other than an intimate partner at least once in their lifetime (1995-2013)[23]	Five countries	N/A	N/A	N/A	3	N/A	N/A	N/A	2	N/A	N/A	N/A	N/A	N/A	3	3	1
Non-partner sexual violence prevalence[24]	9 countries	4.5	2.9	10.1	25.4	0.2	n/d	n/d	14	n/d	7	n/d	n/d	n/d	10.1	n/d	14
Laws on domestic violence[25]	13 countries	Yes	Yes	Yes	No	Yes	No (Bill approved)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Laws on sexual assault[26]	14 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Human trafficking laws[27]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexual harassment laws[28]	15 countries	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Integrated approaches: national action plans[29]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Accessible, affordable, and specialised services, including legal aid, to survivors[30]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Specialised facilities, including places of shelter and safety[31, 32, 33]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comprehensive treatment, including post-exposure prophylaxis (PEP)[34]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

SDG Target achieved
2021 Milestone achieved | Achieved target: continue existing efforts to sustain and further the gains made
-1% to -14.9% | Target not achieved: sustain and expand efforts in order to reach the target.
-15% to -29.9% | Target not achieved: review existing efforts and make considerable investments in order to reach the target.
30% or more | Target not achieved: review and make signicicant efforts to achieve the target.
No target set
N/A - Not applicable
No Data | No Milestone set

[17] United Nations, Sustainable Development Goal SDG Tracker, Our World in Data, https://sdg-tracker.org/gender-equality, accessed: 18 June 2021.
[17] 'WorldsWomen2015_chapter6, https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf, accessed 18 June 2021.
[17] WHO, Intimate partner violence prevalence data by country, World Health Organization, https://apps.who.int/gho/data/view.main.IPVv, accessed 18 June 2021.
[17] Statistique (INSTAT), I.N. de la and ICF (2022) 'Enquête démographique et de santé à Madagascar (EDSMD-V) 2021', https://dhsprogram.com/publications/publication-FR376-DHS-Final-Reports.cfm, accessed: 2 September 2022.
[17] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2022.
[17] Statistique (INSTAT), I.N. de la and ICF (2022) 'Enquête démographique et de santé à Madagascar (EDSMD-V) 2021', https://dhsprogram.com/publications/publication-FR376-DHS-Final-Reports.cfm, accessed: 2 September 2022.
[17] 'WorldsWomen2015_chapter6, https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf, accessed 18 June 2021.
[17] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2022).
[17] Gender Links, (2019) 'Audit of SRHR Laws and Policies in SADC', Gender Links, https://genderlinks.org.za/gmdc/publications/audit-of-srhr-laws-and-policies-in-sadc/, accessed 18 June 2021.
[17] Gender Links (2019) 'Audit of SRHR Laws and Policies in SADC', Gender Links, https://genderlinks.org.za/gmdc/publications/audit-of-srhr-laws-and-policies-in-sadc/, accessed 18 June 2021.
[17] United States Department of State (2020),Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.
[17] Gender Links (2019) 'Audit of SRHR Laws and Policies in SADC', Gender Links, https://genderlinks.org.za/gmdc/publications/audit-of-srhr-laws-and-policies-in-sadc/, accessed 18 June 2021.
[17] Gender Links, Policy and action plans, https://genderlinks.org.za/what-we-do/justice/policy-and-action-plans/, accessed 18 June 2021.
[17] Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/, accessed: 18 June 2021.
[17] Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2020) SADC Gender Protocol 2020 Barometer. 13th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2020/, accessed: 18 June 2021.
[17] GBV Prevention Network (2018) Seychelles: Shelter for Women Victims of Violence Opens in Seychelles, https://preventgbvafrica.org/seychelles-shelter-for-women-victims-of-violence-opens-in-seychelles/, accessed 18 June 2021.
[17] UNFPA Comoros (2021) VBG_: L'UNFPA remet de matériels informatiques et de mobiliers aux comités de veille de Mohéli et d'Anjouan, UNFPA Comoros, https://comoros.unfpa.org/fr/news/vbg-lunfpa-remet-de-mat%C3%A9riels-informatiques-et-de-mobiliers-aux-comit%C3%A9s-de-veille-de-moh%C3%A9li-et, accessed 18 June 2021.
[17] Lowe Morna, C., Rama, K. and Chigorimbo, S. (eds) (2019) SADC Gender Protocol 2019 Barometer. 12th edn. Johannesburg: Gender Links, https://genderlinks.org.za/what-we-do/sadc-gender-protocol/sadc-protocol-barometer/sadc-gender-protocol-barometer-2019/, accessed: 18 June 2021.

Due to the aforementioned challenges in accessing current data, Table 6.2 mostly shares similar numbers to those in the 2021 Barometer. This 2022 Barometer added a new indicator on non-partner sexual violence to align reporting to the SADC Scorecard report.[35] It included two GBV indicators: 1) Proportion (%) of women and girls aged 15 years and older subjected to physical and sexual violence by a partner in the previous 12 months and 2) Non-partner sexual violence.

Both indicators add new information to this Barometer from country scorecards. They point to wide variances across the region. On the first indicator, Lesotho represents a low at 0.8% of women and girls older than 15 reporting physical and sexual violence, while almost half (43%) of Zambians reporting similar crimes. Meanwhile, only half the countries have data on non-partner sexual violence, which shows that one quarter of female respondents in the DRC reported this type of violence, compared to 2.9% in Botswana.

Only three SADC countries (Angola, Comoros and Malawi) have achieved their scorecard goals on the first indicator, with none doing so on the second. Indeed, most remain far off target.

Other indicators remain largely unchanged and, in most cases, quite dated. For more than a decade, GL worked to address these data gaps, spearheading seven comprehensive violence against women and girls (VAWG) and/or GBV baseline studies in Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia, and Zimbabwe (2010 to 2016) and a comprehensive follow-up study in Botswana in 2018.[36]

The existing data shows that:

- Only nine countries have data on the proportion of women who have experienced intimate partner violence (IPV) at least once in their lifetimes.[37]
- Thirteen SADC countries now have domestic violence legislation and 14 have sexual assault legislation. Lesotho approved its long-awaited Counter Domestic Violence Bill.
- The DRC and Tanzania have yet to enact specific domestic violence laws.
- All SADC countries except Angola now have legislation on sexual harassment and all 16 have human trafficking laws.

The latest DHS results for **Madagascar** show high instances of physical violence in the country for women aged 14-49. Activists have expressed deep concern over the increase in spousal injuries and the culture of silence, with half of women not seeking help or telling anyone.

Police at the Botha Bothe station in Lesotho share GBV data management tools in 2022.
Photo: Nyeoe Ntene

[35] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2022).
[36] The studies can be accessed on the GL website: https://genderlinks.org.za/what-we-do/justice/research/violence-against-women-baseline-research/
[37] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2022.

Table 6.3: Overview of Madagascar 2021 DHS findings on domestic violence

Area of concern	Findings
Experience of violence	35% of women aged 15-49 have experienced physical or sexual violence
Husband control	One in five women aged 15-49 (20%) reported experiences of at least three controlling behaviours from her husband or partner.
Intimate partner violence (IPV)	About four in ten women aged 15-49 (44%) experienced emotional, physical or sexual abuse perpetrated by a husband or partner at some point, and 27% reported experiences of one or more of these in the 12 months prior to the survey.
Spousal violence injuries	Among women aged 15-49 who experienced sexual or physical violence at any time, 37% resulted in injuries. In the last 12 months, this rose to 42%.
Seeking help	Among women aged 15-49 who experienced physical or sexual violence, 50% never sought help or told anyone, 19% never sought help but did tell someone about it, and 32% sought help to end the situation.

Source: 2021 DHS Madagascar Report.[38]

Table 6.3 underscores some of the most serious findings from the recent DHS study in Madagascar, illustrating the extent of VAW and controlling behaviours, as well as the challenges presented by stigma and fear, which prevent women from reporting these crimes. Periodic GBV statistics like these make a strong case for increased efforts on prevention. The statistics help show the magnitude and type of violence perpetrated, providing a clear argument for concrete actions and dedicated government budgets to reduce the violence.

Trafficking in persons (TIP)

SADC Gender Protocol Article 20.5: State parties shall:
(a) Enact and adopt specific legislative provisions to prevent trafficking in persons and provide holistic services to the victims, with the aim of re-integrating them into society;
(b) Put in place mechanisms by which all relevant law enforcement authorities and institutions should eradicate national, regional, and international trafficking syndicates;
(c) Put in place harmonised data collection mechanisms to improve research and reporting on the types and modes of trafficking to ensure effective programming and monitoring;
(d) Establish bilateral and multilateral agreements to run joint actions against trafficking in persons among origin, transit and destination countries; and
(e) Ensure capacity building, awareness raising and sensitisation campaigns on trafficking in persons exist for law enforcement officials.
SDGs 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking, sexual, and other types of exploitation; and 16.1 Significantly reduce all forms of violence and related death rates everywhere.

Human trafficking is on the rise globally and regionally because of the COVID-19 pandemic.[39] Despite this, the US State Department 2022 report on Trafficking in Persons shows that SADC leaders' heads remain buried in the sand on this issue, as 15 out of 16 countries have yet to meet even the minimum standards for the elimination of trafficking.[40] Other than Namibia, all SADC countries sit in the second tier position, representing nations that do not meet the minimum standards but are working to do so. Seven countries sit on the Tier 2 watch list (Comoros, DRC, Eswatini, Madagascar, South Africa, Zambia, and Zimbabwe), which represents countries with high rates of trafficking where policymakers have not taken proportional concrete actions to address it.[41]

Namibia retained its ranking in Tier 1 in 2022, making the country a model in combating trafficking in SADC. In 2022, the government continued implementing its 2019-2023 National Action Plan (NAP) on GBV, which addresses all forms of human trafficking, and the Ministry of Gender Equality, Poverty Eradication, and Child Welfare (MGEPECW) and other stakeholders drafted a new five-year NAP on Trafficking in Persons (2022-2027).

As reported in previous years, most SADC countries lack adequate victim identification and protection efforts, and show low conviction rates of traffickers. Several have laws on trafficking that do not align with the 2000 UN Trafficking in Persons Protocol. Factors promoting trafficking include porous borders, poverty and increasing reports on corruption.

In 2021, the UN General Assembly held a meeting to appraise the UN Global Plan of Action to Combat Trafficking in Persons. It noted that the COVID-19 pandemic, with its border closures and lockdowns, worsened existing risks, leaving more people vulnerable to poverty and exploitation.

Other than Namibia, SADC countries do not meet the minimum standards to address trafficking

Ghada Waly, director of the United Nations Office on Drugs and Crime (UNODC), noted the increase of online recruitment and anonymity, citing South Africa, which saw an increase in labour exploitation complaints during the pandemic. Another example from the DRC involved a scheme to target young people. They received an academic scholarship and airline tickets and then found themselves sexually exploited or forced into labour when they arrived at their destination.[42]

[39] COVID-19 and Crime: The Impact of the Pandemic on Human Trafficking, https://www.unodc.org/unodc/en/frontpage/2021/July/covid-19-and-crime_-the-impact-of-the-pandemic-on-human-trafficking.html, accessed 18 September 2022.
[40] United States Department of State (2022),Trafficking in Persons Report, https://www.state.gov/reports/2022-trafficking-in-persons-report/, accessed: 30 August 2022.
[41] United States Department of State (2022),Trafficking in Persons Report, https://www.state.gov/reports/2022-trafficking-in-persons-report/, accessed: 30 August 2022.
[42] COVID-19 an accelerator of human trafficking - UN, https://globalinitiative.net/analysis/covid-19-human-trafficking-un/, accessed on 18 September 2022.

Sexual harassment

SADC Gender Protocol Article 22.1: State parties shall enact legislative provisions and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres and provide deterrent sanctions for perpetrators of sexual harassment.

SADC Protocol Article 22.2: State parties shall ensure equal representation of women and men in adjudicating bodies hearing sexual harassment cases.

Sexual harassment is any form of unwanted words and/or actions of a sexual nature that violate a person's body, privacy, or feelings and make that person feel uncomfortable, threatened, insecure, scared, disrespected, startled, insulted, intimidated, abused, offended, or objectified.[43] It occurs in both the private and public spheres, including in many traditional contexts, formal and informal workplaces, the streets, public transportation, schools and universities, restaurants, malls, at home, in the company of others (family, relatives, and colleagues), and, increasingly, online.[44] Sexual harassment has remained a huge challenge in the SADC region, with a growing number of perpetrators using online anonymity to spread cyber misogyny, stalk women and share revenge pornography, which is the distribution of sexually explicit images or videos of individuals without their consent.

Research points to sexual violence and harassment towards women as a major contributing factor to women's mental health disorders, poor sexual and reproductive health (SRH), injuries and other chronic health conditions, the impact of which can last many years. Prevalence Estimates found that "violence against women is a public health problem of pandemic proportions."[45]

While 15 out of 16 SADC countries have sexual harassment legislation, the increase in new forms of violence, such as OGBV, limits the scope of existing laws. Escalating reports of online abuse and harassment during the pandemic point to the urgent need for countries to develop, adopt, and implement sufficiently stringent sexual harassment laws that include all the spheres in which abuse takes place.

Partner violence is a major contributing factor to women's poor sexual and reproductive health

[43] What is sexual harassment, https://harassmap.org/what-sexual-harassment, accessed: 8 September 2022).
[44] Ibid
[45] WHO. 2021. Violence against women prevalence estimates, 2018. Geneva: World Health Organization. https://www.who.int/publications/i/item/9789240022256, accessed 20 August, 2022.

Zimbabwe: Government approves new sexual harassment policy

A 2020 petition to get Zimbabwean lawmakers to review the country's labour act and address gaps around the issue of workplace harassment seems to have sparked political action, with activists celebrating the rollout of a new policy to create safer work environments in early 2022.

The Zimbabwean government approved the Public Service Sexual Harassment Policy in the first quarter of the year, which sets out to ensure safe workplace environments free from sexual harassment and provide redress to survivors of violence within the public service.

Civil society organisations engaged in nationwide consultations to review the country's Labour Act following the submission of the petition to Parliament in October 2020 by the Emthonjeni Women's Forum (EWF).

As reported in the previous Barometer, the petition called on lawmakers to undertake a comprehensive analysis of the Labour Act to address the scourge of sexual harassment in the world of work.

Speaking at the launch of the policy, Vincent Hungwe, chair of the Public Service Commission, said the policy seeks to address shortcomings in the public service to address sexual harassment. "There has been reluctance by victims to report sexual harassment incidents and cases due to various reasons, including fear of the unknown outcomes, fear of retaliation from the perpetrator, family or societal pressures," he noted.[46]

By establishing formal and informal complaints handling procedures, the new policy attempts to address some of the evident gaps in Public Service Act regulations, such as:

- Lack of an explicit provision for sexual harassment and penalties for it;
- The fact that victims must lodge complaints of sexual harassment with an immediate supervisor, even if they may be the perpetrator of the harassment; and
- There is no built-in dispute handling procedure for sexual harassment cases.

The policy covers some of the common behaviours and actions that constitute sexual harassment and extends to cover new non-verbal conduct such as sharing or displaying of sexually explicit or suggestive material including photographs, reading matter or objects, offensive screen savers, sexually-suggestive gestures, whistling, leering, and sending sexually explicit messages using electronic devices.

Source: Zimbabwe Sexual harassment policy, UNDP.

Government and UN Development Programme (UNDP) representatives launch Zimbabwe's Public Service Sexual Harassment Policy on 22 July 2022 in Harare.
. Credit: UNDP Zimbabwe/Valentine Gwerevende

Obstetric violence

Pregnant or birthing individuals can experience obstetric violence (OV), which includes physical, emotional, psychological, and sexual violence committed by healthcare practitioners, such as doctors, nurses and midwives. Until recently, this institutionalised form of VAW has received scant

[46] Milestone as Zimbabwe Government puts Sexual Harassment Policy in place | United Nations Development Programme, https://www.undp.org/zimbabwe/news/milestone-zimbabwe-government-puts-sexual-harassment-policy-place, accessed: 8 September 2022.

acknowledgement, even though it violates fundamental women's rights.

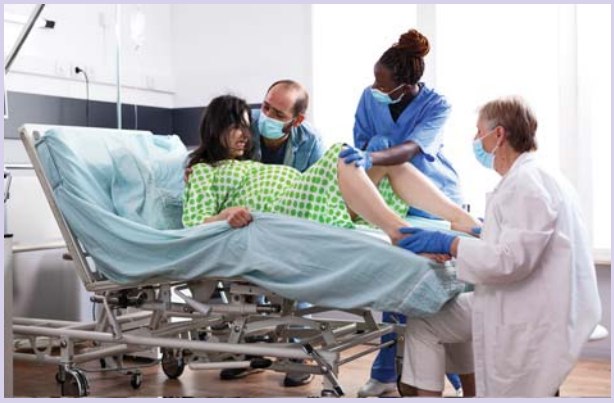
Fighting OV involves recognising the role gender inequality has in creating hierarchical dynamics between doctor and patient.[47] A 2019 analysis of factors that characterise OV showed that power disparities between doctors and patients discourage women from objecting to or speaking out against abusive practices. It also noted that obstetric violence is not limited to pregnant women, that healthcare practitioners mistreat specific groups of women, and that obstetric violence discourages women from consulting maternal health services or obstetrician-gynaecologists.[48]

South Africa: The dark side of birth: obstetric violence is a form of GBV[49]

Many pregnant mothers in South Africa have experienced a form of obstetric violence, an often-ignored form of GBV.

At 23, Nthateng (not her real name) shared one example of this along with the trauma she experienced in the childbirth process. It began with her partner calling an ambulance when she went into labour, which only arrived four hours later. When she finally made it to the hospital, healthcare staff refused to administer pain medication despite her frequent and desperate requests for it.

Instead, Nthateng says they told her to "stop being dramatic" and return to her bed. She did so, and laboured there alone and terrified. Eventually, her water broke and she could feel her baby's head with her hand. Feeling the sudden urge to push, she got off the bed, stood up, legs apart, and screamed loudly - a shout that helped alert a nurse, who came to her room to support the birth.



Women and girls in South Africa often face physical and psychological violence from healthcare providers during childbirth. Credit: @DCStudio

Still in incredible pain, she felt someone cut between her vagina and anus (a procedure known as an episiotomy) as part of the delivery. Afterwards, the healthcare staff neglected to show her Nthateng how to breastfeed or care for her new baby, her first. Yet she recalls nurses shouting at her when her baby cried, admonishing her for not keeping it quiet. She also recalled how another mom in the ward had a psychotic episode and the nurses did nothing to support the woman and instead stood nearby laughing. Now back home and caring for her newborn, Nthateng struggles to come to terms with the experience. The episiotomy means she feels constant pain alongside the exhaustion of being a new mother. She struggles to sleep as frequent nightmares remind her of her time at the hospital. She filed a formal complaint with the hospital and has had no response.

Obstetric violence often ignored

In 2019, the Commission for Gender Equity submitted a report to the United Nations Special Rapporteur that raises the alarm about this often-ignored form of GBV.[50] In it, the authors write "research and investigations conducted over

[47] Thelwell, K. (2020) 6 Things to Know About Obstetric Violence, The Borgen Project, https://borgenproject.org/obstetric-violence/, accessed: 7 September 2022.
[48] Bohren, M.A. (2019) 'How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys', 394, p. 14.
[49] Patterson, T.-L. (2021) The dark side of birth - obstetric violence is a form of GBV, Health-e News, https://health-e.org.za/2021/12/28/the-dark-side-of-birth-obstetric-violence-is-a-form-of-gbv/, accessed: 7 September 2022.
[50] Commission for Gender Equity 2019 Report to the United Nations Special Rapporteur, https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Commission for Gender Equality South Africa.pdf

the last two decades in South Africa have shown that women and girls seeking reproductive healthcare services in the public health system often face physical and psychological violence and mistreatment."

These acts of abuse and mistreatment include psychological abuse in the form of neglect, verbal assault; and discrimination and stigma based on age, gender, sexual orientation, race, class or HIV status. Physical abuse can include slapping, dragging, applying pressure to the abdomen during labour and isolating women in active labour as a form of punishment. OV also includes invasive medical procedures (such as vaginal and cervical examinations, C-sections, episiotomies and hysterectomies) when performed without informed consent or knowledge.

Access to reproductive healthcare is fundamental to women's autonomy over their bodies and their lives. A woman seeking reproductive healthcare has vulnerabilities in those moments, and these experiences have far-reaching effects on her health and the health of her child(ren). Any violence or harassment committed against women accessing reproductive healthcare reflects a serious violation of their human rights.

Obstetric violence is not new

Academic literature on obstetric violence in South Africa dates to a 1997 Medical Research Council (MRC) study of maternal health services in and around Cape Town.[51] It investigated nursing practices at healthcare facilities at the primary, secondary and tertiary levels. At all three tiers of the maternal healthcare system provided by the state, women reported humiliation, neglect and abuse. Researcher Rachelle Chadwick's 2016 guest editorial in the South African Medical Journey warns against the lack of accountability for medical professionals and institutions in South Africa.[52]

She writes, "Calls for legal action and the criminalisation of abusive practices by healthcare professionals are now gaining ground in the SA context. While it is true that the roots of abusive treatment are complex, including health system inadequacies, an insufficient emphasis on an ethics of care in midwifery training, poor working conditions, healthcare professional overload and historical legacies of inequalities, there is also no excuse for failure to hold individuals and institutions accountable for practices that dehumanise, degrade and cause harm to women and girls in some of their most vulnerable[53] moments (i.e. labour and childbirth)."

At crisis point

Although there is a lack of reliable quantitative data in relation to the prevalence of obstetric violence, activists have enough qualitative data to conclude that violence experienced by birthing persons represents a national crisis and should be on the national agenda. According to the auditor general's 2019-2020 report, the National Department of Health (NDoH) faced litigation claims totalling R147 billion ($7.2 billion). NDoH pays billions in medical negligence lawsuits at public hospitals, many connected to maternal and neonatal injuries and deaths. Medico-legal claims against the state are on the rise. They affect service provision and planned improvements.

COVID-19 impact

Even before the pandemic, South Africa had disparities in the spatial distribution of facilities and the availability of skilled birth attendants. Healthcare workers often report that they are under-supported and overworked, which leads to high levels of burnout. The COVID-19 pandemic has complicated this high-pressure situation as healthcare workers now work longer, more demanding hours, often without adequate personal protective equipment.

[51] Jewkes, R., Abrahams, N. and Mvo, Z. (1997) Study of health care seeking practices of pregnant women in Cape Town. Pretoria: CERSA-Women's Health, Medical Research Council. http://196.21.144.194/gender/pregnant.pdf.
[52] Chadwick, R.J. (2016) 'Obstetric violence in South Africa', South African Medical Journal, 106(5), pp. 423-424, https://doi.org/10.7196/SAMJ.2016.v106i5.10708.
[53] Cullinan, K. (2016) Mission impossible? Replacing abuse with empathy, Health-e News, https://health-e.org.za/2016/08/22/mission-impossible-replacing-abuse-empathy/, accessed: 7 September 2022.

Private healthcare is not exempt from these problems. In 2020, a Council for Medical Schemes (CMS) report argued that the high rate of malpractice litigation (a reported 98% of all legal claims in obstetrics relate to vaginal births) in private healthcare may be behind the climbing rates of medically unnecessary C-sections.[54] The CMS estimates that as many as 77% of C-sections have no medical justification, needlessly exposing women to possible complications of major surgery.

System-wide attention and solutions needed

Nthateng's experience is a symptom of a larger set of problems that demand system-wide attention and solutions. There is a need for stronger accountability mechanisms and transparency. Many women who try to get justice face denial, dismissiveness, and a general unwillingness to engage.

Source: Health e-News, by Nonkululeko Mbuli and Rumbi Goredema Görgens.[55]

Effects of GBV

Studies on GBV show that exposure to GBV leads to many adverse health outcomes.[56] This includes HIV and AIDS and other sexually transmitted infections (STIs), induced abortion, low birth weight and prematurity, harmful alcohol use, depression and suicidal tendencies, non-fatal injuries, and fatal injuries (intimate partner homicides).

In Sub-Saharan Africa, research has long identified GBV as a major determinant of HIV and AIDS infections among women. This has seen activists champion several interventions focusing on the eradication of violence against women to fight the spread of the HIV.

The recent Meta study on online violence showed how OGBV limits the innate rights to freedom of speech and association, and affects the livelihoods of women and girls.[57] Online exclusion due to OGBV bars them from accessing health, financial and educational resources, amongst other things. Many public goods and services are now available online. The drawback of this, however, is that many women and girls may not be able to access important information

Online exclusion due to OGBV bars women from accessing health, financial and educational resources

because they do not know where to find it or they worry about OGBV repercussions and risks.

This civic and social information represents an essential element of participation in democratic processes such as elections and referenda. When they lack it, women face alienation within their communities, often unable to apply for jobs or engage in electronic transactions. All of this holds women and girls back. It also impedes progress to achieving the SDGs, which include a goal aligned with access to basic services and states that governments should use technology to inform and empower women.[58]

[54] Council for Medical Schemes, Epidemiology and trends of caesarean section births in the medical schemes' population, 2015 - 2018, https://www.medicalschemes.com/files/Research%20Briefs/Caesarean%20section%20births%20-%20Research%20Brief%201%20of%202020.pdf
[55] Patterson, T.-L. (2021) The dark side of birth - obstetric violence is a form of GBV, Health-e News, https://health-e.org.za/2021/12/28/the-dark-side-of-birth-obstetric-violence-is-a-form-of-gbv/, accessed: 7 September 2022.
[56] García-Moreno, C. et al. (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: World Health Organization.
[57] Understanding-Online-GBV-In-Southern-Africa: An Analysis of eight country prevalence of digitally enabled gender-based violence.
[58] UN Sustainable Development Goals Indicators https://unstats.un.org/sdgs/metadata/?Text=&Goal=5&Target=5.b, accessed 18 November 2021.

Botswana: Lack of data inhibits support for sex workers facing violence, say activists

Sex workers across the region face stigma, police brutality, and discrimination from healthcare providers. They also face GBV but activists do not know how much or what types due to a persistent lack of data and documentation on the topic.

One 2016 study, the Sex Work and Violence in Botswana Needs Assessment, found that 66% of sex workers experienced violence in the year preceding the study, with clients and law enforcement representing the main perpetrators. Tosh Beka, Sisonke Botswana executive director, said sex workers also face a wide range of barriers to access justice in Botswana, both as victims of crime and if police charge them with crimes of prostitution. Selling sex is legal in the country, but soliciting it is illegal.

According to Beka, female sex workers experience an increased risk of physical and sexual violence along with stigma and discrimination. This increased during the COVID-19 pandemic as social media posts spread misinformation linking sex workers to the spread of the virus.

Moreover, accessing SRH services during the pandemic became more challenging although sex workers began using a mobile emergency response system to report cases of violations, some of which the system referred to Botswana Network on Ethics, Law and HIV and AIDS (BONELA) for investigation.

Most sex workers access health services from Botswana Family Welfare Association, a nationally recognised leader in SRH. "We have hotspots in some selected areas where we park our mobile clinic," said outgoing president of the Youth Action Movement, Precious Ndlovu. "We provide those who have tested HIV positive with antiretrovirals (ARVs), condoms, we provide pap smears, and our clients are checked every year or at least twice a year."

With the aim to ensure sex worker human rights become a reality, BONELA has called upon the government to take immediate action guided by human rights principles to promote, protect and satisfy the rights of sex workers.

BONELA and Sisonke Botswana also run Hands Off, which supports sex workers with psychosocial support and counselling, legal services, food packages and linkages with service providers including the police, emergency shelter and relief services.

But the groups say they need better data on the extent of GBV in the community to improve their impact and the lives of their sex worker clients. "Community attitudes need to change so that sex workers can come out in the open and access services, especially HIV services," said BONELA's Cindy Kelemi. "We also need comprehensive programmes to address the needs of children of sex workers who require life skills programmes and psychosocial services as they too become affected by what their parents do for a living."

Furthermore, she said, there is a continued need to support the removal of legal and health-related barriers and address stigma and discrimination through engagement with community leaders and members. She noted that the public should understand that sex work is work and that sex workers are part of our communities: they are mothers, sisters, and aunts, they engage in sex work to improve their socio-economic status. It is in the best public health interest to protect them.

Source: Lephoi, Keneilwe, GL News Service, Botswana.[59]

Activists take part in a sex worker rights protest in Western Cape in South Africa in 2021. Female sex workers in the region experienced an increased risk of physical and sexual violence during the COVID-19 pandemic.
Photo: Sisonke

[59] GBV Prevalence amongst Sex Workers Not Documented. GL News Service Sixteen Days of Activism News series.

Response

SADC Gender Protocol Article 20.1: States parties shall:
(a) Enact and enforce legislation prohibiting all forms of GBV;
(b) Develop strategies to prevent and eliminate all harmful social and cultural practices, such as child marriage, forced marriage, teenage pregnancies, slavery and female genital mutilation; and
(c) Ensure that perpetrators of GBV, including domestic violence, rape, femicide, sexual harassment, female genital mutilation, and all other forms of GBV are tried by a court of competent jurisdiction.
(d) **SADC Gender Protocol Article 20.6**: State parties shall ensure that cases of GBV are conducted in a gender sensitive environment.
(e) **SADC Gender Protocol Article 20.7**: State parties shall establish special counselling services, legal and police units to provide dedicated and sensitive services to survivors of gender violence.
SADC Gender Protocol Article 20.3: States parties shall review, reform, and strengthen their laws and procedures applicable to cases of sexual offences and GBV to:
(a) Eliminate gender bias; and
(b) Ensure justice and fairness are accorded to survivors of gender-based violence in a manner that ensures dignity, protection and respect.
SADC SRHR Strategy Outcome 10: Remove barriers - including policy, cultural, social, and economic - that serve as an impediment to the realisation of SRHR in the region (SDGs 5.1 and 5c).
Maputo Protocol 2(a): States parties shall take appropriate and effective measures to: Enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public.

Critical gaps still exist when it comes to the scope of legislation to respond to emerging and evolving forms of GBV, such as online violence

While the region has made progress on legislation dealing with GBV with specific laws and penal codes, critical gaps still exist when it comes to the scope of legislation to respond to emerging and evolving forms of GBV such as online violence.[60] The following sections focus on legislation around OGBV, delving further into some of the regional updates and presenting possible entry points where lawmakers could amend existing legislation to encompass online violence and harassment.

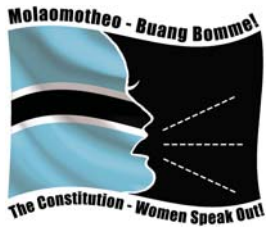
In **Angola**, the 2017 Computer Networks and Systems Protection Law provides for security on the internet.[61] It states that internet providers should promote the registration of users and the implementation of measures and tools for the anticipation, detection and reaction to security risks on their networks. This provision clearly promotes backdoor surveillance through the mandatory registration of internet users. While freedom of expression

[60] SADC regional strategy and 2018-2030 Framework of Action
[61] Angola Computer Networks and Systems Protection Law 7 of 2017.

and privacy activists criticise this feature, others see it as a positive way to protect women in the online space, as it aims to protect all users connected to different platforms and telecommunications service providers in Angola. The Electronic Communications Law (No. 23/11 of 20 June 2017) provides for the protection of citizens online.[62] Article 15 refers to the "protection of citizens in the use of ICTs." It provides for the right to confidentiality of communications, the right to privacy of personal information, including the right of access and consultation, and the right to use this information in strict compliance with constitutional principles and applicable legal rules.

Botswana's 2008 Domestic Violence Act of 2008 set out to protect women from abuse perpetrated within domestic relationships.[63] While the law does not specifically address OGBV, it refers to harassment that may occur electronically via sending, delivering or causing the delivery of letters, telegrams, packages, facsimiles, electronic mail or other objects to someone's home or work.[64] The law, which aims to address GBV in totality, albeit in the context of domestic violence, could be a point of reference for advocates looking to bring in greater specificity on OGBV. The government passed the Cybercrime and Computer Related Crimes Act 2018 to respond to cybercrime and computer-related crimes, and to facilitate the collection of electronic evidence. The law is meant to respond to, and keep up with, new crimes such as cyberterrorism, money laundering, trafficking of illegal and harmful chemicals, cyberstalking and cyber harassment.[65] It also has sections on offensive electronic communication, pornographic or obscene material and non-consensual sharing of material.

In 2022, Botswana struck a group, known as the Dibotelo Commission or the Presidential Commission of Inquiry into the review of the Constitution of Botswana, to support a constitutional review. Representatives of all five major political parties and seven women's rights organisations, with tech-nical support from GL, the UN Resident Coordi-nator's Office in Botswana, UN Women East and Southern Africa Regional Office (ESARO) and the Southern Africa Multi Country Office (SAMCO) made a submission to the commission.



A submission by the group Molaomotheo-Buang Bomme (*The Constitution: Women Speak out*) argues that a compelling reason for the review of Botswana's 55-year-old Constitution is to ensure compliance with global, African, and Southern African regional commitments to attain gender equality.

Key recommendations made on the topic of protection from violence state that government should:

- Guarantee the Constitution includes a section that addresses GBV specifically.
- Be obliged to protect and secure citizens, e.g. Section 12(1) (c) Provision of comprehensive services, including dignified reporting spaces, expedient case management, and closed courts.
- Enhance Section 7 of the Botswana Constitution (Protection from Inhuman Treatment). This could include language on human dignity, for example, Section 10 of the South African Constitution.
- Have a mandatory requirement for the protection of citizens against sexual harassment in all institutions. It noted that having a sexual harassment policy should be a prerequisite for the registration of all, inclusive of political parties, and
- Add in Sec 16 (1): "If he or she has been convicted of any GBV offense," as a criterion for disqualifications for membership of the National Assembly.[66]

[62] Angola Electronic Communications Law 23 of 2011.
[63] UN Women 'Global Database on violence against women' https://evaw-global-database.unwomen.org/en (accessed 13 November 2021).
[64] Botswana Domestic Violence Act 10 of 2008.
[65] C Swanka 'Botswana reviews Cinematography Act to boost creative economy' Sundat Standard 2 September 2019 https://www.sundaystandard.info/botswana-reviews-cinematography-act-to-boost-creative-economy/ (accessed 13 November 2021).
[66] Molaomotheo- Buang Bomme! Submission Paper to the Dibotelo Commission.

Namibia's Cybercrime Bill has languished in draft form since 2013. Government last updated it in 2019.[67] Among other things, it seeks to address electronic harassment and abuse. For instance, in chapter 4, section 14, the Bill stipulates, "a person who intentionally posts or sends [a harmful] data message, or who intentionally causes such a data message to be displayed, commits an offence." Once convicted, offenders must pay a fine not exceeding N$10 000 ($570), or the case may result in imprisonment for a period not exceeding two years. While this section deals with non-consensual sharing of images, cyber threats and serious harms to reputations, it makes no specific reference to women, girls and the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) community as members of society requiring special considerations.

Mozambique has no specific legislation to protect women online; the legal frameworks on women's rights are outdated or have no provisions of relevance for OGBV. This is despite the fact that its constitution clearly establishes total gender equality in all areas of society. It also prohibits all legislative, political, cultural, economic, and social discrimination (Articles 6, 67, and 69). According to Article 6, all citizens are equal before the law, enjoy the same rights and are subject to the same duties, regardless of colour, race, sex, ethnic origin, place of birth, religion, level of education, social position, marital status of the parents or profession. Article 67 states that men and women are equal before the law in all spheres of political, economic, social and cultural life.

Malawi's Penal Code contains provisions that could tackle online violence. It dates back to 1930 and contains archaic language that does not apply to current circumstances. Nonetheless, it includes the offence of insulting the modesty of a woman in section 137. The justice system could use this provision to prosecute those who commit online violence, for example, the non-consensual sharing of intimate images of the victim or others and using profane language against women. Another noteworthy cybersecurity-related law is the 2016 Electronic Transactions and Cyber Security Act (ETCS Act). Leaders also developed a National Cybersecurity Strategy. The ETCS Act establishes a Malawi Computer Emergency Response Team (MCERT) that could support the fight against OGBV. Section 6(2) of the ETCS Act states "the Malawi CERT shall take charge of its information infrastructure protection actions and serve as a base for national coordination to respond to information and communication technology security threats." The Act highlights offences related to computer systems such as child pornography,[68] cyber harassment,[69] offensive communication,[70] and cyberstalking,[71] among others. This is the only act in Malawi that speaks directly to OGBV; however, the country has yet to see it used for in such a case.

Women take part in online training courses during the 16 Days Activism in Curepipe Council, Mauritius, in 2013. Photo: Mary Coopa

South Africa developed a 2020-2030 national strategic plan (NSP) on ending GBVF, which, amongst other things, deals specifically with OGBV.[72] The NSP, an output of the 2018 Presidential Summit in response to the GBVF crisis, aims to provide a multi-sectoral, coherent strategy, policy and programming framework to strengthen a coordinated national response to GBVF by the govern-

[67] Council of Europe 'Namibia: Cybercrime policies/strategies' https://www.coe.int/en/web/octopus/country-wiki-ap/-/asset_publisher/CmDb7M4RGb4Z/content/namibia?_101_INSTANCE_CmDb7M4RGb4Z_viewMode=view/, accessed 3 November 2021.
[68] Electronic Transactions and Cyber Security Act 33 of 2016 sec 85- 'child pornography' is a direct quote from the Act, however the widely accepted terminology is child sex abuse material.
[69] Electronic Transactions and Cyber Security Act 33 of 2016 sec 86.
[70] Electronic Transactions and Cyber Security Act 33 of 2016 sec 87.
[71] Electronic Transactions and Cyber Security Act 33 of 2016 sec 88.
[72] National Strategic Plan on Gender-Based Violence and Femicide 2020 https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf, accessed 8 November 2021.

ment and the country as a whole.[73] The national strategic plan acknowledges the existence of OGBV in the activities, outcomes and outputs outlined in the document. It defines it as any act of GBV against a woman that is committed, assisted or aggravated in part or fully by the use of ICTs, such as mobile phones, the internet, social media platforms or email, against a woman because she is a woman, or affects women disproportionately. Its interventions include addressing online violence and it recognises the specific vulnerability of young women in facing a disproportionate level of online violence.[74] It calls for technology intermediaries to adhere to human rights standards to protect women's rights on online platforms and new technologies. It also calls for the design and roll out of disability-accessible cyber violence and cyber awareness programmes that promote online safety. The NSP requires capacity building for police, prosecutors and the judiciary on emerging cyber threats and it fast tracks legislative measures to address inadequate management of OGBV cases. It notes the need for a deepened understanding of the impact of online violence on women and LGBTIQ persons and potential strategies to address it.[75]

After protracted years spent passing its Domestic Violence Bill, **Lesotho** legislators moved a step closer to enacting the much-anticipated law to address domestic violence in the country.[76] In March 2022, the National Assembly approved the Counter Domestic Violence Bill, 2021. If passed into law, it will ensure Lesotho upholds its commitments to the 2009 AU Gender Policy, 2008 SADC Protocol (as amended), 1997 SADC Declaration on Gender and Development, and 1995 CEDAW.

The bill seeks to abolish abusive practices that degrade children and women, such as forced marriages, the practice of marrying off widows to brothers of their deceased husbands, and the practice of marrying off men to their infertile wives' sisters. It also criminalises incest, in particular sexual relations between parents and their children. The bill will apply to people in domestic relationships and it recognises the discrimination experienced by people because of their age, disability, sexual orientation and gender identity.

> A new Domestic Violence Bill in Lesotho will abolish practices such as forced marriage

The bill affords victims protection in the form of court orders known as protection orders to prohibit perpetrators from doing certain acts. Activists expect it to provide for the establishment of a family court to handle cases arising out of family squabbles as well as hear cases of domestic violence. It also provides for the establishment of restorative justice councils, at which village chiefs will guide proceedings.[77]

In June 2020, **Zambia**'s cabinet passed a resolution to approve the African Union Convention on Cybersecurity and Personal Data Protection. This ensures harmonisation of the new cyber laws and regional cooperation on matters of cybersecurity, cybercrime and data protection. Following this, in March 2021, Zambia passed three ICT-related laws: The Cybersecurity and Cybercrimes Act, Data Protection Act and Electronic Commerce and Transactions Act (reviewed).[78] Of these, the Cybersecurity and Cybercrimes law provides general protections for OGBV. It criminalises the following offences: pornography,[79] child sexual abuse,[80] child solicitation,[81] production, possession and

[73] Ibid
[74] National Strategic Plan on Gender-Based Violence and Femicide 2020 https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf, accessed 8 November 2021.
[75] Ibid
[76] Victory in sight for domestic violence victims - Lesotho Times. Available at: https://lestimes.com/victory-in-sight-for-domestic-violence-victims/ (Accessed: 8 September 2022).
[77] Ibid
[78] The Electronic Commerce and Transactions Act of 2009 was reviewed and unbundled to form the current ECT Act, Data Protection Act and Cybersecurity and Cybercrimes Acts.
[79] Cybersecurity and Cybercrimes Act 2 of 2021 sec 56.
[80] Cybersecurity and Cybercrimes Act 2 of 2021 sec 57.
[81] Cybersecurity and Cybercrimes Act 2 of 2021 sec 58.

circulation of obscene matters or things,[82] unsolicited electronic messages,[83] hate speech,[84] and harassment using electronic means.[85] For instance, it notes, "a person shall not produce or participate in the production of pornography using a computer system. A person convicted of an offence under subsection (1) is liable to a fine not exceeding five hundred thousand penalty units or to imprisonment for a period not exceeding five years, or both."[86] The provision on pornography criminalises and discourages all non-consensual sharing of private images and content through production, distribution, selling, procuring, or circulation.

While there is no reference to online violence in **Zimbabwe**'s Domestic Violence Act, (DVA (2006), lawmakers there gazetted a Cyber Security and Data Protection Bill on 15 May 2020. Enacting it will create the following noteworthy offences, which address OGBV and attract a penalty or a fine or imprisonment for a period not exceeding ten years, or both. These include:

- The transmission of data messages inciting violence or damage to property;
- The sending of threatening data messages;
- The generation and sending of any data message to another person, or posts on any material whatsoever on any electronic medium accessible by any person, with the intent to coerce, intimidate, harass, threaten, bully or cause substantial emotional distress, or to degrade, humiliate or demean the person of another or to encourage a person to harm himself or herself;
- The distribution, making available or broadcasting data concerning an identified or identifiable person knowing it to be false, intending to cause psychological or economic harm; and
- The transmission of data with intimate images without consent.[87]

Support

SADC Gender Protocol Article 23.2: State parties shall ensure accessible, effective and responsive police, prosecutorial, health, social welfare and other services to redress cases of GBV.

SADC Gender Protocol Article 23.3: State parties shall provide accessible, affordable, and specialised legal services, including legal aid, to survivors of GBV.

SADC Gender Protocol Article 23.4: State parties shall provide specialised facilities including support mechanisms for survivors of GBV.

If survivors of GBV face impediments that deny them access to justice in "normal" times, what happens during a pandemic? Jarpa Dawuni, the founder of the Institute for African Women in Law, notes that the COVID-19 pandemic brought "new challenges to judiciaries, and applying a gendered lens to these challenges... highlights extra layers of concerns for women's ability to safely, promptly and efficiently access justice."[88]

[82] Cybersecurity and Cybercrimes Act 2 of 2021 sec 59.
[83] Cybersecurity and Cybercrimes Act 2 of 2021 sec 62.
[84] Cybersecurity and Cybercrimes Act 2 of 2021 sec 65.
[85] Cybersecurity and Cybercrimes Act 2 of 2021 sec 69.
[86] Ibid
[87] Cyber Security and Data Protection Bill 2019 clauses 164, 164A, 164B, 164C and 164E.
[88] The Gendered Face of COVID-19: Women and Access to Justice, https://www.unodc.org/dohadeclaration/en/news/2020/04/gendered-face-of-covid19-women-and-access-to-justice.html, accessed 18 September 2022.

Challenges include legal costs, transport costs to health care facilities, and subjective costs that link to religion, stigma, and tradition. More than ever, state parties must amplify and accelerate survivor-centred approaches that aim to empower the survivor, prioritising the rights, needs, and wishes as well as offering multiple SRHR services to women and girls as they seek to redress cases of GBV. Dedicated funding from governments remains essential as well as collaborative partners to sustain the minimum support mechanisms for survivors of GBV.

As a way of increasing outreach to GBV survivors, the **Zimbabwe** government, with support from the Spotlight Initiative to eliminate GBV, has launched a mobile one-stop centre. "We are taking services to the people," Sithembiso Nyoni, minister of women affairs, community, small and medium enterprises, said at the launch. This innovative approach adds to the existing brick and mortar one-stop centres in Harare, Makoni, Gwanda, Gweru, Rusape, Chipinge and Chinhoyi. Altogether, these centres have assisted more than 8000 survivors to access health, legal, counselling, psychosocial and protection support, with victims of sexual violence accounting for 65% of that number.[89] The mobile centres also respond to concerns of SRH service disruptions during pandemic lockdowns and concerns about a lack of privacy at police stations and health centres for those reporting abuse.

In addition, Nyoni's ministry launched and operationalised a national GBV web-based information portal in collaboration with the Anti Domestic Violence Council of Zimbabwe.[90] Its purpose is twofold: to promote and facilitate access to available services for GBV survivors from community to national level, and to aid GBV service providers in coordinating their own efforts. The portal also serves as a repository of key documents and data resources on GBV in Zimbabwe.

Zimbabwe launched a mobile one-stop centre for GBV survivors who may not be able to access in-person services

Economic justice

Widespread lack of economic independence for women restricts economic growth in SADC and hinders progress on women's economic empowerment efforts across the region. Evidence shows that women constitute more that 50% of the poorest segment of the SADC population.[91] Countries will only sustainably address poverty rates when they can guarantee access and participation of women in all economic sectors. Economic empowerment of women not only positively influences their personal financial situations; it is also central to mobilising their potential for sustainable development and poverty alleviation.

Since 2001, GL has worked with more than 2000 women to document their experiences of GBV as part of its "I" Stories series.[92] In these first-hand accounts of GBV, women have repeatedly said they stay in abusive relationships because they have no choice due to a lack of economic independence. In her article *South Africa:*

[89] 'Healthtimes (2019) 'Zim Launches Mobile One Stop Centres For GBV Survivors', HealthTimes, 6 December, https://healthtimes.co.zw/2019/12/06/zim-launches-mobile-one-stop-centres-for-gbv-survivors/, accessed: 10 September 2022.
[90] GBV Portal, https://www.zimgbvportal.org.zw/about/, accessed: 10 September 2022.
[91] Southern African Development Community: Women Economic Empowerment Programme, https://dev-www.sadc.int/issues/gender/women-economic-empowerment-programme/, accessed: 10 September 2022.
[92] 'I' Stories - Gender Links, https://genderlinks.org.za/what-we-do/justice/i-stories/, accessed 1 July 2021.

Needed - New approaches to ending GBV,[93] GL's Special Advisor, Colleen Lowe Morna, mentions that, "the slogan 'voice and choice' is meaningless to those who do not have the economic means to exercise their agency."

> The COVID-19 pandemic eroded women's economic independence, and increased unemployment and the burden of unpaid work

The COVID-19 pandemic further eroded women's economic independence, and increased unemployment and the burden of unpaid work. More than ever, lawmakers face an urgent need to adopt gender-responsive laws and policies to mitigate these challenges and reduce women's economic dependency on male partners. As the "I" Stories noted, this dependency prevents many women from reporting abuse.

During the opening of the Women Economic Assembly to empower women (WECONA) in October 2021, South African President Cyril Ramaphosa noted that the economic empowerment of women represents one of the pillars of the country's National Strategic Plan of Gender-Based Violence and Femicide. "By improving the economic circumstances of women, we are reducing their vulnerability to abuse and violence," he said. "By being less economically dependent on male partners, women have a better chance of leaving an abusive relationship." WECONA has its eyes on government's commitment to ensure that 40% of all government procurement ends up in the hands of women.[94]

The Sunrise Campaign - empowering women to end violence

In 2013, GL piloted a programme entitled *Empower Women: End Violence*. Known as the Sunrise Campaign, the group employed it to test the hypothesis that increasing women's agency, confidence and economic power would result in less violence for women in relationships and more control over their lives. Results to date show a strong positive correlation between women's economic independence and sustainable solutions to GBV.

The campaign's entrepreneurship course targets survivors of GBV and combines life skills to enhance confidence and agency with basic business skills. While GBV debilitates and destroys self-worth, business builds confidence, negotiation skills, innovation, and resilience. The two forms of training thus complement each other. A unique feature is that local councils have undergone a ten-stage process to become

Centres of Excellence (COEs) for gender in local government anchor the course. The councils include support for survivors of GBV as part of their GBV and local economic development action plans.

The programme has evolved over the years to include handing over primary management to the COEs, a mentorship component, and working with men. In 2021, GL worked with women and girl survivors in Eswatini, Lesotho, Madagascar, Mauritius and South Africa to exercise #Voiceand Choice through increased agency and economic power to prevent GBV and take control of their lives.

[93] Colleen. L. Morna 'South Africa: Needed - new approaches to ending GBV', Women's Voice and Leadership SA, http://www.wvlsa.org.za/south-africa-needed-new-approaches-to-ending-gbv/, accessed: 10 September 2022.
[94] Ibid.

Table 6.4: Sunrise Campaign reach in three countries, 2021-2022

Country	Number of councils	Number of women trained	Number of men trained	Number of councils that completed life skills training	Number of councils that completed men's workshops	Number of councils that completed action planning workshops
Eswatini	12	204	180	12	12	6
Madagascar	13	283	144	13	13	16
South Africa	19	326	173	13	11	6
Total	**44**	**813**	**497**	**38**	**36**	**28**

Source: GL Sunrise Campaign programme August update.

Men, including perpetrators of violence, took part in GBV training and prevention workshops led by GL in Anatanamitarana, Madagascar, in 2021. Photo: Zotonantenaina Razanadratefa

Table 6.4 shows that, by August 2022, GL had worked with 813 women and 497 men from 44 councils in the three countries. GL has also worked with all the councils to review and revise their GBV and Local Economic Development (LED) action plans. The plans include yearlong GBV campaigns. The process began in November 2021 when councils conducted stocktaking exercises during the 16 Days of Activism. To facilitate learning and sharing, all the women entrepreneurs signed up to WhatsApp groups.

"I" Stories from participants in the programme show positive changes in participant businesses and increased personal agency in their lives.

"I am Nomathemba Tema, I am in my 50s. I am from Midvaal in South Africa. My husband and I got into a fight and decided to separate. We had kids together. When we separated, he then got a girlfriend. I did not work or have any financial support since he took care of everything. The girlfriend did not want the kids around and she did not want my husband to support them financially. I refused to send my kids to my husband and his girlfriend. That is when our communication stopped, he also stopped visiting the children and stopped his financial support.

Along my journey I was introduced to GL. I have learned a lot, I gained wisdom, knowledge and skills. After everything that has happened in my relationship and through the help of GL, I told myself that I do not rely on anyone to support me financially, so I started looking for jobs and tried opening up a business so that I am able to support my children. I also used to struggle with low self-esteem, but now my confidence is back and I am happy that I am strong and I do not give up easily. All these because of GL. Thank you GL. I am happy and grateful to be one of your products."

During 2021, GL began working with significant males in the lives of the women and girls, while ensuring that it did not put survivors at risk. The workshops occurred under the banner *Engaging men in GBV prevention*, with the key objectives:

- Understanding what the different forms of gender-based violence are and their impact on survivors.
- Identify ways that men can contribute to GBV prevention.

GL completed training with more than half of the men targeted in the project in Eswatini, Madagascar and South Africa. As shown in the "I" Story below, some men showed appreciation and willingness to engage other men to transform their relationships and end violence against women.

"I am Fani Johannes Maphupha, 48 years of age, living in Lebowakgomo. I am a married man with two kids. I perpetrated GBV for many years. I used to beat my wife whom I really love, because of lack of communication with my wife. I pushed my wife to be someone she is not. Now I am totally a changed man, but I still need professional help because, at the end, I want to be someone who takes care of her and loves her. I will be happy when you can organise me help like counselling. My intention is to help other men. I know, a lot of men are afraid to come out and speak about gender based violence. I want to build a better relationship my wife and I know it should firstly start with me."

Training of service providers

SADC Gender Protocol Article 24: State parties shall introduce, promote, and provide:
(a) Gender education and training to service providers involved in GBV including the police, the judiciary, health, and social workers;
(b) Community sensitisation programmes regarding available services and resources for survivors of GBV; and
(c) Training of all service providers to enable them to offer services to people with special needs.
BPFA +20 Africa Declaration (4.1): Enact and strengthen the enforcement of laws addressing and punishing all forms of violence against women and girls through adequate resource allocation and targeted capacity-building of law enforcement agencies, including the judiciary.

Effective response and support to GBV requires SADC countries to invest in continuous training and education of service providers involved in GBV, including the police, the judiciary, health, and social workers. This is important in addressing new forms of violence such as online violence, and new challenges with old problems, such as those linked to escalations in trafficking in persons and the clinical management of rape victims.

In **Malawi**, the Ministry of Gender, Community Development and Social Welfare, with support from CARE Malawi, trained 133 gender service providers on GBV case management in the context of COVID-19 in 2020.[95] These comprise police victim support units (VSUs) social welfare personnel, child protection officers and psychosocial service providers. The support included training community victim support members in six districts.

[95] Buliyani, B. (2020) 'Care Malawi invests in GBV response', The Nation Online, 29 July, https://mwnation.com/care-malawi-invests-in-gbv-response/, accessed: 10 September 2022.

Prevention

SADC Gender Protocol Article 21.2: State parties shall, in all sectors of society, introduce and support gender sensitisation and public awareness programmes aimed at changing behaviour and eradicating GBV.

Eliminating GBV is not a one-off event with clear timelines but a process that takes into account many factors, including identifying risk factors and the inclusion of programmes and actions that target behaviour change in perpetrators. Emerging forms of GBV require innovative strategies and campaigns to tackle these new forms of violence.

All 16 countries in SADC have campaigns and awareness programmes around GBV prevention. They actively employ social media, including TikTok, Twitter, Facebook, WhatsApp, and Instagram, especially during the annual 16 Days of Activism against GBV.

A 2020 *Her Voice* campaign poster from South Africa's KwaZulu-Natal province. Photo: Coastal Resources Centre

SADC: Case studies from South Africa and Malawi highlight innovative approaches to GBV prevention

We Will Speak Out coalition works with faith communities to end SGBV

We Will Speak Out South Africa (WWSOSA) brings together a coalition of more than 200 individuals along with non-governmental, community, and faith-based organisations.

Its vision for transformed, just and reconciled communities in which SGBV does not destroy lives, has remained consistent since Tear Fund South Africa, Sonke Gender Justice, Christian Aid, the Bureau of Southern Africa, Zoe-Life, and SGBV survivors founded it in 2013.[96]

The impetus for the coalition links to a Tear Fund study that found faith-based communities and institutions often failed survivors, even though they represent the first place many turn for help following abuse.[97] The core purpose of WWSOSA, therefore, is to work with progressive elements in the faith sector to educate and equip faith leaders and members to speak out and act against SGBV, and to mitigate the negative impact on SGBV survivors and their families.[98]

[96] We Will Speak Out South Africa. Not dated. Full Application submitted to Gender Links for the WVL Networking Grant.
[97] WWSOSA: Faith communities ending sexual and gender-based violence. Annual Report for period August 2019 to December 2020.
[98] WWSOSA. Not dated. Full Application submitted to Gender Links for the WVL Networking Grant.

WWSOSA implements an array of projects across four pillars of work that underpin the coalition's ultimate objective: (1) supporting a vibrant and vocal GBV survivor movement; (2) equipping the faith sector; (3) joint advocacy; and (4) engaging men and boys in support of women and girls in ending GBV. The coalition mainstreams the work in Pillar 4 work into all other organisational work and activities.[99]

Organisational documents emphasise that WWSOSA prioritises SGBV survivors as the group most affected by, and most knowledgeable about, effective GBV survivor support services.[100] In this regard, WWSOSA supports the Phephisa Network for GBV survivors, which runs survivor support groups.[101]

We Will Speak Out South Africa (WWSOSA) members work to equip the faith sector with skills to support SGBV survivors. Credit: WWSOSA

WWSOSA's mobilisation work helps the faith sector understand the complexity of SGBV and the role that it can play in addressing harmful social norms. This includes conveying positive and healthy theological messages and offering safe spaces and practical support to survivors."[102]

A secondary aim is to increase the credibility of the faith sector and to include it as an effective partner in efforts towards achieving the objectives of the National Strategic Plan (NSP) to end SGBV and Femicide (NSP).[103] Methods include training, conferences, networking, and alliance building.

"We work with pastors, with church leaders, and we talk to them about how they treat survivors," said one focus group participant from WWSOSA. "We talk to them about changing the language that they use in church, and we help them to take the appropriate steps to help survivors. We are making sure that faith-based organisations become safe places for women."[104]

The six-month Faith Leaders' Gender Transformation Programme is one example of training, which, according to WWSOSA, aims "to gradually shift the dominant narrative in the faith sector by growing an online community of learning comprising change agents in a wide variety of faith communities."

WWSOSA provided extensive input on the NSP to end GBV and Femicide at national and provincial (KwaZulu-Natal) level. WWSOSA focused its contribution on pillars two and four of the NSP, which respectively address prevention, and care and support.[105]

Taking GBV prevention and response to World Bank project sites

In line with its legislative commitments to address GBV, the Government of Malawi committed to ensuring that all World Bank-funded projects consider GBV risks at implementation and build on national systems to provide survivor-centred care.

While these efforts alone will not eradicate GBV, they take an important systematic step to preventing and responding to violence against women and girls.

World Bank-funded projects in Malawi now approach GBV in several innovative ways. The survivor-centred response ensures that all World Bank-financed projects acknowledge the distinctive GBV risks for different stakeholders over the

[99] WWSOSA: Faith communities ending sexual and gender-based violence. Annual Report for period August 2019 to December 2020.
[100] WWSOSA implements an impressive array of related projects.
[101] Ibid.
[102] Ibid.
[103] WWSOSA: Faith communities ending SGBV. Annual Report August 2019 to December 2020.
[104] Rapid Response Teams Focus Group participant.
[105] Ibid

lifetime of a project. Programmes prioritise survivor's interests, treating them with dignity and respect. Further, all response systems look at the various needs of women and men who have experienced violence, whether it is someone to talk to, urgent health care treatment, or legal aid. Many survivors understand their own needs best as they navigate stigma and community networks after experiencing violence.[106]

Using the World Bank's environmental and social frameworks as an entry point, administrators assess every World Bank-funded project for GBV risks. Based on the risks assessed, the Government of Malawi implements certain measures. As a priority, all workers must be trained and sign a code of conduct. Other measures include creating or strengthening systems for survivors to report violence and ensure safe and confidential referral to service providers. For example, in Chikwawa District, the World Bank-funded Shire Valley Transformation Project revamped the services of an existing one-stop centre ensuring a survivor could easily access different services under one roof (legal, medical, counselling and security).[107]

Finally, the scheme prioritises extensive collaboration with women's organisations and government departments that work to address GBV.

Sources: M. Weideman, Women's Voice and Leadership in South Africa (WVL SA) Mid-term Monitoring and Evaluation Report Draft, and Elita Thokozani Chayala; Davies Madalitso Luhanga, and Tanya D'Lima for the World Bank Blog.[108]

Role of the media

SADC Gender Protocol Article 29.7: State parties shall take appropriate measures to encourage the media to play a constructive role in the eradication of GBV by adopting guidelines which ensure gender-sensitive coverage.

The Protocol urges the media to ensure gender equality in and through the media and to challenge gender stereotypes. The Protocol also discourages media from promoting pornography and violence against all persons, especially women and children.[109]

The role of print and electronic media in raising public awareness on GBV prevention, response, and support, especially in this information and digital age, cannot be over-emphasised. Media represents an integral component of creating a gender just society - through factual reporting, influencing political discourse and actions on eliminating GBV, and distilling myths and negative attitudes. This role is especially critical as countries recover from the COVID-19 pandemic, and as citizens of SADC look to the media for accurate information, including on the emerging threats presented by climate change, the monkeypox virus, and political instability. Organisations and governments must continue to find ways of collaborating with media to mount campaigns on GBV.

[106] https://thedocs.worldbank.org/en/doc/741681582580194727-0290022020/original/ESFGoodPracticeNoteonGBVinMajorCivilWorksv2.pdf
[107] http://www.svtp.gov.mw/
[108] Tackling gender-based violence at project sites in Malawi, https://blogs.worldbank.org/nasikiliza/tackling-gender-based-violence-project-sites-malawi, accessed: 10 September 2022.
[109] SADC Protocol on Gender and Development Article 29 (1-7).

Zimbabwe: A survivor's story shows the essential role of media in preventing GBV

Tendai Makombe, a GBV survivor with a disability, said listening to media stories about GBV survivors finding justice gave her the courage to report her abuser.

The visually impaired mother of two enjoys listening to podcasts and other media through a phone application that converts text to audio.

"My daughter used to read newspapers for me all the time when she got home from school," she said. "Our neighbour would give us old newspapers from the previous week. People did not understand how a blind woman could love the news so much. But I got help from [GBV support network] Musasa project... after I read about how other women got help."

Makombe is one of many media consumers benefiting from innovations that help information reach new audiences through less conventional methods. She is also one of many survivors who draw strength from the stories of other survivors.

Sibongile Mpofu, a lecturer at the National University of Science and technology whose research focuses on gender and the media, said media coverage of GBV issues in Zimbabwe occurs mostly during the short period encompassing the 16 Days of Activism.

"The coverage of GBV issues in Zimbabwe is scant and very often event-driven," she said. "Even in the instances where such stories are covered, they often are not contextualised and as a result these GBV stories do not speak to the wider political economy as well as socio-cultural issues."

Journalism lecturer Sibongile Mpofu argues that media coverage of GBV in Zimbabwe is inadequate and mostly shoehorned into the annual 16 Days of Activism. Credit: NUST

Zimbabwe has signed various international and regional instruments that promote gender equality and denounce GBV. Its constitution upholds these commitments at national level. However, Makombe's story illustrates how gaps exist in disseminating these human rights to average citizens as well as how policymakers and others can help fill them.

COVID-19 showed that further innovation remains essential to tell the full GBV story, requiring the media to be alive to changing audience patterns and employ a multimedia approach to reach wider and more diverse audiences.

Source: Extract from Zimbabwe journalist Andile Tshuma's piece for the GL News and Feature Service 16 Days of Activism News series.

Digital media: A fertile ground for OGBV

As noted earlier, Article 29 of The SADC Protocol discourages media from promoting pornography and violence against all persons, especially women and children.[110] Despite this, the scourge of online violence appears to be unrelenting. The 2021 SADC OGBV study by Meta in eight countries notes that, "hate speech, misogyny, dark forms of participation, information disorders and online gender-based violence (OGBV) have become the norm."

Despite the benefits associated with the acquisition and use of digital technologies, the proliferation of ICTs has contributed to the challenges faced by women and girls, including fuelling digitally enabled GBV. The results of the study, which underscore the underreporting of violence described in previous studies by GL and the DHS surveys, are summarised below:

In the case of **Angola**, research revealed that online activists and journalists face targeted threats, although they deal with less violence and harassment than journalists who operate mainly in the traditional media sphere. Some independent online news outlets reported receiving regular calls from government officials who direct them to tone down criticism or refrain from reporting on certain issues.

In **Botswana**, the research found incidents of cyberbullying, harassment and many other forms of OGBV, particularly online abuse of women campaigners and activists. Incidents of cyberbullying have increased due to growth of internet usage, and researchers suspect that most of these cases go unreported in the country.

The **Namibia** report chronicles an environment in which online violence thrives in the absence of appropriate legislation. Existing laws are outdated, gender blind and at most leave legal interpretations to the courts. The lack of gender-disaggregated data on online violence hampers reporting and consequent action in dealing with online violence in the country. Female journalists, women politicians and other women in public roles represent those most targeted, while non-consensual image sharing is amongst the top forms of online violence.

> Incidences of online violence often stem from events occurring offline, which then spread onto online platforms

Researchers found that incidences of online violence in **Malawi** often stem from events occurring offline, which then spread onto online platforms. For instance, in 2019, WhatsApp groups became awash with a video of men from an opposing party attacking and stripping a woman because of the political regalia she wore. Police eventually arrested the men and charged them with insulting the modesty of a woman, robbery, and use of force.

The **Mozambican** report highlights the launch of digital platforms aimed at promoting young people's political participation, especially women. It chronicles the inner workings of Txeka, a digital platform for promoting political participation. It also shares information about an e-platform called Nyandayeyo, which means "help," created with the sole intention of fighting against domestic violence.

[110]SADC Protocol on Gender and Development Article 29 (1-7).

In **South Africa**, research suggests that incidences of OGBV occur primarily on prominent platforms such as Facebook and WhatsApp. Facebook does not require the verification of users who sign up for these services (such as providing a phone number), which makes it easier for those looking to remain anonymous while using the platform. The South African report underscores the fact that most LGBTIQ youth resort to measures such as blocking, deleting offensive content and adjusting privacy settings to cope with cyber victimisation.

The **Zambia** report found that OGBV manifests in the country as cyber-bullying, trolling, hate speech, body shaming and non-consensual sharing of intimate images and videos. These harmful tactics usually target female politicians or political aspirants, socialites, media personalities, activists, bloggers and ordinary female internet users, especially those who regularly share their views online.

In **Zimbabwe**, female politicians, human rights defenders and journalists have also been on the receiving end of OGBV. Journalists such as Ruvheneko Parirenyatwa and Samantha Musa (MisRed) regularly face online attacks. For others, this scourge manifests in the form of cyberbullying and sharing of non-consensual intimate images. Zimbabwe witnessed a rise in GBV cases by more than 40% during the COVID-19 pandemic, as recorded in 2020 through the national GBV hotline operated by Musasa, a civil society organisation focused on GBV.

These findings by Meta show that the most vulnerable groups - women and girls - often have no voice to fight back against OGBV.[111] The absence of specific legal frameworks to protect them against the growing issue is an indictment against lawmakers in the region. Governments must collect and analyse data to understand the manifestation of OGBV so they can protect those they serve.

Restorative justice

SADC Gender Protocol Article 20.4: State parties shall put in place mechanisms for the social and psychological rehabilitation of perpetrators of GBV.
SADC Gender Protocol Article 23.5: State parties shall provide effective rehabilitation and re-integration programmes for perpetrators of GBV.

Data on rehabilitation and reintegration programmes for perpetrators remains scarce in SADC. Men, especially current or ex-partners, represent the main perpetrators of VAW due to many factors, especially negative social constructions of masculinity. Gender activists note that progress in engaging men and boys to desist or prevent violence against women and girls remains sluggish. Part of the social and psychological rehabilitation must start within homes by encouraging men and boys to take the lead as gender champions and drivers of change within communities.

[111] Understanding-Online-GBV-In-Southern-Africa: An Analysis of eight country prevalence of digitally enabled gender-based violence.

Local council teaches youth champions to be community influencers

Look no further than youth if you want to address toxic masculinity and its effect on high rates of GBV.

That's the message underscoring the work of Kanana Council in Lesotho, which trains youth to critically interrogate toxic masculinity and become champions for gender equality and eliminating GBV.

"If we do not take the lead to be examples in our homes, and show the boys how it is done and how they can become better, we will not overcome this issue of abuse as it starts within our homes and with us," says Liteboho Selia one of the council's youth champions.

Violence against women and girls has always bothered Selia, but until he got involved with the council, he did not know how to do anything about it.

In 2021, he participated in adolescent SRHR action planning to learn how to work together with other men to eliminate cases of GBV. He said the training was exactly what he needed.

He learned about the Nokaneng smartphone app, developed by GL Lesotho in partnership with the Ministry of Gender and Youth, Sports and Recreation, Vodacom Lesotho, Main Level consulting and Partnership for the Prevention of Violence Against Women and Girls. The app educates women about their rights and shares services available for GBV. Selia now shows the app to others in his community and teaches them how to use it.

Because many consider it a woman's chore, Liteboho Selia does the laundry in his home in Kanana, Lesotho (pictured in 2021), purposely modelling by his behaviour his efforts to interrogate stereotypes linked to toxic masculinity.
Photo: Nyeoe Nten

His conversations helped him understand men better so he can show young boys how to behave in their homes and how they should treat women. He believes the best time to train boys is while they are still young so they can grow into responsible and compassionate men who respect the women in their lives.

Source: GL Lesotho.[112]

Integrated approaches

SADC Gender Protocol Article 25: State parties shall adopt integrated approaches, including institutional cross-sector structures, with the aim of eliminating GBV.

[112]GL Lesotho local government case studies.

Lack of collaboration often derails progress in efforts to address GBV within and across SADC countries. A multi-stakeholder approach improves coordination and collaboration among different stakeholders and subsequently enhances efficiency in eliminating GBV. While all SADC countries have created national action plans (NAPs) to end GBV, some have become outdated, and others await approval. The bigger point, however, is that NAPs require dedicated funding throughout the planning period to realise any meaningful change. Otherwise, countries will accomplish only marginal gains.

South Africa: GBVF summits both launch and track government progress

In November 2018, South Africa hosted its first Presidential Summit on GBVF following mounting pressure to address the scourge of violence. The summit produced the first ever declaration signed off by civil society organisations and the president committing to end the scourge of GBVF in South Africa, along with the development and subsequent implementation of a NAP on GBV and Femicide. Government also committed R12 billion ($680 million) over three years to implement this work.

While these notable achievements point in the right direction, feminists and women's rights activists worry about stalled progress in meeting the 24 demands put forward by the #TotalShut down movement. The establishment of a National Council on GBVF to coordinate the NSP remains pending. Women activists argue that there has been too much talk and too little action and accountability, especially on how government uses the allocated funds.

In 2021, government requested a second summit, a proactive move that illustrates its commitment; calling for all hands on deck to reduce the high levels of GBVF. Coordination for a second summit began in 2022, including plans to hold nine provincial summits in advance on the themes of accountability, amplification and acceleration.

The Call to Action Civil Society Collective (The Collective), a feminist group of like-minded organisations and individuals, met in July 2022 to take stock of government's progress to date.

Its members define the Collective as a space that provides a platform for networking and providing support for other organisations through education, peer support, networking and for amplification, signal boosting, sharing challenges and resolutions and healing.[113]

The Collective wants South African leaders to prioritise the following six pillars and corresponding issues and needs at the second summit.

Pillar 1: Accountability, governance and coordination

- Understand what various government departments have been able to do and read the NSP to understand the State's responsibility.

[113]CallToAction Summit Planning and Movement Building Report.

Pillar 2: Prevention and building social cohesion

- Fix and create infrastructure that creates an enabling environment for prevention interventions such as streetlights, and police visibility.
- Integrate prevention interventions against key populations (LGBTIQ, persons with disabilities, etc.) and with broader GBV prevention and violence prevention interventions.
- Monitor and evaluate the South African Police response to GBV.

Pillar 3: Justice, protection and safety

- Effectively train and sensitise officials working in the criminal justice system including court personnel.
- Decriminalise sex work.
- Clear the backlog of cases related to GBV and upgrade the case management system.
- Create a countrywide femicide watch system.
- Make information on cases available for victims to access and track progress.
- Intervene to respond to specific barriers that all victims may face in accessing services, and specifically people with disabilities and LGBTIQ persons.

Pillar 4: Response, care support and healing

- Increase state funding for civil society work.
- Remove victim addresses from protection orders to strengthen the safety of survivors.

Pillar 5: Economic power

- Address the pay gap between women and across sectors.
- Implement policies to address gender disparities across sectors.

Pillar 6: Research and information systems

- Coordinate between Pillar 6 and all other pillars to identify specific knowledge gaps that research and information can assist.
- Research case studies on GBV successes then replicate and scale them.
- Align an Afro-Feminist approach to research and information development and dissemination.

Source: CallToAction Summit Planning and Movement Building Report.

In **Zimbabwe**, decision-makers signed the Spotlight Initiative High Level Political Compact (HLPC) on ending Gender Based Violence and Harmful practices.[114] The HLPC initiative commits government to implementing an effective GBV approach in partnership with a range of key stakeholders and partners.[115] Speaking at the launch, President Emmerson Mnangagwa noted, "It is my conviction that accelerated, adaptive and innovative implementation of global, regional and national commitments as outlined in the Action Plan of this HLPC will lead to our ultimate aspiration of a Gender Based Violence free society by 2030."

Zimbabwe remains the only SADC country to launch and operationalise a multi-sectoral and high-level compact on elimination of VAWG under the Global Spotlight Initiative. The compact serves as a model and a good practice that other countries should seek to learn from and replicate within their jurisdiction.[116]

Zimbabwe President Emmerson Mnangagwa launches the High Level Political Compact in Harare in October 2021. Photo: UNDP

[114] High Level Political Compact on Ending Gender Based Violence and Harmful Practices in Zimbabwe | United Nations Development Programme, https://www.undp.org/zimbabwe/publications/high-level-political-compact-ending-gender-based-violence-and-harmful-practices-zimbabwe, accessed: 8 September 2022.
[115] Ibid.
[116] Ibid.

Next steps

- **GBV data collection and information management**: Member countries must embrace the development and operationalisation of GBV data portals. These ensure easy access to data, assist with coordination and minimises gaps in critical indicators, such as on IPV.

- **Prevention**: Member countries need to invest in the primary prevention of GBV. This includes mobilising and sensitising diverse communities about the important role they play in preventing GBV by addressing harmful social norms, structures that support gender inequality, and the general acceptance of VAWG.

- **Media coverage**: Member states and activists within them should continue to utilise the expanding digital media space to promote GBV stories for relevant audiences, including minority and diverse groups.

- **Support**: Decision-makers should embrace survivor-centred approaches in GBV service provision. States should adopt and expand perpetrator rehabilitation programmes and ensure support facilities serve male victims of violence. It is critical to also ensure data for rehabilitation programmes is readily available to enable tracking.

- **Integrated approaches**: There is need for member states to continue strengthening forms of GBV coordination using clear frameworks at country and regional levels, including private partnerships, which remain largely untapped. This includes dedicated funding for developing and implementing costed SGBV action plans.

- **Campaigns**: Cascade campaigns such as the Sunrise campaign to local councils as part of their local economic development initiatives.

- **Diverse groups**: The region urgently needs specific guidelines for inclusion and accessibility to clarify how to provide access to SRHR, HIV and AIDS, and GBV services for diverse groups, including women with disabilities and members of the LGBTIQ community.

- **Online violence**: Intensify public education in the region on digital rights and collectively create reliable data that informs strategies and programme implementation to curb online violence.

- **Evolving forms of GBV**: Countries must urgently review legislation and expand legislative scope to respond to emerging and evolving forms of GBV, including online sexual harassment, stalking, and controlling behaviours.

- **Obstetric violence**: Continue efforts by governments and NGOs to end mistreatment perpetrated by health practitioners. This will improve the physical and mental welfare of women and children and save governments money in legal fees.

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Harmful Practices 7

Instances of child marriage increased across SADC as the COVID-19 pandemic led to lockdowns, school closures and economic strife.
Photo: Gender Links

KEY POINTS

- The negative effects of the COVID-19 pandemic continued to wreak havoc in the region, including in contributing to high numbers of girls who did not return to school due to teenage pregnancy.
- Zimbabwe passed a new Marriages Act that unequivocally punishes child marriage with sentences of up to five years for engaging in any action that leads to, or has potential to result in, child marriage.
- In a ground-breaking case, the Constitutional Court of Zimbabwe increased the age of sexual consent from 16 to 18 years in line with the age of consent to marriage and the definition of a child in its constitution.
- Lesotho continued with, and Botswana embarked on, a constitutional review process. Both countries still have constitutional clauses that allow for discrimination based on customary and personal law. Gender activists hope legislators will amend these during the respective review processes.
- South Africa gazetted a constitutional amendment to make sign language the country's 12th official language.
- After 16 years of advocacy to end child marriage, activists in Mauritius celebrated when the country's lawmakers promulgated a new Children's Act, which bans the practice.
- In Lesotho, the Senate stalled efforts to amend the Laws of Lerotholi to provide for widows' inheritance rights, with some senators arguing they do not have authority to amend these historic laws.
- Zimbabwe launched a National Disability Committee to spearhead the implementation of its new National Disability Policy.
- New research points to increasing rates of female genital mutilation in South Africa.

Introduction

From female genital mutilation (FGM) to child marriage and customary laws that prevent women from owning land, harmful practices that restrict the rights of women, girls and children persist throughout the Southern African Development Community (SADC) region. The COVID-19 pandemic has increased their prevalence in some parts of the region, risking gains made over the past several decades. This chapter examines the causes and effects of these harmful practices in Southern Africa, including on people with disabilities. It explores the constitutional and legal provisions to address them; access to justice; marriage and family rights; child marriages; their impact on people with disabilities; and the rights of widows and widowers.

The context of the COVID-19 pandemic provides a timely framing for this research, which looks at recovery efforts, the possibility of future pandemics and emergencies, and the need for measures to build resilient communities and end harmful practices through law and policy, practice and actions. Because most systemic crises remain gendered, recovery efforts to "build back better" likewise require responses that thoroughly incorporate gender considerations.

Despite the many difficulties caused by the COVID-19 pandemic, SADC countries have continued efforts to provide policy and legislative frameworks for the protection of the rights of women, girls and other vulnerable and marginalised persons. The following examples illustrate some of this important work over the past year:

- South Africa gazetted its 18th constitutional amendment to make sign language the country's 12th official language;
- Zimbabwe launched a National Disability Committee to spearhead the implementation of the National Disability Policy;
- The promulgation of the Marriages Act in Zimbabwe unequivocally bans and criminalises child marriages;
- South Africa advanced the development of a new marriage law regime, which will be put to cabinet for approval by March 2023 as a new legislative framework;
- Lesotho continued a constitutional review process, which started in 2019 and will conclude before year-end; and
- Botswana embarked on a constitutional review process, with public hearings to conclude by 30 September 2022.

South Africa's Department of Basic Education reported that 46 000 pupils did not return to school after COVID-19

Challenges and setbacks in other areas also punctuated the past 12 months, including limited progress in the Democratic Republic of the Congo (DRC) in passing a planned Disability Bill, and in Tanzania, where legislators delayed critical amendments to the country's Marriages Act. Further, Lesotho lawmakers failed to pass long-awaited constitutional modifications before the dissolution of Parliament on 14 July 2022. Among other things, the reforms sought to address traditional and customary law practices that rob women and girls of their rights.

Although COVID-19 pandemic infection rates in Southern Africa have decreased, the outsized impacts of the pandemic, and its disproportionate impacts on women and girls continue to reverberate across the region. Countries have struggled to get tens of thousands of children

who dropped out of school because of the pandemic back into classrooms, including many adolescent girls forced into child marriage or exposed to teenage pregnancy. Recent research shows that gender-related vulnerabilities and inequalities due to COVID-19 place female learners in South Africa at high risk of disengagement from the school system.[1] The Department of Basic Education reported that about 46 000 pupils did not return to school after COVID-19. While researchers did not disaggregate the data by sex, they note that many girls dropped out due to pregnancy.[2]

In August 2020, Zimbabwe introduced a law to enable pregnant girls to return to school as the country faced an unprecedented number of girls dropping out due to pregnancy during the early days of the COVID-19 pandemic. However, practical difficulties of reintegrating the girls back into schools due to stigma and resistance from other students and communities rendered the legislation largely unsuccessful despite government efforts to relax procedures. In 2018, 3000 girls dropped out of school nationwide due to pregnancy; in 2019, the number remained almost the same. It jumped to 4770 in 2020 and a high of 5000 in 2021.[3] Countries across the region saw similar spikes during this period.[4]

The COVID-19 pandemic also negatively affected economies in Southern African countries, at both national and household levels. This resulted in reduction in services and efforts to help women and girls escape harmful practices as lawmakers diverted national budgets to pandemic expenses such as providing vaccines and personal protective equipment. As the region recovers, rebuilding efforts should include reinstating all budget lines linked to eliminating harmful practices such as child marriage. This includes research, public policy interventions, social interventions, and health services that address the needs of girls and women affected by, and at risk of, harmful practices.[5]

A Zambian community comes together to protest child marriage. Photo: Albert Ngosa

[1] Duby, Z. et al (2022) 'Navigating Education in the Context of COVID-19 Lockdowns and School Closures: Challenges and Resilience Among Adolescent Girls and Young Women in South Africa', Frontiers in Education, p. 1
[2] 'School dropouts open up on tough choice between survival and education', Eyewitness News, https://ewn.co.za/2022/01/31/school-dropouts-open-up-on-tough-choice-between-survival-and-education, accessed 20 July 2022
[3] 'Zimbabwe encourages teenage girls to return to school after giving birth during COVID-19', abc News, https://www.abc.net.au/news/2022-01-30/zimbabwe-encouraging-teenage-mothers-to-return-to-school/100788702, accessed 20 July 2022
[4] MIET Africa, The Impact of COVID-19 on Adolescents and Young People in the Southern African Development Community Region, available https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 20 July 2022
[5] UNICEF Technical Note on COVID-19 and Harmful Practices, https://www.unicef.org/media/67506/file/TechnicalNote-COVID-19-and-HarmfulPractices-April%202020.pdf

Table 7.1: Key indicators on harmful practices

	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Constitution																
Constitution has clawback clauses	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No	No	No	No	No
Constitution addresses contradictions between the constitution, laws and practices	Yes	No	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Early child marriages																
Minimum legal age of consent to marriage for women	15	21 21 18	18	15	16	16	18	18	18	18	18	15	18	15	21	18
Minimum legal age of consent to marriage for men	18	18 10 Data not	18	18	18	18	18	18	18	18	18	18	18	18	21	18
Exceptions for women	15	available	A judge can authorise marriage younger than 18 in certain cases and if both parties consent	None	Possible, no age	Possible, no age	Possible, no age	None	16	None	Possible, no age	Possible, no age	None	Supreme Court ordered govern-ment to ban marriage of children younger than 18	16	None
Exceptions for men	16		A judge can authorise marriage younger than 18 in certain cases and if both parties consent	None	Possible, no age	Possible, no age	Possible, no age	None	16	None	Possible, no age	Possible, no age	None	Legislation under appeal	16	None
Percentage young women married by age 18[6]	30		32	37	5	16	40	42	Data not available	53	7	Data not available	4	31	29	34
Percentage young women married by age 15	8		10	10	1	1	12	9	Data not available	14	2	Data not available	1	5	6	4

Source: Gender Links (2019) and Girls Not Brides; https://data.unicef.org/country/ accessed 27 June 2021.

[6] UNICEF Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/, accessed 19 June 2021.

The key indicators in Table 7.1 show that, despite significant progress over the years, countries must do more to bring in progressive policies and align their constitutions with the SADC Protocol on Gender and Development (the SADC Protocol). For example, six of the 16 constitutions still have clawback clauses that take away non-discrimination protections for women and girls. Six constitutions also have different ages of consent for marriage between girls and boys, with girls invariably getting permission to marry before reaching age 18. These countries have constitutionally sanctioned child marriages, making it difficult to challenge this harmful practice within national legal systems.

The percentage of young women getting married before age 18 is worrying. Mozambique ranks highest on this indicator, with 53% of young women married as minors, followed by Malawi at 42% and Madagascar at 40%. South Africa has the lowest percentage of young women married before they turn 18 (at 4%) followed by Eswatini (5%) and Namibia (7%). Child marriage rates in all other countries stand at 10% or more. This illustrates that this harmful practice remains widespread and will require significant work, including legal and constitutional reforms, to eradicate it.

Constitutional and legislative provisions

Article 4:1: State parties shall enshrine gender equality and equity in their constitutions and ensure that any provisions, laws, or practices do not compromise these.
Article 6: State parties shall review, amend, or repeal all discriminatory laws and specifically abolish the minority status of women.

To adhere to the SADC Protocol, member states need to ensure that their constitutions do not compromise key gender provisions. Constitutions, being the supreme law of a country, should generally reflect accepted principles of equality and democracy. These include provisions for non-discrimination based on sex, marital status, promotion of gender equality, removal of clawback clauses, and addressing contradictions between the constitutions, laws, and practices.

In 2022, **Botswana** embarked on a broad-based constitutional review process.[7] Botswana is one of the few countries in Southern Africa that still allows for discrimination based on customary law and personal law. Section 15 (4) (c) of its constitution allows for discrimination based on "adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law," and section 15 (4) (d) allows for discrimination based on customary law. Most discrimination and harmful practices faced by women and girls in Botswana link directly to customary and personal law.

As the country engages in conversations around the development of a revised constitution, activists expect legislators to remove clawback clauses from the constitution and other statutes. It is important to recognise that lawmakers in other countries discarded similar discriminatory constitutional provisions in constitutions following consultative constitutional reviews and reform

[7] Constitutionnet (2022) In Botswana, president appoints constitutional review Commission, https://constitutionnet.org/news/botswana-president-appoints-constitutional-review-commission, accessed 21 July 2022.

processes. Examples include the 2013 Constitution of Zimbabwe. To date, legislators have ensured that Botswana's constitutional review process is broad-based, consultative and participatory, which should ensure that they capture citizens' views on these and other matters. Gender Links has also been documenting women's voices in the constitution-making process in Botswana.

Botswana: Women speak out as part of constitutional review process

To ensure that decision makers hear and reflect women's voices in the constitution-making process and within the new constitution, Gender Links worked with women, women's rights organisations and other interest groups in Botswana to shape their submissions to the Presidential Commission of Inquiry into the Review of the Constitution.

Starting in 2021, Gender Links held three academies on women's political participation: in Palapye (November 2021), Francistown (December 2021), and Gaborone (February 2022).[8] Through the SADC Gender Protocol Alliance, Gender Links also created a roadmap for participation, including the creation of strategic alliances with non-governmental and religious organisations religious, farmers' associations, trade unions, the Botswana Music Association, and the Constitutional Review Commission, amongst others. The Alliance also held meetings with these actors to capture their views in the proposed new constitution.

In its written submission in June 2022, the women's alliance, led by Gender Links, noted, "One of the most compelling reasons for the review of Botswana's 55- year-old Constitution is to ensure compliance with global, African and Southern African commitments to attain gender equality."[9]

In its recommendations, the Alliance proposed the introduction of a standalone chapter on women's rights, reinforcing the principles of non-discrimination based on gender. Such a chapter,

Women take part in the Gender Links constitution academy in Palapye, Botswana, on 9 November 2021. Photo: Gender Links

it submitted, must provide for policy and legal measures aiming at accelerating the elimination of discrimination against women and promoting gender equality.

It also recommended the removal of provisions that exempt issues such as family matters, and the introduction of provisions on compliance of all laws, including customary law, with international human rights standards.[10] More than 225 individuals and organisations subsequently endorsed the written submission: 194 from Botswana, 27 from Southern Africa and eight from other regions of the world.[11]

On 25 July 2022, Gender Links' coordination work led to an oral submission to the Presidential Commission into the Review of the Constitution by a women's coalition called Women Speak Out. It comprised women from all five major political parties, women's rights organisations and civil society partners.

Source: Gender Links.

[8] Gender Links (2021) Concept Note on Women's Political Participation and the Constitution, https://genderlinks.org.za/wp-content/uploads/2022/03/BotswanaWPP_conceptnoteWPPandConstitutionUPDATED_clm_032022.docx, accessed 17 August 2022.
[9] Gender Links (2022) Submission to the Presidential Commission of Inquiry into the Review of the Constitution of Botswana (The Dibotelo Commission), https://genderlinks.org.za/wp-content/uploads/2022/06/BotswanaConstitutionSubmissionGender_062022.pdf, accessed 19 August 2022.
[10] Gender Links (2022) Submission to the Presidential Commission of Inquiry into the Review of the Constitution of Botswana (The Dibotelo Commission), https://genderlinks.org.za/wp-content/uploads/2022/06/BotswanaConstitutionSubmissionGender_062022.pdf, accessed 18 August 2022.
[11] Gender Links (2022) Botswana Women Speak Out on Constitution, https://genderlinks.org.za/news/bots-women-speak-out-present-submission-to-dibotelo-commission/ accessed 19 August 2022.

Table 7.2: Key gender provisions of SADC Constitutions

Country/Constitution	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Provides for non-discrimination generally	Yes, Article 23	Yes, Section 15	Yes, Article 2	Yes, Articles 11, 12 and 13	Yes, Section 20	Yes, Chapter II, Sections 1 and 18	Yes, Article 8	Yes, Section 20	Yes, Article 3	Yes, Article 35	Yes, Article 10	Yes, Article 27	Yes, Chapter 1	Yes, Article 13	Yes, Article 23	Equality and Non-Discrimination Section in the Declaration of Rights
Provides for non-discrimination based on sex specifically	Yes, Article 21	Yes, Section 3	Yes, Article 2	Yes, Articles 14, 36 and 45	Yes, Section 20	Yes, Section 18	Yes	Yes, Article 20	Yes, Section 16	Yes, Article 36	Yes, Article 10	No	Yes, Chapter 2, Section 9	Yes, Article 9	Yes, Article 23	Section 23, Declaration of Rights
Provides for non-discrimination on the basis of sex and others e.g. marital status, pregnancy	Yes, Article 21	Yes, Section 15	Yes, Article 2 (sex only)	Yes, Articles 40	Yes, Section 20 (2)	Yes, Section 18	Yes, Article 8	Yes, Sections 13 and 20	Yes, Section 16	Yes, Article 39	Yes, Article 14	Yes, Article 30	Yes, Section 9	Yes, Article 16	Yes, Article 23	Section 23, Declaration of Rights
Provides for the promotion of gender equality	Yes, Articles 21 and 35	No	Yes, Articles 3, 34, 38, 61	Yes, Article 14	Yes, Section 28	Yes, Chapter III, Sections 26 and 30	Yes	Yes, Article 13	Yes, Article 16	Yes, Article 120	Yes, Article 95	No	Yes, Section 9	Yes, Article 66	Yes, 231	Gender equality a Founding Value and Principles; gender balance a National Objective
Has other provisions that relate to gender equality	Yes, Articles 36 and 77	No	Yes, Articles 34, 38, 61	Yes, Article 16	Yes, Section 28	Yes, Section 26	Yes, Article 17	Yes, Sections 19 and 18	No	Yes, decrimina-lisation of homo-sexuality and termination of pregnancy	Yes, Article 8	No	Yes, Section 12	Yes, Article 13	Yes, Articles 45, 69 and 231	The Declaration of Rights in the new Constitution has been expanded to include equality and non-discrimination
Addresses contradictions between the constitution, laws and practices	Yes, Article 239	No	No	No	Yes, Section 2 and Article 20	Yes, Section 18	Yes, Article 160	Yes, Article 5	No	Yes, Article 143	Yes, Article 19	Yes, Article 5	Yes, Chapter 7, Sections 15 and 30	Yes, Article 30	Yes, Article 1(1)	Lawmakers began a law review and reform process following the 2013 elections, but progress has been slow in achieving alignment

Source: Gender Links.

Table 7.2 provides a synopsis of some of the key constitutional provisions on gender in all SADC countries, noting that:

- All SADC constitutions provide for non-discrimination generally.
- All SADC constitutions (except Seychelles) provide for non-discrimination based on sex, specifically. They also (including Seychelles) provide for non-discrimination on the basis of sex and others, e.g. marital status and pregnancy.
- The constitutions of Botswana and Seychelles do not provide for the promotion of gender equality.
- The constitutions of some countries, including Lesotho and Botswana, still allow for discrimination based on personal and customary law. Because of this and because reform efforts remain incomplete, women and girls still face discrimination and experience a plethora of harmful practices in these countries.

Efforts to review some of the constitutions and related legislative provisions continue in several countries in the region, despite challenges and delays. In addition to the Botswana constitutional review process, Lesotho lawmakers continue to undertake political and constitutional reform efforts. Whilst originally framed from a political perspective, Lesotho's constitutional review process has provided an opportunity to address other flawed aspects of its constitution, including those impacting women and girls.

The Expert Report on Constitutional Reforms (incorporating public consultations and submissions) recommended reforms addressing various harmful practices against women and girls. It suggested creating a unified and expanded Bill of Rights and the removal of section 18 of the Constitution: a clawback clause allowing for discrimination based on customary and personal law. The report identified this section as a major constitutional impediment to the rights of women and girls and recommended a change to succession and inheritance laws that perpetuate discrimination against women and girls.[12]

The constitutions of Botswana and Seychelles do not provide for the promotion of gender equality

The constitutional review also addressed disability, land ownership, age of majority, chieftainship, and religion and religious rights.[13] All these issues represent significant concerns for women and girls' rights in the country as attendant practices have led to discrimination against them. Unfortunately, lawmakers did not adopt the constitutional changes at dissolution of Parliament on 14 July 2022 as the country prepared for elections. Similarly, they stalled the process of amending the customary law code to address women's inheritance rights. Activists see these delays as a setback to efforts to create a national constitutional and legal framework that complies with the requirements of the SADC Protocol. The expectation is that the new parliament and government will prioritise completion of these processes to ensure better protections for women and girls in the country.

[12] Government of Lesotho (2019) Expert Report on Constitutional Reforms (Incorporating Public Consultations and Written Submissions), https://www.gov.ls/download/expert-report-of-constitutional-reforms/, accessed 21 July 2022, p. 7.
[13] Government of Lesotho (2019) Expert Report on Constitutional Reforms (Incorporating Public Consultations and Written Submissions), https://www.gov.ls/download/expert-report-of-constitutional-reforms/, accessed 21 July 2022, pp. 7, 26, 29, 30-33.

Lesotho: Proposed modernisation of 115-year-old customary law code sparks political row

A war of words over the proposed amendment of a historic customary law code has divided politicians in Lesotho. Among other things, the amendment would give widows control over their husbands' estates.

In February 2022, the National Assembly of Lesotho passed the Laws of Lerotholi (Amendment) Bill of 2022. The Laws of Lerotholi is a historic document compiled around 1907 that enshrines Basoto customs that courts in the country can enforce, some of which discriminate against women and girls.

Until now, customary law has treated widows as minors when it comes to access to, and administration of, their deceased husbands' estates. The Bill remains stuck in the Senate, which has refused to pass it. Divided lawmakers have expressed differing views on the amendment, with some arguing that they cannot amend the Laws of Lerotholi because they represent a codification of customary law rather than an act of parliament.

Some senators, such as Thaba-Bosiu Principal Chief Khoabane Theko, argue that the Ministry of Gender in Lesotho "should be pushing to enact a law to cater for the empowerment of women without necessarily seeking to make the Lerotholi laws an Act of Parliament."[14] Meanwhile, Likeleli Tampane, Minister of Gender and Youth, Sports and Recreation, has accused Theko of playing politics to prevent the modernisation of the 115-year-old laws.

Likeleli Tampane, Lesotho's Minister of Gender and Youth, Sports and Recreation, and Thaba-Bosiu Principal Chief Khoabane Theko. The two leaders have publicly clashed over the issue of amending the country's customary law code, the Laws of Lerotholi. Photo courtesy of Lesotho Times

The proposed amendments address harmful practices that hinder women from inheriting from their husbands. The political spat has delayed the promulgation and implementation of these progressive provisions aimed at protection of women's inheritance rights in the country.

Source: Lesotho Times Newspaper, 15 July 2022.

Access to justice

Article 7: Equality in accessing justice

1. State parties shall put in place legislative and other measures which promote and ensure the practical realisation of equality for women. These measures shall ensure:

• Equality in the treatment of women in judicial and quasi-judicial proceedings, or similar proceedings, including customary and traditional courts and national reconciliation processes;
• Equal legal status and capacity in civil and customary law; including, amongst other things, full contractual rights, the right to acquire and hold rights in property, the right to equal inheritance, and the right to secure credit;

[14] Lesotho Times (2022) Tampane, Theko Clash Over Laws Of Lerotholi, https://lestimes.com/tampane-theko-clash-over-laws-of-lerotholi/, accessed 22 July 2022.

• The encouragement of all public and private institutions to enable women to exercise their legal capacity;
• Positive and practical measures to ensure equality for women as complainants in the criminal justice system;
• The provision of educational programmes to address gender bias and stereotypes and promote equality for women in the legal systems;
• That women have equitable representation on, and participation in, all courts, including traditional courts, alternative dispute resolution mechanisms and local community courts; and
• Accessible and affordable legal services for women.

African experts define access to justice as "the ability of people to seek and obtain a remedy through formal or informal institutions of justice, and in conformity with human rights standards."[15] For most women in the region and especially those living in rural areas, access to the courts remains a challenge. Women require access to courts not only to have criminal or civil cases heard, but also to access other services such as registration of marriages.

Access to courts remains a persistent challenge, especially for those women living in the rural areas

The inaccessibility of the courts is one of the reasons for low marriage registration in Southern Africa. In the absence of a registered marriage, women are more vulnerable to harmful practices such as property grabbing upon the death of a husband or partner or property loss at divorce. Registering marriages represents an important way of fighting such practices. Zimbabwe's new Marriages Act expands the availability of marriage registration services by appointing traditional leaders[16] and heads of the country's embassies[17] as marriage officers.

In 2020, the Africa Judges and Jurists Forum (AJJF), with support from the Open Society Initiative for Southern Africa (OSISA), conducted a study to understand the impact of COVID-19 on the administration of justice by the courts in Botswana, Malawi, Mozambique, Zambia and Zimbabwe. Researchers conducted desktop research and facilitated key informant interviews as part of the project, with women in these five countries comprising 60% of the 40 interviews conducted.[18]

Among other things, the study found that COVID-19 restrictions in these countries:
- Worsened the inaccessibility of courts and legal representation;
- Severely undermined the capacity of the courts to performs even some of the most basic functions;
- Severely limited (and in some cases suspended) some of the constitutionally guaranteed rights;
- Created delays in the resolution or finalisation of cases;
- Constrained civil society, para-legals and university legal aid clinics from providing legal awareness at a time when such awareness was needed the most; and
- Undermined efforts to ensure transparency in court processes.

[15] Justice in Transition and the Complexities of Access, ACCORD, https://www.accord.org.za/conflict-trends/justice-transition-complexities-access/, accessed 28 June 2021.
[16] Government of Zimbabwe, 'Marriages Act: Chapter 5:15], section 9
[17] Government of Zimbabwe. 'Marriages Act: Chapter 5:15], section 11
[18] Access to Justice During Lockdown in Southern Africa: A Case Study of Zimbabwe, Zambia, Mozambique, Malawi and Botswana, https://africajurists.org/wp-content/uploads/2021/publications/Access-to-Justice-During-Lockdown-in-Southern-Africa.pdf, accessed 9 September 2022.

To address these challenges, it made seven recommendations:

1. Digitise court services to provide litigants and the public with the option to use virtual means to bring cases to the court as well as observe court proceedings.
2. Judiciaries should consider allowing certain matters to be adjudicated entirely on the basis of written submissions, without requiring physical attendance by the parties and lawyers.
3. Recruit acting judicial officers and allocating resources to enable the judiciaries to recruit and appoint acting judicial officers to assist in clearing these backlogs.
4. Develop COVID-19 protocols for courts to protect users from COVID-19.
5. Scale up civic education on key human rights issues.
6. Allow law-based civil society and para-legals to resume their work.
7. Design and execute programmes targeted at assisting victims of rights violations.

Marriage and family rights

Article 8: Marriage and family rights
1. State parties enact and adopt appropriate legislative, administrative, and other measures to ensure that women and men enjoy equal rights in marriage and are regarded as equal partners in marriage.
2. Legislation on marriage shall therefore ensure that:
(a) No person under the age of 18 shall marry;
(b) Every marriage takes place with free and full consent of both parties;
(c) Every marriage including civil, religious, traditional, or customary, is registered in accordance with national laws; and
(d) During the subsistence of their marriage the parties shall have reciprocal rights and duties towards their children with the best interest of the children always being paramount.
3. State parties shall enact and adopt appropriate legislative and other measures to ensure that, where spouses separate, divorce, or have their marriage annulled:
(a) They shall have reciprocal rights and duties towards their children with the best interest of the children always being paramount; and
(b) They shall, subject to the choice of any marriage regime or marriage contract, have equitable share of property acquired during their relationship.
4. States parties shall put in place legislative and other measures to ensure that parents honour their duty of care towards their children, and maintenance orders are enforced.
5. States parties shall put in place legislative provisions which ensure that married women and men have the right to choose whether to retain their nationality or acquire their spouse's nationality.

Marriage laws and practices in SADC remain heavily influenced by patriarchal norms that view men as heads of the family, with everything within a family, including children, belonging to men. In Eswatini, family, customary and patriarchal norms heavily mediate women's access to land and do not recognise women's right to own land during and at dissolution of marriage by either death or divorce. Civil society organisations in Eswatini and the SADC region have worked to bring this negative state of affairs to the attention of international human rights mechanisms.

A 2021 study identified gender-based discrimination in accessing land as a violation of women's rights in Eswatini

For example, Eswatini was up for the Human Rights Council's Universal Periodic Review (UPR) in November 2021. Women's Rights Organisation and the Women and Law in Southern Africa (WLSA) Research and Education Trust Eswatini filed a shadow report in partnership with the Advancing Rights in Southern Africa (ARISA) programme. The UPR's Summary of Stakeholders' Submissions captured WLSA and ARISA's submissions, in particular that "women were very often unlawfully subjected to land grabbing, evictions and disinheritance, a situation that had been heightened by the COVID-19 lockdown where victims had very limited options for seeking redress for rights violations."[19] The UPR adopted this language and recommended to the Government of Eswatini to "Make further efforts to bring the legislation into compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to enable women's enjoyment of fundamental human rights, such as the right to property and inheritance."[20]

This issue is also a recurring theme in the CEDAW committee recommendations to the country, highlighting the need for action to address women's property rights in marriage and in families.

Zambia's House of Chiefs recently lent its support to women's rights and gender equality in access to land. Like many other countries, women in Zambia have less access to land and other natural resources compared to men. In November 2021, the country's House of Chiefs adopted the *Gender Guidelines for Traditional Leaders in the Management of Natural Resources in their Chiefdoms*. These guidelines buttress women's land and resource rights in the country's 288 chiefdoms and "provide traditional leaders with tools to encourage gender equality in policies and practices at the local level."[21] This example illustrates the importance of working with men - and within long-established systems - to modernise traditional practices in sustainable ways and eliminate harmful gender norms, especially those within the marriage and family settings.

Polygamy

Although the once widespread practice of polygamy has been slowly dying out in Southern Africa, many communities still practice it. Polygamy discriminates against women because it permits men to marry many wives, yet women cannot marry multiple husbands. Critics of polygamy note that women in polygamous relationships face an increased risk of exposure to HIV and AIDS. Research shows that relatively poor child health and reduced economic independence for the women in such relationships have been associated with polygamous unions. Wives in such settings often have very little access to their husbands' estate, with the possible exception of the first wife.

In a stark illustration of the inherent inheritance challenges faced by subsequent wives in polygamous marriages in the event of the husband's death, the late Zulu King Godwin

[19] Human Rights Council, Summary of Stakeholders' Submission on Eswatini, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G21/224/04/PDF/G2122404.pdf?OpenElement, accessed 21 July 2022.
[20] Human Rights Council, Matrix of Recommendations on Eswatini, OHCHR | Universal Periodic Review - Eswatini, accessed 19 August 2022.
[21] Land Portal Foundation, Zambia's House of Chiefs Speak Up for Gender Equality, https://landportal.org/blog-post/2022/01/zambia%E2%80%99s-house-chiefs-speak-gender-equality, accessed 22 July 2022.

Zwelithini's first wife Queen Sibongile Dlamini Zulu has approached the courts to claim half of her late husband's estate. At the time of his death, Zwelithini had six wives.

Sibongile Dlamini Zulu has approached the courts to claim half of her late husband's estate even though he had six wives. Credit: Twitter

Zimbabwe's new Marriage Act provides that parties to any marriage have equal rights and obligations during, and at dissolution, of the marriage. This is an important provision in promoting equality between a husband and wife, especially because Zimbabwe's customary law stipulates that the husband is the head of the household and therefore required to make all critical decisions affecting it. This new provision scraps that practice and gives wives a voice in the affairs of the household and in marriage. The Act, however, still recognises polygamy and specifically acknowledges the harmful practice of widow inheritance as long as the parties to the marriage are older than 18, consent to the marriage and face no other legal impediments.

In a controversial move, the **South Africa**n Department of Home Affairs (DHA) released a green paper in 2021 that detailed a proposed alignment of the country's marriage laws to its constitution.[22] Section 4 of the green paper addressed polygamous marriages. The Recognition of Customary Marriages Act 120 of 1998 (RCMA) provides for polygamous marriages between a man and more than one woman. In the green paper, South Africa sought to make this acceptable by providing for women to be able to marry several husbands, even though this practice is uncommon and unlikely to become widely practiced. However, in August 2022, Government published a white paper, which is a refinement of the green paper that considers submissions from members of the public and interest groups and organisations.[23] In it, the government's recommended policy position and rationale on the issue of polyandry notes that the proposal received widespread negative media and public attention. It concluded, "While there is no constitutional or legal basis for rejecting polyandry, it is recommended that this proposal should not be included in the marriage policy or statute"[24] and that "polyandry doesn't seem to be practiced widely enough to warrant recognition at this stage of development of the country's constitutional democracy."[25] Lawmakers have indicated that government will present the draft marriages legislation to cabinet for approval by March 2023.[26]

Zimbabwe's new Marriage Act provides that parties to any marriage have equal rights and obligations

[22] Department of Home Affairs - Know Your Green Paper on Marriages in South Africa, http://www.dha.gov.za/index.php/notices/1449-know-your-green-paper-on-marriages-in-south-africa, accessed 21 June 2021.
[23] Government of South Africa (2022) White Paper on Marriages in South Africa, http://www.dha.gov.za/images/PDFs/White-Paper-on-Marriage-in-SA-5-May2022.pdf, accessed 17 August 2022.
[24] Government of South Africa (2022) White Paper on Marriages in South Africa, http://www.dha.gov.za/images/PDFs/White-Paper-on-Marriage-in-SA-5-May2022.pdf, accessed 17.
[25] Government of South Africa (2022) White Paper on Marriages in South Africa, http://www.dha.gov.za/images/PDFs/White-Paper-on-Marriage-in-SA-5-May2022.pdf, accessed 17.
[26] Businesstech (2022) South Africa is changing its marriage laws from next year, https://businesstech.co.za/news/lifestyle/570998/south-africa-is-changing-its-marriage-laws-from-next-year/, accessed 22 July 2022.

Whilst the provision on polyandry solicited the most responses from the green paper, it is important to note the other important proposals in the paper. These include raising the age of consent to marriage to 18 years without exception, and ensuring that no marriage can occur without the full and free consent of the parties concerned. Currently, the presence of both parties is not required for some religious marriages, such as Hindu and Muslim marriages.[27] The proposals also harmonise the country's marriage regime, ensuring that all marriages receive the same treatment and recognition in line with constitutional provisions on equality and non-discrimination.

Child marriages

SDGs 5.3: Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation.
CEDAW Article 16(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent; Article 16 (2) The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.
ICPD 6.11: Countries should create a socio-economic environment conducive to the elimination of all child marriages and other unions as a matter of urgency and should discourage early marriage.
Maputo Protocol Article 6(a) no marriage shall take place without the free and full consent of both parties; Article 6(b) the minimum age of marriage for women shall be 18 years.
SADC Protocol Article 8.2a: No person under the age of 18 shall marry.
SADC UN CSW Resolution calls upon all governments to enact and intensify the implementation of laws, policies, and strategies to eliminate all forms of gender-based violence and discrimination against women and girls in the public and private spheres and harmful practices, such as child, early, and forced marriage, female genital mutilation and trafficking in persons, and ensure the full engagement of men and boys in order to reduce the vulnerability of women and girls to HIV.
The SADC Model Law on Child Marriage defines "child marriage" as "a statutory or customary union in which one party is a child or both of the parties are children.[28] The same Model Law defines a child as any person under the age of 18 years in line with other international human rights instruments.[29]

Over the last two years, as the COVID-19 pandemic led to lockdowns, school closures and economic strife across the region, instances of child marriage increased. A recent report by UNICEF and United Nations Population Fund (UNFPA), titled *Child Marriage in COVID-19 contexts: Disruptions, Alternative Approaches and Building Programme Resilience*, also found that disruptions related to the pandemic affected regional and national work on ending child marriage.[30] This includes school-based interventions; community engagement; adolescent and youth-friendly sexual and reproductive health services; and field research and studies.

[27] Department of Home Affairs - Know Your Green Paper on Marriages in South Africa, http://www.dha.gov.za/index.php/notices/1449-know-your-green-paper-on-marriages-in-south-africa, accessed 22 July 2022.
[28] 'SADC Model Law on eradicating Child Marriage and Protecting Children already in Marriage', https://www.girlsnotbrides.org/documents/484/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf, accessed 28 June 2021.
[29] Article 1 of the Convention on the Rights of the Child defines a child as every human being below the age of 18 years.
[30] Child Marriage in COVID-19 contexts: Disruptions, Alternative Approaches and Building Programme Resilience https://www.unicef.org/esa/media/7651/file/Child-Marriage-in-COVID-19-contexts.pdf, accessed 10 September 2022.

The report noted, "Emerging evidence about increasing incidence of child marriages and teenage pregnancies during the pandemic, as well as projected long-term adverse impacts over the next decade, underscore multiple vulnerabilities young people face when child marriage interventions and related programming are disrupted."[31]

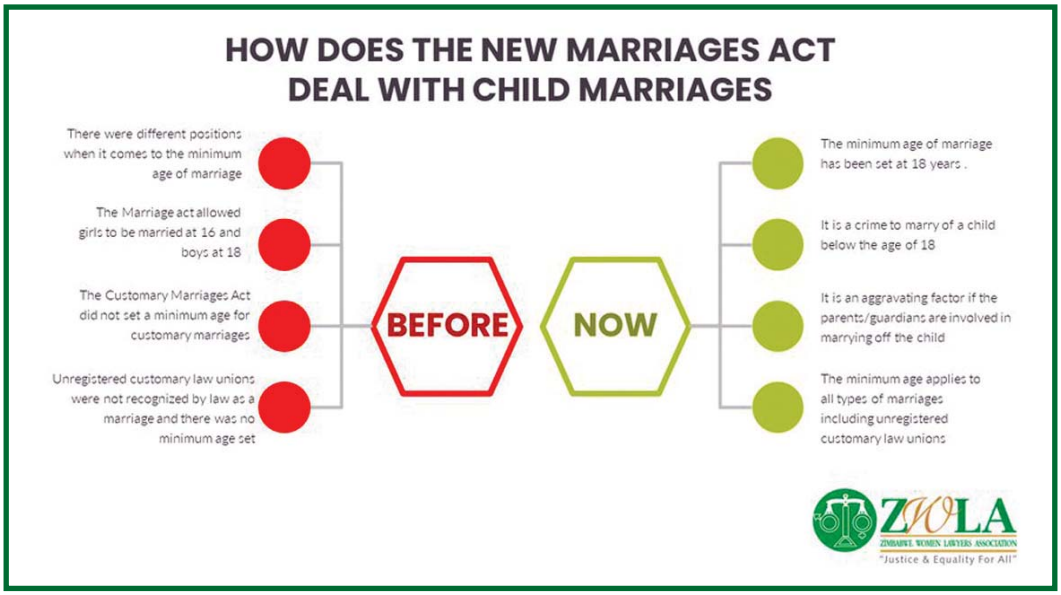
Among other recommendations, the report called for a strengthening of child protection and mental health systems at community level through health, social welfare services, and support to police, education and health services.

The Government of **Zimbabwe** and civil society organisations have been making strides in their efforts to comply with the SADC Model Law and relevant international standards to end child marriages in the country.

Parliament passed the Marriages Amendment Bill into law on 8 March 2022, and on 27 May 2022, the President assented to the Act. It outlaws child marriages in line with the constitution and a 2018 constitutional court ruling that affirmed the unconstitutionality of child marriages. The new Act criminalises any action that leads to, or has the potential to lead to, child marriage, with offenders facing jail time of up to five years.

Further, on 24 May 2022, the Constitutional Court of Zimbabwe ruled to increase the age of sexual consent from 16 to 18 years. In doing so, it struck down provisions of sections 70, 76, 83 and 86 of the Criminal Law Code. These provisions had regarded a young person as someone younger than the age of 16 for purposes of sexual offences. These provisions meant that the law considered a person older than 16 but younger than 18 and of sound mind capable of consenting to sex.

The decision elicited mixed reactions. Some viewed it as progressive while others saw it as a populist attempt by adults to control adolescents, without consulting with those youth they intended to protect. Others saw the value in raising the age of sexual consent to protect children from predatory adults, noting that the courts should treat consensual sex between youth, especially adolescents close in age, differently. Some Zimbabweans also raised concerns that the issue of sexual consent is being confused with consenting to, and accessing, sexual and reproductive health services and supports, which could lead to facilities denying access to youth younger than 18.



A public education poster created by the Zimbabwe Women Lawyers Association explains changes in the new Marriages Act related to child marriages. Credit: ZWLA

[31] Ibid.

Zimbabwe: Death of young bride during childbirth sparks renewed advocacy to end child marriage

The case of Anna Machaya, a 14-year-old who died while giving birth in a church shrine in the city of Mutare on 15 July 2021, became a rallying cry for Zimbabwean advocates against child marriages when media reported that the child's parents had forced her to leave school and get married at age 12.

The case exposed the issue of child marriages, which has long been a problem in Zimbabwe, with many of these marriages going unreported due to legal inconsistencies around age of consent to marriage, age of consent to sex and age of consent to access sexual and reproductive health (SRH) services.

With the recent passage of the Marriages Act, lawmakers addressed some - but not all - of these inconsistencies. Machaya's death has spurred gender activists and others in the country to accelerate their advocacy on the issue. Following the incident, members of the women's movement, through the Women's Coalition of Zimbabwe (WCoZ), convened a meeting to discuss the proliferation of child marriages and to plan a response. Key actions included launching a campaign to end child marriages, dubbed #JusticeforAnna.

As part of the campaign, the coalition published a statement on 8 August 2021 calling for the Zimbabwean police to investigate the matter and arrest perpetrators and accomplices. They also called on traditional leadership, community, media, the Ministry of Justice, Legal and Parliamentary Affairs, Zimbabwe Gender Commission and other stakeholders to work with the police on all cases of child marriage.

WCoZ then set up an Anna Machaya working group, which wrote to Paul Nyathi, assistant commissioner of police, to discuss the matter and map out possible synergies with the Zimbabwe Republic Police (ZRP) in combating child marriages and child abuse in the country.

WCoZ also participated in radio programmes discussing the Machaya case and the scourge of child marriage in the country. Along with traditional media, the activists used social media to share infographics on safeguarding survivors and the rights of children.

WCoZ noted the importance of this type of advocacy due to knowledge gaps around the laws and their provisions regarding sex with minors and child marriage.

The group decried those in the public and media who shared social media posts that included photos of Anna Machaya, calling it an ethical lapse and unacceptable way for media or concerned citizens to cover or commemorate the death of a child. On World Photography Day, WCoZ instead encouraged people to post pictures of themselves holding a sign or poster calling for #justiceforanna.

Many shared these images on social media, especially WhatsApp, which helped raise awareness about the case and the cause. On 8 August 2021, the ZPR announced an investigation into the matter, which they quickly followed a few days later with the arrests of Machaya's husband, who faces charges of child rape, and her parents.

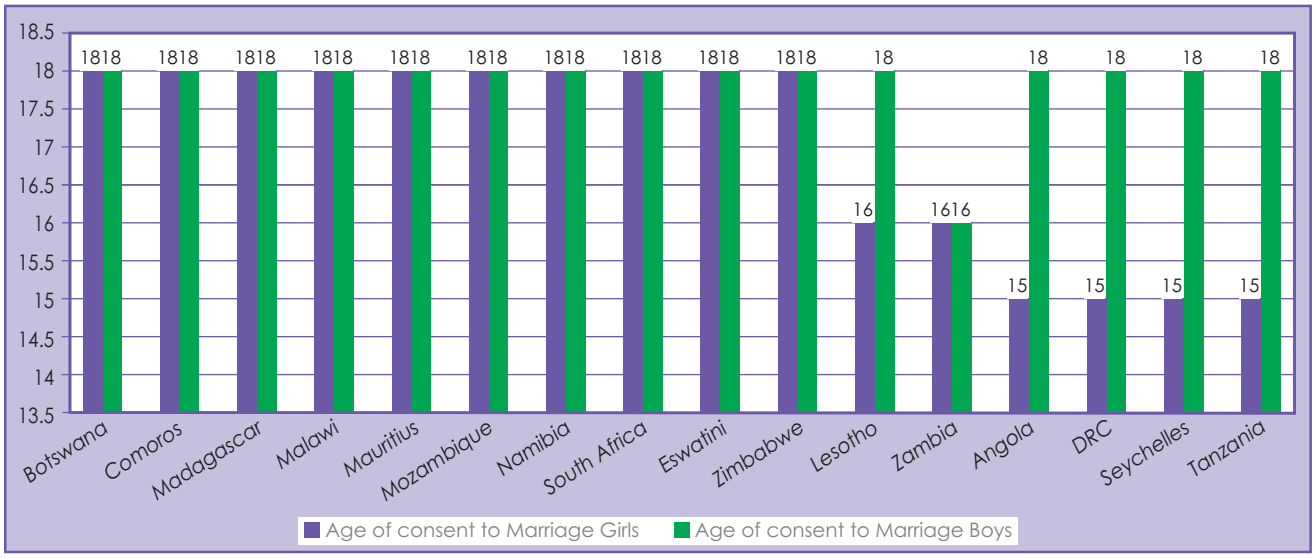
The passing of the Marriages Act, and the constitutional court case increasing the age of consent to sex to 18 years, both in 2022, indicate that advocacy efforts to fight child marriage and child sexual abuse have gained traction in the country following Machaya's death. Additionally, Margaret Mukahanana-Sangarwe, chairperson of the Zimbabwe Gender Commission (ZGC), announced in April 2022 that the commission would conduct investigations into apparent sexual exploitation, abuse of young girls and child marriages across the country.

Source: Women's Coalition of Zimbabwe.

Minimum age of marriage

The SADC Model law on Child marriage defines child marriage as "a statutory or customary union in which one party is a child or both of the parties are children."[32] It also defines a child as any person under the age of 18 years in line with other international human rights instruments. In line with the SDG 5.3, The Maputo Declaration, SADC Protocol Article 8.2a, and the SADC Model law on Child Marriage, most SADC countries have set the minimum age of consent to marriage at 18 years, but some have yet to review the minimum age limits.

Figure 7.1: Age of consent to marriage for girls and boys by country



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

Figure 7.1 shows that most SADC countries have set the age of consent to marriage at 18. Six countries - Angola, DRC, Lesotho, Seychelles, Tanzania, and Zambia - have lower ages of consent to marriage for girls, boys, or both. The lower ages of consent do not line up with regional expectations for countries to domesticate the SADC Model Law on Child Marriages, which seeks to end all forms of child marriage.

Article 24 of the **Angola**n Family Code represents an example of the type of exception found in some SADC laws.[33] It states, "Only those over 18 years old can marry." However, the law goes on to say that, "Exceptionally, a man who has completed 16 years and a woman who has completed 15 years may be authorised to marry when, considering the circumstances of the case and taking into account the interests of minors, marriage is the best solution." Such authorisation "will be granted by the parents, guardians or whoever holds the responsibility, and may be supplied by the Court, after hearing the opinion of the Family Council, when the non-authorisation proves unjustified."

For a long time, **Mauritius** refused to sign and ratify the SADC Protocol on Gender and Development because it prohibited child marriage. Mauritius argued that this provision contradicted its own civil code, which allowed children to be married before age 18. Civil society organisations worked hard to change the civil code to remove barriers preventing Mauritius legislators from signing and ratifying the Protocol.

[32] 'SADC Model Law on eradicating Child Marriage and Protecting Children already in Marriage,' https://www.girlsnotbrides.org/documents/484/model-law-on-eradicating-child-marriage-and-protecting-children-already-in-marriage.pdf, accessed 28 June 2021.
[33] 'Angola National Legislation', https://www.icmec.org/wp-content/uploads/2018/07/ICMEC-Angola-National-Legislation.pdf, accessed 23 June 2021.

Mauritius: Patience is rewarded as long-time advocacy efforts lead to new law to end child marriages

Following 16 years of advocacy, activists in Mauritius celebrated in January 2022 when the country's lawmakers promulgated the Children's Act (CA) 2020, with a provision on banning child marriage.

In line with international law, the Act stipulates that a child is a person younger than 18 years. As such, no person shall cause or force a child younger than 18 to marry, in either a civil or religious ceremony. This offence now carries a fine and the possibility of imprisonment.

The Act provides for the complete abolition of child marriage and consequently the concept of *émancipation par marriage* (emancipation through marriage) within Section 73. It repeals existing provisions of the Mauritian Civil Code, whereby parents or legal guardians could permit children between 16-18 years to marry in the presence of a judge. It is now also illegal for children to live in *concubinage* (cohabitation) in accordance with Section 12.

Gender Links' advocacy to end child marriage began in 2016 with an emphasis on lobbying Mauritius to sign the SADC Protocol on Gender and Development. In 2018, the advocacy group Sitwayin Angaze wrote a letter to lawmakers and held a press conference at which they raised three pertinent issues. These included Mauritius's failure to sign the SADC Protocol, delays in the passing of the Children's Bill, and the gendered and adverse health effects of child and teenage pregnancy.

GL Mauritius and senior advocates from Mauritius also raised this issue while participating in the 71st session of the CEDAW committee, held at the United Nations in 2018. They put forward clear recommendations to ban child marriages and called for the creation of an authority to monitor marriages. In the Concluding Observations of the Committee in 2018, CEDAW appealed to the State to implement new legislation to protect women and girls.

Representatives of the Sitwayin Angaze movement Melanie Vigier de Latour-Berenger, Lovena Sowhee, Anushka Virahsawmy, and Nudhar Bundhoo held a press conference on 28 June 2018 in Port Louis to denounce Mauritian authorities for failing to sign the SADC Protocol. Photo: Gender Links

In addition, activists organised consultation workshops to understand the challenges faced by youth, parents, community leaders, and other NGOs. The Office of the Ombudsperson for Children issued a call for contributions from members of the public on the topic of child marriages.

The Attorney General's Office led the designing and drafting of the law, which involved meeting with stakeholders, surveys and data collection, a revision of the existing law, and finally a vote in Parliament on the Bill. Legislators designed the law in line with the United Nations Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child. GL Mauritius participated in various meetings, continuously lobbying for a ban on child marriage.

Alliance partner organisations collaborated to host advocacy activities to address taboos concerning sexuality and lodge complaints with the police and the Child Development Unit (CDU). They also coordinated online classes and trainings for children, adolescents and adults on adolescent sexual and reproductive health and rights (ASRHR) topics.

While many cultural and religious beliefs and patriarchal ideologies initially presented roadblocks in the fight against prohibiting child marriages, the wellbeing of children took precedence in the end. Thanks to the Children's Act 2020, Mauritius now bans child marriages, which means advocacy efforts can shift to ensuring proper implementation of the law as well as trainings with councillors, nurses, doctors and others to ensure they relay accurate information to the public in the coming years.

Source: Gender Links: Mauritius ASRHR Policy Case Study.

Tanzanian activists have seen little progress in amending the Law of Marriage Act in their country.[34] It has been two years since the Court of Appeal upheld a 2016 High Court judgment that outlawed child marriage and declared it unconstitutional.[35] Specifically, the upper court gave the government a one year timeline to amend sections 13 and 17 of the Marriage Act that allows a girl as young as 15 to be married with parental consent and a 14-year-old girl to marry with court consent. Child rights activists in Tanzania worry that continued delays in closing legal loopholes leaves room for discrimination and continued harm to girls and women. Advocacy efforts continued in 2022, with the Gender Desk of the Tanzanian Police calling on the government to amend the law, arguing that the current law is detrimental to girls' health. It also noted that a girl married at age 14 could have as many as 10 children by age 30 due to vulnerability and lack of knowledge about sexual and reproductive health rights.[36]

Persons with disabilities

Article 9: Persons with disabilities: State parties shall, in accordance with the SADC Protocol on Health and other regional and international instruments relating to the protection and welfare of people with disabilities to which member states are party, adopt legislation and related measures to protect persons with disabilities that take into account their particular vulnerabilities.

Seven SDG targets specifically mention persons with disabilities (education, accessible schools, employment, accessible public spaces and transport, empowerment and inclusion, and data disaggregation).[37]

People with disabilities in SADC face a myriad of challenges, including lack of access to SRHR information, goods, and services. In many cases, women and girls with disabilities remain unable to make decisions about their own body and life - essential human rights often overlooked compared to other groups. Many live without sufficient government support and face exclusion from relevant programmes. According to UNICEF, widespread underestimation of the abilities and potential of children with disabilities creates a vicious cycle of under-expectation, under-achievement and low priority in the allocation of resources.[38]

In the DRC, with approximately 10 million disabled people - close to one in eight people in the country - activists hope the proposed 2020 Disability Rights Bill will bring significant change.[39] The Bill would address the discrimination and harmful cultural practices directed specifically at women and children with disabilities. Children with disabilities in the DRC often face accusations of witchcraft.[40] The proposed Bill represents a critical piece of legislation aimed at addressing this issue and providing disabled children with protection. However, promulgation of the Bill has stalled, with legislators making little progress to move it forward since introducing it in 2020.

[34] Msichana Initiative (2021) 'Ending child marriage: Stakeholders' collective efforts in reviewing of the Law of the Marriage Act.', February, https://msichana.or.tz/ending-child-marriage-stakeholders-collective-efforts-in-reviewing-of-the-law-of-the-marriage-act/, accessed 23 June 2021.
[35] The Attorney General v Rebeca Z, Gyumi, Civil Appeal Number 204 of 2017, October 2019.
[36] AllAfrica (2022) Tanzania: Police Gender Desk Pushes for Amendment of Marriage Act, https://allafrica.com/stories/202202180484.html, accessed 22 July 2022.
[37] United Nations Convention on the Rights of Persons with Disabilities.
[38] UNICEF (2007) Promoting the rights of children with disabilities (2007). Florence: Innocenti Research Centre (Innocenti digest, 13), https://www.un.org/esa/socdev/unyin/documents/children_disability_rights.pdf, accessed 15 July 2021
[39] New bill offers hope to people with disabilities in DR Congo, France 24, https://www.france24.com/en/africa/20201203-new-bill-offers-hope-to-people-with-disabilities-in-dr-congo, accessed 24 June 2021.
[40] 'SADC Gender Protocol 2020 Barometer Chapter 7 Harmful Practices', https://genderlinks.org.za/wp-content/uploads/2020/08/Chap7-Baro2020-HARMPRACrev2.pdf, accessed 24 June 2021.

In **Zimbabwe**, the government launched a National Coordination Committee to implement its National Disability Policy on 7 July 2022.[41] This followed the launch of the policy in June 2021. In creating the committee, the government has shown its commitment to protecting the rights of people with disabilities. Government launched the policy in coordination with the United Nations Partnership on the Rights of Persons with Disabilities (UNPRPD). The National Coordination Committee will provide guidance to the implementation of the policy and its launch, in line with government's roadmap. Edward Kallon, United Nations Resident Coordinator in Zimbabwe, noted that the launch marked "a milestone to operationalise the policy and move forward the agenda of inclusion and rights of persons with disabilities."[42]

> Zimbabwe's 2021 National Disability Policy sets standards for the inclusion of Persons with Disabilities in all facets of life

Zimbabwe: New policy seeks to end harmful practices against people with disabilities

Paul Mavima, Zimbabwe's Minister of Public Service, Labour and Social Welfare, helps launch the national coordination committee for the implementation of the National Disability Policy in Harare on 7 July 2022.
Photo courtesy of Technomag

The Zimbabwe National Disability Policy contains the following key provisions to end harmful practices against people with disabilities and their families:

- Enforce investigation and prosecution of harmful traditional, religious and any other practices that result in the sexual abuse of persons with disabilities in all contexts.
- Traditional healers and religious prophets that prescribe sex with girls and women with disabilities as a "cure" for HIV, a conduit for getting rich, and for any other reason must be combated and prosecuted.
- The investigation and prosecution of persons who earn an income by forcefully "using" persons with disabilities as commercial sex workers, must be enforced.
- Persons with disabilities must not be denied marriage, family, parenthood and relationships at appropriate ages as provided by the law and on an equal basis with others.
- Persons with disabilities who are of marriageable age, must not be denied their right to found a family on the basis of free and full consent of the intending spouses.
- Incidences of people who ill-treat persons with disabilities, who would have married their family members must be investigated and, where appropriate, the perpetrators must be prosecuted.
- Persons with disabilities including children, shall retain their fertility on an equal basis with others. Sterilisation of persons with disabilities without their free and informed consent is an offence.
- Persons with disabilities should not be denied the right to decide on the number and spacing of their own children, to have access to age appropriate information, reproductive and

[41] The Sunday Mail (2022) NEW: Committee for National Disability Policy Launched, https://www.sundaymail.co.zw/new-committee-for-national-disability-policy-launched, accessed 22 July 2022.
[42] The Sunday Mail (2022) NEW: Committee for National Disability Policy Launched, https://www.sundaymail.co.zw/new-committee-for-national-disability-policy-launched, accessed 22 July 2022.

family planning education and child rearing practices - supports that enable them to exercise these rights must be provided.
- Raise awareness against the harmful practice of blaming, ill-treating and abandoning mothers who give birth to children with disabilities.
- Mothers who give birth to children with disabilities and their partners must be given appropriate support within the healthcare and the social welfare system immediately after delivery of the child and thereafter.
- Include the subject of disability and sexuality, particularly the individual's right to exercise free and informed consent, in the curriculum of all health and allied professionals, all social workers, all educators and support staff, justice delivery officials that include police and Court officials, and any other relevant officials.
- Rehabilitation officials must be trained on how to provide information and how to support the sexuality of children and adults with disabilities.
- Punishing persons with disabilities who engage in sexual relations of their choice is an offence - like everyone else, persons with disabilities have the right to engage in consensual sexual relations.
- Persons with disabilities must be included in holistic sexual education programmes in schools, rehabilitation institutions and communities and other relevant fora.
- All sexual health programmes including HIV programmes (prevention, treatment, care and support) should not offer blanket solutions to communities at the exclusion of persons with disabilities.
- All sexual health programmes must offer accessible physical infrastructure, information, and communication and services.
- Ensuring confidentiality, all sexual health statistics, including HIV statistics, must be disaggregated on the basis of disability and must be submitted to the Department of Disability Affairs, Ministry of Public Service, Labour and Social Welfare in November of each year.
- Raise awareness about the sexual rights of persons with disabilities and encourage the open acknowledgement and discussion of the subject of sexuality of persons with disabilities in society.
- Persons with disabilities, including children with disabilities, must not be forced into any arrangement on the fallacious belief that they are asexual beings for example, sharing bedding with persons of the opposite sex.
- Promote the concept of and support the development of peer counselling programmes as a self-help programme that holds the potential to enable the self-growth of persons with disabilities.
- Rehabilitation institutions, schools and healthcare facilities must provide free sanitary products to women and girls with disabilities.
- Persons with disabilities must be empowered to claim their agency and to challenge practices of oppression that characterise their experiences of sexuality.
- Sexual health information, including that of sexual and reproductive health must be provided in accessible formats, such as Zimbabwean Sign Language and Braille.

Source: Zimbabwe National Disability Policy, 2021.

On 19 July 2022, the **South Africa**n government gazetted the Constitution 18th Amendment Bill 2022 to amend section 6 of the Constitution to include sign language as the country's 12th official language. Ronald Lamola, Minister of Justice, noted that persons with hearing disabilities experience high levels of marginalisation and exclusion due to social, psychological and structural challenges.[43] Such exclusion and marginalisation, Lamola noted, occurs in social circles, at work, in schools, at places of worship and at many leisure, cultural and sports events. Including sign language as an official language

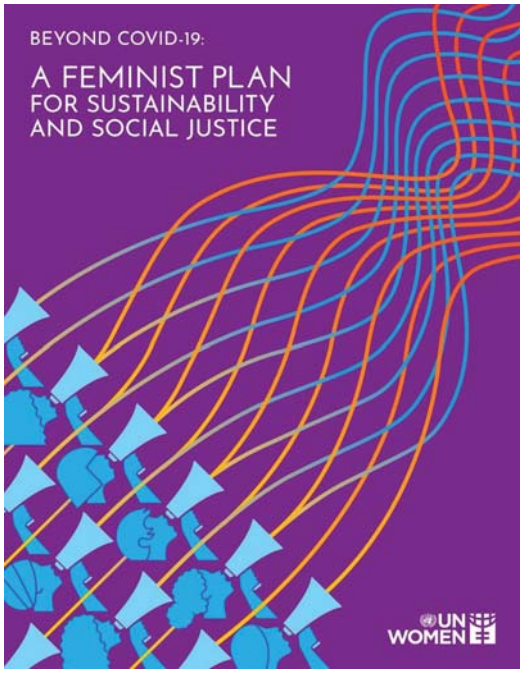
[43] Government of South Africa, 'Invitation for Public Comments on the Constitution of the Republic of South Africa, 1996: Amendment to section 6 of the Constitution' https://www.gov.za/sites/default/files/gcis_document/202207/47049gen1156.pdf, accessed 21 July 2022.

aims to ensure state provision of resources for its wider use to protect the rights of people with hearing disabilities. This will help remove barriers and practices that perpetuate their exclusion from various spaces.

In South Africa and throughout SADC, girls and women with hearing disabilities often face sexual and gender-based violence because of their disability and subsequently find it difficult to interact with law enforcement and other authorities when reporting the abuse. This leads to delays in access to justice, for example, when health facilities, police stations and courts spend considerable time seeking the services of sign language interpretation. The inclusion of sign language as an official language, if properly implemented, means that interpretation services will become a standard service at all relevant government institutions.

The rights of widows and widowers

Article 10: Widows' and widowers' rights
1. State parties shall enact and enforce legislation to ensure that widows and widowers:
(a) Are not subjected to inhuman, humiliating, or degrading treatment;
(b) Automatically become the guardians and custodians of their children when their husband/wife dies unless otherwise determined by a competent court of law;
(c) Have the right to an equitable share in the inheritance of the property of their spouses;
(d) Have the right to remarry any person of their choice; and
(e) Have protection against all forms of violence and discrimination based on their status.
CEDAW, Article 16(b) provides for widows, the same right freely to choose a spouse and to enter into marriage only with their free and full consent; among other protections that are given to widows.



In its statement to commemorate International Widows' Day in 2022, UN Women noted the many cultural and legal barriers that still affect widows, including denial of pensions and inheritance.[44] The group noted that COVID-19 exacerbated many of these obstacles. It called for the development of social policies and practices that address the needs of widows in line with its feminist recovery plan from COVID-19.

The Feminist recovery plan provides a "visionary but practical roadmap for putting gender equality, social justice, and sustainability at the centre of the recovery and transformation."[45] It maps the ambitious and transformative policies

[44] UN Women (2022) Statement for International Widows' Day, https://www.unwomen.org/en/news-stories/statement/2022/06/un-women-statement-for-international-widows-day, accessed 22 July 2022.
[45] UN Women (2022) Beyond COVID-19: A Feminist Plan for sustainability and social justice, https://www.unwomen.org/en/digital-library/publications/2021/09/beyond-covid-19-a-feminist-plan-for-sustainability-and-social-justice, accessed 22 July 2022.

- on livelihoods, care, and the environment - required to build an equal and sustainable future,[46] specifically recognising the rights of widows as requiring attention given that COVID-19 revealed and worsened inequalities.

Dubbed the Feminist Plan for Sustainability and Social Justice, the UN Women plan seeks the development of context-specific policy pathways, tailored political strategies, and financing to "build back better" from the COVID-19 pandemic. This includes help to secure rights for the most vulnerable and marginalised, including widows.

Increasing work on this front includes the development of legislative provisions to protect widows' rights in some countries.

In **Namibia**, the law allows a widow to remain on her deceased husband's land even after she remarries. Harmful customary practices amongst some communities, however, lead to the confiscation of a deceased man's property from his widow, highlighting the need to educate citizens about the law and to ensure its enforcement in order to protect widows.[47]

In **Zimbabwe**, the 2020 Supreme Court case of *Chigwada v Chigwada*[48] underscored the need for continued legal clarity on the issue of widow and widower rights. The case involved a woman whose deceased husband through a community of property marriage bequeathed his share of the matrimonial home to his son from a previous marriage. The widow stayed in the house in question. Citing the doctrine of freedom of testation, the Supreme Court ruled that anyone has the right to bequeath their property to whomsoever they choose. Before this judgment, the courts in Zimbabwe split over the issue of whether or not spouses could legally disinherit each other. The high court judgment stipulated different legal frameworks in succession for various situations, including when spouses marry in community of property, out of community of property, or when a spouse dies intestate (without a will) or testate (leaving behind a will).

In its ruling, the Supreme Court stated that "The law of testamentary disposition, which is based on the universal principle of equality of men and women, gives a right to a person married out of community of property to dispose of his or her estate by will to whomsoever he or she chooses. Decisions of the high court to the effect that a testator is bound to leave his or her property to the husband or wife and declaring [wills] to the contrary to be void are inconsistent with the law. They should no longer be followed."

While the judgment might appear to be gender neutral and based on equality of men and women, such wills often negatively affect women. Thus, the ruling has a substantively negative impact on widows compared to widowers and runs contrary to section 56 (3) of the Constitution, which outlaws discrimination based on gender. Similarly, section 26 (c) of the Constitution enjoins the state to take measures to ensure that "in the event of dissolution of a marriage, whether through death or divorce, provision is made for the necessary protection of any children and spouses." Disinheriting a spouse through a will would not equate to protection of such spouse upon the dissolution of marriage through death. Scholarly arguments and women's rights groups have therefore continued to challenge the view of the Supreme Court on the basis that it runs contrary to the Constitution.[49] Civil society organisations have engaged government[50] to review the Wills Act[51] to address the issue.

[46] UN Women (2022) Beyond COVID-19: A Feminist Plan for sustainability and social justice, https://www.unwomen.org/en/digital-library/publications/2021/09/beyond-covid-19-a-feminist-plan-for-sustainability-and-social-justice, accessed 22 July 2022.
[47] Department of State (2022) Namibia Human Rights Report, https://www.state.gov/wp-content/uploads/2022/02/313615_NAMIBIA-2021-HUMAN-RIGHTS-REPORT.pdf, accessed 18 August 2022.
[48] Chigwada v Chigwada & Others SC188/20.
[49] Basutu S Makwaiba (2022) The Supreme Court of Zimbabwe's ChigwadaDecision and Its Implications for Testamentary Dispositions and Enforcement of Section 26 of the Constitution of Zimbabwe, https://perjournal.co.za/article/view/12889/18587, accessed 18 August 2022.
[50] Interview with a senior officer of the Zimbabwe Women Lawyers Association on 18 August 2022.
[51] Government of Zimbabwe, 'Wills Act: [Chapter 6:06]', akn-zw-act-1987-13-eng-2016-12-31.pdf (zimlii.org), accessed 19 August 2022.

Female Genital Mutilation (FGM)

SDGs 5.3 Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation (FGM).

Female genital mutilation (FGM) refers to, "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons." Global estimates show that at least 200 million girls and women have undergone FGM in 31 countries. Demographic and Health Surveys and Multiple Indicator Cluster Surveys highlight these stark figures. In Africa, the practice is most prevalent in Somalia, Djibouti, and Guinea. In Southern Africa, Tanzania has the highest number of FGM cases.[52]

Reports show that both the South African government and the World Health Organisation do not acknowledge South Africa as a country that practices FGM.[53] However, research similarly shows that the Venda people and some migrant communities practice FGM.

In 2022, research by the University of the Witwatersrand revealed that doctors at the Rahima Moosa Mother and Child Hospital in Johannesburg and other hospitals in the country often come across gruesome cases of FGM, some of which lead to death during childbirth.[54] The research found that some migrant northeast African communities practice FGM. It further found that "little research has been conducted on FGM in South Africa, despite increasing reports of women arriving in South African hospitals showing signs of genital mutilation."[55]

These critical findings show that further research and investigations on harmful practices will help activists better understand the extent of the issue. Such practices can go unnoticed or undocumented. With increasing migration and intermingling amongst communities and cultures, harmful practices can also be imported from different countries and communities, hence the need for continuous research and monitoring to protect women and girls.

Next steps

- **Scrap discriminatory laws**: The government of Tanzania must uphold the Supreme Court ruling to amend the Law of Marriage Act in line with the SADC Model Law on Child marriage. Delays in closing these types of legal loopholes leads to continued discrimination and marginalisation of girls and women throughout the region.
- **Bolster access to justice**: To ensure equality of women as complainants in accessing justice, legislators must remodel customary court

[52] Female Genital Mutilation (FGM) Statistics, UNICEF DATA, https://data.unicef.org/topic/child-protection/female-genital-mutilation/, accessed 25 June 2021.
[53] Kitiu B (2012) Female Genital Mutilation in South Africa, https://africlaw.com/2012/06/07/female-genital-mutilation-in-south-africa/, accessed 25 July 2022.
[54] Smillie S (2022) The Knife Between her Thighs, https://www.wits.ac.za/news/latest-news/research-news/2022/2022-03/the-knife-between-her-thighs.html, accessed 25 July 2022.
[55] Smillie S (2022) The Knife Between her Thighs, https://www.wits.ac.za/news/latest-news/research-news/2022/2022-03/the-knife-between-her-thighs.html, accessed 25 July 2022.

structures across the region. Access to justice must include access to related services, such as marriage registration.

- **Continue to campaign and advocate**: Inspired by successful campaign efforts following the tragic death of Anna Machaya, activists should continue to explore innovative advocacy and campaign techniques that incorporate traditional leaders and those affected by the issue, such as teen mothers.
- **Enforce child marriage laws**: Moving beyond rhetoric, decision-makers must accelerate sufficient law enforcement and monitoring to delay marriage and protect the rights of women and girls to achieve the desired outcomes of age-at-marriage laws.
- **Enhance policy support**: Legislators must implement recovery efforts and update policies following the COVID-19 pandemic by employing a gender perspective given the gendered impact of the pandemic and its disproportionate impact on women and girls.
- **Gather more evidence**: Activists and experts must undertake new research to understand what fuels harmful practices, including their proliferation and response measures in the context of COVID-19. It is also important to carry out research in countries, and amongst communities and families that appear free from harmful practices, because many harmful practices remain hidden.
- **Scale up institutional support**: Zimbabwe's National Disability Committee and others like it require adequate resources to perform their mandates.
- **Ensure people with disabilities participate in all efforts to support them**: The public consultation process ahead of the passing of South Africa's 18th Constitutional Amendment must fully involve the participation of persons with hearing and other disabilities. Similarly, all efforts to ensure people with disabilities realise their rights should guarantee their consultation and inclusion throughout.

Fehizora Rafalimanana, journalist from Madagscar, interviews Fela RAZAFINJATO, president of the NGO, Sembana Mijoro, which supports people with disabilities.
Photo: Zoto Razanadratefa

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Sexual diversity

8

Protesters rally outside South Africa's Parliament in solidarity with LGBTIQ victims and survivors of violence during the End Queer and Trans Hate Campaign in Cape Town in April 2021.
Photo: Gallo Images/Brenton Geach

KEY POINTS

- Botswana recently joined four Southern African countries (Angola, Mozambique, Seychelles, and South Africa) and decriminalised same-sex relationships.
- Courts rejected challenges to allow for the registration of LGBTIQ organisations in Eswatini and same sex marriages in Namibia.
- There is growing evidence that diversity and inclusivity increase productivity and business performance.
- Activists continue their push to include affirmative action for LGBTIQ persons in economic policies and legislation.
- As the pandemic wanes, governments should revisit their health responses and redesign them according to the ASPIRE principles: acknowledge, support, protect, prevent indirect discrimination, ensure representation and be evidence based.
- Religious and cultural fundamentalism continues to fuel violence and discrimination against LGBTIQ persons.
- There is a need for discussions and strategies to address the growing prevalence of conversion therapy across the region.
- Increased intersections between LGBTIQ, feminist and youth movements help strengthen each of them and create more sustainable impact through joint initiatives.

Introduction

The *Equality Index*, produced by EqualDex in 2022, shows that most Southern African countries lag behind other parts of the world on equality for the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) community. *Equaldex*, a collaborative knowledge base for the LGBTIQ movement, aims to crowdsource every law related to LGBTIQ rights to provide a comprehensive and global view of the LGBTIQ rights movement.

The *Equality Index* uses a ranking from zero to 100 (with 100 being the most equal) to help visualise the legal rights and public attitudes towards LGBTIQ people in different countries. It represents an average of two measurements: the legal index and the public opinion index.

Equality is a fundamental human right. Photo: Centre for Human Rights, Faculty of Law, University of Pretoria

The LGBTIQ legal index measures the current legal status of 13 different issues and the public opinion index measures attitudes towards LGBTIQ people using surveys and polls. Note that public opinion data is not available in every country. In these cases, the Equality Index represents only the legal rights of LGBTIQ people in the country.

Table 8.1: Equality Index for Southern Africa[1]

COUNTRY	EQUALITY INDEX	LEGAL INDEX	PUBLIC OPINION INDEX
South Africa	78	97	59
Seychelles	68	68	-
Angola	63	79	47
Mozambique	62	69	56
Mauritius	62	71	52
Namibia	58	62	55
Botswana	56	75	37
Democratic Republic of the Congo	52	52	-
Lesotho	44	68	19
Madagascar	38	65	11
Eswatini	33	44	22
Zimbabwe	29	50	8
Malawi	22	39	5
Zambia	22	37	7
Comoros	21	21	-
Tanzania	20	26	13

Source: Equality Index, 2022.

[1] https://www.equaldex.com/, accessed 9 September 2022.

Table 8.1 ranks countries from highest to lowest on the Equality Index, illustrating that LGBTIQ persons do not enjoy equality in SADC. Rankings range from a high of 78% in South Africa to 20% in Tanzania. Eight countries score less than 50% and only one is more than 70%. Notably, legal scores rank higher than - or equal to - public opinion scores in all countries where both exist. South Africa scores highest at 97% in the legal index as well as the public opinion index at 59%, with a gap of 38 percentage points between the two indicators. This shows that public opinion needs to catch up with legal provisions. Eswatini, Lesotho, Madagascar, Malawi, Tanzania and Zimbabwe score less than 20% on the public opinion index.

These findings and others in this chapter point to the need for vigorous advocacy and lobbying for policy and legislative changes accompanied by public education and awareness on LGBTIQ rights.

Tanzania: Government continues its crackdown on LGBTIQ people

People who distribute materials related to same-sex partnerships on social media will face the music, the government of Tanzania warned in September 2022.

The Minister of Information, Communication and Information Technology called upon administrators of social networking platforms like WhatsApp to take immediate action or face consequences.

Homosexual acts remain illegal in Tanzania and those found guilty of the offence face a jail term of up to 30 years.

Nape Nnauye, Tanzania's minister for information, communications and information technology. Photo: The Citizen

Recent crackdowns on LGBTIQ people and groups have sparked a pushback from human rights groups and other governments.

"It is extremely regrettable that Tanzania has chosen to take such a dangerous path in its handling of an already marginalised group of people," said Joan Nyanyuki, Amnesty International's regional director for East Africa, the Horn and the Great Lakes.[2]

Nnauye said some internet users have been republishing same-sex materials online. He cited numerous instances of information shared on social media that included movies with same-sex relationships, which he claimed sparked controversy in the community.

He said it is the responsibility of everyone to protect children from inappropriate content, especially on social networks. Further, Nnauye warned that the government would go after all content, even when users share it to raise awareness in support of LGBTIQ rights.

Source: Muyonga Jumanne, The Citizen, 12 September 2022.

[2] Tanzania: 'Dangerous' plans for homophobic taskforce must be abandoned immediately, https://www.amnesty.ca/news/tanzania-dangerous-plans-for-homophobic-taskforce-must-be-abandoned-immediately/, accessed 24 September 2022.

Table 8.2: Sexual diversity baseline indicators in 2022[3]

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi
Criminalisation of same sex consensual acts								
Consensual same-sex acts decriminalised	Yes	Yes	No	Never criminalised	No	Never criminalised	Yes, for those over 21	No
Gender/s			Male only		All genders		All genders	All genders
Years in prison/other			Up to five or a fine		Undeter-mined			14
Protection								
Protection against discrimination								
Specific constitutional provisions	No	No	No	No	No	No	No	No
Broad protections	Yes	No	No	No	No	No	No	No
Employment	Yes	Yes	No	No	No	No	No	No
Criminalisation of violence/discrimination against LGBTI communities								
Hate crimes/ aggra-vated circumstances	Yes	No	No	No	No	No	No	No
Incitement to hatred/ violence	Yes	No	No	No	No	No	No	No
Ban on conversion therapy								
CT banned	No	No	No	No	No	No	No	No
Recognition of LGBTI+ rights								
Same sex marriages	No	No	No	No	No	No	No	No
Civil unions	No	No	No	No	No	No	No	No
Joint adoption of children	No	No	No	No	No	No	No	No
Second parent adoption of children	No	No	No	No	No	No	No	No
Changing identity								
Changing sex/ gender markers	Nominally possible	Potentially possible	Not possible	Not possible	Not possible	Not possible	Not possible	Nominally possible
Name change	Nominally possible	Possible	Not possible	Possible	Possible	Possible	Possible	Nominally possible
LGBTI+ organisations								
Able to register	Yes	Yes	No	No	No	Yes	No	No
Able to operate freely	Yes	Yes	No	No	No	Yes	No	No

[3] https://www.equaldex.com, Accessed August 2022.

INDICATORS	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Criminalisation of same sex consensual acts								
Consensual same-sex acts decriminalised	No	Yes	No	Yes	Yes	No		No
Gender/s	Male only		Male only			All genders		Male only
Years in prison/other	Five		Undeter-mined			Life		One
Protection								
Protection against discrimination								
Specific constitutional provisions	No	No	No	No	Yes	No		No
Broad protections	No	No	No	No	Yes	No		No
Employment	Yes	Yes	No	Yes	Yes	No		No
Criminalisation of violence/discrimination against LGBTI communities								
Hate crimes/ aggra-vated circumstances	No	No	No	No	No	No		No
Incitement to hatred/ violence	No	No	No	No	No	No		No
Ban on conversion therapy								
CT banned	Yes	No	No	No	Yes	No		No
Recognition of LGBTI+ rights								
Same sex marriages	No	No	No	No	Yes	No		No
Civil unions	No	No	No	No	Yes	No		No
Joint adoption of children	No	No	No	No	Yes	No		No
Second parent adoption of children	No	No	No	No	Yes	No		No
Changing identity								
Changing sex/ gender markers	Possible	Nominally possible	Possible	Not possible	Possible	Not possible		Not possible
Name change	Possible	Nominally possible	Possible	Possible	Possible	Not possible		Possible
LGBTI+ organisations								
Able to register	Yes	Yes	Yes	Yes	Yes	No		Yes
Able to operate freely	Yes	No	Yes	Yes	Yes	No		No

Table 8.2 shows that:

- Five out of 16 SADC countries have decriminalised same-sex consensual acts: Angola, Botswana, Mozambique, Seychelles, and South Africa. DRC and Lesotho have not ever criminalised homosexuality, so laws in those countries require further clarity. Madagascar decriminalises homosexuality for those older than 21 but criminalises it for anyone younger than 21.
- Four countries (Comoros, Mauritius, Namibia, and Zimbabwe) criminalise homosexuality for men only.
- Only South Africa has constitutional provisions to protect LGBTIQ people.
- Six countries (Angola, Botswana, Mauritius, Mozambique, Seychelles and South Africa) have employment protections for LGBTIQ people.
- Only Angola criminalises hate crimes and incitement to violence against LGBTIQ communities, while only Mauritius and South Africa ban conversion therapy (the pseudoscientific practice of trying to change an individual's sexual orientation from homosexual or bisexual to heterosexual using psychological or spiritual intervention).[4]
- Some countries, like Mauritius, have contradictory legislation, criminalising homosexual sex acts yet protecting LGBTIQ people from discrimination in the workplace and banning conversion therapy.
- Only South Africa recognises same sex unions, civil unions, joint adoption of children and second parent adoption of children.
- Four countries explicitly allow people to change sex and/or gender markers[5] and their names (Mauritius, Namibia, South Africa, and Zambia), while four others nominally allow these changes (Angola, Botswana, Malawi and Mozambique).
- LGBTIQ organisations can legally register in nine countries (Angola, Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa, and Zimbabwe) and operate freely in seven countries in Angola, Botswana, Lesotho, Mauritius, Namibia, Seychelles and South Africa.

Sections on global, continental, and national legislative frameworks align with last year's Barometer with one significant change. In Botswana, the High Court rejected the government's appeal to overturn its judgement that decriminalised homosexuality. Despite the government's initial opposition to the decriminalisation of homosexuality, the president of Botswana has now committed to promote LGBTIQ rights.

In Botswana, the High Court rejected the government's appeal to overturn its judgement that decriminalised homosexuality

[4] https://en.wikipedia.org/wiki/Conversion_therapy, accessed 15 July 2019.
[5] When state and government agencies change the gender identifier, sex marker, sex identifier on official documents such as a birth certificate or driver's license.

Botswana: After a rejected appeal, government vows to honour LGBTIQ rights[6]

Botswana's president vowed to implement a High Court ruling decriminalising homosexuality after losing an appeal to overturn the ruling in November 2021.

President Mokgweetsi Masisi attempted to assure the country's LGBTIQ community that he would respect the court's decision and protect their rights.

"We ask and expect everyone to respect the decisions of our court," he said during a meeting with members of the Lesbians, Gays and Bisexuals of Botswana (LEGABIBO).

LGBTIQ activists gather outside the Botswana High Court following its decision to reject a government appeal in early 2022. Credit: Monirul Bhuiyan

He assured them that political concerns and not animosity towards the LGBTIQ community motivated his appeal to the court, which it rejected in November 2021, recalling, "We live in a rather conservative society."

The president's invitation to members of the LGBTIQ community marks a major turning point in Botswana. Five years ago, the LEGABIBO group went to court to circumvent a government ban on its existence. In 2019, the court in Botswana's capital, Gaborone, ordered the government to amend laws punishing same-sex relationships, calling them "relics of the Victorian era" that "oppress a minority."

The government appealed the decision in October 2021, arguing that Parliament should decide on this "political issue," not the courts. Botswana's LGBTIQ citizens have lived in "constant fear of being discovered or arrested," Justice Ian Kirby said in November. "This has sometimes led to depression, suicidal behaviour, alcoholism or drug abuse."

Source: Rédaction Africanews with AFP, 25 January 2022.

The impact of COVID-19

A new report by Pan Africa International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-PAI) on the resilience of the LGBTIQ community during the COVID-19 pandemic underscores the need for investment in strengthening LGBTIQ organisations.[7]

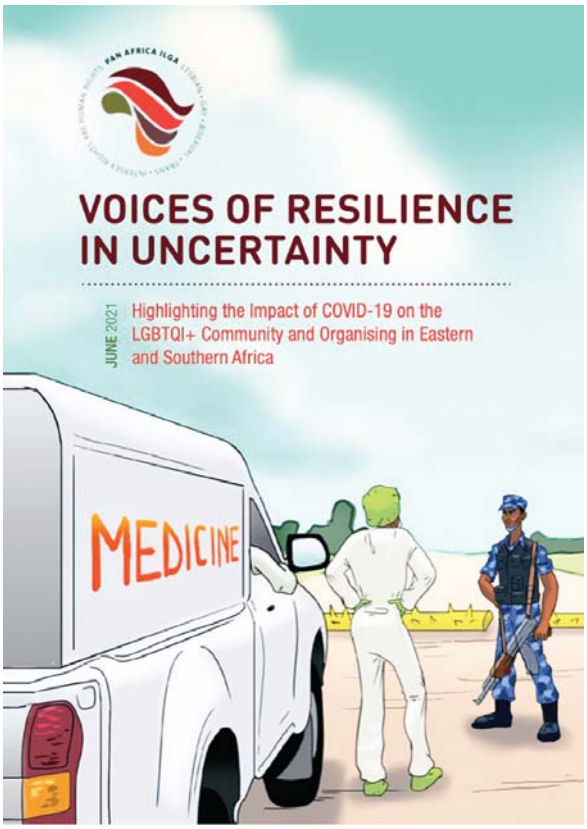
The report, titled *Voices of Resilience in Uncertainty*, highlighted the impact of COVID-19 on the LGBTIQ communities and their organisations in Botswana, Eswatini, Namibia, Malawi, South Africa, Tanzania, Zambia and Zimbabwe as well as in the East African nations of Burundi, Ethiopia, Kenya, Rwanda and Uganda.

The report covers the period from mid-March 2020 (the intensive phase of most countries' public health response) to April 2021, when

[6] https://www.africanews.com/2022/01/25/botswana-president-vows-to-honour-gay-rights-judgment//

[7] https://76crimes.com/2021/10/22/report-covid-19-threatens-lgbtiq-africans-and-their-organisations/, accessed 10 September 2022.

researchers surveyed communities. It notes that LGBTIQ communities experienced some of the worst economic impacts of COVID-19 lockdowns, including loss of income and lack of basic treatments for themselves and their household members.



Researchers also found that many LGBTIQ organisations struggled to adapt their operations to the new normal and had to adopt trial-and-error strategies. At first, the organisations adjusted reasonably well to lockdowns but, as months progressed, most of them encountered problems, the report said.

"For example, shelters that remained operational during the lockdown period lacked specific guidelines on response to instances where residents test positive for COVID-19 or require testing incoming residents," the report stated.

The report called for the following priority actions:
- Access to government relief;
- Increased access to primary health, HIV and AIDS, sexual and reproductive health and rights (SRHR), mental health services, and to shelter services;
- Bridging the digital divide and access to information;
- Providing free legal aid;
- Creating a just economic landscape for LGBTIQ persons;
- Engagement with local authorities on the lack of services for LGBTIQ communities;
- Strengthening LGBTIQ organisations' institutional capacity; and
- Public awareness and education to reduce stigma and discrimination.

Mauritius: Young Queer Alliance used "e-outreach" to reach beneficiaries during COVID-19 lockdowns

Due to the COVID-19 pandemic, the Young Queer Alliance (YQA) organisation in Mauritius faced challenges in conducting its normal activities, such as the distribution of condoms and gels, HIV testing, street advocacy, space safe activities (hiking, film viewing, and workshops), and counselling.

COVID-19 also significantly affected the core funding for the non-governmental, youth-led and apolitical organisation that seeks to empower individuals and organisations and promote equality for LGBTIQ people.

Restrictions imposed by the government also limited its mobility and its work with beneficiaries across the country. Thus, the organisation came up with a new strategy of "e-outreaching" its recipients. This strategy includes contacting beneficiaries through social media platforms (Facebook and WhatsApp), telephone and email to provide online

counselling, sharing of information on HIV and AIDS, and facilitating online activities to ensure continuity of its services.

To respond to these unique challenges, YQA developed a COVID-19 guide for LGBTIQ people in Mauritius, which includes HIV-related precautions to take during COVID-19. This toolkit is the first of its kind in Mauritius and YQA turned it into an animated video.

YQA also conducted an online survey during the pandemic, which showed the challenges faced by LGBTIQ Mauritians due to COVID-19. These mainly include violence and stigma in family settings leading to heightened levels of anxiety and mental health issues.

Using its strategic plan as a baseline, the YQA intends to develop a comprehensive social support package for LGBTIQ people.

Source: Young Queer Alliance in Mauritius Pride Profile, NDI, accessed 12 September 2022.

Legal and policy frameworks

This section covers the global, continental and regional instruments that promote the rights of LGBTIQ communities. It begins with an overview of seminal international declarations. These overarching frameworks provide entry points for lobbying and advocacy at national level.

Global instruments

The UN is the sum of its member states, many of which do not tolerate LGBTIQ rights. As such, the Sustainable Development Goals (SDGs) do not include any specific references to LGBTIQ people or issues. Nevertheless, to ensure that the global development agenda does not leave LGBTIQ communities behind, the United Nations Development Programme (UNDP) developed the lesbian, gay, bisexual, transgender and intersex (LGBTI) Inclusion Index to inform evidence-based development strategies to advance their inclusion. Following extensive multi-sectoral and civil society consultations, the five priority dimensions for measurement in the Inclusion Index comprise political and civic participation, economic well-being, personal security and violence, health, and education.[8]

To bring greater clarity and coherence to states' human rights obligations, the International Commission of Jurists and the International Service for Human Rights, on behalf of a coalition of human rights organisations, developed a set of international legal principles based on the application of international law to human rights violations based on sexual orientation and gender identity.[9] Although stakeholders first adopted these Yogyakarta Principles in 2007, and updated them in 2017, they remain non-binding. However, they provide comprehensive guidance to states, including: rights to universal enjoyment of human rights, non-discrimination, and recognition before the law; rights to human and personal security; economic, social, and cultural rights; rights to expression, opinion, and association; freedom of movement and asylum; rights of participation in cultural and family life; rights of human rights defenders; and rights of redress and accountability.[10]

The UN has rolled out several instruments that enshrine these rights, and SADC countries have signed on to many of them.

[8] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf
[9] http://yogyakartaprinciples.org/introduction/
[10] https://www.pgaction.org/inclusion/pdf/handbook/en.pdf

Table 8.3: Overview of key UN instruments and SADC commitments[11]

Country	International Convention on Civil and Political Rights	International Covenant on Economic, Social, and Cultural rights	Convention on Torture	Convention on the Elimination of all Forms of Discrimination Against Women	Convention on the Rights of the Child	UN Centre for Regional Development (SDGs)	International Convention on the Elimination of all forms of Racial Discrimination
	(ICCPR)	(ICESRC)	(CAT)	(CEDAW)	(CRC)	(CRD)	(ICERD)
Angola	SP	SP	S	SP	SP	SP	S
Botswana	N	N	N	SP	SP	S	S
Comoros	S	S	SP	SP	SP	SP	SP
DRC	SP	SP	SP	SP	SP	SP	SP
Eswatini	SP	SP	SP	SP	SP	SP	SP
Lesotho	SP	SP	SP	SP	SP	SP	SP
Madagascar	SP	SP	SP	SP	SP	SP	SP
Malawi	SP	SP	SP	SP	SP	SP	SP
Mauritius	SP	SP	SP	SP	SP	SP	SP
Mozambique	SP	N	SP	SP	SP	SP	SP
Namibia	SP	SP	SP	SP	SP	SP	SP
Seychelles	SP	SP	SP	SP	SP	SP	SP
South Africa	SP	SP	SP	SP	SP	SP	SP
Tanzania	SP	SP	N	SP	SP	SP	SP
Zambia	SP	SP	SP	SP	SP	SP	SP
Zimbabwe	SP	SP	N	SP	SP	SP	SP

Table 8.3 provides an overview of the relevant UN instruments and the status of SADC member state commitments. All instruments promote equality, non-discrimination for all citizens, and protection from hate crimes. It classifies the status of commitments in three ways:

1. None means a state has not committed to the instrument, indicated with an "N."
2. Signatory means a state has signed an agreement but has not ratified it at national level, indicated with an "S."
3. State party means a state has ratified the instrument at national level, which means it must domesticate it, indicated with an "SP."

Ten SADC countries have committed to implementing all seven instruments: DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Namibia, Seychelles, South Africa, and Zambia. Botswana, Tanzania and Zimbabwe have not signed the Convention on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

Angola has not ratified the CAT and International Convention on the Elimination of all forms of Racial Discrimination (ICERD). Meanwhile, Botswana lags in several areas as it has not committed to the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social, and Cultural rights (ICESRC) or CAT and it has only signed up to, but not domesticated, the Convention on the Rights of the Child (CRD) and ICERD.

While progress by countries in SADC to implement relevant instruments has stalled in some areas, the UN has increasingly focused on sexual diversity at the global level. The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA World) conducted an analysis of thematic reports submitted to the UN Human Rights Council and General Assembly.

[11] https://ilga.org/downloads/Treaty_Bodies_SOGIESC_references_2016_ILGA.pdf

Table 8.4: UN thematic reports with good or strong LGBTQ references in 2020[12]

Mandate	Report topic	References
Special Rapporteur in the Field of Cultural Rights	Cultural rights defenders January 2020 (41st Session Human Rights Council (HRC))	Good references to LGBTIQ and sexual orientation and gender identity (SOGI): cultural rights include LGBTIQ rights, challenges defenders face and need for protection
Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression	Artistic Freedom of Expression: July 2020 (44th Session HRC)	Good reference to LGBTIQ, sexual minorities (suppression of LGBTIQ activists, artists, and artistic events and expression)
Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association	Celebrating women in activism and civil society: the enjoyment of the rights to freedom of peaceful assembly and of association by women and girls: July 2020 (75th Session General Assembly (GA))	Good reference to LGBTIQ (women with multiple and intersecting forms of marginalisation, police violence and restrictions on overseas funding)
Special Rapporteur on Freedom of Religion or Belief Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard Of Living, and on the Right to Non-Discrimination in this Context	Freedom of religion or belief and gender equality: August 2020 (43th Session HRC) COVID-19 and the right to adequate housing: July 2020 (75th Session GA)	Very strong reference to SOGI-based violence and discrimination in the name of religion or belief Strong references to LGB, transgender and gender-diverse persons and SOGI. (A separate section on LGBTIQ persons' right to housing during the pandemic; a recommendation on data collection)
Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-Discrimination in this Context	Guidelines for the implementation of the right to adequate housing: December 2019 (43rd Session HRC)	Good references to LGBTIQ and "sexual identity" (vulnerability and discrimination in housing)
Special Rapporteur on the Rights of Indigenous Peoples	The impact of COVID-19 on the rights of Indigenous peoples: July 2019 (75th Session GA)	Good references to LGBTIQ and SOGI (example from Thailand; recommendation to pay attention to the situation of Indigenous LGBTIQ persons; call to collect and analyse data on indigenous LGBTIQ and two-spirit persons in the health-care system; no discrimination based on SOGI)
Special Rapporteur on the Right To Privacy	Summary of activities on surveillance, health data, business enterprises use of personal data and protection against gender-based privacy infringements: February 2020 (43rd Session HRC)	Good references to sexual orientation, gender identity and expression, and sex characteristics (SOGIESC): Considerations of the right to privacy of people with diverse SOGIESC in relation to treatment of persons deprived of their liberty; changing rooms and health-related data
Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity	"Conversion therapies" practices: May 2020 (44th Session HRC)	Explores practices of so-called "conversion therapy" across the globe, including their impact on victims, their human rights implications and their connection with violence and discrimination based on sexual orientation and gender identity, as well as measures

[12] https://ilga.org/lgbti-rights-special-procedures-UN-experts-push-for-better-protection

Mandate	Report topic	References
		adopted to prevent them and to penalise or prosecute those who perform them and remedies provided to victims
Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity	COVID-19: July 2020 (75th Session GA)	Discusses the impact of COVID-19 on the human rights of LGBTIQ and gender-diverse persons, communities and/or populations; analyses the impact of the pandemic on social exclusion and violence and the interaction with institutional drivers of stigma and discrimination; and analyses measures adopted in the context of the pandemic aimed at persecuting LGBTIQ and gender-diverse persons or with indirect or unintended discriminatory effects and identifies good practice
Special Rapporteur on the Promotion of Truth, Justice, Reparation and Guarantees of Non-Recurrence	The gender perspective in transitional justice processes: July 2020 (75th Session GA)	Strong reference to LGBTIQ and gender perspectives considered in conceptualisation, design and implementation of national transitional justice strategies and mechanisms
Special Rapporteur on Violence Against Women, its Causes and Consequences	Violence against women journalists: May 2020 (44th Session HRC)	Good references to LGBTIQ people, LBTI women, LT journalists and LGBTIQ issues (in the context of attacks, abuses and harassment experienced by journalists, and retaliation for covering certain issues)

Table 8.4 illustrates that most thematic reports submitted to the UN Human Rights Council and General Assembly contain information on LGBTIQ communities. In 2020, 39 reports (more than 50% of all thematic reports) mentioned some LGBTIQ-related topics, with 12 of these reports - as shown in Table 8.4 - including good or strong references to LGBTIQ populations.

Activists welcome the ongoing attention to LGBTIQ human rights issues by the UN structures and encourage mandate holders to strengthen their analysis of specific populations within LGBTIQ communities. This includes LBQ women, trans or intersex persons and LGBTIQ persons with disabilities.

Activists welcome the ongoing attention to LGBTIQ human rights issues by the UN structures and encourage mandate holders to strengthen their analysis of specific populations within LGBTIQ communities

Conversion therapies cause “unimaginable suffering,” says UN expert

Young LGBT people drop out of school three times more than non-LGBT people and trans people contract HIV 47 times more than gay men and 76 times more than the general population, according to a UN expert.

The reason for these gigantic discrepancies, says Victor Madrigal-Borloz, the UN independent expert on protection against violence and discrimination based on sexual orientation and gender identity, “is that too often a trans person who is ill will not seek health services for fear of being ridiculed and will not receive the care they really need.”

In his unique role, Madrigal-Borloz advocates for a world free of the criminalisation of gender orientation and gender identity, including the elimination of conversion therapies.

He notes that countries that criminalise different sexual orientations or gender identities often encourage the use of "conversion therapies," which aim to change a person's sexual orientation or gender identity on the false premise that LGBT and gender variant people are sick.

According to a report by Madrigal-Borloz to the UN Human Rights Council, at least 68 countries practice conversion therapies. This includes an estimated 700 000 lesbians, gay, trans, or gender variant people in the United States and 14 000 in Switzerland.

Conversion therapies cause profound physical and psychological trauma to people of all ages, he says. UN mechanisms against torture have called these practices tantamount to acts of torture or cruel, inhuman or degrading treatment.

The independent expert makes observations and advises states on corrective measures. In light of the suffering caused by conversion therapy, Madrigal-Borloz explicitly recommends that member states prohibit these practices, repealing laws that permit them as well as those that criminalise diversity of sexual orientation and gender identity.

Victor Madrigal-Borloz is the UN's independent expert on protection against violence and discrimination based on sexual orientation and gender identity.
Photo: UN Photo/Jean-Marc Ferré

For example, Ghana lawmakers are considering a law that would punish anyone suspected of being LGBTIQ with five years in prison and conversion therapy. Along with nine other human rights experts, Madrigal-Borloz wrote to Ghana's head of state to note that the law constituted "a fundamental departure from the State's international obligations" and to give him “examples of the pernicious effects the law would have on people living in Ghana - including the unimaginable suffering that conversion therapy would cause.”

Source: UN News, accessed 12 September 2022.

Continental instruments

Two binding treaties that apply at the regional level strengthen the fight to curb violence against people based on their real or imputed sexual orientation or gender identity. The African Charter on Human and Peoples' Rights (also known as the Banjul Charter), represents the principal treaty and guarantees the principles of non-discrimination and equality before the law; the rights to life, dignity and physical integrity; the guarantee against cruel, degrading or inhuman treatment or punishment; and the right to a fair hearing before competent national courts.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), in addition, requires state parties to take specific measures to combat violence against women, regardless of their sexual orientation or gender identity.[13]

In 2014, the African Commission on Human and Peoples' Rights adopted Resolution 275: Resolution on Protection against Violence and other Human Rights Violations against Persons based on their real or imputed Sexual Orientation or Gender Identity. It provides clarity on the import of the clauses in the African Charter for LGBTIQ communities. Resolution 275 calls on member states to:

1. Ensure that human rights defenders work in an enabling environment free of stigma, reprisals, or criminal prosecution because of their human rights protection activities, including the rights of sexual minorities; and
2. End all acts of violence and abuse, whether committed by state or non-state actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence, including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.[14]

The first clause in resolution 275 commits member states to allowing LGBTIQ organisations to operate freely. This is currently only possible in Angola, Botswana, Lesotho, Mauritius, Namibia, Seychelles, and South Africa. Nine SADC countries actively restrict these organisations. The second clause commits member states to creating a legal environment that criminalises violence against LGBTIQ persons in all its forms and ensures prosecution of perpetrators of such violence.

Angola is the only country in SADC that has specific hate crime legislation that protects LGBTIQ people from violence and discrimination. Other countries should urgently adopt similar legislation.

Progress and setbacks on LGBTIQ rights in Africa: An overview of the last year

June 2022 marked the anniversary of the 1969 Stonewall riots over the treatment of LGBTIQ people by New York City police, which activists commemorated a year later with a protest march. Pride marches and parades are now ubiquitous in many countries.

Pride month is a time to reflect on progress but also ongoing challenges in advancing the rights of LGBTIQ people.

Many countries in Africa have poor reputations when it comes to LGBTIQ rights. The anthro-

[13] lhttp://cfnhri.org/uploads/files/resolution_275_eng.pdf
[14] http://www.achpr.org/sessions/55th/resolutions/275/

pologist Zethu Matebeni has parodied this uniformly gloomy view in a piece entitled "*How Not to Write About Queer South Africa.*" But the same volume also highlights the ways in which "African political, religious and traditional leaders" marginalise sexual and gender minorities.

When it comes to the rights of sexual and gender minorities in Africa, the past year has been a mixed bag.

South Africa, notwithstanding strong legal protections, continues to battle violence directed against LGBTIQ people. In 2021, at least 24 people were reportedly murdered in bias-motivated attacks. The Ministry of Justice is revising its policy and approach to combating systemic gender-based violence in the country.

Of the 69 countries that criminalise same-sex relations, 33 are in Africa. In most cases, these laws represent remnants of colonial rule, and the vague wording of these prohibitions, such as "carnal knowledge against the order of nature" resonates with the decorum of that era. Although the examples are few, there has been some progress over the last year on the protection of LGBTIQ rights in Africa.

In November, the Botswana Court of Appeal upheld a lower court decision to decriminalise consensual same-sex conduct. The court found that the Penal Code provisions outlawing "carnal knowledge of any person against the order of nature" were unconstitutional as they violate the right to privacy, the right to liberty, security of person, and equal protection under the law, and the right to freedom from discrimination. Judges on the Botswana high court said that these archaic laws belong "in the museum or the archives."

In Mauritius, three cases are challenging the constitutionality of a law that punishes consensual same-sex conduct with up to five years in prison.

Pride participants in Eswatini call for stronger rights and protections for LGBTQ organisations.
Photo: Africa Revisita

At the same time, Mauritius' Equal Opportunities Act 2008 protects against discrimination based on sexual orientation, including in employment, education, and accommodation.

Freedoms of expression and association have also been tested during the past year. Despite decriminalising same-sex relationships in 2015, Mozambique has still not allowed a prominent LGBTIQ rights group, Mozambique Association for Sexual Minority Rights (LAMBDA), to officially register as a non-governmental group. In neighbouring Eswatini, the high court asserted that LGBTIQ people, like anyone else, had rights to freedom of association and expression, but nevertheless upheld a decision to deny the registration request of Eswatini Sexual and Gender Minorities, a local LGBTIQ rights group.

Within the African regional human rights system, the African Union used the pretext of objecting to the observer status granted to the Coalition of African Lesbians to limit the autonomy of the African Commission, berating the body for acting contrary to African values by recognising the lesbian group.

Source: Graeme Reid, Director, Lesbian, Gay, Bisexual, and Transgender Rights Program, Daily Maverick, 22 June 2022.

Regional instruments

No SADC instruments currently exist specifically to address LGBTIQ rights. This is indicative of the resistance amongst legislators in most SADC states to address the needs of these communities. South Africa remains the exception, with some of the most progressive laws, policies, and practices in the world. Given the policy-rich global and continental environment, activists need to continue to lobby and advocate for a regional protocol on the rights of LGBTIQ people - one that includes global and continental provisions within a SADC context.

Three SADC instruments speak to improving SRHR in member states:

1. Strategy for Sexual and Reproductive Health and Rights in the SADC region, 2019-2030;
2. SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights among key populations; and
3. Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region.

The ***SADC SRHR strategy*** includes LGBTIQ people in its list of beneficiaries (adolescent girls and young women; women of a reproductive age; men and boys; and key populations including sex workers, people who inject and use drugs, prisoners, men who sleep with men (MSM) and LGBTIQ, migrants, refugees, mobile populations, people living with disabilities, and victims of sexual exploitation).[15] However, the SRHR strategy makes no other specific reference to the needs of LGBTIQ people.

The ***SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights*** does not include LGBTIQ people. However, it does identify MSM and transgender people as key populations. All key populations named in this strategy face elevated levels of stigma and discrimination, which impede their access to health services, including HIV and SRH services. They also face stigma and discrimination in healthcare settings, the workplace, families, and within communities.[16]

The ***Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region*** takes a similar approach by referencing LGBTIQ persons as a key population. It calls on states to:

1. Review and revise or develop new policies that support access to integrated SRH and HIV services for key populations, especially adolescents, youth, migrant populations, LGBTIQ persons, and people with disabilities; and
2. Put systems in place, including the necessary facility and community service provision modifications and infrastructure, to facilitate access to SRH and HIV services by key populations, especially adolescents, youth, LGBTIQ persons, and people with disabilities.[17]

All SADC states have signed up to the 2019 SADC SRHR Strategy and the 2018 SADC Regional Strategy for HIV Prevention, Treatment, Care and Sexual and Reproductive Health and Rights. However, some member states have yet to implement the provisions of these guiding instruments. Since the adoption of the 2019 SADC SRHR Strategy, none of the states has submitted reports on their performance towards achieving the stipulated targets.

This raises important questions about accountability and the enforcement of SADC instruments. Should there be sanctions for countries that do not domesticate the relevant instruments? Recent developments in Botswana and Seychelles point to high-level support for LGBTIQ rights as the presidents of both countries committed to guaranteeing LGBTIQ rights.

[15] https://genderlinks.org.za/wp-content/uploads/2018/11/1-Final-signed-SADC-SRHR-Strategy-2019-2030.pdf
[16] https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf
[17] http://www.integrainitiative.org/wp/wp-content/uploads/2015/12/tmp-11285-SADC-Min-Stds-Eng-final-1158402048.pdf

Seychelles: "Open and frank" discussion heralds new era as president welcomes LGBTIQ activists

"We should live in a society where anyone be free to live their lives as they please regardless of gender or orientation. As long as we respect one another and are tolerant to others views."

These sentiments, spoken by Seychelles President Wavel Ramkalawan, marked a turning point for government and LGBTIQ relations in the country in 2022 as Ramkalawan met with Naddy Vidot, the chairperson of the LGBTI Seychelles Association at State House. LGBTI Seychelles is a non-government organisation that advocates for sexual orientation and gender identity rights.

Members of the LGBTI Seychelles Board accompanied Vidot, including Emily Gonthier, the organisation's vice chair, and its secretary, Sasha Alis.

The president said he welcomed the opportunity and briefing on the work of their association, its objectives and plans for the future.

During the meeting, Vidot and other members of LGBTI Seychelles shared information about their strategies in relation to three main areas of focus: legal reforms, health and education. The discussions also touched on national education, anti-bullying awareness in schools, health services, human rights matters, adoption process and other legal reforms.

Seychelles LGBTI leaders pose with President Wavel Ramkalawan in Victoria in 2022.
Photo: LGBTI Seychelles

Speaking to the local media after the meeting, Alis expressed appreciation for the discussion.

"It is a momentous historic moment for LGBTI, for us to have been able to meet with the President. We had an interesting discussion on tangible issues such as national education, sensitisation in schools, legal affairs, and health, and the possibility for LGBTI people in Seychelles to obtain equal rights and access to different facilities and services. The discussion with the President was open and frank. We are all satisfied with our meeting."

Source: Colin Stewart, Erasing 76 Crimes, August 2022.

Constitutional provisions

It is important to include protections for gender and sexual orientation in country constitutions. This guarantees long-term protections for LGBTIQ people. Fourteen SADC countries include equality and non-discrimination clauses in their constitutions, but do not include sexual orientation. A constitution provides fundamental foundational principles that apply to all citizens. Governments should not use a constitution to exclude any individuals or groups.

Only **South Africa** has specific provisions in its constitution recognising the rights of LGBTIQ people. Chapter two (the Bill of Rights of the South African Constitution) states under sub- section nine: "The state

may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth... No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection... National legislation must be enacted to prevent or prohibit unfair discrimination... Discrimination on one or more of the grounds listed in subsection 3 is unfair unless it is established that the discrimination is fair."

The **Comoros** Constitution of 2018 guarantees equality in Article 2 as follows: "The Union of the Comoros equally recognises the equality of all citizens before the law, without distinction of race, sex, religion, political belief, and it assures all citizens the full enjoyment of fundamental freedoms."[18] Article 3 further elaborates on these rights: "All Comorians of the two sexes enjoying their civil and political rights are electors, within the conditions determined by the law." This clause does not recognise any other genders except for female and male. This has a fundamental impact on gender non-conforming persons.

LGBTIQ activists have lauded **South Africa** for its progressive constitution, often referred to as one of the best in the world. The efficacy of a constitution is only as powerful as the manner in which citizens and lawmakers leverage it in specific legislation to advance equality for all citizens.

Table 8.5 overleaf shows the slow and steady progression of the South African legal and constitutional context concerning LGBTIQ rights and it demonstrates the need for a concerted and strategic lobbying and advocacy plan to advance LGBTIQ rights and protections. It is also evident that political will to bring in progressive legislation has waned. Legislators tabled the Prevention and Combatting of Hate Crimes Bill in South Africa in 2016 but they have not yet propagated it into law.

The law remains stalled because some legislators say the Bill contradicts freedom of speech. Activists maintain that it is necessary to address violence, noting the murders of 40 lesbians since 2000; with an average of ten lesbians raped each week by men who subscribe to the view that rape "corrects" one's sexual orientation. Qualitative studies have revealed perpetrators' claims that rape will "cure" lesbians and make them heterosexual. Gay men have also been victimised and terrorised.

Thus, despite constitutional protection, the brutal violence faced by the LGBTIQ community continues. The Forum for the Empowerment of Women (FEW) and others have spoken out against this form of violence since the 2000s. Activists established the Anti-Hate Crime Task Force and mandated it to develop a response to violence against LGBTIQ communities. However, police do not keep separate statistics on murders motivated by homophobia or transphobia, making it difficult to develop a viable policy to combat hate crime.[19]

LGBTIQ activists have lauded South Africa for its progressive constitution, often referred to as one of the best in the world

[18] https://www.constituteproject.org/constitution/Comoros_2018.pdf?lang=en
[19] https://ourconstitution.constitutionhill.org.za/todays-issues-the-constitution-is-beautiful-on-paper-but-in-reality-it-is-not/

Table 8.5: Constitutional and legal rights timeline for LGBTIQ rights in South Africa

YEAR	CONSTITUTIONAL AND LEGAL RIGHTS[20]
1996	**The new Constitution** The inclusion of a specific prohibition of discrimination based on sexual orientation in the 1996 Constitution represented a significant achievement. South Africa became the first country in the world to explicitly prohibit the discrimination of gays and lesbians. However, at the time legislators passed the Constitution, laws remained on the statute books that criminalised same-sex sexual identities and the country provided no legal recognition to same-sex relationships.
1999	**The first court judgment on LGBTI rights** In the case of the National Coalition for Gay and Lesbian Equality v. Minister of Justice and Others, NCGLE and the South African Human Rights Commission challenged the constitutionality of existing laws, which criminalised sodomy. The court focused on the equality clause and drew on previous tests for determining unfair discrimination. In its landmark ruling, the court considered the harmful social and psychological impact of the criminalisation of sodomy on gay men and found that it fundamentally affected their dignity. The court found the provisions of the Sodomy Act to be unfair and declared them unconstitutional.
2000	**Recognising the rights of lesbian and gay partnerships** In the case National Coalition for Gay and Lesbian Equality and Others v. Minister of Home Affairs and Others, the Constitutional Court considered the constitutionality of a provision of the Immigration Act. The provision allowed a foreign opposite-sex partner of a South African citizen to live in South Africa but denied the same treatment to a foreign same-sex partner of a South African. The court found that the statute unfairly excluded same-sex couples. It introduced the notion of "reading in" particular words to a statute rather than sending it back to Parliament and ordered that the words "or partner in a permanent same-sex life partnership" be added to the act.
2002	**Extending the rights accorded to same-sex life partners** The LGBTIQ community steadily continued to make significant gains in the courtroom to expand their freedoms. Once government recognised lesbian and gay partnerships in the Immigration Act, several other cases followed which accorded rights to same-sex life partnerships. These included pension benefits (Satchwell v. President of the Republic of South Africa, 2002), adoption rights (Du Toit v. Minister of Welfare and Population Development, 2003) and the right of a lesbian couple to artificial insemination (J v. Director General, Department of Home Affairs, 2003). All of these cases focused on the unfair discrimination of particular laws and the infringement of the dignity of the partnership. They resulted in the court order to read in the words "or permanent same-sex life partnership" to extend the rights in question to same-sex couples.
2006	**The Civil Union Act** The institution of marriage - with its symbolic and practical implications - came under the spotlight in the case of Minister of Home Affairs v. Fourie, Marié Fourie and Cecelia Bonthuys. Fourie and Bonthuys, who had been living together in a committed relationship since 1994, claimed that government had unfairly discriminated against them because they could not marry under the Marriage Act 25 of 1961. In a landmark judgment, the Constitutional Court found the Marriage Act unconstitutional, stating that it violated section 9 of the Constitution - the Right to Equality. The Court gave Parliament one year to pass new legislation. The Civil Union Act 17 came into force in 2006, making South Africa the first country in Africa, and the fifth in the world, to legalise same-sex marriages.
2016	**The Prevention and Combating of Hate Crimes and Hate Speech Bill**[21] The Bill aims to reduce offensive speech and curb hate crimes in South Africa. Legislators introduced the Bill in 2016 and it sits before the South African National Assembly. Some of the stated intentions of the legislation include to "provide for the prevention of hate crimes and hate speech" and to "provide for effective enforcement measures" against those who express their "prejudice or intolerance towards the victim." The bill has been subject to much debate, with some groups expressing concern over the implications of restricting speech. Others have contended that the bill is necessary given the level of discrimination in South Africa.

[20] https://ourconstitution.constitutionhill.org.za/timelines/sexual-orientation/
[21] https://en.wikipedia.org/wiki/Prevention_and_Combating_of_Hate_Crimes_and_Hate_Speech_Bill

South Africa: Open letter rejects "unconstitutional fatwa" against LGBTIQ Muslims

Queer Muslims and their allies participate in a 2019 Pride march. Photo: Ben Gingell

The Muslim Judicial Council (MJC) and the Jamiatul Ulama of South Africa have announced that those who consider themselves homosexual are out of the fold of Islam. They have called for *takfir* (excommunication) of the Muslim lesbian, gay, bisexual, transgender, queer, intersex community.

The MJC is a self-appointed, unelected and entirely male body, save for the head of their Women's Forum, that does not represent the Muslim community on any democratic basis. They also do not have religious authority, as Islam is not a system that is organised along the lines of such religious intermediaries between people and God.

Section 9 of the Constitution forbids discrimination on the basis of sex, gender or sexual orientation, and applies to government and private parties. Section 15 provides for the recognition of religious legal systems and marriages that are not inconsistent with the Constitution. The rights of LGBTIQ people under the South African Constitution cannot be trumped by cultural or religious authority, especially the right to life.

The MJC's fatwa amounts to hate in a context where the lives of LGBTIQ people are already in danger. The fatwa is based on ignorance and reinforces oppression and injustice rather than supporting just, fair and equal rulings.

The MJC and associated bodies such as the Jamiatul Ulama South Africa have published other articles and statements which incite hate against LGBTIQ persons. LGBTIQ persons in South Africa are clearly protected by the Constitution and other laws. We encourage them to use the available channels (Equality Court, Commission for Gender Equality or South African Human Rights Commission) to hold persons/institutions accountable for homophobia/transphobia.

All people deserve to enjoy a life free from oppression and discrimination. Together we can dismantle oppressive institutions and build safe, affirming and kind spaces for LGBTIQ Muslims and all persons.

Source: Rumana Akoob, Gabriel Hoosain Khan, Fatima Shabodien, Nelisiwe Msomi, Shireen Hassim, Seehaam Samaai, Shaazia Ebrahim, Mahomed Jameel Abdullah, Safia Khan, Rumain Akoob, Ty Khan, Shahra Sattar, Jamilla Jade Madingwane, Mangaka Molaqa, Shabir Madingwane, Nompilo Molaqa, Gulshan Khan, Mishka Wazar, Nokuthula Mjwara, Fairoze Diedricks, Maushami Chetty, Lorenzo Wakefield, Shiraz Soeker, Sharon Cox, Phumi Mtetwa and Elsbeth Engelbrecht, Muhsin Hendricks, Haroon Wadee, Shameez Joubert, Waseem Imam Saheb, Alex Sutherland, Seth Deacon, Simone Cupido, Shakira Qwabe and Zama Mthunzi, Daily Maverick, 12 July 2022.

Status of same-sex consensual sexual relations in SADC

Most SADC countries criminalise same-sex consensual sexual acts or sodomy for men through various means. However, many variations exist in terms of the way countries enforce the legislation.

Table 8.6: Status of same-sex consensual sexual acts

Country	Current status
Angola[22]	***Decriminalised*** Sexual orientation is an aggravating factor for several crimes as discrimination (art. 212) or incitement to discrimination (art. 380), injury (art. 213) and defamation (art.214), and corpse desecration (art. 223, in conjunction with articles 221 and 222). Sexual orientation is also included as a characteristic of persecution, which constitutes a crime against humanity (art. 382), protecting sexual minorities in times of extreme violence and internal turmoil.
Botswana[23]	***Pending a government appeal*** Botswana Penal Code sections 164(a), 164(c), 165, and 167. High Court ruled unanimously that the relevant sections are unconstitutional; the attorney requested and received leave to appeal the decision. The appeal is set for 12 October 2021.
Comoros[24]	***Criminalised*** Penal Code of the Federal Islamic Republic of Comoros 138, Article 318. "(3) Without prejudice to the more serious penalties provided for in the preceding paragraphs or by articles 320 and 321 of this Code, whoever will have committed an improper or unnatural act with a person of the same sex.
Democratic Republic of the Congo[25]	***Never explicitly outlawed*** On 22 October 2010, the Congolese parliament sent the Sexual Practices Against Nature Bill to the Socio-Cultural Committee. The Bill gained widespread support both publicly and within the government, and the National Assembly considered it constitutional. Legislation had yet to be drafted.
Eswatini	***Criminalised*** Eswatini criminalises same-sex sexual activity despite no law explicitly outlining this, as Section 252(1) of the Constitution (2005) states that Roman-Dutch Common Law, as interpreted in 1907, applies to any regulations or laws in place prior to independence in 1968 and not subsequently overturned. As such, "sodomy" remains a crime. In 2005, media reported that the government had plans to include prohibitions of all male homosexual acts and lesbian acts in its revision of the Sexual Offences laws with proposed penalties of imprisonment for a minimum period of two years.[26]
Lesotho	***Not criminalised*** Under Article 52 of the Penal Code Act (effective 2012), "sodomy" is not mentioned among the unlawful sexual acts. Furthermore, the Code does not have any provisions criminalising same-sex consensual relations, therefore revoking the previous common law crime of "sodomy." In this sense, Section 2(2) of the Code states, "no person shall be tried, convicted or punished for an offence other than an offence specified in this Code or in any other written law or statute in force in Lesotho."[27]
Madagascar	***Criminal for those younger than 21*** Prior to and following its independence from France in 1960, the Criminal Code (2005) has not prohibited consensual same-sex sexual acts between adults in Madagascar. However, article 331 sets the age of consent at 14 for heterosexual sexual acts and 21 for same-sex sexual acts.
Malawi	***Criminalised*** Section 153 of the Penal Code states that anyone who has had "carnal knowledge of any person against the order of nature" is guilty of a felony and is liable to face imprisonment for up to 14 years. Additionally, Section 156 criminalises "indecent practices between males," whether in public or private, imposing a penalty of imprisonment for five years and/or corporal punishment. In December 2010, the parliament passed a bill amending the Penal Code (effective in January 2011), which introduced Section 137A to criminalise "indecent practices between females," imposing a penalty of imprisonment of five years.

[22] https://africlaw.com/2021/03/05/decriminalisation-of-consensual-same-sex-acts-in-angola-and-the-progress-of-lgbti-human-rights-in-lusophone-africa/
[23] https://harvardhrj.com/2020/03/decriminalising-homosexuality-reshaping-the-landscape-in-botswana-and-a-missed-opportunity-in-kenya/
[24] https://www.hrw.org/video-photos/interactive/2020/06/22/human-rights-watch-country-profiles-sexual-orientation-and
[25] https://www.refugeelegalaidinformation.org/democratic-republic-congo-lgbti-resources
[26] ILGA World: Eddie Bruce-Jones Lucas Paoli Itaborahy, State-sponsored Homophobia: A world survey of laws prohibiting same sex activity between consenting adults (2012), 36.
[27] Southern Africa Litigation Centre, Laws and Policies Affecting Transgender Persons in Southern Africa: Lesotho (Johannesburg: SALC, 2017), 92

Country	Current status
Mauritius	***Criminalised*** The Criminal Code (1838) Article 250 (1) states that any person found guilty of "sodomy or bestiality" shall be liable to up to five years' "penal servitude." In 2007, the government introduced the Sexual Offences Bill, which would have deleted the crime of sodomy (see Section 24), and set an equal age limit of 16 years for sexual acts (Sections 11 to 14). However, parliament never passed the bill.[28] In June 2020, the Supreme Court of Mauritius authorised four young activists to challenge the constitutionality of Section 250(1) of the penal code.[29]
Mozambique	***Decriminalised*** In July 2014, the parliament approved Law 35/2014 repealing earlier criminalising provisions, namely articles 70 and 71 of the 1886 Penal Code, as modified by Law No. 177 (1912) and Executive Order-Law No. 39688 of 1954. These colonial provisions imposed penalties on people who "habitually practiced vices against nature." The revised Penal Code came into force in June 2015.
Namibia	***Criminalised*** No codified legislation in Namibia directly criminalises same-sex sexual activity; as such, lawmakers derive criminalisation from interpretations of Roman-Dutch Common Law. However, the Criminal Procedure Act 25 (2004) outlines in Article 299 the need for verifiable evidence that an accused person committed the "offence of sodomy or attempted sodomy," providing clear evidence of *de jure* criminalisation.
Seychelles	***Decriminalised*** In July 2016, an amendment to the country's Penal Code (1955) repealed Sections 151(a and c), removing them from the updated version of the provision, which criminalised "carnal knowledge of any person against the order of nature."
South Africa	***Decriminalised*** Following a case decided by the Constitutional Court of South Africa, the state abrogated laws carried through from the Penal Code of 1955 in which Article 600(1) and 601 criminalised consensual same-sex sexual conduct between adults, including the common-law crime of sodomy. Lawmakers retroactively applied the ruling to all cases of "sodomy" dating back to 1994.[30]
Tanzania	***Criminalised*** Section 154 of Tanzania's Penal Code (1998) prohibits "carnal knowledge of any person against the order of nature," with a prescribed penalty of 30 years to life imprisonment. Sections 138a and 157 also prescribe a five-year imprisonment for "gross indecency."
Zambia	***Criminalised*** Per Amendment Number 26 of 1933, Article 155 of the Penal Code states that any person who "has carnal knowledge of any person against the order of nature" has committed a felony and is liable to receive a sentence of up to 14 years in prison. Additionally, Article 178(g) of the Penal Code (1930) criminalises any act of "soliciting for immoral purposes in a public place."
Zimbabwe	***Criminalised*** Article 73 (1) of the Criminal Law (Codification and Reform) Act (Act No. 23) (2004) criminalises anal intercourse between males as well as "any act involving physical contact other than anal sexual intercourse that would be regarded by a reasonable person to be an indecent act." For these two types of conduct, the Code imposes a penalty of imprisonment for up to a year and/or a fine.

An analysis of Table 8.6 shows:

- Seven countries - Angola, Botswana, DRC, Lesotho, Mozambique, Seychelles and South Africa - have decriminalised consensual same-sex sexual acts or never criminalised them in the first place. In Madagascar, same-sex consensual sexual acts are legal for citizens older than age 21 but against the law for everyone else.
- In Mauritius, four young LGBTIQ people have taken a legal challenge to the country's Supreme Court.
- In Eswatini, lawmakers have enshrined the criminalisation of same-sex consensual sexual acts in the country's constitution.
- Consensual same-sex sexual acts remain a crime in Comoros, Eswatini, Malawi, Mauritius, Namibia, Tanzania, Zambia and Zimbabwe.

[28] National Report submitted in accordance with paragraph 5 of the Annex to Human Rights Council Resolution 16/21: Mauritius, A/HRC/WG.6/17/MUS/1, 17 July 2013, para. 17.
[29] "Code pénal: La communauté LGBT obtient l'autorisation pour une plainte constitutionnelle" Le Mauricien, 17 June 2020.
[30] Pat Reber, "South Africa Court Upholds Gay Rights" Associated Press, 9 October 1998 (as reproduced in Sodomy Laws, 11 July 2004).

There is an urgent need for these countries to embark on penal and criminal code reviews to decriminalise same-sex consensual acts. The situation in Eswatini represents an especially challenging case because the decriminalisation process will require a constitutional amendment. In the absence of enabling policy and legislative frameworks, state-sponsored homophobia and transphobia will persist.

Mauritius: Gay activists challenge criminalisation of same-sex relations at top court

Section 250 of Mauritius' Criminal Code criminalises sodomy with up to five years in prison. That may soon change after four young LGBTIQ people challenged the law in the country's Supreme Court.

The four plaintiffs, members of the Young Queer Alliance, a Mauritian LGBTIQ rights group, brought their case in 2019. They come from Hindu, Christian and Muslim backgrounds and three of them were the first public officers to come out as gay.

The Young Queer Alliance in a statement notes two of the plaintiffs have been in a committed relationship for seven years. They and the other two plaintiffs argue Section 250(1) does not have a place in a modern and democratic Mauritius.

"LGBTIQ people should benefit from the same protection afforded to other citizens such as protection from discrimination and should enjoy the same freedom of expression and right to privacy as them," says the Young Queer Alliance. "Section 250 is contrary to the values of democracy and treats LGBTIQ people as second-class citizens. There is no justifiable reason why section 250(1) should be maintained in our criminal code when it concerns two consenting adults."

LGBTQ activists march for the recognition of their rights. Photo: Anjelee Beegun, Collectif_Arc-En-Ciel

The Young Queer Alliance notes the plaintiffs have requested the Supreme Court to declare that "sexual orientation forms part of and is implied in the definition of sex as enacted under Sections 3, 3 (a) and 16 of the Constitution of Mauritius, a declaration that Section 250 of the Criminal Code Act is unconstitutional and alternatively, a declaration that Section 250 of the Criminal Code does not apply to consensual acts of sodomy performed by consensual adults."

Jean Daniel Wong of Collectif Arc-en-Ciel, an NGO that focuses on human rights issues in Mauritius, noted that case is a historic moment for the country. "This was a truly historic moment for our nation, which has always placed equality and non-discrimination at the heart of the very fabric of our society," said Wong. "Section 250 stands in stark contrast to the ideals of our Constitution. LGBTIQ rights are human rights. Who we are and who we love should never be reasons for discrimination or abuse. It is time for our country to provide us with the same legal protections and equality before the law as all citizens of Mauritius."

The Supreme Court last considered the case on 1 June 2022. If it repeals Section 250(1), Mauritius will join South Africa, Angola, Botswana and other African countries that have decriminalised consensual same-sex sexual relations.

Source: Daniel Itai, Washington Blade, 21 June 2022.

Employment

Only six SADC countries protect LGBTIQ peoples' rights to equal access to employment: Angola, Botswana, Mauritius, Mozambique, Seychelles, and South Africa. Such protection in employment represents a critical first step to ensuring inclusive workplaces for members of the LGBTIQ community. It is crucial for employers to remain vigilant in preventing discrimination against people due to their sexual orientation and/or gender identity and expression.

Around the world, LGBTIQ persons face exclusion, stigma, discrimination, violence and harassment based on their actual or perceived sexual orientation, gender identity, gender expression or sex characteristics. Documented acts of violence include attacks, targeted killings, sexual violence, threats and hate speech, perpetrated by both state and non-state actors. Such mistreatment occurs within families, on the streets, at schools, and within business and workplaces.[31]

Increasing evidence bolsters the business case for LGBTIQ inclusion

A growing body of research that presents economic arguments and a "business case" for inclusion of LGBTIQ people in workplaces and wider economic activity has proven persuasive among some policymakers.

The emergence of economic arguments for inclusion is due in part to the fact that the utilisation of human rights discourse to overcome criminalisation, discrimination, exclusion and violence against LGBTIQ people has had significant limitations in some settings. Thus, advocates have sought pragmatic approaches to make their case in a way that they hope garners the attention of policymakers.

Additionally, in some contexts, multilateral corporations provide incentives for partners that demonstrate social responsibility through enhanced engagement with historically excluded groups in their workforce, as well as among their consumers.

Researcher Lee Badgett (2014) conducted one of the first studies to attempt to cost LGBTIQ exclusion. She presented clear evidence of stigma and exclusion of LGBTIQ people in India and argued that the effects can be costly to the Indian economy. Badgett developed a conceptual model linking exclusion of LGBTIQ people with economic development through the factors of lower productivity and output because of employment discrimination and constraints on labour supply. Other factors included inefficient investment in human capital because of lower returns to education and discrimination in educational settings; lost output because of health disparities linked to exclusion; and social and health services required to address the effects of exclusion that might be better spent elsewhere.

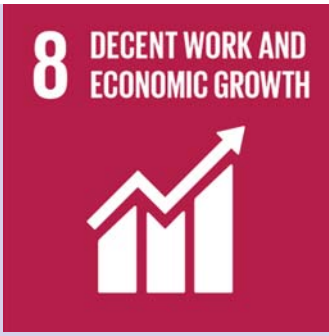
LGBTIQ people and allies campaign for human rights and justice.
Photo: National LGBT Chamber of Commerce

[31] https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_846108.pdf

Estimates using the model suggest that just the two factors of exclusion of LGBTIQ people - health disparities and workplace discrimination - could lead to a loss of 0.1% to 1.4% of India's GDP.

In their inception report making the business case for LGBTIQ inclusion for the Open for Business coalition of multinational corporations, Miller and Parker (2015) analysed the economic opportunities associated with improving LGBTIQ inclusion and found that it bolsters economic performance demonstrated by stronger growth and higher levels of entrepreneurialism at a macro-economic level.

At a corporate level, they contend that inclusion leads to superior performance and innovation, and, at the level of the individual LGBTIQ employee, leads to enhanced productivity. They also summarise what they believe to be the risks for businesses operating in countries that criminalise LGBTIQ people and have high legal levels of discrimination in society. These include threats to employee safety and security, including criminal conviction, harassment and violence; compliance concerns when business codes conflict with national law; and brand and reputational risks including negative opinions held by employees and consumers; and the possibility of activism against businesses, such as boycotts.



In response to the significant legal, social, and economic challenges of LGBTIQ people, activists and researchers increasingly push the private sector to respond to these issues by actively promoting the well-being of LGBTIQ employees and consumers. One important emerging method involves benchmarking in the form of workplace equality indices that track and promote corporate policies of diversity and inclusion.

Source: Felicity Daly, African Human Rights Policy Paper 4, Developing Evidence for LGBTIQ Inclusive Policy in Africa: A Literature Review, accessed 12 September 2022.

Violence and discrimination

LGBTIQ people are entitled to equal respect for their dignity and equal respect, protection and fulfilment of their fundamental human rights, just like everyone else. Yet widespread violations of these rights continue: killings, torture, sexual violence, criminalisation, and arbitrary detention. Harmful practices such as conversion therapy, forced sterilisation, surgery and treatment on trans and intersex people, and degrading examinations remain far too common in the region. Widespread stigma, harassment, bullying and discrimination at work, at home, in education, health, housing, sports and access to public services also persist across Southern Africa.

Tackling these issues means more than changes in laws and policies - it requires greater acceptance, support and celebration of LGBTIQ people by everyone in society, including within the family.[32]

LGBTIQ people are entitled to equal respect for their dignity and equal respect, protection and fulfilment of their fundamental human rights, just like everyone else

[32] https://www.ohchr.org/en/calls-for-input/2021/call-input-thematic-report-gender-sexual-orientation-and-gender-identity, accessed 12 September 2022.

Despair as landmark LGBTIQ billboard vandalised in Zimbabwe

Excitement at the historic placement of a billboard affirming LGBTIQ equality in the Zimbabwe city of Bulawayo in 2021 soon turned to anger and sadness when vandals targeted the inclusive message.

Local LGBTIQ rights group Gays and Lesbians of Zimbabwe (GALZ) placed their groundbreaking billboards in the country's two largest cities, Bulawayo and the capital, Harare - an unthinkable move just two years ago. The signs marked Pride Month in the region and aimed to increase public awareness of the importance of LGBTIQ human rights.

The billboards, installed in high visibility areas, shared the message: *"Munhu Munhu/Umuntu Ngumuntu [a person is a person]: Dignity, Rights and Respect for all Zimbabweans."*

The signs feature a person's open hands holding a rainbow ribbon and include the organisation's website www.galz.org. Activists associated with the organisation expressed frustration when, just days after they erected the billboard in Bulawayo, it was completely defaced with black paint.

The organisation said the vandalism "is a stark reminder of the culture of hate, intolerance and impunity which still affects sections of Zimbabwean society." The group added that the act "only reaffirms our belief that the message has been received and it further emboldens our quest to keep pushing boundaries and expressing ourselves."

The billboards represented a bold initiative in a country in which same-sex relationships remain illegal and government has historically suppressed LGBTIQ people's right to free expression.

In a statement, GALZ noted that the signs represent "strong advances in the battle for freedom of expression in Zimbabwe." It also expressed its "utter contempt [for] any persons resorting to primitive acts of violence when putting across their point of view."

Source: Robert Igual, Mambaonline, 27 October 2021.

Before and after: Criminals vandalised the LGBTIQ billboard just days after activists installed it in Bulawayo. Photo: Mambaonline

The Armed Conflict Location & Event Data Project (ACLED) is a disaggregated data collection, analysis, and crisis-mapping project. ACLED collects information on the dates, actors, locations, fatalities, and types of all reported political violence and protest events around the world. In December 2021, ACLED launched a report entitled *Political Violence Targeting LGBT+ Communities in Africa*, which covered the period October 2020 to October 2021.[33]

Figure 8.1: Political violence targeting LGBTIQ communities in Africa by sub-event type

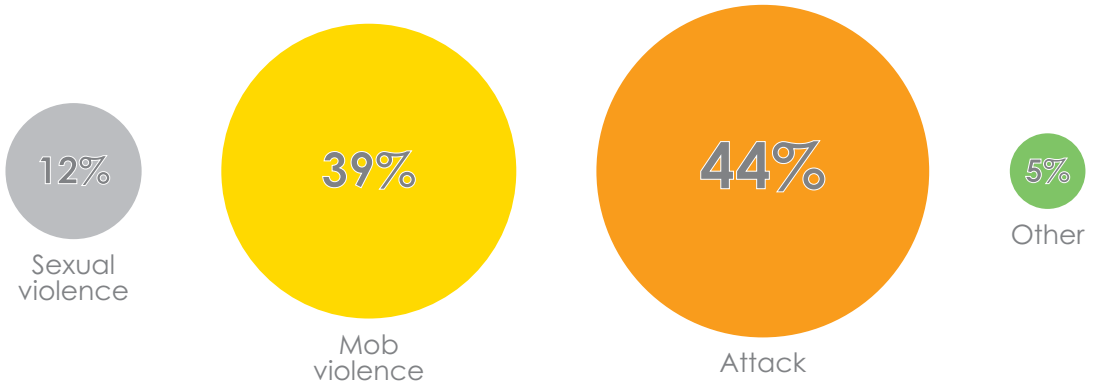


Figure 8.1 includes research from all 16 SADC countries combined with data from across the continent. It shows that violent mobs represent one of the primary perpetrators of political violence targeting LGBTIQ civilians, with mob violence accounting for more than a third of all political violence targeting this vulnerable group.

The often anonymous nature of these acts allows perpetrators to enjoy impunity for the violence. Furthermore, in countries with anti-LGBTIQ legislation, perpetrators often assume the role of vigilantes. Vigilante groups believe they deliver justice, emerging to address perceived failures in local security structures and enforce the laws, as they understand them.

Non-sexual attacks account for nearly half of all political violence targeting LGBTIQ civilians in Africa. Anonymous or unidentified armed groups carry out about half of these attacks. In some cases, both state and non-state actors have carried out attacks and raids against organisations, shelters, and clinics, as well as activists working on LGBTIQ issues.

Additionally, 12% of political violence targeting LGBTIQ civilians in Africa takes the form of sexual attacks by organised armed groups. This figure is notably high when compared to the civilian population at large, where sexual violence constitutes less than 3% of all violence targeting civilians in Africa. This suggests that this type of political violence disproportionately targets the LGBTIQ population. State forces, namely police, carry out the vast majority - more than 80% - of such violence in Africa.

Oppressive legislative environments - as well as homophobic and transphobic political rhetoric - can embolden perpetrators of political violence targeting LGBTIQ civilians. This includes mobs, state forces, or non-state armed groups. State actors, at times, exploit anti-LGBTIQ and other discriminatory legislation to justify extrajudicial acts of violence, as violent mobs take enforcement of what they believe to be the law into their own hands.[34]

These findings point to a critical and urgent need for public education and awareness, particularly around changing attitudes and behaviours towards LGBTIQ communities.

[33] https://acleddata.com/2021/12/14/political-violence-targeting-lgbt-communities-in-africa/, accessed 10 September 2022.
[34] https://acleddata.com/2021/12/14/political-violence-targeting-lgbt-communities-in-africa/, accessed 10 September 2022.

South Africa: Activists celebrate verdict in gang rape case while lamenting ongoing violence against LGBTIQ community

A South African court in 2021 found three men guilty in the gang rape of a gay man - the first time a court in the country issued a guilty verdict in a male rape case.

Austin Fritz, Rodney Beukes and Peter John Adams kidnapped a young gay man in the Western Cape's Ceres region in August 2017 and repeatedly raped him, lawyers told the Worcester Regional court.

Lawyers said it was the second time the trio had targeted the victim, who did not report the first attack.

"A young gay man, gang-raped by three straight men, and all three have been found guilty of kidnapping and rape, which is a great win for us," Sharon Cox, from LGBTIQ outreach organisation The Triangle Project, told Eyewitness News. "We've had these cases before and we've never had success with them. This is the first time that we have a guilty verdict in a gay male rape."

However, the judge could not sentence the three men, because a 2016 hate crime bill that would protect LGBTIQ South Africans remains pending. The conviction has renewed calls from LGBTIQ advocates for the government to implement the 2016 legislation, the Prevention and Combating Hate Crimes and Hate Speech Bill.

South African LGBTIQ activists also lamented government delays in passing the bill while protesting in early 2021 following the murders of four LGBTIQ people in less than a month. The

People march through the streets of Cape Town to Parliament to demand justice for the 2021 murder of Andile "Lulu" Ntuthela in the Eastern Cape. Photo: Ashraf Hendricks

brutal murders of Lonwabo Jack, Nathaniel Mbele, Andile "Lulu" Ntuthela and Sphamandla Khoza led to protests at the South African parliament in April 2021 as LGBTIQ people demanded tangible action over the rise in hate crimes.

But just two months later, in June, violence continued with the murder of two lesbians, Anele Bhengu and Lulama Mvandaba.

Such horrifying attacks claimed the lives of at least 16 LGBTIQ people in the first six months of 2021 in the country. However, the true scale of violence remains unclear as most hate crime cases go unreported, according to the Department of Justice and Constitutional Development. Fear and discrimination in the justice system mean witnesses do not always come forward.

Source: Ashraf Hendricks, Ground Up, 17 April 2021.

LGBTIQ people and the media

Mainstream media contributes to the ongoing backlash against LGBTIQ people, according to the Other Foundation's *Canaries in the Coalmine* report, which includes data from several SADC countries. The connection between the two has long been associated with Malawi, where the state arrested Tiwonge Chimbalanga and Steven Monjeza in 2009 after the Nation newspaper

portrayed their engagement party as a freak-show. The media sensationalised the subsequent trial of the two, garnering international headlines and denunciation.

Journalists have fuelled similar "moral panic" in sensationalist reporting connected to sodomy cases in Botswana, Zambia and Zimbabwe; in Eswatini around the public outing of activists; and in Zambia when several men attempted to marry their foreign male partners. While the reporting associated with these stories causes harm, some activists also see them as an opportunity to raise awareness and bring visibility to a group of people that media often ignores. These stories can prompt empathetic or supportive responses as well as criticism and further victimisation.

Increasingly, with the growth of social media across the region, activists have been tailoring their messages and sharing positive stories that target stigma and misconceptions. LGBTIQ organisations increasingly depend on social media for this awareness raising as well as to make connections with other groups across communities and borders.[35]

Malawi: Journalists learn from past mistakes that prompted attacks against LGBTIQ people

In the one-bedroom shack where she lives in the Cape Flats township of Tambo Village, Tiwonge Chimbalanga keeps a file containing press clippings.

It is close on 12 years since Chimbalanga, a transgender woman, made world headlines after Malawian police arrested her for marrying her then-partner, Steven Monjeza, in what many believe was the country's first same-sex marriage. Among the press clippings in her file, however, there is only one report from a Malawian newspaper.

On a torn black-and-white page (making it difficult to tell which publication printed it), the report speaks of how "the issue of gays has caused a lot of stress to the nation."

Chimbalanga says she refused to speak to journalists from her country and the story does not quote Chimbalanga (or "Aunty Titi," as she is affectionately known).

"Me, I did not talk to any journalists from Malawi," she says, firmly. "Only my lawyers talked to those journalists. Me, Aunty Titi, I did not speak to anyone. No."

Tiwonge Chimbalanga still keeps a file of media clippings that documented her wedding to Steven Monjeze, which led to the couple's arrest and detention.
Photo: David Harrison

Victor Chikalogwe a founding member of the Centre for the Development of People, (CEDEP), recalls: "Journalists would be there, asking her, 'So, are you a woman?'; 'Do you have a vagina as well?'; 'Who does who with your so-called husband?' And people are there, laughing. It was chaos. It was terrible. So terrible."

Journalist James Chavula says "the Chimbalanga case [took] journalists by storm... it showed us that some of us have allowed ourselves to be so biased that our newsrooms have become extensions of the religious groups that we belong to. So it really exposed us. We talk about objectivity. We talk about being balanced in our reporting. We talk about accuracy. But all

[35] https://theotherfoundation.org/wp-content/uploads/2016/10/Canaries_Summary_epub_Draft4_MJ6-2.pdf

that was shattered in the way that case was reported."

A 2019 report, *Under Wraps: A survey of public attitudes to homosexuality and gender non-conformity in Malawi*, found that 3.5% of Malawians older than 16 identify as LGBTIQ. This, the report noted, is more than double the ratio for South Africa (1.4%) and "well above the 2% rate that many countries are clustered at."

Spurred by the "horrendous" reporting on LGBTIQ issues, Chavula formed a group of journalists determined to "start debunking the myths" and addressing what he calls "our gaps."

"A few of us came together. We approached the organisations that were involved in human rights and we put forward the idea that we needed training to understand LGBTI issues to start reporting [on] them correctly, to start debunking the myths and misconceptions, and to start reporting it with a human face," Chavula says.

With assistance from CEDEP and the Centre for Human Rights and Rehabilitation, the group formed "an underground movement of journalists who want to correct these narratives." In their bid to achieve this, the group took part in a number of training sessions.

The distrust the country's LGBTIQ people have of the media may persist for a long while, but Chavula believes that "putting a face to these stories; putting a name to these stories" can do a great deal towards healing the rift - as well as fostering acceptance."

Source: Carl Collison, Daily Maverick, 31 December 2021.

Conversion therapy

"Conversion therapy" has become a common umbrella term to refer to any sustained effort to modify a person's sexual orientation, gender identity or gender expression. Originally conceived in the mid-20th century as a response to what scientists then considered a "pathology," the medical field framed and administered these approaches as "therapies." Under such a paradigm, doctors at the time understood heterosexuality and the alignment of the sex assigned at birth with the gender identity as "the biologic norm" and characterised sexual diversity as a deviation, a perversion or a mental illness that they could cure, shift or "convert" with specific "treatment."[36]

Now, LGBTIQ activists and most members of the medical field view the use of these approaches as problematic for various reasons:[37]

- Common definitions of the word "therapy" refer to any treatment "of a physical problem or an illness," or "someone with a particular illness," or a "treatment that helps someone feel better, grow stronger, etc., especially after an illness." Therefore, using this term to refer to efforts that aim to change a person's sexual orientation, gender identity or expression implies that these characteristics constitute illnesses or that there is something to "heal" or "cure" in those who are not cisgender, gender conforming or heterosexual.
- The use of the term "therapy" conveys that adherents of these approaches ground their practices on sound medical or scientific research but an extensive list of reputable medical and mental health professional associations have repudiated these practices precisely because they lack scientific support.

[36] See, generally: Eli Coleman, "Changing Approaches to the Treatment of Homosexuality: A Review", American Behavioral Scientist 25, No 4 (1982); Jack Drescher, "I'm Your Handyman: A History of Reparative Therapies" in Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives (New York: Haworth Medical Press, 2001); Tom Waidzunas, The Straight Line: How the Fringe Science of Ex-Gay Therapy Reoriented Sexuality (Minneapolis: University of Minnesota Press, 2015), 35-66.
[37] https://ilga.org/downloads/ILGA_World_Curbing_Deception_world_survey_legal_restrictions_conversion_therapy.pdf

- The wide array of practices that were (and still are) employed with the aim of modifying a person's sexual orientation or gender identity is so vast and diverse that the term "therapy" does not accurately reflect the nature of many of the practices involved. This is especially the case when practitioners employ brutal or heinous methods. In this sense, the use of the word "therapy" is clearly inadequate in cases during which a "patient"/victim faces humiliation, debasement, intimidation, abuse or even rape.
- The term "conversion" implies that people can actually be changed or "converted," whereas most serious medical practitioners question the efficacy of any of these attempts.

Mauritius and South Africa both ban conversion therapy. Conservative cultural and religious ideologies and restrictive legal environments that criminalise consensual same-sex relations legitimise these harmful practices and embolden conversion therapy practitioners. Conversion therapy takes on various forms, including exorcism, drinking herbs, rape and other forms of sexual assault, prayer, or laying of hands for healing as well as beatings and coercion into relationships, sex or marriage.[38]

"I" Story: How they tried to pray my gay away and why it is not okay

It was June 2016 when I stood scared, cold, and alone at a campsite at Wemmershoek, roughly one hour's drive from my university in Stellenbosch, considering whether it was worth living. It was well past 22:00, and inside roughly 100 students were praising a god I have come to learn hated my existence.

I was a youth councillor at a Christian camp, and hours earlier, I told a best friend - a fellow councillor - that I was gay. Her response was: "James, you know I'll never be able to condone it." Her words felt like glass piercing my skin, and I cried because all I wanted was to know that I'm okay, that I'm loved, and that I didn't have to prove my worth anymore.

I was 21, and by this time, I'd been "suffering" from homosexuality for nine years - battling every year to pray the gay away. When I was 13, a charismatic church first started trying to change my sexuality, and from that point, my shame grew every year. It became a dark cloud - a shadow - that followed me wherever I went and broke any semblance of self-confidence.

Hours were spent in prayer groups trying to get to the "root" of what might have been the "open door" that allowed the "demon" of homosexuality

to enter my life. Days were spent at "freedom weekends" where the church studied every bit of my family tree to see whether I might have had a gay uncle or aunt who might have led to me being queer.

In small groups dedicated to "recovering homosexuals," we were made to watch documentary upon documentary about how gay people can never be happy and can never have healthy relationships - a ruthless fear I carry to this day.

But Sundays at church were always the worst. Every week, like clockwork, the pastor would call upon his congregants to "repent" for their sins. I would go to the front, lying on the ground, crying - pleading with god to relieve me from my curse.

[38] https://gmhan.org/news/member-blog-conversion-therapy-remains-prevalent-in-africa-governments-must-protect-lgbtq-persons-from-this-form-of-abuse, accessed 10 September 2022.

And random strangers - always men - would, without asking, lay their hands on my back and pray that god restores my "masculinity," my "manhood," and show me his "fatherly" love.

And all I ever experienced was shame - someone not worthy to speak to the god above. I was depressed and I was afraid: I felt like a small child hiding in the corner while all the world did was point out my flaws; sin clinging like dirty oil to my skin. Would I ever be happy?

I became a captive of my sexuality, so afraid that someone would spot my homosexuality or allude to it in conversations. When I started interning at News24 at the age of 23, a colleague remarked: "But you're gay, aren't you?" I could feel my heart rate increase and tears formed in my eyes. Because, even after all those years of begging and praying, all those years of crying, and the perpetual shame, god could still not "heal" me.

And what made things worse was that no matter how much I tried to police my behaviour and act like a heterosexual man, people could still see the gay in me. I had hoped that it was a phase, something I would outgrow, but somehow I had to accept that it was something I had to live with. And that thought nearly pushed me over the edge.

In South Africa, we rarely speak about conversion therapy, even though it is still happening. At my former church in Stellenbosch alone, I know of at least 20 people who have been negatively affected by these harmful practices. And I know for a fact that it happens in many other churches like the one I attended.

I tremble to think of the many lives that have been destroyed by conversion therapy. Often, I think of the men in my "recovering homosexuality" small group, and my heart breaks over the self-hatred they experience. And I feel ashamed that I too prayed that god would "heal" them - so indoctrinated I was.

The truth is, for more than ten years, I tried to pray the gay away, and the result is someone struggling to accept their inherent self-worth and battling with bouts of depression. Someone who became petrified of dating, petrified that he would end up dying alone. And someone whose biggest desire is to have a wholesome relationship, but who has been brainwashed to think that for him it is simply unattainable.

And I've come to learn that God is not a God of shame. He will never make his children feel unworthy. Accepting my sexuality has been one of my most liberating experiences because I no longer have to apologise for being alive. I feel a freedom I could never have imagined, almost like I can breathe for the very first time. Shame is no longer a marker of my existence. And I know that one day I too will have a happy partnership and a wholesome family - something the church so badly wanted to take away from me.

Source: James De Villiers, News24, 16 June 2022.

Recognition of LGBTIQ rights

Recognising LGBTIQ human rights and enshrining them in law and policy represents an integral part of a multi-pronged process to ensure that members of the LGBTIQ community enjoy the same rights and freedoms as all other citizens. These include, amongst others, the right to marriage, adopt children, and free expression.

> ...to ensure that members of the LGBTIQ community enjoy the same rights and freedoms as all other citizens

Same sex marriages and civil unions

Only South Africa provides for same sex marriage and civil unions in its legal frameworks. All other SADC countries define marriage as a union between a woman and a man. Namibia had an opportunity to recognise same sex marriages in January 2022 but its high court ruled against it.

Namibia: Court rules it cannot recognise same-sex marriages

On 20 January 2022, Namibia's High Court ruled that it could not force government to grant legal recognition to same-sex marriages conducted outside of the country.

The couples represented in the case, both legally married in South Africa and Germany, launched the challenge against Namibia's failure to recognise same-sex marriages because the non-Namibian spouse in each partnership was unable to obtain work or residency permits.

In its decision, the court expressed sympathy with the couples' position and emphasised that discrimination based on sexual orientation is unacceptable under domestic and international law. Nevertheless, it concluded that a decades-old Supreme Court judgment binds it. That ruling found that the Immigration Control Act, which provides certain benefits to spouses of Namibian citizens, does not recognise same-sex relationships.

Linda Baumann of Namibia Diverse Women's Association, a feminist organisation, pointed to other recent court victories in Namibia and told Human Rights Watch that the ruling represents a step in the right direction because judges affirmed "the existence of LGBTI people as part of our community."

The couples will likely appeal to overturn the Supreme Court's old ruling, or lawmakers could act to change the status quo.

Source: Ryan Thoreson, Human Rights Watch, 25 January 2022.

Namibian Johann Potgieter and his South African spouse Daniel Digashu are parties in the high court case. Photo: Mambaonline

Joint adoption of children and second parent adoption of children

Preventing LGBTIQ people from adopting children violates their rights, yet South Africa is the only SADC country that allows same-sex couples to adopt children. In South Africa, a partner in a same-sex relationship can also adopt the other partner's biological or adopted child regardless of the legal status of their relationship.

Changing sex designation, name, or gender marker

The ability to change a gender marker or name represents a critical right for transgender and gender-diverse people. Experts refer to this as "legal gender recognition." In countries where people cannot change gender markers, the ability to change names represents a stopgap measure. Research conducted by ILGA suggests that, even where it is possible to change names and gender markers, the process remains inordinately difficult.

Table 8.7: Conditions under which citizens can change gender markers[39]

Country	Relevant law	Conditions	Issue
Angola	Código do Registo Civil 2015, Section 87	Although s. 78 of the Code does not allow alterations of details entered in the registration of records of the Civil Registrar, s.87 permits changes, including change of name where there is a change of facts which alter the legal identity or status of the person.	Unclear, no specific reference to trans and diverse gender identities.
Botswana	National Registration Act 26 of 1986, s.16	Section 16. Material change. (1) Where the registrar is of the opinion that any change in the particulars relating to a registered person materially affects his registration, he shall record the change and notify the Registrar of National Registration of the circumstances and recommend that the person concerned should be issued with a new identity card. […] (3) The particulars relating to the new identity card and its holder shall be recorded in the national register and the register of the area in which that person is registered.	At the discretion of the registrar not an unconditional right.
Malawi	National Registration Act 13 of 2010 (not trans specific).	Section 20(1) provides that where a change in particulars of a registered person materially affect his registration, the district registrar shall record the change and notify the Director of the circumstances and recommend that the person be issued with a new identity card. Section 21(1) provides that every registered person may, when he is satisfied that his appearance has changed so as to make it likely that his identity may be questioned, apply to the district registrar for the issue of a new card with a more recent photograph.	Unclear, no specific reference to trans and diverse gender identities.
Mozambique	Código do Registo Civil 2004	Section 85(1) gives the Civil Registrar general authority to make changes when there is a change of facts which alter the legal identity or status of the person registered.	Unclear, no specific reference to trans and diverse gender identities.
Namibia	Births, Marriages and Deaths Registration Act 81 of 1963; Identification Act 2 of 1996	The Secretary may on the recommendation of the Secretary of Health, alter in the birth register of any person who has undergone a change of sex, the description of the sex of such person and may for this purpose call for such medical reports and institute such investigations as he may deem necessary. The Act does not define "change of sex". Applications in terms of s.7B are done on a case-by-case basis- as long as a person can provide medical reports of their "change of sex". Once the application is granted, a trans person can apply for a new identity document and passport. Namibia does not provide gender affirming healthcare in the public health system, making the Act largely inaccessible. A transgender person who has not had a "change of	Comprehensive legislation, barrier in the public health system.

[39] https://ilga.org/downloads/ILGA_Trans_Legal_Mapping_Report_2017_ENG.pdf

Country	Relevant law	Conditions	Issue
		sex" could use s.12(1)(a) of the Identification Act 2 of 1996. It states that "if an identity document does not reflect correctly the particulars of the person to whom it was issued, or contains a photograph which is no longer a recognizable image of that person", the person shall hand over the identity document to the Minister. Section 12(3) states that the Minister shall cancel it and replace it with an improved identity document. The majority of trans people who have made applications to update their photographs have not been successful.	
South Africa	Alteration of Sex Status and Sex Descriptor Act, No.49 of 2003	(2) Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register. There are no directives from the National Department of Home Affairs (DHA) on how to interpret the Act, and in practice this causes arbitrary obstacles such as requiring proof of gender reassignment surgery, long waiting periods for applications to be processed (averaging 1-7 years), what forms to use and what documents and applicant must bring.	Comprehensive legislation, barrier in Home Affairs.
Zambia	National Registration Act 19 of 1964	Section 9(2): In any case where a national registration card issued to a registered person ceases in any material particular to accurately represent his identity, such person shall, without undue delay, produce his national registration card and give such particulars as shall be necessary for the issue of a new national registration card to a registrar who… shall issue to such person a new national registration card	Unclear, no specific reference to trans and diverse gender identities.
Not possible currently, or a law or policy needed in Comoros, DRC, Eswatini, Lesotho, Madagascar, Mauritius, Seychelles, Tanzania and Zimbabwe.			

Source: ILGA, 2017.

Table 8.7 lists the relevant laws and conditions applicable to changing gender markers in those SADC countries that allow it in some way. It illustrates that a variety of acts and laws provide for the change, but issues arise when transgender or gender-diverse people attempt to attain their rights under these laws.

At a practical level, the inability to change gender markers affects trans people in several ways:[40]

- Certain institutions, both private and public, may require a legal gender identity on official documents, this includes health care services;
- If a person presents themselves in a gender opposite to their gender marker, it makes it difficult to engage in everyday activities, everything from opening a bank account to applying for a job or driver's licence, to boarding a plane;
- Most countries still use a binary gender system of male and female. This also applies to visa applications, which people often need to complete in person; and
- Correctional services, also known as imprisonment/prison/incarceration or gaol. Gender markers will determine where prison officials house an individual during imprisonment.

[40] https://www.betrue2me.org/resources/be-true-2-me-guideline-legal-gender-marker-and-forename-change/

Intersex

> Though we speak of intersex as an inborn condition, intersex anatomy does not always show up at birth

Intersex is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not fit the typical definitions of female or male. For example, a person might be born appearing to be female outwardly but having mostly male-typical anatomy.

Alternatively, a person may be born with genitals that combine the typical male and female reproductive organs and sexual anatomy. For example, a girl may be born with a noticeably large clitoris, or lacking a vaginal opening; a boy may be born with a notably small penis, or with a divided scrotum that has formed more like labia. A person may also be born with mosaic genetics, so that some cells have XX chromosomes and some have XY.

Though we speak of intersex as an inborn condition, intersex anatomy does not always show up at birth. Sometimes a person does not discover their intersex anatomy until they reach puberty or find out they are infertile. Some people live and die with intersex anatomy without ever knowing.[41]

In 2013, the third International Intersex Forum issued the Malta Declaration,[42] which sets out key demands to end discrimination against intersex people and ensure the right of bodily integrity, physical autonomy, and self-determination. The demands include numerous calls for change related to healthcare, legal issues, surgery, and participation.

Zambia: Female footballer ousted from competition due to "too high" testosterone levels

Football authorities blindsided Barbra Banda, a top player on the Zambian women's team, when they found her ineligible to compete in the Women's Africa Cup of Nations in July 2022 after a "gender verification procedure" determined her testosterone levels are "too high."

Fédération internationale de Football Association (FIFA), the highest global authority in football, encourages such tests, which contradict the organisation's human rights responsibilities.

FIFA's policy states that any football association or medical officer's request for a player to undergo an involuntary "gender verification procedure," based on suspicion about her sex, is permissible.

The outdated and discriminatory FIFA policy dates back to 2011. In Banda's case, the Confederation of African Football (CAF) appears to have carried out the sex test, though a CAF spokesperson later denied this.

[41] https://isna.org/faq/what_is_intersex/
[42] https://oiieurope.org/malta-declaration/

A representative of the Football Association of Zambia said CAF conducted the test, but conceded that the national organisation must also test its players. Policies like FIFA's mean women footballers face surveillance based on gender stereotypes and bodily characteristics.

There is precedent for this harm and of athletes effectively pushing back. In 2014, the Athletics Federation of India ousted one of its women runners for having high testosterone, and banned her from competition. That athlete, Dutee Chand, took her case to the Court of Arbitration for Sport, which reinstated her and scrapped the global sex testing regulations for women runners. Unfortunately, it introduced new, narrower regulations in 2018.

Caster Semenya, the famed South African runner, is currently challenging a similar ruling at the European Court of Human Rights.

Regardless of who conducted the sex test on Banda, her medical information is now public - a clear violation of her right to privacy. To meet its international human rights responsibilities, FIFA needs to change course, adjust its policy, and stand firm on the side of current and aspiring women athletes.

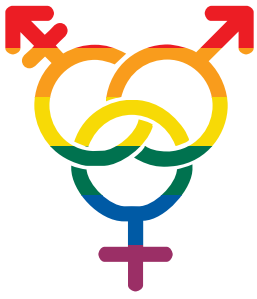
Zambia's Barbra Banda (11) celebrates after scoring a goal against China during a women's soccer match at the 2020 Summer Olympics. Photo: Andre Penner

Source: Kyle Knight and Minky Worden, Human Rights Watch, 13 July 2022.

Transgender

Transgender denotes or relates to a person whose sense of identity and gender does not correspond with their birth sex. Transgender (or trans) people use different terms and pronouns to describe themselves. It is always best to clarify these descriptors and use the language and pronoun that a person prefers.

Transgender people express their gender identities in many different ways. Some people use their dress, behaviour and mannerisms to live their lives in the way that feels right for them. Others take hormones and may have surgery to change their body so it matches their gender identity.[43]



[43] https://www.plannedparenthood.org/learn/gender-identity/transgender

Meet "The Sheriff," Lesotho's first openly trans political candidate

Sheriff Mothopeng will stand in the Lesotho election in October 2022.
Photo: Lesotho Express

Sheriff Mothopeng, a trans man, will have made history with a run for a seat in Lesotho's upcoming parliamentary election, hoping to represent the Thaba Putsoa district. The Lesotho Express called Mothopeng, the first openly trans person to run for political office in the country, "an activist that never tires." Sadly, Mothopeng lost his position in the Revolution for Prosperity (RFP) political party's list due to a legal challenge from other members in the party.

After interviewing all the potential candidates, the Party finalised it's electoral list. Members of the party who won constituencies were removed and replaced by those who performed well in the interview process. Mothopeng was one these candidates. The candidates who were removed challenged their removal citing that it was unconstitutional. Their challenge was upheld and Mothopeng was removed from the RFP.

Mothopeng, 43, is an LGBTIQ activist and archaeology professional who grew up in Maphotong Ha Elia in Roma, which then had about 30 households and has since grown to a bigger village of more than 70 households.

"Issues around human rights, service delivery and equal access to resources and opportunities and community service are very close to my heart," he told Lesotho Express, noting he has advocated for human rights for the past 14 years.

"I want to bring about a change in my time. I want to be a voice of the voiceless with influence and a change that I would like to see in my country, hence I joined politics," he says. "This is not new to me; I have dedicated my life to representing and protecting Basotho basic human rights throughout Africa and beyond.

"Lesotho, like most other African countries, is faced with a handful of economic, social and political challenges, where history has shown how HIV and other related co-morbidities have been used for self-enrichment by those in power at the expense of our people."

Mothopeng says he believes that a win in his Thaba Putsoa constituency come October would be a win for LGBTIQ inclusion in the country and recognition in the Parliament of Lesotho. He noted that he has fought stigma and discrimination, as Lesotho remains conservative, legally silent, and "less supportive" of LGBTIQ people.

These challenges have not deterred nor dampened his political quest. He said he must stand up and be counted and be the change that he wants to see in the world, hence he questions "If not us, then who will bring the change to our doorstep?"

Source: 'Marafaele Mohloboli, Lesotho Express, 12 August 2022.

LGBTQ sexual and reproductive health and rights

Every person has a right to the highest attainable standard of physical and mental health without discrimination. The right to health includes freedom to control one's health and body, including sexual and reproductive freedom, and freedom from non-consensual medical treatment and interference, as well as entitlements.

A UN human rights report found that LGBTIQ and gender diverse people face discriminatory and often violent barriers impeding their full and equal enjoyment of the right to the highest attainable standard of physical and mental health.[44]An independent UN expert identified structural drivers of exclusion in the research and gave an overview of health-related violence and discrimination.

It also highlighted sexual orientation and gender identity and their relation to the health-related commitments of the Sustainable Development Goals (SDGs), with a particular focus on SDG3 - "ensure healthy lives and promote wellbeing" - identifying obstacles and challenges to implementation, as well as good practices. As the midpoint of SDG implementation draws near, the report outlines six fundamental steps aimed at ensuring the SDGs' pledge to "leave no one behind" becomes a reality for all despite the challenges presented by the COVID-19 pandemic. It bases these on the mandate's ASPIRE guidelines: acknowledgment, support, protection, identifying and addressing indirect discrimination, representation, and evidence-based action.[45]

The ASPIRE guidelines are:

- **A**cknowledge that LGBT and gender diverse persons live everywhere. Denying the existence of LGBTIQ persons in any society is a violation of their human rights at all times, but it is particularly harmful in times of a pandemic, when understanding the different ways it impacts their lives is the key to effective and efficient responses.
- **S**upport the work of LGBTIQ civil society and human rights defenders (and learn from their significant achievements). Civil society organisations are vital to fill in the gaps left by states. They have forged a complex system of early warning, sense of community, advocacy and follow-up over the last five decades. That system is an asset of profound value for the global community.
- **P**rotect LGBTIQ persons from violence and discrimination in the pandemic context (and prosecute perpetrators). Humanitarian situations exacerbate pre-existing inequalities, putting the most vulnerable at further risk. Governments must limit measures to combat the pandemic to the protection of public health; they must not advance anti-LGBTIQ agendas.
- **I**ndirect discrimination represents a real and significant risk (and stigmatisation against LGBTIQ persons must be prevented). Indirect discrimination occurs when an otherwise neutral provision or practice puts a marginalised population at a disadvantage compared to others or disproportionally affects them.
- **R**epresentation of LGBTIQ persons in the process of design, implementation and evaluation of specific measures is essential (and it needs to be meaningful). Policymakers should not rely on intuitive thinking when designing responses that will affect the LGBTIQ community. Only the effective involvement of concerned populations will create responses with increased positive impact.
- **E**vidence and data concerning the impact of COVID-19 on LGBTIQ persons must be collected (and states must follow good practices). Disaggregation of data ensures decision makers understand how the pandemic affects different populations. States also need to ensure that victims of human rights violations perpetrated during the pandemic will have access to redress, including reparations.

[44] The UN Report to the UN Human Rights Council on the realisation of the right of persons affected by violence and discrimination based on sexual orientation and gender identity to the enjoyment of the highest attainable standard of physical and mental health, in relation to SDG3.
[45] https://www.ohchr.org/en/documents/thematic-reports/ahrc5027-report-right-enjoyment-highest-attainable-standard-physical-and

LGBTQ organisations

The ability to organise and operate freely represents a vital right for LGBTIQ organisations advocating for change. As well as organising events and promoting their rights, these groups often provide safe spaces and shelter for LGBTIQ youth to talk about their sexuality or gender identity. In countries where registration of an LGBTIQ organisation remains impossible, LGBTIQ activists often register using generic umbrella names, such as those used by women's groups or human rights groups. Inability to formally register and operate freely also impedes fundraising. LGBTIQ groups can only legally register in nine SADC countries, with seven others (Comoros, DRC, Eswatini, Madagascar, Malawi, Tanzania and Zambia) outlawing it.[46]

DRC queer rights activist forced to go into hiding

Crammed into a boat with more than 100 people, Cherie* prayed nobody would recognise her. "I wore a hat and a balaclava," the transgender woman, 33, says of her attempts to remain under the radar. A few hours earlier, shortly before midnight, she had fled her home in the eastern Democratic Republic of the Congo (DRC) after the police tried forcing her front door in the hope of arresting her.

After the six-hour boat ride to a neighbouring province, Cherie, a founding member and head of the non-profit queer rights organisation Rainbow Sunrise Mapambazuko, made her way to where she is now living in hiding.

"It all started with threatening messages and insults from the youth in our neighbourhood," she said. "I could not walk in the streets of our neighbourhood because the community did not want to see me. My presence bothered them.

"They accused me of inciting the youth of our neighbourhood to become homosexuals and that I promote homosexuality. They insulted me by saying, 'You, *pede* [faggot], we will kill you. We will burn you alive. You bewitch our neighbourhood youth to become homosexual. You are a curse. You bring bad luck. We will burn your house.'"

LGBTQ person in the DRC are subject to police attacks and imprisonment.
Photo: Jana Ašenbrennerová

Difficult as the almost daily barrage of threats was, Cherie's decision to flee her home came after facing the prospect of arrest. "This is when I called my lawyer, who went to the prosecutor's office to find out the reason for the warrant," she said. "My lawyer then asked me to leave that neighbourhood because the people there wanted me to be arrested and put in prison."

[46] Canaries in the Coal mine, 2017, accessed 1 July 2020, http://theotherfoundation.org/canaries-in-the-coal-mines/

According to the lawyer, who chose to remain anonymous, Cherie faces charges of criminal association, rape and pimping. "All these charges against Cherie were brought by young people and religious groups in her neighbourhood who consider her a public danger because of her work and her [sexual] orientation [and gender identity], which they consider contrary to Congolese morals," he said. "They want to see Cherie in prison at all costs."

The lawyer said the case against Cherie would close if "there is the financial means to pay for justice." Failing this, she faces a maximum sentence of ten to 15 years in prison "with fines that can reach $10 000."

Cherie and other queer rights activists established Rainbow Sunrise Mapambazuko in 2010. "What prompted us to create our organisation was the context of violence against LGBTIQ people in our region. We created our organisation to help people in difficulty and to promote our rights," she said.

Cherie's case is not the first time Rainbow Sunrise Mapambazuko has been targeted. In December 2012, the police surrounded the organisation's offices "in an apparent attempt to arrest the group's leader," one report noted. Although they did not succeed, Rainbow Sunrise Mapambazuko activists "would continue to be targeted."

In May the following year, police arrested the then head of the organisation on charges of promoting homosexuality. While detained, police tortured him and denied him food and water. He also said he had been "raped with sticks at least three times and beaten by inmates." Authorities released him after he paid $400. After a failed attempt to assassinate him on his return home, he fled to neighbouring Uganda and, eventually, Europe.

Cherie vowed, however, that she will continue her work as an activist once her ordeal is over. "Activism is very important to me. I really care about my fellow human beings who are victims of rights violations every day. I have made it my goal to defend their rights, our rights."

** Not her real name.*

Source: Carl Collison, New Frame, 22 September 2022.

Intersectionality

In its 2021 annual report, the ILGA World makes the case for the integration of feminist movements and youth voices in the LGBTIQ vision for an equal and just society. It states that the many intersections between these movements will strengthen each and create bigger impact through joint initiatives. Oxford Dictionary defines intersectionality as "the interconnected nature of social categorisations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage."

Uniting feminist and LGBTIQ movements[47]

The past year saw amplified attacks against gender equality and inclusivity from many angles and aggressors. These attacks often ignore one important feature of the groups they go after: LGBTIQ movements have feminist and women's organisations as consistent allies, and trans, bisexual, and lesbian women have been contributing to feminist movements since their inception.

In a ground-breaking initiative, ILGA World brought women, feminist movements, LGBTIQ groups, and trans-led organisations together to launch the Affirmation of Feminist Principles. It outlines values that the coalition sees as fundamental to the achievement of gender equality, and it amplifies the inclusive positions that feminists have long taken in relation to understanding gender, sex, and sexuality.

To date, more than 2000 individuals and human rights groups from across the world have signed on to this statement and encouraged others in their networks to do the same. Throughout the year, ILGA World also deepened its cooperation with women-led organisations and those working on sexual and reproductive health rights, and held three days of dialogue with different organisations, institutions, permanent missions and donors: uniting all to respond to gender backlash and anti-trans narratives.

Young people: the leaders of tomorrow[48]

In recognition of International Youth Day 2022, the Global Queer Youth Network, supported by ILGA World, called for intergenerational solidarity and communication in the ongoing push for an equal world for all - with particular focus on the future of the global LGBTIQ community.

They noted that, as LGBTIQ activist elders continue to progress through life, young people must increasingly listen, learn, and advocate on the issues that affect LGBTIQ communities. Similarly, the wider LGBTIQ community must listen to, meaningfully support, and advocate on behalf of, LGBTIQ young people.

Creating an equal world for all ages requires intentional intergenerational partnerships and reciprocal knowledge sharing, as recent statistics suggest increasing numbers of young people identify with, and find safe spaces within, the LGBTIQ community. Advocacy for intergenerational LGBTIQ solidarity must be sustainable, participatory, and community oriented.

The first suggestion for progress towards a future of intergenerational solidarity is to ensure meaningful participation of LGBTIQ youth voices in discussions, processes, and systems that affect their lives, now and in the future. Meaningful participation means creating avenues to access high-level advocacy spaces and ensuring these spaces recognise the intersectional needs of LGBTIQ youth. Barriers to access for LGBTIQ youth can range from financial capacity to personal safety concerns, from geographic barriers to the digital divide.

Meaningful participation in the context of the work of the Global Queer Youth Network has always meant taking a holistic and intersectional approach to accessing advocacy spaces. In practice, this has manifested as providing financial support for participation in consultations (such as The Together Conference), ensuring individuals are supported throughout their preparation and engagement in the advocacy space (such as speaking on panels with high-

[47] https://ilga.org/downloads/ILGA_World_Annual_Report_2021.pdf
[48] https://ilga.org/international-youth-day-22

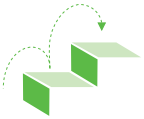
level officials), and creating in-community networks to share advocacy opportunities and resources. This multi-method support approach allows for increased participation from individuals who would otherwise have limited capacity to engage in advocacy.

Additionally, within the space of meaningful participation, it is vital to consider inputs from LGBTIQ youth advocates and activists from an intersectional understanding of age and experience. As reported by many within our network of activists, youth voices are not equally respected to those of their older peers and colleagues. The youth voice must be considered within the context of the individual's lived experience and consider this experience as expertise.

The intersectional issue of access to educational spaces and professional workplaces remain key to understanding the needs of, and developing solutions to, limited participation or meaningful input from young LGBTIQ people. Without providing clear pathways to engage in procedural, civil society, and other stakeholder spaces of power, we will continue to leave out LGBTIQ young people's voices. These pathways must consider equity for those who already exist at the margins of access to education, employment, and personal safety.

Moreover, the intensity of LGBTIQ advocacy can be emotionally, mentally, physically, and financially draining. Without appropriate support and information on how to develop healthy self-care practices, LGBTIQ youth advocates will continue to burn-out from engagement in advocacy spaces.

The elements proposed above sit at the core of the work of the Global Queer Youth Network and its Together Statement. This document links to a comprehensive and multi-issue informed consultation with LGBTIQ youth and covers five key issue areas: health, housing, education, employment, and political participation. Meaningful and sustainable consultation with, support for, and celebration of, LGBTIQ youth is vital for an equal future for all.



Next steps

- Gender activists and LGBTIQ groups should come together to create concerted, coordinated and intersectional campaigns across the region to challenge discriminatory laws and policies. These should include timelines and key deliverables, including the elimination of conversion therapy and the passage of hate crimes legislation.
- The SADC media requires diversity training to ensure that they fairly and appropriately represent the LGBTIQ community and its concerns.
- Continue to lobby and advocate for LGBTIQ sensitive policies that address workplace discrimination and violence.
- Policymakers must ensure comprehensive sexuality education, including the promotion of mutual tolerance and respect in schools, regardless of sexual orientation or gender identity.
- To level the playing field, lobby for affirmative action policies for LGBTIQ people in the labour market.
- Engage with, and support, sports associations to develop awareness-raising activities that highlight discrimination against LGBTIQ persons in sport.
- Representation is key, so policymakers, business owners and others must support greater visibility for LGBTIQ persons and issues and provide opportunities for them to participate in decision-making structures in all sectors.
- Increase data collection and research on LGBTIQ concerns across all sectors and countries; new resources will help establish baselines in key areas, thus allowing researchers and activists to understand the issues and challenges as well as track progress.

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The SADC Protocol on Gender and Development

Encompasses

commitments made in all regional, global and continental instruments for achieving gender equality.

Enhances

these instruments through a Monitoring, Evaluation and Reporting Framework.

Advances

gender equality by ensuring accountability by all SADC Member States, as well as providing a form for the sharing of best practices, peer support and review.

Southern Africa

Gender Protocol Alliance

The #VoiceandChoice 2022 Barometer, a flagship publication of the Southern Africa Gender Protocol Alliance, is being launched in October 2022 at a time when we are emerging from the dark shadow that COVID-19 cast across our region and the world.

COVID-19 posed serious challenges and disruptions to key global, regional and national systems and services. HIV prevention, testing and treatment suffered in the midst of drug stock outs owing to supply chain challenges. The lock downs brought about heightened shadow pandemics - gender based violence, sexual violence and teenage pregnancies all increased. Hundreds of thousands of teenagers fell pregnant, and have not returned of school, with reduced options for their own future as well as that of their children. Most of the recorded "teen pregnancies" are a result of rape, defilement, and abuse yet somehow, this part of the narrative is not substantively covered in reports and other data collection avenues. Even more concerning is the fact that the perpetrators are often not held accountable.

We need to do better!

Anne Githuku-Shongwe
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Joint United Nations Programme on HIV/AIDS (UNAIDS)

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